Informing the development of Tasmania’s long-term plan for mental health

A review of policy documents and related literature

Prepared for the:
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SUPPORTED BY
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Executive summary

Background
In Australia, as in other developed countries, considerable reform in mental health care has taken place in the last 50 years. These reforms have brought about changes in the way services are organised and delivered and have created opportunities and challenges in leadership and on the education, recruitment, and retention of the mental health workforce. In recognition of these opportunities and challenges and in order to drive change, national and state governments in most developed countries have produced and implemented health policies and plans that aim to meet the needs of their populations. The Tasmanian Department of Health and Human Services (DHHS), through the Mental Health, Alcohol and Drug Directorate, is developing a long-term plan for mental health (the Plan).

Aim of the review
The aim of this review is to examine and synthesise local, national and international mental health policies and related research, in order to inform the development of the Plan.

Methods
The review comprised two principal sections:

Review of mental health policies (including suicide prevention policies)
Web searches were conducted to identify the most recent, publicly available, online mental health policy documents from Australia, New Zealand, England, Scotland, Wales, Northern Ireland, the Republic of Ireland and Canada. Identifying and descriptive information from each policy document was summarised in a series of templates. Information from the summary templates was synthesised and documented in the following sections:

- Objectives and guiding principles
- Service/program components
- Specialised service types
- Sectors driving policy and relationship with other government sectors
- Populations specifically identified as having particular service delivery needs
- Monitoring and evaluation

Review of related literature
The literature review was designed to answer the following questions:

1. What does the literature tell us about the burden of disease, the prevalence of mental illness, the associated economic, health and social costs and the cost/s of inaction?

2. What evidence should the Tasmanian Government take into consideration in planning for a comprehensive, integrated and responsive mental health care system that is:
   a. multi-sectoral
   b. takes a life-course approach
   c. promotes human rights
d. reflects recent scientific evidence and/or best practice
e. empowers mental health consumers

3. What contemporary models of care does the literature suggest regarding the most appropriate service streams and clinical service priorities to ensure that we provide the best overall mental health care for all Tasmanians?

4. What are the attributes of a mental health workforce that would support the delivery of a comprehensive, integrated and responsive mental health care system?

5. What contemporary models of care will support the achievement of a mental health system that meets the National Mental Health Standards and that promotes equitable access to services in a state such as Tasmania, with its rural and dispersed population?

6. What additional evidence would influence the commissioning of services that ensure a focus on promotion, prevention and early intervention?

7. What guidance does the literature provide regarding evaluation of the mental health service system?

Results
The review revealed remarkable consistency across policy documents in terms of their objectives and guiding principles, their service scope and the types of specialised services that they identify, their emphasis on collaboration with a range of sectors that are likely to influence outcomes and recovery for people with mental illness, and their focus on populations with particular service delivery needs. The literature suggests that the broad frameworks provided by other policies are sound, and that there is evidence that particular strategies and interventions might be helpful in operationalising these frameworks.

Conclusions and recommendations
On the basis of the review, we make the following recommendations:

1. Tasmania’s new Plan should include the following themes and priority areas: whole-of-government approach; person-centred care; recovery approach; rights of consumers; carer and consumer participation; social and economic participation; enhanced access to services; coordination and continuity of care; quality of care and safety; workforce development; differences across the lifespan; recognition of diversity; research and innovation; evidence based service delivery; promotion, prevention and early intervention; and stigma reduction.

2. The scope of Tasmania’s new Plan should be in line with contemporary Australian policy documents.

3. Tasmania’s new Plan should maintain a whole-of-government approach and should have an enhanced focus on inter-sectoral collaboration.

4. Tasmania’s new Plan should have an enhanced focus on social and economic participation to encourage a recovery focused approach.

5. Tasmania’s new Plan should take a life-course approach to the provision of mental health services, and recognise early childhood and adolescence as specific areas of focus.

6. The Tasmanian Government should be aware of the implications of human rights legislation for mental health system reform.

7. People with lived experience, their families and carers, should be consulted and included in the planning and policy process.
8. Models of service delivery used in other jurisdictions but not currently used in Tasmania should be considered for future implementation in Tasmania.

9. The increasing emphasis on population prevention and promotion, early intervention and stigma reduction should be maintained in Tasmania’s new Plan.

10. The increasing emphasis on workforce development, including the development of peer support workers, should be maintained in Tasmania’s new Plan.

11. The needs of priority populations should be further considered in Tasmania’s new Plan.

12. Equitable access to services in rural populations should be enhanced in Tasmania’s new Plan.

13. Collaboration with research institutions should be further explored in the Tasmanian context in order to provide an avenue for ongoing collaborative access to evidence-based research.

14. Tasmania’s new Plan should include measurable indicators or desired outcomes in order that success or progress can be evaluated.
1 Introduction

1.1 Background

The 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB), which focused on anxiety, affective and substance use disorders, estimated that these disorders affect 20.0% of Australians aged 16-85 in any 12-month period. Data from the 2007 NSMHWB showed that 11.9% of the general Australian adult population made use of any services within a 12-month period. The 2010 Survey of High Impact Psychosis (SHIP), which focused on the less common but more severe psychotic illnesses (including schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder), estimated that these disorders affect 0.5% of Australians aged 18-64 in any 12-month period. Service use in this population was high, with 81.0% of participants using services for physical health reasons and for 95.3% using services for mental health reasons.

Data from the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) showed that mental and substance use disorders were the leading cause of non-fatal burden of disease worldwide. Mental disorders have a substantial impact on individuals, families, workplaces, society and the economy. According to the 2013 National Mental Health Report, total spending on mental health services by the major funders in Australia in 2010-11 was $6.9 billion, representing 7.7% of total government health spending. Mental disorders also have large economic impacts in other areas including out-of-pocket personal expenses, carer/family costs, lost productivity and costs to NGOs. Having a mental disorder reduces the likelihood of completing school or higher education, working full-time, working in a highly paid professional career and decreases quality of life. Moreover, mental illness may impact on personal relationships, and connection to and participation in the community.

In Australia, as in other developed countries, considerable reform in mental health care has taken place in the last 50 years. This reform has focused on the shift from institutional care to community rehabilitation and the use of services provided by non-government organisations, the recognition of mental health as having equal value to physical health, and on efforts to support person-centred recovery. These reforms have brought about changes in the way services are organised and delivered and have created opportunities and challenges in leadership and on the education, recruitment, and retention of the mental health workforce.

In recognition of these opportunities and challenges and in order to drive change, national and state governments in most developed countries have produced and implemented health policies and plans that aim to meet the needs of their populations. These policies are influenced by some common conceptual frameworks, including: the understanding of mental health and mental illness (and the role of programs and services) across a continuum from prevention through early intervention and treatment to continuing care; the importance of mental health promotion across this continuum; coordination and integration of care; inter-sectoral collaborative care; social inclusion; the recovery approach (which has been defined as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’); and consumer and carer participation in service delivery. The National Framework for Recovery-oriented Mental Health Services, which was released in 2013, aims to provide a national understanding and consistent approach to recovery-oriented mental health practice and service delivery. It complements existing professional standards and competency frameworks at a national and state level. The Framework states that recovery occurs within the context of gender, age and developmental stages as well as within a web of relations including the
individual, family and community, and is contextualised by culture, privilege or oppression, history and the social determinants of health.

Reforms to the mental health service system in Australia have occurred through the National Mental Health Strategy. The Strategy commenced in 1992 with the endorsement by Health Ministers of a National Mental Health Policy,¹⁶ and aimed to set a common course of action by governments and ensure collaboration on policy and service development issues that required a common focus. The Strategy has progressed through a series of five-year national mental health plans. The current plan, which is the fourth, has the following priority areas:¹⁷

- Social inclusion and recovery
- Prevention and early intervention
- Service access, coordination and continuity of care
- Quality improvement and innovation
- Accountability: Measuring and reporting progress

More recently, a number of whole-of-government national plans and initiatives have been produced and endorsed by Federal and state and territory First Ministers, through the Council of Australian Governments. In addition, the states and territories (other than the Northern Territory) have mental health policies, which are informed by major state and national policy and funding priorities.

### 1.2 The Tasmanian context

The Tasmanian Department of Health and Human Services (DHHS), through the Mental Health, Alcohol and Drug Directorate, is developing a new long term plan for mental health. The scope of the plan will include publicly funded clinical mental health services (including inpatient, extended treatment and forensic mental health services), community mental health care (provided primarily by the community sector), and effective coordination of linkages between these public sector, specialised clinical services and providers in primary care and the private sector.

The new plan will be informed by Tasmania’s new Mental Health Act 2013, the previous strategic plan (*Tasmanian Mental Health Services: Strategic Plan 2006-2011*), the current mental health promotion, prevention and early intervention framework (*Building the Foundations for Mental Health and Wellbeing 2009*) and the *Tasmanian Suicide Prevention Strategy 2009-2014*. It will also consider the National Health and Hospital Reforms (NHHR) and national initiatives such as Partners in Recovery (PIR), the roll out of the Early Psychosis Prevention and Intervention Centre (EPPIC) model and the National Disability Insurance Scheme (NDIS). Further, the Plan will consider the Tasmanian Government’s ‘One State, One Health System, Better Outcomes’ health reform agenda which will include the creation of a new statewide Tasmanian Health Service (THS), and the move to one primary healthcare organisation for the State.

Tasmania faces a number of challenges including the prevalence of co-occurring conditions and multiple impairments; the demands of an ageing population; and difficulties faced by those living in rural areas in accessing statewide services. The plan will also consider the social determinants of mental health, including the social gradient, stress, early life experiences, social exclusion and social support, addiction, work and unemployment.
1.3 Aim of the review

The aim of this review is to examine and synthesise local, national and international mental health policies and related research, in order to inform the development of a new long term plan for mental health for Tasmania.
2 Methods

2.1 Review of mental health policies (including suicide prevention policies)

2.1.1 Identifying policy documents

Policy is the process by which a government interprets ideas and converts them into actions. Policy is an iterative process, changing to reflect changing societal values and the rise of new ideas and concepts. We acknowledge the distinction between policies and plans outlined by the World Health Organisation, which views policies as long-ranging, visionary, organised statements of values, principles and objectives for improving the mental health of the population, and plans as more detailed sets of actions that allow for the implementation of policies by articulating strategies and activities, resources required, targets and indicators and time frames. However, for the purposes of this project, we use the terms ‘mental health policy documents’ and ‘suicide prevention policy documents’ to refer to all identified policies, plans and strategies. It should be noted that, in Australia, there is a national mental health policy which provides broad guidance to the states and territories to develop plans to implement the policy taking local circumstances into account. It would be consistent with the direction taken in other jurisdictions for Tasmania to develop a Plan that is guided by the 2008 National Mental Health Policy.

We conducted web searches to identify the most recent, publicly available, online mental health policy documents from Australia, New Zealand, England, Scotland, Wales, Northern Ireland, the Republic of Ireland and Canada. In the cases of Australia and Canada, documents were sought from each state, territory or province. The following search terms were used: ‘mental health policy’, ‘mental health strategy’ and ‘mental health plan’. These search terms were entered into Google (along with the relevant jurisdiction) or into the relevant jurisdiction’s website (typically those of the Department of Health or its equivalent). Due to lack of relevance to the Tasmanian context, we did not include policy documents from countries with very different health care systems (e.g., the United States or developing countries).

We conducted additional web searches to identify current national and state- or territory-level suicide prevention policy documents from Australia. The following search terms were used: ‘suicide prevention policy’ and ‘suicide prevention strategy’ and ‘suicide prevention plan’. Again, these search terms were entered into Google (along with the relevant jurisdiction) or into the relevant jurisdiction’s website. Suicide prevention policy documents from Australia were analysed in detail, with an emphasis on how suicide prevention policy documents intersected with mental health policy documents.

2.1.2 Extracting relevant information

We extracted identifying and descriptive information from each identified mental health policy document, and summarised it in a template. The identifying information included the full reference for the document. The descriptive information included:

- Scope
- Core elements of policy/priority areas
- Key objectives
- Sector leading policy development
• Relationship with other sectors
• Approach/guiding principles/conceptual framework
• Priority populations
• Service types/interventions/programs
• Monitoring and evaluation Indicators/data collection/benchmark/targets
• Supporting documents

For suicide prevention policy documents, not all of the above fields were relevant, so we extracted information regarding:
• Key objectives
• Approach/guiding principles/conceptual framework
• Priority populations
• Interventions/programs
• Monitoring and evaluation

Additional notes were taken, as relevant.

2.1.3 Information synthesis and analysis

In order to describe areas of commonality and difference across policy documents, information from the summary templates was synthesised and has been documented in the following sections:

• Objectives and guiding principles outlined in the policy documents: This section reports on a thematic analysis which identified common themes emerging with respect to objectives and guiding principles.

• Service/program components identified in mental health policy documents: This section describes the components identified in policy documents at a broad level. We classified these components according to a modified version of a framework we had used previously, which split them into: specialised clinical services (for general and special populations); mental health community support sector services; primary care and/or general health services; and universal mental health promotion and mental illness prevention programs. Because suicide prevention was the subject of separate policy documents in most Australian jurisdictions, suicide prevention programs were added to this list.

• Specialised service types identified in mental health policy documents: This section provides more detail about service types included in some of the key components described above.

• Sectors driving policy and relationship with other government sectors: This section evaluates the inter-sectoral relationships outlined in the policy documents, to identify: (a) the different sectors which collaborate with the mental health sector; and (b) different mechanisms and examples of collaboration. Sector relationships were categorised as ‘acknowledged’ (where the sector was mentioned but no detail was provided) or ‘detailed’ (where information about the nature and structure of the collaboration was provided). It should be noted, however, that ‘detailed’ could range from very specific inter-sectoral collaboration formalised in legislation to much less far-reaching collaboration (e.g., pilot projects and mental health training in other sectors).
• Populations specifically identified in policy documents as having particular service delivery needs: This section articulates the populations highlighted in policy documents as warranting particular attention from a service delivery perspective.

• Monitoring and evaluation identified in mental health policy documents: This section focuses on the extent to which mental health policy documents make reference to monitoring and evaluation. If the need for monitoring and evaluation was mentioned but no further information given, monitoring and evaluation was categorised as ‘mentioned without detail’. If further detail was given, this was categorised as ‘embedded (and detailed) in policy’. If the evaluation strategy was available as a separate document, this was noted (along with the title and link to the document). Where benchmarking or target setting was included in the policy documents this was noted as well as information about whether the methodology for target setting was included. The availability of evaluation reports was also noted, along with titles and link to the documents.

### 2.2 Review of related literature

The literature review was designed to answer the following questions:

• What does the literature tell us about the burden of disease, the prevalence of mental illness, the associated economic, health and social costs and the cost/s of inaction?

• What evidence should the Tasmanian Government take into consideration in planning for a comprehensive, integrated and responsive mental health care system that is:
  o multi-sectoral
  o takes a life-course approach
  o promotes human rights
  o reflects recent scientific evidence and/or best practice
  o empowers mental health consumers

• What contemporary models of care does the literature suggest regarding the most appropriate service streams and clinical service priorities to ensure that we provide the best overall mental health care for all Tasmanians?

• What are the attributes of a mental health workforce that would support the delivery of a comprehensive, integrated and responsive mental health care system?

• What contemporary models of care can you describe that will support the achievement of a mental health system that meets the National Mental Health Standards and that promotes equitable access to services in a state such as Tasmania, with its rural and dispersed population?

• What additional evidence would influence the commissioning of services that ensure a focus on promotion, prevention and early intervention?

• What guidance does the literature provide regarding evaluation of the mental health service system?

Due to time constraints, it was not possible to conduct systematic literature searches for each question given above. The literature review therefore took the form of a series of narrative reviews.
which are presented as ‘evidence summaries’. We drew on systematic reviews and/or other seminal
documents of relevance to the given question, making reference to both the academic literature and
the ‘grey’ literature in this exercise. Our longstanding experience in the mental health policy arena
meant that we were familiar with many of the relevant papers and reports (and in fact had authored
a number of them ourselves).
3 Findings from the review of policy documents

3.1 Overview of the policy documents

We identified 35 current or recent mental health policy documents from 23 jurisdictions, representing the majority of jurisdictions in the eight countries selected for consideration\(^1\). A further 11 Australian suicide prevention policy documents were identified. The first column of Table 1 lists the mental health and suicide prevention policy documents identified.

In Australia, every jurisdiction except the Northern Territory had a publicly available mental health policy document. Most of these policy documents covered identified time periods; some jurisdictions have policy documents which appear to have lapsed but we were unable to find more recent policy documents available online. The New South Wales and Tasmanian mental health policy documents are out of date, with new documents expected within the next year. The majority of international jurisdictions also had mental health policy documents, with the exceptions being Northern Ireland and several provinces in Canada (Prince Edward Island, The Yukon, and Saskatchewan). We could not locate an English language mental health policy document for the province of Quebec.

Every Australian jurisdiction had a publicly available suicide prevention policy document, although several of these are out of date (e.g., Queensland, Victoria, Western Australia and the Northern Territory). The current national suicide prevention policy document was developed in 2007.

Jurisdictions varied in the mix of mental health policy documents available. Most Australian jurisdictions had a primary policy document supplemented by documents focusing on specific areas. For example, in addition to all jurisdictions having separate suicide prevention policy documents, three states and territories (the Australian Capital Territory, Queensland and Tasmania) had a separate promotion, prevention and early intervention policy documents, and both the Australian national level and New South Wales had some form of policy document focussing on interagency collaboration (COAG National Roadmap for Mental Health Reform 2012-2022 and the New South Wales Interagency Action Plan for Better Mental Health). Western Australia had a community rehabilitation framework document, A Recovery Vision for Rehabilitation: Psychiatric Rehabilitation Policy and Strategic Framework, focused on mental health community support sector services and their interaction with clinical services. In addition, New Zealand had individual policy documents with a narrower scope, including New Zealand’s Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand, which focused on specialised clinical services for perinatal women and infants. The Australian national and Victorian jurisdictions also had suicide prevention policy documents explicitly devoted to Aboriginal and Torres Strait Island people.

The remainder of Chapter 3 describes areas of commonality and difference across the identified policy documents, under each of the following headings:

- Objectives of the policy documents
- Service components identified in mental health policy documents.
- Specialised service types identified in mental health policy documents.

\(^1\) As outlined in the Method, the terms ‘mental health policy documents’ and ‘suicide prevention policy documents’ to refer to all identified policies, plans and strategies.
• Sectors driving policy and relationship with other government sectors.
• Populations specifically identified in policy documents as having particular service delivery needs.
• Monitoring and evaluation identified in mental health policy documents.

3.2 Objectives and guiding principles outlined in the policy documents

All the reviewed policy documents made statements which could be considered objectives and guiding principles (i.e., statements that expressed a goal to be achieved, an underlying philosophy or an area in which to focus reform activities). For the purposes of the current document, we have described all of these as objectives and guiding principles, although we recognise that there are nuanced differences between them. Objectives and guiding principles varied from very general statements about improving the mental health and wellbeing of the population to much more specific statements about the direction reforms should take or the framework within which they should be undertaken. We conducted a thematic analysis of the main objectives and guiding principles outlined in the Australian mental health policy documents. However, it is acknowledged that other topics or areas may have been included in the policy documents but not necessarily identified as one of the main objectives and guiding principles. Fourteen recurring themes were identified; these are summarised in Table 1 and outlined in more detail below.
| Jurisdiction, full title of policy document and abbreviated title | PPEI | stigma reduction | recovery approach/resilience | rights of consumers/respect | carer/consumer participation | social/economic participation | access | enhance response | Coordination/continuity of care | quality of care/safety | workforce | differences across the lifespan | recognises diversity | person-centred care | research and innovation | evidence based service delivery | whole of government approach |
| **Australia** | | | | | | | | | | | | | | | | | | | |
| National Mental Health Policy 2008 \[^1\] [National Policy] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| Fourth National Mental Health Plan 2009-2014 \[^2\] [Fourth Plan] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| The Roadmap for Mental Health Reform 2012-2022 \[^3\] [COAG Roadmap] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| National Suicide Prevention Strategy (2007- ) \[^4\] [National Suicide Prevention Strategy] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| National Aboriginal and Torres Strait Islander Suicide Prevention Strategy May 2013 \[^5\] [National ATSI Suicide Prevention Strategy] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| **New South Wales** | | | | | | | | | | | | | | | | | | | |
| NSW: a new direction for mental health 2006 \[^6\] [A New Direction] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| Community strategy | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| New South Wales Interagency Plan for Better Mental Health 2008 \[^7\] [Interagency Plan] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| NSW Suicide Prevention Strategy 2010-2015 \[^8\] [Suicide Prevention Strategy] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| **Victoria** | | | | | | | | | | | | | | | | | | | |
| Because Mental Health Matters, Mental Health Reform Strategy 2009-2019 \[^9\] [Mental Health Strategy] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |
| Next Steps: Victoria’s Suicide Prevention Forward Action Plan 2006 \[^10\] [Suicide Prevention Forward Action Plan] | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + |

\[^1\] National Policy
\[^2\] Fourth Plan
\[^3\] COAG Roadmap
\[^4\] National Suicide Prevention Strategy
\[^5\] National ATSI Suicide Prevention Strategy
\[^6\] A New Direction
\[^7\] Interagency Plan
\[^8\] Suicide Prevention Strategy
\[^9\] Mental Health Strategy
\[^10\] Suicide Prevention Forward Action Plan
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<th>Jurisdiction, full title of policy document and abbreviated title</th>
<th>PPEI</th>
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<th>care/carer/consumer participation</th>
<th>social/economic participation</th>
<th>access</th>
<th>enhance response</th>
<th>Coordination/continuity of care</th>
<th>quality of care/safety</th>
<th>workforce</th>
<th>differences across the lifespan</th>
<th>recognises diversity</th>
<th>person-centred care</th>
<th>research and innovation</th>
<th>evidence based service delivery</th>
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<td>Victorian Aboriginal Suicide Prevention and Response Action Plan 2010-2015&lt;sup&gt;30&lt;/sup&gt; [Aboriginal Suicide Prevention Plan]</td>
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<td>Queensland Plan for Mental Health 2007 – 2017&lt;sup&gt;31&lt;/sup&gt; [Plan for Mental Health]</td>
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<td>Open Minds, Healthy Minds Ontario’s Comprehensive Mental Health and Addictions Strategy[^4] [Strategy]</td>
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Notes:
PPEI, Prevention, promotion and early intervention

a. Northern Ireland and the Canadian provinces of Prince Edward Island, The Yukon and Saskatchewan did not have publicly available core mental health policy documents. The Canadian province of Quebec did not have a publicly available English-language policy document.
3.2.1 Whole-of-government approach

The whole-of-government approach refers to the involvement of multiple levels of government (local, state and national) and multiple government agencies (including multi-agency organisations).

3.2.1.1 Australian mental health policy documents

The whole-of-government approach is a major focus in Australian jurisdictions. Partnerships between services and agencies and inter-sectoral collaboration have been prioritised at a national level, with National Mental Health Strategy documents identifying that the ability of the mental health sector to improve mental health and mental illness is limited by the many determinants of good mental health that fall outside the remit of mental health services.

The whole-of-government approach has also been embraced by all states and territories. In Victoria, for example, this distinguishes the current policy document from its predecessors. There is an emphasis on the need to both build capacity to address mental health problems in non-mental health sectors, and also to support and encourage mental health services to reach out to other sectors. Reforms focus on increasing support in the community for recovery and social and economic participation in sectors like justice (e.g., through pre- and post-release transitional mental health programs for prisoners) and employment (e.g., through creation of accessible training and job opportunities through partnerships with business groups). Victorian reforms also reflect an increased focus on planning and governance in the context of whole-of-government cooperation, through the establishment of two bodies to oversee and further reform through a whole-of-government approach: Mental Health Boards or Committees to sit under Health Service Boards, and a statewide Mental Health Reform Council. Mental Health Boards or Committees will bring together clinical, psychosocial and primary health services and consumer and carer representatives, for joint oversight. The Mental Health Reform Council will bring together sectors central to progressing reform, supported by non-government stakeholders (represented by Partnership Groups).

By way of a second example, New South Wales describes its whole-of-government approach at a state level through its interagency plan, a document which complements its main mental health policy document. The interagency plan operationalised whole-of-government accountability and partnership through mapping all actions in three key areas – prevention and early intervention, community support, and emergency responses – to responsible government departments. Responsibility for reviewing progress of this Plan has also been assigned outside of the mental health sector, and rests with the Human Services Chief Executive Officers Forum which reports annually to the Cabinet Committee on Human Services.

The whole-of-government approach has been identified by multiple jurisdictions, including New South Wales, Victoria and the Australian Capital Territory as a mechanism for providing initiatives aimed at holistic improvement of the mental health and wellbeing of Indigenous populations. New South Wales identifies that the complexity of needs prevalent in Aboriginal communities requires a whole-of-government response, and identifies initiatives such as partnership arrangements to increase primary health access between NSW Health, Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal mental health positions in Area Mental Health Services. Victorian policy documents reference an out-of-scope policy document, The Victorian Indigenous Affairs Framework, which focuses on improved responsiveness of services, with particular emphasis on holistic approaches beyond the mental health sector (including maternal and early childhood health and development, preventing family violence and reducing substance misuse in Indigenous communities). The Australian Capital Territory focuses on training, noting that a whole-of-
government cultural awareness training package is currently being considered by an Indigenous Taskforce, which would involve a core block of information for all services with additional department-specific information for different agencies.

3.2.1.2 International mental health policy documents

Internationally, different mental health system structures make comparisons of whole-of-government approaches difficult, however most countries acknowledge that some form of collaboration across levels of government is important. For example, England identifies existing relationships across central government departments and non-government organisations and, increasingly, on localised funding and implementation of programs across health and other sectors. Similarly, Ireland and Wales both express cross-government commitment to all sectors working together, with the Irish document identifying a pre-existing structure of high level committees and groups able to facilitate interagency cooperation, described as ‘joined-up government’.

The significance of the whole-of-government approach has been identified in the majority of the suicide prevention policy documents, both nationally and at a state and territory level. Some jurisdictions express this as an objective or principle (e.g., New South Wales, Queensland, Western Australia), whereas others mention it elsewhere. New South Wales explicitly states that ‘the Strategy was developed to provide the basis for a coordinated whole-of-government approach to suicide prevention in New South Wales’, and this is acknowledged in the title of the document.27

3.2.2 Prevention of mental illness and promotion of positive mental health and wellbeing

According to the widely adopted ‘spectrum of interventions’ population framework developed by Mrazek and Haggerty,8,65 prevention can refer to activities designed to avert or mitigate the effects of mental illness at universal (whole population), selective (at-risk populations) or indicated (high risk populations) levels. Promotion of positive mental and emotional health applies at all points of intervention along the spectrum, including in treatment and continuing care.

3.2.2.1 Australian mental health policy documents

Prevention of mental illness and promotion of positive mental health and wellbeing are listed as objectives in the core mental health policy documents from all Australian jurisdictions and the majority of international jurisdictions. Prevention and promotion are usually addressed within the main mental health policy document of the jurisdiction, but some jurisdictions have a separate document covering prevention and promotion activities.

The actions and general themes underlying promotion and prevention are similar across jurisdictions. Typical examples include Victoria, Tasmania and the Australian Capital Territory, all of which emphasise the promotion of protective factors and reduction of risk factors (e.g., mitigating the impact of social and health inequities in the development of mental illness). Prevention in other aspects of social and emotional wellbeing, including resilience training and promotion of physical activity, are also commonly mentioned. Prevention and promotion activities are often classified based on the location of their delivery (e.g., workplace and school based interventions) and/or by the specific group they target (e.g., older persons, new parents or culturally and linguistically diverse communities).
3.2.2.2 International mental health policy documents

Internationally, similar themes emerge, with several policy documents highlighting additional areas of focus. For example, England emphasises prevention of physical ill health in people with mental illness, mentioning various indicators that include smoking rates in people with mental illness and rates of presentations of self-harm at hospitals. The English Department of Health has also published a document called *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, which makes an economic argument for the scale-up of promotion and prevention activities in mental health. The desire to expand on promotion and prevention is also evident in the Irish policy documents, which includes as one of its key actions the introduction of training and education programs to develop capacity and expertise at national and local levels for evidence-based prevention and promotion strategies.

Promotion and prevention are a key strategic direction in the Canadian national policy document, which focuses on strengthening community awareness of mental health and mental illness and identifies several key populations (children and youth, working adults and seniors). The Canadian provinces also prioritised promotion and prevention, with several unique foci, including continued promotion and prevention initiatives in collaboration with First Nations, Inuit and Métis (commonly abbreviated to FNMI) populations in Alberta, prevention activities for people with co-occurring mental health and problematic substance use and/or gambling disorders and those in conflict with the law in Manitoba, and implementing prevention strategies targeting Foetal Alcohol Spectrum Disorder in British Columbia.

3.2.2.3 Australian suicide prevention policy documents

Like the broader area of mental health promotion and mental illness prevention, suicide prevention activities are regarded as spanning the spectrum of interventions. Prevention of suicide is viewed as a priority across the board, and activities in this area tend to be related to fostering protective factors like mental health and resilience and mitigating the effect of factors that predispose people to risk. With the exception of Queensland’s and Victoria’s suicide prevention policy documents which pre-date the National Suicide Prevention Strategy, all Australian jurisdictions are aligned with the LIFE Framework which forms the basis for the National Suicide Prevention Strategy.

3.2.3 Stigma reduction

3.2.3.1 Australian mental health policy documents

Australian national mental health policy documents identify stigma reduction as important, with the *Fourth National Mental Health Plan* identifying a sustained and comprehensive national stigma reduction strategy as a key action. Stigma reduction is also given as a reason (and desired outcome) of mainstreaming mental health into the wider health sector in national documents.

Stigma reduction is specifically outlined as an objective in the policy documents of only two states and territories, South Australia and the Australian Capital Territory. However, it is noted throughout the policy documents in many jurisdictions where it is not identified as an objective, often mentioned in conjunction with prevention activities. Stigma reduction is often seen as a means of improving social inclusion for people with mental illness (see, for example, the policy documents from New South Wales and Tasmania), and is identified as a reason for their poor rates of physical health and high rates of premature mortality. With only one exception (South Australia), policy documents do not take the argument to the next stage and explicitly frame stigma reduction (and associated improvements in social inclusion and physical health) as a human right.
A range of specific actions have been proposed to combat stigma. For example, Victoria, Queensland, Western Australia and South Australia all make mention of training initiatives for the mental health and non-mental health workforces and media campaigns for the wider community. Tasmania identifies consumer and carer delivery of anti-stigma programs as a method of reducing stigma towards mental illness in the workforce, and Victoria aims to encourage and train workforces to employ people with mental health problems.  

Certain populations are consistently identified as requiring attention, particularly because stigma was likely to be seen as negatively affecting service utilisation. By way of example, culturally and linguistically diverse communities are mentioned by New South Wales, Queensland, Western Australia and Tasmania, asylum seeker and refugee communities are given prominence by Victoria, and drought-affected farmers are noted by Tasmania. Tasmania also acknowledges that LGBTI populations may experience high rates of social exclusion, discrimination, isolation and other social prejudices because of their sexual or gender identity. This may result in poorer mental health outcomes, an increased risk of mental illness, may contribute to low levels of service utilisation.

**3.2.3.2 International mental health policy documents**

Internationally, the emphasis on stigma is similar to that in Australia. There is wide recognition of the stigma associated with mental illness and its consequences, and focus on particular groups (e.g., FNMI, immigrant populations and older people are acknowledged by the Canadian provinces of Manitoba, New Brunswick and Newfoundland). Interventions to address stigma have been highlighted in the policy documents of various countries, most notably the well-established and internationally recognised anti-stigma campaign ‘Like Minds, Like Mine’ which is referenced by New Zealand. British Columbia has an additional, noteworthy emphasis on the potentially stigmatising nature of language, calling on the reshaping of language surrounding the mental health system (for example, referring to people with mental health problems as service users) as a way of reducing stigma. Ireland additionally outlines several actions to combat stigma, organised under the categories of ‘Contact Actions’ (initiatives to increase contact with people with mental health problems), ‘Education Actions’ (education and awareness-raising activities), and, in a significant departure to the terminology embedded in Australian policy documents, ‘Challenge Actions’ (which include the possibility of taking legal action in cases of discrimination).

**3.2.4 Intervening early**

**3.2.4.1 Australian mental health policy documents**

Early intervention, both in early childhood and at times of vulnerability to emerging mental illness across the lifespan, is an objective in the policy documents of Australian jurisdictions. In the Australian documents, early intervention is operationalised as the delivery of services that are appropriate and accessible, and the provision of training for the mental health and non-mental health workforces to recognise the signs of emerging mental illness.

Early intervention is an area where whole-of-government coordination and inter-sectoral partnerships are important, as it is necessary to build and maintain relationships with individuals and organisations that come into contact with people who may be at heightened risk of mental illness. Examples include the early childhood centres, community groups, local government agencies and workplaces, as well as a range of networks at local and regional levels and beyond. Several policy documents give examples of the non-traditional settings that are relevant to early intervention. For example, Victoria mentions the importance of sporting clubs and general health services (citing the
Families at Work program, where anger management and social skills groups are run by nursing, occupational therapy and speech pathology staff), and the Australian Capital Territory discusses the role of the community support sector in supporting young carers.

### 3.2.4.2 International mental health policy documents

Early intervention is also an objective or guiding principle in the policy documents of the majority of international jurisdictions. An example is provided at a national level by Canada, which highlights the need to train families and the community more broadly in mental health awareness.

### 3.2.5 Different approaches across the lifespan

#### 3.2.5.1 Australian mental health policy documents

In Australia, the National Mental Health Strategy documents and the policy documents from Victoria and the Australian Capital Territory explicitly identify the need to take a lifespan approach to mental health care, and documents from other jurisdictions implied this in some way. The National Mental Health Strategy emphasises that care cannot be delivered in a ‘one size fits all’ model across the lifespan, as the prevalence of mental illness is highest in early adulthood, and because the family plays a different role in a person’s life, with different levels of involvement and support, at different ages (e.g., in infant and child health and in the care for older people). Victoria categorises its reform areas by age, and the Australian Capital Territory conforms closely to the guiding principle of taking different approaches at different stages in the lifespan.

#### 3.2.5.2 International mental health policy documents

Internationally, Wales and New Zealand both recognise the need for age-appropriate responses to access and service delivery in their guiding principles, and commit to a health service that is inclusive across the lifespan. The national Canadian policy document, and the policy documents from Alberta, also commit to promotion of mental health across the lifespan as an objective, focusing on certain age-specific environments (e.g., schools, workplaces) while also committing to equitable service delivery regardless of age.

#### 3.2.5.3 Australian suicide prevention policy documents

Australian suicide prevention policy documents also recognise the lifespan approach, with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy doing this directly and the remainder doing so indirectly.

### 3.2.6 A focus on recovery

#### 3.2.6.1 Australian mental health policy documents

Recovery is a major component of the spectrum of interventions, and objectives or guiding principles addressing the recovery paradigm appear in policy documents from all Australian jurisdictions, although they vary in their level of detail.

Several jurisdictions provide definitions of recovery which stress that recovery is not synonymous with cure, as many people will continue to have recurring or persistent symptoms of mental illness, and that recovery instead represents ‘a personal journey toward a new and valued sense of identity, role and purpose together with an understanding and accepting of mental illness with its attendant
Psychiatric rehabilitation services are generally considered to be recovery-oriented services; however a recovery orientation can and should be embedded into clinical services.

Jurisdictions identify the need to work within a framework or action plan that delivers services that view recovery as both a ‘process and as an outcome’, noting that this may require a significant cultural and philosophical shift in mental health service delivery, as recovery approaches have mainly been delivered and advocated for by non-government service providers. By way of example, the ACT Mental Health Services Plan 2009-2014 identifies a pre-existing framework (Pathways of Recovery: 4As Framework for Preventing Further Episodes of Mental Illness, published by the Australian Government in 2005) upon which their recovery services and models will be built.

Elements necessary to meet community needs for recovery include: involvement of consumers, carers, families and the community; workforce development (including expanded roles for recovery and peer support workers); increased access to community-based recovery services (e.g., alternatives to inpatient care such as intensive in-home treatment and support for older people); a whole-of-government approach that improves access to services from other sectors (e.g., supported housing and accommodation).

Some jurisdictions provide additional detail beyond their objectives or guiding principles, including outlining financial commitments. For example, the NSW Community Mental Health Strategy identifies that a proportion of the $41.5 million earmarked for community rehabilitation services will be directed to the introduction of Recovery and Resource Services to increase the capacity of non-government organisations to provide quality social and leisure opportunities for people with a mental illness, based on best practices.

Some jurisdictions also identify specific indicators or targets that they are working towards and/or note specific outcomes that they are intending to achieve. For example, Victoria had, at the time of writing its policy document, established 68 step up/step down prevention and recovery care (PARC) beds to provide intensive short treatment options for consumers recovering from an acute episode, or to prevent avoidable admission to an acute inpatient facility. Victoria’s key policy document commits to providing an additional 70 PARC beds. Similarly, Queensland includes a key indicator for residential recovery programs (15 places per 100,000 population for residential recovery programs). The Australian Capital Territory attaches outcomes or targets to actions (e.g., ‘90% of clinically managed mental health consumers have completed a relapse prevention plan as part of their recovery plan).

### 3.2.6.2 International mental health policy documents

Internationally, around half of all jurisdictions considered in the current analysis include the recovery approach in their policies’ objectives or guiding principles. Key examples come from New Zealand and Ireland. New Zealand provides substantial detail on their interpretation of the recovery approach, which is defined as living well in the community with natural supports, while also acknowledging that for many older people, especially those with progressive disorders, concepts such as ‘quality of life’ and ‘dignity’ may be more relevant than recovery. New Zealand places considerable emphasis on developing a mental health system structure that would help support recovery, focussing on consumer independence as a goal (rather than encouraging long term dependency on support services). To achieve this, policy documents outline the need for whole-of-government approach to examine how services are delivered, and to create a stepped care model that promotes recovery, including investment in programs (such as housing and employment) that actively support return to natural community supports. New Zealand identifies a clear role for processes such as case management in this new model. New Zealand policy documents also
Ireland argues that ‘recovery should be adopted as a cornerstone’ of the policy, stating that ‘a recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user’s particular needs, goals and potential and should address community factors that may impede or support recovery’. Targets for rehabilitation and recovery services are also included (e.g., one service user-provided support centre/social club per 100,000 [population]).

Even in international jurisdictions where recovery is not explicitly included as an objective or guiding principle, policy documents make some reference to the concept. For example, Scotland operationalises the recovery framework throughout, including in a commitment to work with the Scottish Recovery Network, a national body established with the purpose of taking the recovery model forward, and in the recommendation to use the Scottish Recovery Indicator as an approach to refocus services on a wider range of outcome and objectives in the mental health system.

3.2.6.3 Australian suicide prevention policy documents

Australian suicide prevention policies tend to focus on the concept of ‘resilience’ rather than recovery. Resilience is the ability to cope with stress and traumatic events and to adapt to life changes/difficulties and respond positively to difficult situations; coping involves seeking support from friends and family and utilising other coping strategies and problem-solving skills to effectively deal with difficulties. The main national suicide prevention policy documents and those from Western Australia, South Australia, the Australian Capital Territory and the Northern Territory all emphasise resilience, as do the national and Victorian Aboriginal and Torres Strait Islander suicide prevention policy documents. Resilience is also documented as an action area or outcome of the suicide prevention policy documents.

3.2.7 Increased social and economic participation

Increased social and economic participation usually encompasses stable housing and education, training and employment opportunities for people with mental illness. Some of the activities related to increasing social inclusion are delivered within the mental health sector (e.g., targeted efforts to reduce stigma and increase community awareness), but many are the primary responsibility of sectors outside mental health (e.g., the housing sector, the employment sector). For this reason, social and economic participation is closely linked to a whole-of-government approach. It is also connected to recovery.

3.2.7.1 Australian mental health policy documents

Social and economic participation (or related concepts like social inclusion and community building) are identified as an objective or guiding principle at a national level and by individual states and territories. South Australia provides a prime example; social inclusion and community building are major foci of this document which builds on the strategic reforms and developments outlined in an earlier document written by the South Australian Social Inclusion Board. South Australia’s social inclusion and community building agendas aim to create environments that support positive mental health, by strengthening community resilience and addressing risk factors such as unemployment, homelessness and family violence. South Australia also identified the importance of a collective effort from all sectors to promote social inclusion.
3.2.7.2 International mental health policy documents

Internationally, there are similar trends in the discussion surrounding participation and inclusion. For example, the Canadian national documents identify full participation in work, education and community life through the provision of the right combination of services, treatments and supports as key to recovery. They also stress the role schools, workplaces and other community settings can play in full social and economic participation. Similarly, as part of its evaluation of mental health outcomes, England aims to develop an equivalent to ‘economic participation’ for children, which extends existing indicators on school attendance to consider participation and achievement outcomes.

3.2.7.3 Australian suicide prevention policy documents

South Australia’s suicide prevention policy documents mentions social inclusion as an objective, the only Australian suicide prevention policy document to do so.

3.2.8 Person-centred and individualised approaches, with recognition of diversity and cultural appropriateness

Person-centred and individualised approaches acknowledge that each individual may have different goals and aims for treatment. They also acknowledge the fundamental differences that individuals and cultural groups may have in their understanding of and approach to mental health and mental illness.

3.2.8.1 Australian mental health policy documents

Person-centred approaches are outlined in the vision or conceptual approaches of several domestic jurisdictions, including at the Australian national level (in the COAG Roadmap on National Mental Health Reform 2012-2022) and by Victoria and South Australia (the latter of which identifies that the unique nature of every individual’s physical, social, emotional, cultural and spiritual dimension and the need to receive respectful, culturally appropriate and individually tailored care). Western Australia and Tasmania also identify the need for person-centred supports and services in both clinical and rehabilitation services, and both identify strategies to achieve this (e.g., the formal adoption of person-centred approaches by mental health services and the training and development of mental health workers in person-centred care in the case of Western Australia, and inclusion of consumers, carers and partners in the development of services in the case of Tasmania).

3.2.8.2 International mental health policy documents

Internationally, New Zealand has identified the need for a conceptual framework based on the principles of person-centred and person-directed approaches, viewing these as core values underpinning resilience and recovery in the BluePrint II document. Canada and the United Kingdom also recognise the need for person-centred services, with, for example, New Brunswick identifying ‘Government will better align and integrate its efforts to provide seamless service by placing the person living with mental illness at the centre of treatment and care’ as a goal, and the Scottish policy documents stating that ‘Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions’.

In Australia, New Zealand and Canada there are examples of policy documents focusing on a holistic, person-centred approach to the health and wellbeing of Indigenous populations. These documents
flag a collaborative, consultative approach to introducing new services that recognises diversity and cultural appropriateness.

3.2.8.3 Australian suicide prevention policy documents

Australian suicide prevention policy documents tend not to explicitly use the term ‘person-centred’ care in descriptions of their objectives or guiding principles. However, national policy documents and the policy documents from Queensland, Victoria, Western Australia, South Australia and the Northern Territory all make reference to diversity and/or culturally sensitive approaches.

3.2.9 Respect for the rights of consumers

3.2.9.1 Australian mental health policy documents

The national Australian policy documents emphasise the rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected, in line with national and international agreements and international jurisdictions. Additionally, the national Aboriginal and Torres Strait Islander Suicide Prevention Plan declares that it is ‘based on respect and recognition for Aboriginal and Torres Strait Islander communities, culture and history’. At a state and territory level, respect for the rights of consumers is specifically identified as an objective or guiding principle only in the policy documents from South Australia and Western Australia, but a range of objectives on consumer participation, person-centred approaches and social inclusion and participation are premised on an acknowledgement of consumer rights.

3.2.9.2 International mental health policy documents

The picture with respect to international policy documents is similar. Some make direct reference to consumer rights as an objective or guiding principle, and others make less direct reference to consumer rights in the context of other policy directions. Scotland and Canada provide examples of the former. Scotland makes a commitment to working with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental health care. Canada identifies alignment with the United Nations Convention on the Rights of Persons with Disabilities as a key objective and emphasises that the rights of First Nations, Inuit, and Métis should be prioritised.

3.2.10 Improved access and responsiveness

Access to the right services and information can be impeded by structural factors, such as lack of appropriate services (e.g., due to location or to a mismatch with complexity of need). It can also be the result of other barriers, such as stigma and discrimination, cultural and language barriers or lack of awareness of available services.

3.2.10.1 Australian mental health policy documents

Many Australian jurisdictions identify access as an objective or guiding principle, and several make reference to actions to increase access. Australia’s Fourth National Mental Health Plan identifies ‘Access to the right care at the right time’ as an objective, emphasising that people with mental illness should have ‘... timely access to high quality, coordinated care appropriate to their condition and circumstances, provided by the most appropriate services.’ National policy documents also acknowledge that lack of access leads to significant delays between symptom onset and treatment, which can lead to worsening of symptoms and long-term negative consequences. They provide a
range of high level suggestions for improving access, including governments and service providers working together to establish organisational arrangements, integrated approaches in the community support sector for hard-to-reach populations (e.g., people at risk of homelessness) to access supports and clinical services, and expansion of existing models of more accessible services for certain populations (e.g., integrated services for young people) and funding of new ones. National documents also note that increased emphasis on a no ‘wrong door’ for people with early signs of mental illness would also improve access and treatment rates. They also suggest some more specific actions for improving access, although these are also fairly high level. These include supporting people to access natural supports (e.g., family and self-help groups) and providing online information and consultation services. Improving access is also linked to a trained and well distributed workforce, including peer support and childcare and education providers.

At a state and territory level, several jurisdictions identify key objectives or guiding principles related to streamlining or expanding access (e.g., Victoria and Queensland). Of the jurisdictions that do not specifically identify access as an objective, most refer to initiatives to improve access throughout their documents. For example, Western Australia identifies the need for close ties with universal services, stating that the integration of mental health services into primary health care as a ‘good investment’ in terms of increasing access, and identifies the importance of rolling out early intervention services such as telephone helplines and telepsychiatry to increase access, especially in rural and remote regions.

Removing barriers to access for key population groups (e.g., Indigenous and culturally and linguistically diverse communities) is also seen as a priority in many local policy documents. For example, Western Australia and the Australian Capital Territory emphasise the importance of doing this, offering suggestions for improving the responsiveness of mainstream services (e.g., through additional support, training and other initiatives) and for developing separate, population-specific services (e.g., services targeted towards children of parents with a mental illness). New South Wales and Queensland single out those involved with the justice system as a particular group for whom access is problematic, and reinforce the notion that ongoing collaboration between the mental health and justice sectors is crucial. Several jurisdictions also identify young people as a target group, and some (e.g., New South Wales) make suggestions about what services would be required to improve access (e.g., holistic, non-stigmatising centres that offer specialist advice and support within and outside normal office hours and are co-located with services that address more general health issues).

Some jurisdictions note that access to non-mental health services is also important for improving mental health outcomes. For example, Victoria and Western Australia highlight access to general health services and access to child care for families at risk. Western Australia notes that access to more flexible funding and self-directed services would allow greater choice and autonomy for individuals, families and carers.

There is a general consensus across a number of jurisdictions (e.g., Victoria, Western Australia and South Australia) that providing access to the ‘right mix’ of public, private and community support services is important. This may include increased access to newer models of care (e.g., residential high dependency units, intensive in-home treatment and support for older people with severe mental illness), ‘intermediate’ or sub-acute care in non-hospital settings, and prevention and recovery care services, as well as non-clinical services (e.g., individually tailored packages of psychosocial outreach support linked to a range of secure and affordable long-term housing options). New South Wales focuses on ensuring a mix of community-based access points into services too, suggesting traditional entry points (e.g., general practitioners, hospital emergency
departments and community health centres) might be complemented by telephone intake and triage services, police and other government agencies, and non-government organisations.

Other investments in improving access through new modes of communication identified by the Australian Capital Territory include a planned National Health Call Centre Network will result in around the clock access to information and advice on mental health and other health issues regardless of geographical location. Electronic health records and other digitalisation of health records should also increase access and continuity of care. The Australian Capital Territory has identified the goal of establishing an Access and Information service, which would create linkages across the whole health network and would be capable of informing the community about available mental health and non-mental health services and linking them to the most appropriate one. Queensland has also committed funding to establish an Access and Information service (known as the Consumer Integrated Mental Health Application), which will enhance access to clinical and service information needed to support service delivery and evaluation.

Some jurisdictions have given consideration to improving access in rural and remote areas. New South Wales, for example, offers a detailed strategy, based on the Rural Mental Health Emergency and Critical Care Access Plan, to guide improvements in emergency and acute care responses in these areas, with actions including development and implementation of telepsychiatry models (e.g., the Child and Adolescent Psychological Telehealth Outreach Service), among others.

### 3.2.10.2 International mental health policy documents

As in Australia, the need for consistent and equitable access to high quality services is also a key theme internationally. The international documents emphasise a range of issues to be addressed that are associated with access. One of these is the balance between centralisation and localisation of service delivery, and the impact that this has on access. England has produced a policy document dedicated to improving the effectiveness and accessibility of services, which includes recommendations about supporting local-level control of mental health services while also reducing waiting times and access. New Zealand identifies a need to shift focus from ‘accessing services’ to ‘responding in ways that make a difference in people’s lives’ and, like England, tries to balance the drivers of more centralised delivery (e.g., economies of scale and consistency of services) with the drivers of more local delivery (e.g., ease of access).

Another aspect of access that is raised in international documents relates to the integration between different parts of the mental health care system and between the mental health care system and the general health care system. Canada emphasises the importance of timely access to physical health care for people with mental health problems, arguing that if care is conceptualised as tiers, people should be able to access care across all tiers rather than be restricted within one tier. In a similar vein, Ireland identifies the need to clarify access arrangements between different levels of care and improve integration between services.

Several international policy documents also focus on the affordability of services. For example, Canada argues that there should be no barriers to access to excellent care and medications for families who cannot afford to pay for private health care or medication expenses. Ireland and England both echo this sentiment, and stress the need for advocates to represent consumers and to ensure that factors like income inadequacy do not affect access to care.

Some international policy documents also consider non-traditional methods of access. The province of British Columbia, for instance, has explored the use of telehealth and electronic communicator software as a means of improving access and increasing satisfaction levels amongst consumers.
British Columbia has also experimented with ways to deliver more accessible addiction services through outreach programs in homes, schools, jails and on the street.

Monitoring levels of access against relevant indicators has also been given priority in some international policy documents. For example, England articulates indicators against which levels of access can be measured (e.g., numbers of people receiving services in a 12-month period, numbers of people seeking help who did not receive services in a 12-month period).

3.2.10.3 Australian suicide prevention policy documents

Four Australian jurisdictions identify access as an objective or guiding principle in their suicide prevention policy documents, namely Victoria (in its Aboriginal and Torres Strait Islander Suicide Prevention Plan), Queensland, Western Australia and the Australian Capital Territory. The majority of other Australian jurisdictions make mention of access to appropriate services elsewhere in their suicide prevention policy documents, but do not elevate it to the level of an objective or a guiding principle.

3.2.11 Coordination and integration of services

3.2.11.1 Australian mental health policy documents

The majority of Australian jurisdictions identify some form of coordination and/or integration of services in their objectives or guiding principles in their core mental health. A small number (e.g., Victoria and Tasmania) mention integration and coordination as processes to achieve better mental health outcomes at other points in their documents. Collaboration within and across sectors is seen as being a way of providing a more coordinated approach to care and likely to promote recovery. Within the mental health sector, coordination and integration of services is encapsulated in models like the stepped care approach. Across sectors, they are viewed as being promoted by facilities like shared information systems.

3.2.11.2 International mental health policy documents

Internationally there is considerable emphasis on coordination and integration too. In Canada, for example, certain provinces outline strategies for coordination. In Newfoundland, these strategies include the establishment of Regional Interdisciplinary Teams in each of the four health regions to provide the critical connections among the various components and levels of the mental health system. Beyond the mental health system, Newfoundland has also strengthened partnerships with mental health and addictions organisations nationally and locally to provide pathways to care for consumers. Ontario’s policy documents also outline several examples of integrated models, including one which manages access to mental health and addictions supportive housing units, provided by 29 organisations in Toronto through a common application form and single wait list. Intensive Case Management and Assertive Community Treatment Team providers in Toronto operate under a model that will eventually incorporate all Greater Toronto Area providers into one coordinated access point, which will provide information, telephone screening, make referrals for crisis, meet short- and long-term service needs, and offer access to peer and transitional supports.
3.2.12 Consumer and carer participation in the mental health system

3.2.12.1 Australian mental health policy documents

Consumer and carer participation in the mental health system is identified as an objective in documents relating to the National Mental Health Strategy. Respect and support for consumers and carers is highlighted in the National Mental Health Policy and the COAG National Action Plan, and consumer feedback on the mental health system is prioritised, with planned reporting against agreed standards of care including the consumer and carer experience.\(^67\)

National policy documents identify the need to strengthen awareness regarding the range of services available, and to increase consumers’ and carers’ choices regarding the most appropriate services and supports. Individualised funding mechanisms, including the National Disability Insurance Scheme (NDIS), may play a role in these choices, and these are also outlined in national policy documents. National policy documents also aim to increase the involvement of Aboriginal and Torres Strait Islander people and their families in the development and implementation of culturally appropriate services.\(^22\)

Greater support for consumers and carers to be part of the service delivery system is also a theme in national documents, and indicators include the ‘Proportion of total mental health workforce accounted for by consumer and carer workers’.\(^22\) Encouragement and support should be provided to consumer and carer workers in maintaining their physical and mental health and planning ahead for financial, lifestyle and treatment decisions during periods in which they are unwell.\(^22\)

At a state and territory level, a number of policy documents emphasise strengthening consumer and carer participation in care decisions and in service planning and delivery. Jurisdictions like Queensland and the Australian Capital Territory stress the importance of consumer and carer led and directed services, and note that it is important to capitalise on existing consumer and carer expertise and to recognise that the priorities of consumers and carers may not be the same as those of service providers. Western Australia stresses the need to gain consent from the consumer to involve families and carers in policy, planning and service delivery and the rehabilitation and the recovery journey.

Various policy documents mention specific state-level initiatives aimed at increasing formal participation, including involving consumers and carers in formal governance arrangements. The Australian Capital Territory commits to establishing an inter-sectoral process to oversee the design, implementation and monitoring of mental health system reform, and propose that consumers and carers should have a place at the decision-making table.

Formalised employment opportunities for consumers and carers in mental health non-government organisations are outlined by New South Wales. A role for paid consumer and carer consultants in relevant services is also identified by Tasmania, in the context of stigma reduction initiatives.

The potential creation of formalised links between consumers and carers and research and training institutes are also identified. For example, Victoria flags the creation of an Institute for Mental Health Workforce Development and Innovation (including the development of a collaborative Centre of Excellence for Consumers and Carers) as a possible initiative to explore, and Western Australia’s documents mention the development of a Psychiatric Rehabilitation Consortium focused on psychiatric research and education. Both would include consumers and carers, and academics, service providers, practitioners and other relevant parties.
Some jurisdictions also identify policies for consumer and carer participation. The Australian Capital Territory published a policy document outlining mechanisms for consumer and carer participation in 2007 (Consumer Participation and Carer Participation across Mental Health ACT) and Queensland flagged the development of a Queensland Government Consumer, Family and Carer Participation Policy. Tasmania gives emphasis to costing and implementing a Consumer and Carer Participation Framework. All three recognise the benefits of consumer and carer participation in governance and service delivery, both in mental health services and community sector organisations.

3.2.12.2 International mental health policy documents

Consumer and carer participation is also commonly acknowledged in international policy documents although it is often the case that not much additional detail is provided about strategies to build capacity in this area. Examples of specific actions outlined to improve consumer and carer participation exist in the Irish policy documents, which suggest that the adult education system should offer appropriate and supported access to training for consumers and carers that would equip them to represent themselves and others. Ireland also encourages consumers and carers to give feedback (and service providers to offer them opportunities to do so) on their experiences, and to influence developments within these services. England’s policy documents include indicators on enhancing health-related quality of life for carers and treating carers as equal partners (measured by the proportion of carers who report they have been included or consulted in discussions about the person they care for). England also describes formal mechanisms for participation that include the use of advisory groups that include consumer and carer representation (e.g., the Ministry Advisory Group on Mental Health Strategy, which advises on service improvement).

3.2.13 Workforce development

3.2.13.1 Australian mental health policy documents

Workforce development is identified as an objective or guiding principle in the policy documents of the majority of Australian jurisdictions, and the issues surrounding the mental health workforce are additionally identified as important within the text of all policy documents.

Planning for the expansion and distribution of workforce is a concern in national policy documents; flagged actions include a National Mental Health Workforce Strategy, the finalisation of the National Mental Health Service Planning Framework, increasing the use of trained mental health peer support workers, promoting career pathways for those in the mental health field, and collaboration with workforce accreditation and registration agencies.  

At a state and territory level, several jurisdictions (e.g., Queensland, Tasmania and the Australian Capital Territory) flag the development of workforce strategies or plans. Queensland and Tasmania both note that this plan should be consistent with the National Practice Standards for the Mental Health Workforce which outlines core competencies. Other jurisdictions (e.g., South Australia) identify the need for workforce development planning strategies more generally, without specifying the need for a separate plan.

Most jurisdictions give emphasis to recruiting, training and retaining mental health professionals. Queensland, South Australia and the Australian Capital Territory discuss undergraduate and postgraduate courses for careers in mental health, continuing professional development for the existing mental health workforce, and training for the broader health workforce (clinical and non-clinical) in the recovery approach. Queensland identifies specialised mental health workforce recruitment and retention as a priority, mentioning strategies like re-entry plans. New South Wales
discusses the placement of graduates in mental health and drug and alcohol services to strengthen relationships between the sectors. Victoria canvasses the possibility of creating an Institute for Mental Health Workforce Development and Innovation as a cross-sector initiative.28

Some jurisdictions have given particular thought to recruiting, training and retaining a strong mental health workforce in rural and remote areas. In particular, New South Wales and Western Australia identify a number of innovative strategies, including, for example, attracting people from rural and remote areas to train as mental health professionals by offering distance education and online courses.

Training of those working in the general health sector (e.g., general practitioners, maternal and child health nurses) and in other sectors (e.g., child protection workers, teachers, youth workers) is also given priority, because these professionals are often well-placed to work collaboratively with the specialised mental health workers to facilitate a coordinated response.28 By way of example, New South Wales discusses the provision and expansion of mental health training programs for new and established general health professionals. New South Wales also identifies sectors like housing and justice as ones where mental health training to increase knowledge and awareness of mental illness would be valuable.

Some jurisdictions discuss the non-mental health workforce in more detail, advocating the need for training tailored to the particular at-risk groups they see. For instance, New South Wales makes special mention of training general practitioners to respond to postnatal depression and other disorders, and Western Australia gives particular emphasis to offering mental health training to youth workers and Aboriginal health workers.

3.2.13.2 International mental health policy documents

New Zealand and Canada’s national policy documents highlight the need for a dedicated mental health workforce development strategy, as do the policy documents of Alberta and Manitoba. Collectively, these documents make reference to the strategy defining core competencies for the workforce, prioritising efforts with respect to recruitment and retention, and providing a framework for monitoring progress.

Like Australia, international jurisdictions give considerable emphasis to training of both the mental health workforce and the non-mental health workforce. Alberta, for example, discusses the importance of working with Alberta Advanced Education and Technology (AAET) and educational institutions to ensure programs contain the appropriate mental health content, and prioritises strategies for strengthening the FNMI workforce.56 Scotland emphasises the importance of training general practitioners to recognise and manage mental illness. New Zealand focuses on building the capacity of the broad workforce that deals with priority populations, and in particular with Maori and Pacific peoples. New Zealand and Manitoba both support further development of the peer support workforce and seek ways to encourage people with mental illness to take up positions at all levels within the mental health workforce.

Several international jurisdictions discuss workforce development in the context of comorbidity, focusing on the need for mental health workers to understand addiction and for those working in the addiction services to understand mental illness. Manitoba does this via its Co-occurring Disorders Initiative, emphasising both training and a targeted anti-stigma campaign for a workers in addiction services (and others).

3.2.13.3 Australian suicide prevention policy documents
Of the Australian suicide prevention policy documents, only the National Aboriginal and Torres Strait Islander Suicide Prevention strategy made reference to the workforce in its objectives, highlighting the need to ‘build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels’.24

3.2.14 Building the evidence base

3.2.14.1 Australian mental health policy documents

A core theme of the National Mental Health Strategy is that there should be a strong emphasis on building the evidence base around mental illness and its treatment. This involves monitoring and evaluating existing services to ensure that they are delivering high quality care, as well as fostering research to generate new knowledge that can reduce the impact of mental illness.

At the national level, the Fourth National Mental Health Plan focuses on accountability and discusses a number of ways of ensuring that services are appropriate, efficient and effective (e.g., monitoring consumer outcomes, undertaking benchmarking exercises). It also promotes innovative research through a targeted strategy (the National Mental Health Research Strategy) which aims to create ‘explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.’ 67

States and territories also give emphasis to monitoring and evaluation as a means of ensuring service quality, often in the context of the National Standards for Mental Health Services. For example, Queensland and Tasmania outline plans to develop comprehensive quality and safety plans, and Western Australia discusses continuous service improvement framework that involves feedback about performance. Some jurisdictions (e.g., South Australia) focus on particular areas (e.g., quality and safety of medicines).

Research and innovation are also frequently mentioned. For example, Victoria aims to create an organised statewide research and knowledge management capacity to provide a robust evidence base on mental health care. Queensland plans to develop a statewide framework for mental health research. Western Australia announces an intention to establish a Research and Development register that would include comprehensive information about research studies, including their outcomes. In all cases, relationships with key research institutions are seen as crucial.

3.2.14.2 International mental health policy documents

Internationally, there is also an emphasis on monitoring and improving service quality evident in most policy documents. By way of example, New Zealand prioritises this through a partnership between its Health Quality and Safety Commission and its National Health Board. Alberta has established a system performance framework which involves: working with accrediting, professional and other bodies to continue to improve quality assurance and patient safety standards, processes and procedures for mental health (and addiction) services; implementing a comprehensive system performance framework to monitor, evaluate and report on mental health (and addiction) outcomes, programs and services; and engaging consumers and carers in the monitoring and evaluation process at the system, program and service levels. Newfoundland and Ontario have committed to the further development of meaningful indicators of quality in mental health (and
addition) services, and to making these publicly available. Scotland has also committed to develop indicators of quality in its inpatient and community services.

### 3.3 Service/program components identified in mental health policy documents

As noted in Chapter 2, we examined the scope of services and programs described in the policy documents in terms of the components they covered, using a framework that we had developed for a previous exercise. This framework classified them as: specialised clinical services (for general and special populations); mental health community support sector services; primary care and/or general health services; and universal mental health promotion and mental illness prevention programs. We also added suicide prevention programs to this list.

It is worth noting here that we identified universal promotion and prevention services/programs (i.e., those that target the whole population) separately from selective and indicated services/programs (i.e., those that target at-risk and high-risk populations, respectively). We did this because the former tend to be identified separately from the treatment system, whereas the latter are often delivered through parts of the treatment system covered by the other components. For example, early intervention services, which target both at-risk and high-risk populations, tend to be delivered within the context of specialised clinical services.

It is also worth noting that we did not include addiction services among the components in our classification. Mental health and substance use have been formally considered separate policy areas in Australia since the 1990s, and Australia’s national and state and territory policy documents do not tend to cover addiction services, except in the context of discussing comorbidity and inter-sectoral collaboration. However, with the need to address the high level of mental health and substance use comorbidity, most jurisdictions, including Tasmania, have amalgamated these services (at least at a Directorate level) and are currently working to develop and strengthen links between them. Internationally, addiction services are included in some policy documents, depending on where they sit in relation to the mental health service system. They are not discussed further here.

As Table 2 shows, all Australian and international jurisdictions make reference to the full gamut of services/programs identified above in their policy documents, reflecting a commitment to delivering services/programs across the full spectrum of interventions. All Australian jurisdictions have separate policy documents that are explicitly devoted to suicide prevention, including the Northern Territory for which core mental health policy documents were not located. Most core mental health policy documents acknowledge suicide as an issue to varying extents too.
### Table 2: Mental health service components identified in mental health policy documents

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<th>Jurisdiction and abbreviated title of policy document</th>
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<th>Specialised clinical services (Special Population)</th>
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<th>Universal mental health promotion and mental illness prevention services</th>
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Notes:

a. Full titles and references for policy documents are given in Table 1.

b. Northern Ireland and the Canadian provinces of Prince Edward Island, The Yukon and Saskatchewan did not have publicly available core mental health policy documents. The Canadian province of Quebec did not have a publicly available English-language policy document.
3.4 Specialised service types identified in mental health policy documents

We conducted a more detailed analysis of the service types mentioned within the service components listed in Table 2. Figure 1 summarises the service types described. Additional information is provided for those that relate to the specialised clinical services (general and special populations) and mental health community support sector services, on the grounds that these are the core business of state and territory mental health departments and are likely to be most informative in the Tasmanian context. Table 3 and the text which follows indicates the extent to which these service types are mentioned in Australian and international mental health policy documents, and provides additional detail about them. Additional information is provided on some emerging models of specialised mental health service delivery.
Figure 1: A taxonomy of mental health care services

Mental health services

- Universal promotion and prevention services
  - Mental health promotion
  - Mental illness prevention
  - Suicide prevention

- Primary care and/or general health services

- Specialised clinical services (general and special populations\(^1\))
  - Bed-based services:
    - Acute inpatient unit
    - Sub-acute or step-up/down\(^2\)
    - Non-acute/extended care
    - Community residential/supported accommodation\(^2\)
  - Psychiatric emergency care
  - Community services/teams:
    - Assessment, intake & referral
    - Early intervention
    - Case management
    - Crisis assessment & treatment
    - Assertive community treatment
    - Mobile support/treatment
    - Outreach
    - Continuing care
    - Rehabilitation and recovery services

- Mental health community support sector services
  - Family and carer services
  - Personalised support services
  - Group support services
  - Mutual support and self-help
  - Education, employment and training
  - Care coordination

Notes:
1. Services for special populations may encompass one or more of the specialised clinical mental health service types.
2. Sub-acute or step-up/down services and community residential/supported accommodation services are delivered under a range of models which vary in their clinical input and governance arrangements. These services could also be classified as ‘mental health community support sector services’ but have been placed here under specialised clinical services in order to categorise them with other bed-based services.
Within the category of specialised clinical services (general), service types which were identified in policy documents include:

- Acute inpatient units, including secure acute inpatient units and psychiatric intensive care units or beds, which are specialised psychiatric units within general or psychiatric hospitals for the treatment of acute mental health problems requiring short-stay (usually <1 month), intensive bed-based treatment;
- Sub-acute mental health services, also known as step-up/step-down services or intermediate care, which provide transitional bed-based treatment to consumers with high needs that is less intensive than acute inpatient treatment but more so than traditional community based mental health services. This includes crisis housing and transitional housing programs;
- Non-acute or extended care inpatient units, including secure units, which provide staffed rehabilitation, treatment or extended care to long stay (usually >6 months) patients in a bed-based setting;
- Community residential units and/or supported accommodation options, including bed-based residential rehabilitation services located in the community, as well as personalised support packages assisting consumers to obtain and sustain housing in the community;
- Psychiatric emergency care services, including dedicated mental health emergency beds and/or specialised mental health consultation and treatment teams located within general emergency departments;
- Community mental health services/teams operated by the government and providing multi-disciplinary in-home and out-of-home care including outpatient and day clinics, sometimes identified by further specialised functions including:
  - Assessment, intake and referral, including triage of consumers to appropriate services
  - Early intervention
  - Case management (including service coordination/linkage, monitoring, referral and advocacy)
  - Crisis assessment and treatment, usually on an outreach basis
  - Assertive community treatment teams
  - Mobile support and treatment teams
  - Outreach or home-based care
  - Continuing care
  - Rehabilitation and recovery services, including day programs;
- Consultation and consultation-liaison services for mental health, providing psychiatric assessment, advice and treatment by specialised mental health professionals or teams to consumers in non-specialised settings, such as general hospital wards or primary care.

3.4.1.1 Australian mental health policy documents

In Australia, within the category of specialised clinical services (general), national and state and territory policies all mention bed-based mental health services, particularly acute psychiatric inpatient care (8 of 8 jurisdictions), with the majority of jurisdictions also identifying sub-acute beds (6 of 8 jurisdictions), non-acute or extended care beds (7 of 8 jurisdictions), and community residential rehabilitation services or supported accommodation options (7 of 8 jurisdictions).

Similarly, all Australian jurisdictions identify specialised community mental health services or teams. These services are sometimes mentioned at a high level and sometimes more detailed functions or particular specialised teams are also identified. The most commonly identified specialised teams or functions are early intervention (7 of 8 jurisdictions), crisis assessment and treatment (6 of 8 jurisdictions), mobile intensive support (5 of 8 jurisdictions), outreach (5 of 8 jurisdictions), and
rehabilitation and recovery services (5 of 8 jurisdictions). Other community mental health service functions also mentioned by half or less than half of jurisdictions are assessment, intake and referral (often in the form of 24 hour telephone triage and assessment services, 4 of 8 jurisdictions), assertive community treatment teams (3 of 8 jurisdictions), and general case management or continuing care functions (2 of 8 and 1 of 8 jurisdictions, respectively).

Other specialised mental health service types mentioned by only a few jurisdictions in their policies include dedicated psychiatric assessment teams or units in emergency departments (2 of 8 jurisdictions), and consultation liaison with other services, including primary care (2 of 8 jurisdictions).

3.4.1.2 International mental health policy documents

Internationally, policies reviewed from New Zealand, the United Kingdom, the Republic of Ireland and Canada had a similar focus on bed-based mental health services and specialised community mental health teams. In contrast to Australia, however, international jurisdictions mostly identify acute psychiatric inpatient facilities (13 of 14 jurisdictions) and community residential rehabilitation or supported accommodation (11 of 14 jurisdictions), and make very little mention of sub-acute or non-acute inpatient facilities (with only the Canadian province of Alberta including this). With respect to specialised community mental health services, the majority of international jurisdictions reviewed identify this service type, with a particular focus on early intervention specialised teams or functions (12 of 14 jurisdictions). Crisis assessment and treatment is also identified as a specialised function by 10 of 14 international jurisdictions, with other specialised community team functions less commonly identified.

3.4.2 Specialised clinical services (special populations)

Within the category of specialised clinical services (special populations), a number of service types for special populations were identified. These are summarised in Table 4 and listed below:

- Forensic mental health services, which may include a range of specialised programs targeted at people in contact with the criminal justice system, such as secure forensic beds, community forensic mental health teams, prison/offender mental health and court diversion programs;
- Specialised mental health services for people with co-morbid mental illness and drug and alcohol disorders;
- Specialised personality disorder services, especially for people with borderline personality disorder;
- Mother-baby services, including perinatal and infant specialised mental health units or services;
- Eating disorder services, which may include statewide specialised inpatient units and/or consultation-liaison teams;
- Services for specific cultural groups, such as Indigenous communities, culturally and linguistically diverse populations, or refugees, generally as specialised community teams or statewide services;
- Dual disability services for people with both mental illness and intellectual disability;
- Neuropsychiatric, neurodevelopmental and brain disorder services;
- Early intervention in psychosis services, which generally consist of specialised community mental health teams and/or dedicated inpatient beds for people in the first years of treatment for onset of psychotic disorder and are largely targeted at youth populations;
- Integrated youth services, which may include a range of service models where specialised youth mental health services are co-located with other services such as substance abuse services and general health services (e.g., headspace);
• Child and family services, particularly specialised community mental health teams and/or inpatient units focusing on children and adolescents and their families;
• Specialised mental health services for deaf or hearing impaired people;
• Specialised mental health services for homeless people, generally in the form of community mental health outreach teams who provide services to people who are homeless and have a mental illness;
• Services for rural and remote populations, including special community mental health or consultation-liaison teams and telepsychiatry services.

3.4.2.1 Australian mental health policy documents

The reviewed policies identified a range of specialised service types within the category of specialised clinical services (special population). Key service types mentioned by more than half of Australian jurisdictions are forensic mental health services (7 of 8 jurisdictions), targeted services for specific cultural groups such as Indigenous or culturally and linguistically diverse populations (7 of 8 jurisdictions), dedicated child and family services (7 of 8 jurisdictions), mother-baby or specialised perinatal and infant mental health services (5 of 8 jurisdictions), and early intervention in psychosis services, mostly for young people but sometimes with no target age group specified (5 of 8 jurisdictions). Other service types targeted at special populations which are also mentioned frequently are those for eating disorders (4 of 8 jurisdictions), rural populations (4 of 8 jurisdictions), comorbid mental and substance use disorders (3 of 8 jurisdictions), mental health services for homeless people (3 of 8 jurisdictions), and integrated youth services (including the co-location of mental health, substance abuse and general health services in one setting; 3 of 8 jurisdictions).

3.4.2.2 International mental health policy documents

Internationally, forensic mental health services, comorbid mental and substance use disorder services and dedicated child and family services are the most frequently identified services targeted to special populations (all jurisdictions). In Canadian jurisdictions, service delivery for mental and substance use disorders is integrated within one system and policies generally covered both groups of disorders.

Services targeted at specific cultural groups (12 of 14 jurisdictions), services for homeless people (11 of 14 jurisdictions), those for rural populations (11 of 14 jurisdictions) and early intervention in psychosis services (9 of 14 jurisdictions) are also frequently identified. These types of services for special populations were similar to those commonly identified by Australian jurisdictions.

3.4.3 Mental health community sector

Within the category of mental health community sector services, service types which were identified in policy documents include:
• Family and carer services providing families and carers of people with a mental illness with support to maintain their caring role and wellbeing, such as mental health respite care services which provide short term relief from caring responsibilities, family and carer support services, and family education;
• Personalised support services, which provide flexible and tailored one-on-one support from a support worker in a person’s home or community, including assistance with living skills, community access, emotional support and/or individual advocacy;
• Group support services aimed at improving psychosocial functioning through group-based social, recreational or prevocational activities led by a mental health worker, such as clubhouses, drop-in centres, non-clinical day programs and leisure activities;
• Mutual support and self-help services or groups providing information and peer support delivered by people with a lived experience of mental illness;
• Education, employment and training services which support people to pursue vocational goals, including employment placement and support;
• Care coordination services provided by a facilitator to ensure that all of a consumer’s clinical and non-clinical care needs are being met.

3.4.3.1 Australian mental health policy documents

Specialised mental health service types within the category of mental health community support sector services are identified by the majority of jurisdictions in their policies. These mental health community support sector services are often provided by or in collaboration with non-government providers. Key services identified in this area are education, employment and training services (7 of 8 jurisdictions), personalised support services (6 of 8 jurisdictions), group support services (6 of 8 jurisdictions), mutual support and self-help including peer support (6 of 8 jurisdictions), and family and carer support services including respite care (5 of 8 jurisdictions). A sixth service type of care coordination is identified by half of the Australian jurisdictions.

3.4.3.2 International mental health policy documents

Mental health community sector service types are also recognised internationally. The service type most commonly identified is mutual support and self-help services, including peer support (all 14 jurisdictions). Family and carer support services (12 of 14 jurisdictions) and education, employment and training services (12 of 14 jurisdictions) are also commonly mentioned in international policy documents. However, internationally there is very little mention of group support services (2 of 14 jurisdictions).

3.4.4 Emerging models of specialised mental health service delivery

3.4.4.1 Bed-based mental health care in the community

The review of Australian mental health policies indicates that there is a clear trend towards increasing provision of bed-based mental health care in sub-acute and community settings. The National Mental Health Strategy sets a framework for this, and it is echoed in many state and territory policies. For example, the Australian Capital Territory discusses provision of care in the least restrictive environment, New South Wales and South Australia mention tailoring service intensity to meet consumer needs, and New South Wales talks about care being provided in the community to increase consumer autonomy, community connections and quality of life.

A key area of expansion identified by the majority of Australian jurisdictions is that of sub-acute bed-based mental health services. These are also commonly referred to as step-up or step-down services or intermediate care, and provide a transitional bed-based treatment service to consumers with high needs which is less intensive than acute inpatient treatment but more so than traditional community based mental health services. It is argued that these services may be used to avert acute inpatient admission or to allow early discharge from acute facilities and/or a smoother transition back into the community. There are a number of existing or proposed models for these sub-acute mental health services, which may be administered by state or territory mental health services or non-government agencies, but they are generally staffed by a mixture of clinical and non-clinical mental health professionals and most commonly located in the community, or a mix of hospital and community based facilities. An example of this service type is the Victorian Prevention and Recovery Care (PARC) services.
Another avenue of reform of bed-based specialised mental health services described in several jurisdictions’ policy documents involves a shift towards community-based residential rehabilitation facilities or beds, to be achieved either by moving existing facilities into the community or opening new beds in community locations (e.g., Australian Capital Territory). As noted above, this aligns with the principles of care in the least restrictive environment. The policies generally promote the provision of a range of rehabilitation and extended care options designed to meet the needs of consumers, with most facilities provided in the community, but also including secure rehabilitation beds and hospital-based rehabilitation facilities for a small number of consumers with more complex needs (e.g., South Australia, Australian Capital Territory).

As part of the spectrum of community-based rehabilitation, most Australian jurisdictions also identify a need for expansion of supported accommodation options for people with severe and persistent mental illness. Two examples of models of service provision for supported accommodation include the New South Wales Housing and Support Initiative and the Queensland Housing and Support Program. These programs involve a partnership between departments of health, housing and non-government community support services to provide a package of care including public housing and clinical and psychosocial support to help recipients maintain housing and live successfully in the community. Further to this aim, several jurisdictions’ policies identify a need for flexible or brokerage funding for consumers with complex needs, to allow the purchase of a range of services as needed, with one example being flexible accommodation options for people living in rural and remote areas (e.g., Western Australia).

### 3.4.4.2 Youth mental health services

A second key trend in the reform of mental health services is a focus on specialised youth mental health services, emphasised frequently in the reviewed mental health policies. There has been a traditional separation in Australian specialised mental health services between children and adolescents aged under 18 years, adults of working age, and older persons aged 65 years and over. Increasingly, some jurisdictions are moving towards providing mental health services targeted at adolescents and young adults, in addition to or as a replacement for child and adolescent mental health services for these age groups. For example, the Australian Capital Territory has introduced a Four Life Stage Model, which targets service separately towards children aged 0-11 years, and youth aged 12-25 years, also identifying separate sub-acute services for youth in two age groups (14-17 years and 18-25 years), youth-targeted inpatient facilities, and day programs for adolescents. New South Wales also highlights the introduction of separate community mental health services for youth, including integrated services for those aged 14-24 years, similar to those proposed by Victoria for 12-25 year olds. Queensland also emphasises a need for community and residential services for young people aged 15-25 years. Further to this, more than half of Australian jurisdictions identify early intervention in psychosis services as an important service type, most of which are specifically targeted at these youth age groups. Many policies also highlight the need for mental health promotion, prevention and early intervention services to focus on children and youth.

These trends are consistent with national mental health reforms, with successive federal budgets allocating additional funds to the expansion of youth *headspace* and early psychosis centres across Australia, for example with the 2014-15 federal budget allocating $14.9 million over four years for ten new *headspace* centres and an evaluation of the program, and $18.0 million over four years for the establishment of a National Centre for Excellence in Youth Mental Health.71

### 3.4.4.3 Innovative solutions for rural and remote mental health care
Many jurisdictions in Australia identify a need for targeted solutions for the delivery of specialised mental health services to people living in rural and remote areas, as do a number in Canada. A complex interplay of factors is highlighted by jurisdictions, including the practical challenges of providing services to small, geographically dispersed populations, difficulties in recruitment and retention of the mental health workforce in rural and remote areas, and the unique needs of sub-populations in rural and remote areas, including Indigenous populations and farmers. The most detailed outlines of challenges for service delivery and service provision plans for rural and remote areas can be found in the policy documents of New South Wales and Alberta.

There is an increasing focus on providing mental health care to people living in rural and remote areas within their community wherever possible. Models of service delivery identified for rural areas include: working in partnership with and building the capacity of existing primary care and community services to provide mental health care; outreach consultation liaison by specialised mental health staff or teams; 24-hour statewide mental health triage services for crisis and emergencies; specialised centres for rural and remote mental health, providing research, education, training and support, such as the Centre for Rural and Remote Mental Health in New South Wales or the Centre for Rural and Remote Mental Health Queensland; and ongoing support and professional development for key mental health staff working in isolated settings. The availability of increasingly sophisticated e-health technologies, including web-based, mobile and telehealth platforms, was highlighted by many jurisdictions as an opportunity to expand and streamline rural and remote mental health services, with telepsychiatry and e-mental health services facilitating the mental health assessment and treatment of hard to reach populations, including those in rural and remote areas.

3.4.4.4 Consumer-operated services and peer workers

Consumer-operated services, particularly community crisis and respite services providing short term accommodation for consumers in need of respite, emergency or crisis support, are identified by several jurisdictions as an area for further expansion. Most policy documents also discuss the need to include consumers in many aspects of service planning and delivery, including increasing the role of consumers as service providers. As part of this, peer workers or consumer consultants are promoted by some jurisdictions, to be integrated into existing clinical services. For example, Queensland directly employs consumer consultants to provide support to consumers and their support network, including information about mental illness and support services, and to improve consumer engagement within mental health services and advocate for consumer rights. Mutual support and self-help services, including peer support, are also identified by most Australian jurisdictions as an important part of the mental health service system, with these services largely being provided by the non-government sector. Arguments for increasing involvement of consumers in care delivery centre on their impact in increasing consumer satisfaction and engagement with mental health services.
Table 3: Specialised mental health service types identified in mental health policy documents

<p>| Jurisdiction and abbreviated title of policy document | Acute inpatient unit | Sub-acute or step-up/down | Non-acute/extended care | Community residential/supported accommodation | Psychiatric emergency care | Assessment, intake and referral | Early intervention | Case management | Crisis assessment and treatment | Assertive community treatment | Mobile support/treatment | Outreach | Continuing care | Rehabilitation and recovery services | Community teams - unspecified | Consultation-liaison | Family and carer services | Personalised support services | Group support services | Mutual support and self-help | Education, employment and training | Care coordination |
|-------------------------------------------------------|----------------------|---------------------------|-------------------------|-----------------------------------------------|---------------------------|--------------------------------|-----------------|----------------|-------------------------------|-----------------------------|---------------------|---------|----------------|----------------------------------|--------------------------|-----------------------|-----------------------------|---------------------------|------------------------|-----------------------------|-----------------------------|
| <strong>Australia</strong>                                         |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| National Policy                                       | +                    | +                         | +                       | +                                            | +                         | +                               | +               | +              |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Fourth Plan                                           | +                    | +                         | +                       | +                                            | +                         | +                               | +               | +              |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| COAG Roadmap                                          | +                    |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| <strong>New South Wales</strong>                                   |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| A new direction                                       | +                    | +                         | +                       | +                                            | +                         | +                               | +               | +              |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Community strategy                                    | +                    | +                         | +                       | +                                            | +                         | +                               | +               | +              |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Interagency Plan                                      | +                    |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| <strong>Victoria</strong>                                           |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Mental Health Strategy                                | +                    | +                         | +                       | +                                            | +                         |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| <strong>Queensland</strong>                                        |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Plan for Mental Health                                | +                    | +                         | +                       | +                                            | +                         | +                               | +               | +              |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Health Promotion                                      | No specialised service types identified | | | | | | | | | | | | | | | | | | | | | | |
| <strong>Western Australia</strong>                                 |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Mental Health 2020                                    | +                    | +                         | +                       | +                                            | +                         | +                               | +               | +              |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Rehabilitation                                        | +                    | +                         | +                       | +                                            | +                         |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| <strong>South Australia</strong>                                   |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Mental Health and Wellbeing                           | +                    | +                         | +                       | +                                            | +                         |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| <strong>Tasmania</strong>                                           |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| Services Plan                                         | +                    | +                         | +                       | +                                            | +                         |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| PPEI Plan                                              | +                    |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |
| <strong>Australian Capital Territory</strong>                      |                      |                           |                         |                                               |                           |                                 |                 |                |                               |                             |                     |                     |                                 |                           |           |                            |                                 |                        |                        |                             |                      |</p>
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<sup>a</sup> Full titles and references for policy documents are given in Table 1.

<sup>b</sup> ‘Forensic services’ may include a range of specialised programs such as secure forensic beds, community forensic mental health, prison/offender mental health and court diversion programs

<sup>c</sup> ‘Integrated youth services’ may include a range of service models where specialised youth mental health services are co-located with other services such as substance abuse services and general health services.
3.5 Relationships with other government sectors outlined in policy documents

There is considerable variation in the extent to which details of relationships between mental health and other sectors are described in the local and international policy documents we examined. Some jurisdictions (e.g., New South Wales), provide extensive details and include among their core policy documents some sort of interagency plan. More commonly, however, jurisdictions make mention of whole-of-government approach but provide comparatively little detail of which sectors should be involved and how inter-sectoral collaboration might occur (e.g., New Zealand).

The key sectors mentioned in given policy documents are summarised in Table 5, and more detail is given below. Table 5 distinguishes between policy documents that acknowledge that collaboration with a given sector is important but provide no further detail (Level 1 collaboration) and policy documents that provide further information about collaboration with that sector (Level 2).

3.5.1 Health (non-mental health)

Within the health system, partnerships between mental health services and the primary care and acute health systems are important in developing a more holistic approach to health and recovery, and for maintaining good physical health in people with mental health problems or mental illness. All jurisdictions in Australia and most international jurisdictions acknowledge collaboration between the mental health sector and the broader health sector as important.

Australian policy documents often focus on entry points into the mental health system as targets for collaborative arrangements. The National Mental Health Strategy emphasises primary care (citing improvements achieved through programs such as Better Access) and emergency departments (which have seen the development in recent years of new models of care, including psychiatric emergency care centres, short stay units and dedicated mental health and drug and alcohol practitioners. A range of health and related services provided in the community are also mentioned (e.g., Tasmania acknowledges that maternal and child health centres also provide a possible point of screening and entry into care).

Within primary care, general practitioners often warrant a mention in policy documents because they play a major role in managing mental illness, especially in rural and remote areas where specialised care may not be easily available. Both Victoria and Queensland, for example, acknowledge the significant part played by general practitioners and mention a variety of sources for improving their access to secondary consultations, care coordination and discharge planning support (e.g., primary mental health teams, psychosocial support services).

Some jurisdictions emphasise the role of general practitioners in identifying and managing physical health problems in people with mental health problems. For example, Western Australia mentions the establishment by the Office of Mental Health of an advisory group (HealthRight – Duty to Care) which includes general practitioners and a range of other stakeholders with an interest in identifying systemic changes required to meet the general health needs of people affected by mental illness. New South Wales discusses ways of better equipping general practitioners to assist people presenting with mental health problems, including clinical networks and purpose-designed training. Queensland has also linked general practitioners into the mental health system via Partners in Mind, a cooperative initiative between Queensland Health and General Practice Queensland.
A number of jurisdictions consider ways of systematising service delivery so that mental health professionals and mainstream health professionals deliver care in a coordinated fashion. One example is integrated primary and community care services in New South Wales, in which general practitioners work closely with community drug and alcohol and mental health services. Another example comes from Victoria, where community health services provide sites for colocation of mental health services with general health, drug and alcohol, dental health and other services.

Less emphasis is given to the relationship between mental health and physical health in acute settings, but the policy documents in various jurisdictions mention emergency departments as an important point of entry into the mental health system. They also describe consultation-liaison services through which consumers with comorbid medical conditions are seen by a psychiatrist at the request of a medical or surgical consultant or team.

Internationally, there is also recognition that mental health and physical health are closely related, and that this requires the mental health sector and the general health sector to work together. This intent is exemplified in the English policy documents which identify overarching strategies to be implemented by the Department of Health, and describe on-the-ground programs that promote mental health in general health settings (e.g., a health visitors program).

### 3.5.2 Emergency services

The need for inter-sectoral collaboration between mental health services and emergency services is flagged by a number of jurisdictions, on the grounds that emergency services sometimes become involved in instigating mental health care (e.g., in cases where a person is deemed to be at risk to themselves or others or is exhibiting other challenging behaviours and/or when a person is heavily affected by drugs or alcohol). Several jurisdictions note the need for better coordination between crisis assessment teams, police and the ambulance service.

The main mechanisms for appropriate collaboration include: adequate training for emergency staff, and ability to access specialised services rapidly and have sufficient information transfer to allow them to do their job; collaborative development of protocols to guide and support transitions between service sectors and jurisdiction; improved linkages and coordination between mental health, alcohol and other drug and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health problems; and provision of education and training programs about mental health and suicide prevention to frontline workers in emergency, police, welfare and associated sectors.

Specific examples of inter-sectoral collaboration in this area are provided by New South Wales and Queensland. New South Wales has a formal agreement between the mental health, police and ambulance sectors which is supported by a formal inter-agency coordination committee (known as the Inter-Department Committee) and by a network of local inter-agency local protocol committees. New South Wales Police and New South Wales Ambulance have outlined specific priorities for the partnership (e.g., improved coordination between agencies, improved timeliness to access specialised mental health care in a mental emergency, and improved safety). Queensland’s Mental Health Intervention Program formalises collaborative responses between the Queensland Police Service, Emergency Services and public mental health services.

### 3.5.3 Community services

Access to appropriate community services can influence the treatment and recovery of people with mental illness. The importance of linking with community services is identified in the policy
documents of every national and international jurisdiction. Community services represent a broad group of services that may include women’s services, transcultural services (including services providing assistance to victims of torture and trauma), carer respite services, sexual assault services and family support services, to name a few. They may also include a number of services that are considered in subsequent sections, including drug and alcohol services, disability services, aged care services and vocational and employment services. This overlap should be borne in mind in interpreting Table 5; the analysis may represent something of an undercount of recognition of sectors that are ‘rolled up’ into community services.

An example of community service collaboration described in policy documents is collaboration between mental health and transcultural health services. Several jurisdictions identify the need for improved coordination between services that can be accessed by people from culturally and linguistically diverse backgrounds and propose a range of initiatives to achieve this. For example, Western Australia identifies partnerships between community settlement services in rural and remote regions as a method of facilitating community acceptance of refugees which could assist recovery. The Australian Capital Territory is supporting its Transcultural Mental Health Network, is committing funding to a transcultural mental health liaison officer position, and is resourcing the Mental Health Community Coalition to employ a project officer to implement the ‘Stepping Out of the Shadows’ training package produced by Multicultural Mental Health Australia.

### 3.5.4 Drug and alcohol services

In Australia, mental health services and drug and alcohol services are increasingly becoming integrated, at least at a Directorate level. There is acknowledgement, however, that the two sectors need to work even more closely together to best cater for the needs of those with comorbidities and this is reflected in many Australian mental health policy documents.

Broad mechanisms for collaboration outlined in Australian jurisdictions include establishing linkages between mental health services and drug and alcohol services, improving communication and information-sharing between them (e.g., introducing shared systems of unique identifiers), and the development of joint care plans for people with multiple and complex needs.

Further work is required to determine best practice in delivery of services to people with comorbid mental health problems and substance use problems. National Mental Health Strategy documents identify that new service delivery and care models (e.g., co-location) may be beneficial, and some have been funded under the Strategy. The most prominent of these is headspace, which provides a one-stop-shop offering services for young people with a range of mental health and substance use (and general health) concerns.

Some states and territories also argue for structural changes to overcome service silos. For example, Victoria aims to develop a service system in which the capacity to respond to dual diagnosis is core business in mental health and drug and alcohol services, suggesting that this requires the development of local networks, staff training and access to consultation, and shared care arrangements. Victoria has begun to provide some integrated services (e.g., Child FIRST sites which provide integrated family mental health and drug and alcohol services). The Australian Capital Territory has structured services to consider mental health and drug and alcohol problems as core services and gives a number of examples of specific partnership agreements (e.g., a mental health comorbidity clinician who provides clinic sessions each week at the key community sector drug and alcohol service, comorbidity workers within drug and alcohol agencies, and access to mental health training for drug and alcohol Supported Accommodation Assistance Program (SAAP) workers).
Western Australia outlines a program by which drug and alcohol workers act as consultants to mental health services.

Some international mental health policy documents also highlight the importance of strengthening relationships between the mental health sector and the drug and alcohol sector. It should be noted, however, that some international jurisdictions (e.g., New Zealand and Canada) view mental health and drug and alcohol as a single sector, so inter-sectoral linkages are not relevant here.

### 3.5.5 Disability services

Disability services are also mentioned by all Australian jurisdictions and several international jurisdictions. Nationally, relationships with key government and non-government bodies with responsibility for disability are as a way for the sectors to closely engage on implementing mental health reform. On a national level, policy documents identify that individual funding mechanisms, such as the National Disability Insurance Scheme (NDIS), may alter the way that the mental health consumers utilise services.\(^\text{22}\)

At a service delivery level, mental health community sector services are increasingly being recognised as influential in the recovery of people with mental health problems, and an important partner to clinical services. Non-government organisations are acknowledged as an important collaborator with clinical mental health services here, as the non-government sector provides many of these support services in Australia.

Some jurisdictions provide specific examples of initiatives that promote collaboration between clinical services and mental health community sector services. For instance, New South Wales discusses the enhancement of programs such as the New South Wales Family and Carer Mental Health Program (founded on a mandated partnership between Area mental health services and four non-government organisations) and the Recovery and Resource Services, support for non-government organisations working towards accreditation and expansion, and partnerships between mental health and drug and alcohol non-government organisations.

An additional noteworthy example of disability collaboration is the provision of additional funds to Disability Services Queensland to employ clinicians to provide services for people with an intellectual disability and mental illness.

### 3.5.6 Aged care

Linkages between the mental health and aged care sectors are identified as important by the majority of the Australian jurisdictions. Internationally, this is also given emphasis by New Zealand. Collectively, the policy documents in these jurisdictions give emphasis to ensuring that specialised and primary mental health care providers work with aged care services to support older people with mental illness where they live, whether that be at home or in a residential facility (e.g., via ‘in-reach’ services). They also note the importance of good discharge planning in the event that an older person is admitted to hospital, stressing that this should involve all parties responsible for his or her care and should consider factors like housing and financial stability. They also discuss partnerships between mental health care providers and aged care services in the context of looking after people with severely and persistently challenging behaviours associated with mental illness and/or dementia. They also discuss early intervention.

By way of example, New South Wales refers to a range of policy and program areas designed to improve service delivery for older people including: service agreements and/or protocols in all area
health services that promote collaboration between mental health and aged care services; respite and community residential services for older people; and an integrated services project for consumers with challenging behaviours. Victoria makes mention of increasing the capacity of aged care mental health specialists to provide in-reach, and improving discharge planning. Western Australia discusses ways of increasing the capacity of primary care and aged care providers to identify mental health problems as they emerge and offer early intervention to prevent or delay their progression.

3.5.7 Vocational and employment services

Many local and international policy documents recognise the bi-directional relationship between employment and mental health and illness. Being employed can be protective against mental health problems and, conversely, poor mental health can jeopardise vocational training options, employment opportunities and job security. For this reason, vocational and employment services are commonly discussed as being an important avenue for collaborative activity.

Much of the policy discussion of employment focuses on models which support people with mental illness to prepare for working, remain employed or return to employment. These are reliant on partnerships between clinical service providers, community support agencies, vocational training institutions, and employment support agencies. A specific example of the discourse around linkages with vocational and employment services can be found in the policy documentation from Western Australia. Western Australia provides work readiness and assistance programs for youth (including Workright, Workability Employment Strategy and TAFE support). Western Australia also notes the importance of providing bridging services, which interface with adult services, to maintain engagement with mental health services. Western Australia also identifies some obstacles, however, including the presence of only one specialised psychiatric open employment agency (with a waiting list of several years), and the difficulties experienced by people with severe and persistent mental illness in accessing the generic supported employment and job placement agencies provided in the state through the Australian Government. The suggested solution is continued liaison between the state-based Office of Mental Health and the Australian Government to ensure appropriate levels of supported employment services and support strategies to ensure access to generic supported employment and job placement agencies.

3.5.8 Housing

Appropriate supported accommodation and housing models are mentioned by all Australian and international jurisdictions, and government and non-government sector collaboration is identified as key to achieving secure and stable housing. Most mention the need to develop better partnerships between government departments responsible for the portfolios of mental health, public housing, disability services and community services, the private sector and housing associations. They see this as a means of providing housing linked with appropriate support, and as a way of coordinating clinical and non-clinical support programs with housing services.

An example of the kinds of specific housing partnerships outlined in policy documents is provided by New South Wales. New South Wales mentions the Housing and Support Initiative (which provides housing linked to clinical and psychosocial rehabilitation services for people with mental disorders, according to their level of severity) and the Joint Guarantee of Service (a strategy outlining the roles and responsibilities of agencies delivered in partnership between the Departments of Health and Housing and the non-government sector).
Other examples are provided by the Australian Capital Territory and Western Australia. The Australian Capital Territory has encouraged Crisis Assessment and Treatment Team and Assertive Treatment Teams to work in tandem with housing services (and employment and education services). Western Australia has promoted better liaison between the Supported Accommodation Assistance Program (SAAP) and Youth Accommodation Services, and the development of protocols between housing providers and child and adolescent services.

Internationally, the majority of jurisdictions have highlighted the importance of housing in terms of mental health outcomes. For example, Ireland outlines in some detail the difficulties faced by people with severe or recurring mental health problems, noting that housing benefits were often not structured to assist people who require repeated or prolonged inpatient stays and other forms of care during the recovery process. Ireland notes that there is often confusion about which sector has responsibility for housing people with mental health problems and places the responsibility for supplying housing firmly with local housing services, suggesting that there should be close involvement from the mental health sector. Ireland also identifies the need for a formalised ‘advocate role’ to advise on issues with housing discrimination and social exclusion.

### 3.5.9 Education

Collaboration with the education sector (including early childhood education, primary and secondary education, and higher education) is seen as particularly important for the implementation of promotion, prevention and early intervention initiatives. Many jurisdictions note that school-based programs addressing factors that promote good mental health (e.g., resilience) and risk factors that influence poor mental health (bullying, challenging behaviours, healthy eating, body image, and drug and alcohol problems) are available in limited geographical areas, but that there is a need to expand them more broadly.

Jurisdictions discuss ways of improving inter-sectoral links at a range of levels. Some focus on governance arrangements, proposing shared local and regional level service agreements between, for example, schools, community-based mental health services and child protection services. Others focus on the service delivery end of the spectrum, mentioning a range of activities to ensure that school teaching and counselling staff can access relevant training and advice and support from mental health specialists.

Examples of efforts in this area are provided by New South Wales and Western Australia. New South Wales provides an example of training in this regard, highlighting its School-Link program, through which school and TAFE staff work with mental health workers from the Departments of Juvenile Justice and Community Services share skills and work together to manage adolescent depression and related disorders. In Western Australia, a statewide mental health trial, run by the Department of Education and Training, aims to keep students with a mental illness engaged in mainstream education by employing education assistants.

### 3.5.10 Justice

The need for mental health services to collaborate with the justice sector is also widely acknowledged in mental health policy documents. This reflects concern for the fact that prisoners and ex-prisoners have high rates of mental illness and often other complex needs. The justice system is also identified as providing unique opportunity to screen, identify and connect or reconnect with people with untreated mental illness through court diversion services. The need for discharge planning and case management to ensure people are provided with adequate mental
health support at crucial transition points (e.g., into and out of prison) is identified as key to reduce the risk of relapse and reduce the risk of recidivism.

Various jurisdictions provide examples of models for improving collaboration in this area. Western Australia has developed approaches to transporting people with mental illness to and from hospital and court that do not involve uniformed police and police vehicles, has facilitated police and mental health teams to work together to divert people with mental health problems from being charged at the time of incidents, and has created a safe and secure facility for the detention and treatment of accused offenders who are unable to stand trial because of unsoundness of mind. Victoria has encouraged the development of mental health strategies in other sectors (e.g., police, justice) which articulate ways of addressing the needs of those who come into contact with police, courts and prisons.

Several jurisdictions give additional emphasis to models of service collaboration that may help to address the needs of children and youth in the justice system (e.g., by developing interventions tailored for children and youth in custody). For example, the Australian Capital Territory addresses this by promoting the sharing relevant information and inter-agency support between child protection and youth justice services.

3.5.11 Indigenous affairs

Relationships between the mental health sector and Indigenous affairs are also given prominence in many mental health policy documents. Partnerships with organisations representing Indigenous populations in Australia (Aboriginal and Torres Strait Islander people), Canada (First Nation, Metis and Inuit populations) and New Zealand (for the Maori populations) have been identified as the way forward in designing and delivering culturally appropriate, holistic services.

Many of the strategies that are proposed relate to improving mainstream mental health services (e.g., by employing Indigenous people and improving the cultural competency of non-Indigenous staff) and offering tailored Indigenous services as appropriate. Specific examples are provided by New South Wales, Victoria and Western Australia. New South Wales has promoted partnerships between New South Wales Health, primary mental health services in Aboriginal Community Controlled Health Services and Aboriginal mental health workers in Area Mental Health Services. Victoria is delivering culturally supportive social and emotional wellbeing and recovery services delivered through new collaborative arrangements between the Victorian Aboriginal Health Services, Victorian Aboriginal Community Controlled Health Organisations, local Aboriginal organisations and mental health services. Western Australia has integrated disability support carers who provide psychiatric rehabilitation into rural and remote Aboriginal and Torres Strait Islander Aged Care Services.
Table 5: Relationship between mental health and other government sectors as described in policy documents

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<thead>
<tr>
<th>Jurisdiction and abbreviated title of policy document</th>
<th>Relationship with other government sectors</th>
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<td></td>
<td>Health (non-mental health)</td>
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<td>Australia</td>
<td>Level 1</td>
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<td>Level 2</td>
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<td>Fourth Plan</td>
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<td>COAG Roadmap</td>
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<td>New South Wales</td>
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<td>A New Direction</td>
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<td>Community mental health strategy</td>
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<td>Interagency Plan</td>
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<td>Victoria</td>
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<td>Western Australia</td>
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<td>Jurisdiction and abbreviated title of policy document¹</td>
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<td>Mental Health 2020</td>
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<td>Rehabilitation</td>
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<td>South Australia</td>
<td>Mental Health and Wellbeing</td>
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<td>Australian Capital Territory</td>
<td>Mental Health Services</td>
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<td>Building a Strong Foundation</td>
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<td>Relationship with other government sectors</td>
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<td>Plan</td>
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<td><strong>Nova Scotia</strong></td>
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<td>Strategy</td>
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<td>Strategy</td>
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<tr>
<td><strong>Total (by jurisdiction)</strong></td>
<td><strong>Level 1 or 2</strong></td>
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</tbody>
</table>

Notes:

a. Full titles and references for policy documents are given in Table 1.

Level 1: Inter-sectoral collaboration is acknowledged as important without further detail being provided

Level 2: Further information about collaboration was provided, ranging from some explanation of an example of inter-sectoral collaboration with minimal details provided to highly detailed and very specific examples.
3.6 Populations specifically identified in policy as having particular service delivery needs

All jurisdictions address the needs of some priority populations, either by identifying certain population groups or by highlighting particular population-specific services or interventions. For the purposes of this analysis, we considered either to be indicative of a priority population. Broadly, we identified four categories of priority populations: populations defined by their stage in the lifespan; populations from particular socio-demographic groups; populations with multiple or complex needs; and other populations. These are summarised in Table 6 and described further below.

Some caveats should be noted. Firstly, some comparisons across different jurisdictions were difficult, as the scope of the mental health system varies. For example, as noted earlier, while comorbid drug and alcohol use is commonly identified in Australian policy documents, the policy documents from some other countries (e.g., Canada) consider substance abuse as part of the core business of their mental health system. Secondly, suicide prevention policy documents tend to identify populations in a narrower way than those of mental health documents, and populations identified as being at risk in suicide prevention documents may or may not have mental health problems. Thirdly, it is quite possible that certain groups, while not singled out as priority groups, are being addressed through plans at the local level, or through inclusive programs which adequately address their needs. The lack of identification as a priority population does not imply a particular group is outside the scope of the policy document.

3.6.1 Populations defined by their stage in the lifespan

The most commonly identified priority populations in mental health policy documents are defined by age group. One or more policy document from each Australian and international jurisdiction identifies children, adolescents and young people, and older people as priority populations, based mainly on the different presentations of illness across the lifespan and the need for age-specific services and promotion interventions to reach these populations.

3.6.2 Populations from particular socio-demographic groups

In countries with significant Indigenous populations (Australia, Canada and New Zealand), the vast majority of jurisdictions identify the unique needs of this population, including culturally appropriate ways of perceiving mental health and wellbeing, and the importance of consulting with the community and training the workforce. Expanding the national availability of high quality and culturally appropriate mental health services and supports for Aboriginal and Torres Strait Islander people is also identified in national Australian policy documents.

Culturally and linguistically diverse populations are also identified as a priority population by the majority of jurisdictions. These populations are variously defined; in some cases the definition is broad and includes all people from different cultural and language groups, in others refugees are considered a separate priority population, and in still others the inclusion criteria are not clear. Culturally and linguistically populations are a diverse group with differing needs and, in some cases, high rates of mental illness. Jurisdictions tend to identify the need for culturally appropriate services and an understanding of cultural norms (e.g., around gender).

Both nationally and internationally, culturally and linguistically diverse communities are commonly mentioned in the context of stigma reduction initiatives. There is a recognition that there may be differences between groups in terms of their personal and family priorities and their cultural
understanding of mental illness and different emotional states. Irish and Canadian policy documents emphasised that culturally and linguistically diverse communities require access to information and treatment in a range of languages, and that the provision of professional interpreters is essential. Ireland also notes that the community development model provides a useful framework for providing initiatives to reach out and engage with people from minority groups, complementing clinical services.

Other populations also feature prominently in the mental health policy documents of some jurisdictions. These populations tend to have high rates of mental illness or risk factors for mental illness and/or present certain challenges for service delivery. In Australian jurisdictions considerable emphasis is given to rural and remote populations, and sub-groups within them like drought-affected farmers and fly-in-fly-out workers. Some of these population groups reflect the particular circumstances of the given jurisdiction. For example, drought-affected farmers are identified by Tasmania but not Western Australia, and the reverse is true for fly-in fly-out workers. Rural and remote populations feature in Australia’s policy documents and in those of Canada, but they are not so relevant in the Welsh policy documents.

Gender and sexual identity define some of the other population groups identified in mental health policies. Women are identified in several jurisdictions’ mental health policy documents as having specific service needs, predominantly related to services for gender-based violence and abuse, and for perinatal and postnatal depression. Men are less commonly identified in mental health policy documents; specific objectives or reforms pertaining to men as a priority population are described in only one jurisdiction (Victoria), despite their low rates of service access and higher rates of substance use. By contrast, men are noted as a priority population in the majority of Australian jurisdictions’ suicide prevention policy documents, reflecting the high rate of suicide in this group. Gay, lesbian, bisexual, transgender and intersex populations are identified as a priority population in fewer than half of all Australian and international jurisdictions.

Homeless people are identified as a target group in the majority of national and international jurisdictions, although many jurisdictions do not go into detail about the mental health needs of homeless people, focusing more on housing services. An exception to this is the Irish policy document, which outlines the mental health needs of the homeless in some detail and identifies that community based care (including assertive outreach) as a promising service model to address these needs. Ireland also proposes an initiative to prevent individuals falling through the gaps in the system if they become homeless, which involves community mental health teams taking responsibility for and following up with each individual.

3.6.3 Populations with multiple or complex needs

People with complex needs (e.g., physical ill health or disability, intellectual disability, dementia) are also recognised in Australian and international policy documents, although less consistently than some other groups. Some policy documents identify the high comorbidity between physical illness and disability and mental ill health, and outline a variety of strategies to ensure that those with mental illness have comprehensive medical care for their physical needs and that those with chronic physical illness or disability are monitored and screened for emerging mental illness. Good linkages between specialised mental health services and primary care are advocated here (e.g., in the Australian Capital Territory), as are consultation-liaison services (e.g., in Ireland).

In jurisdictions where people with intellectual disability are identified as a priority group, reform areas focus on reducing care inequities and improving continuity of care. In Ireland, for example, extensive recommendations are made about the mental health care of people with intellectual
disability, including provision of a spectrum of facilities to provide a flexible continuum of care based on need, and provision of services by a catchment-based specialised mental health of intellectual disability team. Ireland additionally emphasised the importance of promotion and prevention for people with Intellectual disability.

People with dementia and associated behavioural disturbances are identified as having special service delivery needs, particularly because their numbers are growing as the population ages. Meeting their needs requires a specialised approach involving collaboration between mental health, general health and the aged care sectors, and dedicated training of relevant service providers.

### 3.6.4 Other populations

Carers feature in the policy documents of every Australian jurisdiction and in the majority of those from overseas as well. Having said this, much of the emphasis is on ways to increase carer participation and carer support, rather than on the mental health needs of carers as individuals.

As noted earlier, populations identified in suicide prevention policy documents are not necessarily subsets of people with mental health problems. Australian suicide prevention policy documents appropriately target additional populations at higher risk of suicidal behaviours, such as men, people with a mental illness, people bereaved by suicide and people who experience trauma/abuse.
<table>
<thead>
<tr>
<th>Jurisdiction and abbreviated title of policy document</th>
<th>Stages across the lifespan</th>
<th>Priority population groups</th>
<th>Populations with multiple/complex needs</th>
<th>Other populations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>Adolescents/young people</td>
<td>Older people</td>
<td>Indigenous populations</td>
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<td>Australia</td>
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<td>4th Plan</td>
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<td>COAG Roadmap</td>
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<td>National Suicide Prevention Strategy</td>
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Table 6: Populations identified in policy documents as having particular service delivery needs

- CALD including refugees, migrants
- Veterans; CALD including refugees
- Men; people with mental illness; people bereaved by suicide
- Men; people with a mental illness; people who use alcohol/drugs; people with personal or family history of suicidal behaviour; people bereaved by suicide; people who experience family/relationship breakdowns; people affected by abuse/trauma; people in institutional settings; people in high risk occupational groups; people who are...
<table>
<thead>
<tr>
<th>Jurisdiction and abbreviated title of policy document*</th>
<th>Stages across the lifespan</th>
<th>Priority population groups</th>
<th>Populations with multiple/complex needs</th>
<th>Other populations</th>
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<td>Older people</td>
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<td>Rural and remote</td>
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<td>Perinatal &amp; postnatal women</td>
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<td>Physical ill-health/disability</td>
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<td>Carers and family</td>
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<td>Stages across the lifespan</td>
<td>Priority population groups</td>
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Notes:
GLBTI, Lesbian, Bisexual, Transgender, Intersex; COPMI, children of parents with mental illness.
a. Full titles and references for policy documents are given in Table 1.
b. Substance use is only considered a priority population in policy documents where substance use is not core business.
3.7 Monitoring and evaluation

Monitoring the implementation of a policy and evaluating its success in meeting key objectives is an important part of the planning process and is key in informing the development of future policies. Although some jurisdictions have multiple policy documents, monitoring and evaluation strategies need to be focused on each individual policy, as the evaluation is linked to the content of the policy itself rather than the jurisdiction’s overall mental health care. The majority of Australian and international core mental health policy documents reviewed mention the need for a monitoring or evaluation framework for the policy (see Table 7). However, many mention the importance of monitoring and evaluation without providing detail of a strategy within the document, although some of these indicate that a monitoring and evaluation strategy would be developed as a separate document. We found these documents in three cases (Western Australia, Scotland, Alberta), but we were unable to identify them in the remaining cases suggesting that they had either not been developed or had not been made publicly available.

The policy documents that do describe their planned evaluation strategies provide varying levels of detail. All describe a set of key indicators against which progress should be measured. These indicators tend to align with the key objectives or priority areas of the policy. However, in most cases, the suggested indicators are not supported by measurable targets. One example where measurable targets are provided is the Australian Fourth National Mental Health Plan, which outlines a number of indicators for monitoring change under each of its priority areas, such as: ‘participation rates by people with mental illness of working age in employment’ under Social Inclusion and Recovery; ‘percentage of population receiving mental health care’ under Service Access, Coordination and Continuity of Care; and ‘proportion of total mental health workforce accounted for by consumer and carer workers’ under Quality Improvement and Innovation. In this case, the Fourth National Mental Health Plan is the only policy reviewed to also have an identified stand-alone strategy document for monitoring and evaluation - the Fourth National Mental Health Plan Measurement Strategy. This strategy provides a more detailed methodology for how indicators and targets have been or will be developed.

Others policy documents provide more detail within the proposed indicators, suggesting a direction of change or goal for some or all indicators. For instance, the Tasmanian Mental Health Services Strategic Plan 2006-2011 identifies a list of indicators of progress towards desired outcomes for each of its six strategic priority areas. The Strategic Plan notes that success by the completion of the plan will be indicated by significant progress in indicators such as ‘standard evidence-based model of care throughout service’, ‘increased capacity in the non-government sector’ and ‘staff recruitment and retention rates better than other states’. A qualitative analysis of progress towards these goals is included in the 2008 Taking Stock and Moving Forward Progress Report.

Several policy documents, including the Tasmanian Strategic Plan, go one step further and provide specific benchmarks or targets for the successful implementation of the policy. These are provided in varying levels of detail. In the case of the Tasmanian Strategic Plan, the Australian Capital Territory’s Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014, and the national-level Roadmap for National Mental Health Reform 2012–2022, a few concrete targets are provided within a much larger list of general indicators as per the earlier examples. For example, the Roadmap selects several indicators to provide provisional targets against, such as ‘readmission to hospital within 28 days of discharge: 12% or less by mid-2014’, ‘percentage of the population receiving clinical mental health services: 12% by mid-2014’ and ‘accreditation levels against the National Mental Health Standards: 100% by mid–2014’. Similarly, within the broad list of indicators in the Tasmanian Strategic Plan, there are a few with targets for 2011, such as ‘engagement of 3.0% of the community with significant mental illness’ and ‘all
consumers have individual plans developed collaboratively with them’. The Queensland Plan for Mental Health 2007-2017 provides somewhat more detailed targets for program implementation, numbers of mental health staff, beds and housing places, with a stepped plan for outcomes to be achieved by 2011 and by 2017.

While the trend in Australia has been to provide limited measurable targets within core mental health policy documents, two policies from Canadian provinces provide good examples of more detailed target setting. Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia highlights key milestones for achievement against which the plan’s success will be measured:

‘1. The number of British Columbians who experience positive mental health will increase by 10 per cent by 2018.
2. The number of young British Columbian children who are vulnerable in terms of social-emotional development will decrease by 15 per cent by 2015.
3. By 2014, 10 per cent fewer British Columbian students will first use alcohol or cannabis before the age of 15
4. The proportion of British Columbians 15 years of age or older who engage in hazardous drinking will be reduced by 10 per cent by 2015.
5. By 2015, the number of British Columbians who receive mental health and substance use assessments and planning interventions by primary care physicians will increase by 20 per cent.
6. By 2018, through implementation of integrated primary and mental health and substance use services, there will be a 20 per cent reduction in the number of days mental health and substance use patients occupy inpatient beds while waiting for appropriate community resources.’

The structure of these targets and timelines is similar to those identified in the Action Plan for Mental Health in New Brunswick 2011-18:

‘1. 400 youth served [by inter-departmental case management process] by 2013
2. By 2018, there will be a 15 per cent reduction in psychiatric unit hospital days
3. By 2014, about 100 will receive early psychosis intervention services
4. By 2015, a staff survey will reveal positive changes in the attitudes, practices and skills of staff
5. By 2015, the Community Mental Health Centre Client Satisfaction Survey will indicate an increase of 10 per cent of CMHC clients reporting the highest level of engagement in their treatment plan
6. By 2017, there will be a 10 per cent reduction in the waitlist in Community Mental Health services
7. By 2014, 100 front line staff will receive cultural competency training
8. By 2014, at least 140 new clients will be provided services through Telemental Health
9. By 2015, Your Recovery Journey program is delivered to 100 participants by SSNB in conjunction with Activity Centres
10. By 2016, 375 frontline workers in government will receive the Changing Minds program
11. By 2017, increase by 15 per cent the number of persons with a mental health issue who report a high sense of belonging in their communities
12. By 2014, 300 youth will have participated in the Youth Engagement Initiative.’

These examples demonstrate how indicators or desired outcomes can be stated in a way that is measurable, so that success or progress can be evaluated. Although six policy documents provide at least some targets in this format, none of these policies detail a clear methodology for how the targets were developed, with the exception of the further details that is provided in the Fourth National Mental Health Plan Measurement Strategy, the companion document to the Fourth National Mental Health Plan.
Relatively few of the policy documents that articulate evaluation plans are accompanied by publicly available evaluations or progress reports, but some do. These reports provide an opportunity to reflect on progress made within the life of the plan and to identify the successes of the policy and areas in need of further reform. In Australia, evaluations are available for the Fourth National Mental Health Plan, and the Queensland, Tasmanian and Western Australian mental health services plans. The National Mental Health Report 2013 provides quantitative data to assess progress in the indicators identified for the Fourth National Mental Health Plan, but without reference to specific targets. The Tasmanian Taking Stock and Moving Forward Progress Report also provides an assessment of progress towards indicators, but in the form of a qualitative evaluation drawing on stakeholder consultation. The Queensland Plan for Mental Health 2007–2017: Four Year Report October 2011 provides the most detailed evaluation by comparing actual investment, program rollout, staff and bed numbers and readmission rates, for example, against the indicators and benchmarks outlined in the original Plan. The WA Mental Health Commission’s Annual Report 2012/13, while of broader scope, also provides a mix of qualitative and quantitative evaluation of the progress of the mental health system against a range of WA planning documents. The report includes comparison of actual mental health services data against targets for key performance indicators set as part of the Government Budget process (but not included in WA’s Mental Health 2020: Making it personal and everybody’s business). This format and that in the Queensland evaluation provide examples of how progress can be evaluated in detail against benchmarks.

The majority of Australian suicide prevention policy documents acknowledge the importance of evaluation but do not provide details about how this will be actioned. The National Suicide Prevention Strategy has been evaluated and a report was produced by Australian Healthcare Associates in 2014. The evaluation encountered data limitations, some of which were associated with having been commissioned retrospectively rather than being a part of the strategy itself. Other suicide prevention policy documents were founded on evaluations of earlier strategies and/or indicate that evaluations will be conducted in the future; for example, the Australian Capital Territory’s strategy was based on an evaluation of the 2005-2008 strategy and there is an undertaking to evaluate the current strategy at the end of its lifespan.
<table>
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(fd) It is indicated that an evaluation strategy or progress report will be published in future, but this document was unable to be located.

(A) Fourth National Mental Health Plan Measurement Strategy: Proposed Data Sources, Specifications and Targets for the Fourth Plan Progress Indicators
(B) National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011
(C) Evaluation of Suicide Prevention Activities
(D) Queensland Plan for Mental Health 2007–2017 Four Year Report, October 2011
(E) The Mental Health Services Strategic Plan 2006-11: Taking Stock and Moving Forward Progress Report
(F) Mental Health 2020 Action plan 2011-2012, 2012-2013
(H) Mental Health Dashboard
(I) National Benchmarking Project
(J) Action Plan
(K) Rising to the Challenge
(L) One year evaluation
4 Findings from the literature review

4.1 What does the literature tell us about the burden of disease, the prevalence of mental illness/ill-health, the associated economic, health and social costs and the costs of inaction?

4.1.1 Prevalence of mental disorders and service use in Australia

The 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB), which focused on anxiety, affective and substance use disorders, estimated that these disorders affect 20% of Australians aged 16-85 in any 12-month period. Twelve-month prevalence rates for anxiety, affective and substance use disorders were estimated to be 14.4%, 6.2% and 5.1% respectively. The lifetime prevalence rate for these disorders was estimated to be 45.5%. Data from the 2007 NSMHWB showed that 11.9% of the general Australian adult population made use of any services within a 12-month period. According to the 2007 survey, only 34.9% of those meeting the criteria for a mental disorder made use of services, although a recent study suggests that this is likely to have increased to 46% in 2009-10.

The 2010 Survey of High Impact Psychosis (SHIP), which focused on the less common but more severe psychotic illnesses (including schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder), estimated that these disorders affect 0.45% of Australians aged 18 to 64 in any 12-month period. The most frequently recorded of these disorders was schizophrenia, which accounted for 47% of diagnoses. Service use in this population was high, with 81.0% of participants using services for physical health reasons and for 95.3% using services for mental health reasons.

4.1.2 Burden of disease attributable to mental disorders

Data from the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) has been used to estimate the fatal and non-fatal burden of disease attributable to mental and substance use disorders. Fatal burden of disease is measured in years lost to premature mortality (YLLs) while non-fatal burden of disease is measured in years lived with disability (YLDs). The results of the study showed that mental and substance use disorders were the leading cause of non-fatal burden of disease worldwide, accounting for 22.9% of all YLDs. Contribution to fatal burden of disease is relatively low, with these disorders accounting for 0.5% of all YLLs.

Disability-adjusted life years (DALYs), which are a measure of overall disease burden, are expressed as the number of years lost due to ill-health, disability or early death. In 2010, mental and substance use disorders accounted for 7.4% of all DALYs worldwide. To put this in perspective, these disorders were responsible for more of the global burden than HIV/AIDS and tuberculosis, diabetes or transport injuries. In Australia, mental and substance use disorders were the second leading cause of non-fatal burden (after musculoskeletal diseases) and fourth leading cause of total burden (after cancers, musculoskeletal diseases, and cardiovascular and circulatory diseases), explaining 12.9% of total DALYs and 22.3% of total YLDs in 2010 respectively.

The contribution of individual disorders to the total mental and substance use disorders DALYs (both worldwide and in Australia) is given in Table 8.
Table 8: Contribution of each disorder to the mental and substance use disorders DALYs in 2010

<table>
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<tr>
<th>Mental disorder</th>
<th>Worldwide (%)</th>
<th>Australia (%)</th>
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<tbody>
<tr>
<td>Unipolar depressive disorders</td>
<td>40.5</td>
<td>28.5</td>
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<tr>
<td>Anxiety disorders</td>
<td>14.6</td>
<td>18.0</td>
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<tr>
<td>Drug use disorders</td>
<td>10.9</td>
<td>19.3</td>
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<td>Alcohol use disorders</td>
<td>9.6</td>
<td>8.5</td>
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<td>Schizophrenia</td>
<td>7.4</td>
<td>8.4</td>
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<td>Bipolar affective disorder</td>
<td>7.0</td>
<td>5.8</td>
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<tr>
<td>Pervasive developmental disorders</td>
<td>4.2</td>
<td>3.7</td>
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<tr>
<td>Childhood behavioural disorders</td>
<td>3.4</td>
<td>2.2</td>
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<tr>
<td>Eating disorders</td>
<td>1.2</td>
<td>4.5</td>
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<tr>
<td>Other mental and behavioural disorders</td>
<td>0.8</td>
<td>0.9</td>
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<tr>
<td>Idiopathic intellectual disability</td>
<td>0.6</td>
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The results of the study also showed that DALYs varied by age and sex, with the highest proportion of total DALYs occurring in people aged 10-29 years. The burden associated with depressive and anxiety disorders rose in childhood (ages 1-10 years) and peaked in adolescence and early to middle age (ages 10-29 years). The burden associated with schizophrenia and bipolar disorder peaked between 25-50 years of age.

The worldwide burden of mental and substance use disorders increased by 37.6% between 1990 and 2010, which for mental disorders was largely driven by population growth and ageing rather than increases in prevalence. In contrast, increased burden of alcohol, opioid, and cocaine dependence between 1990 and 2010 was largely driven by an increasing prevalence of these disorders.

4.1.3 Economic, health and social costs of mental disorders

Mental disorders have a substantial impact on individuals, families, workplaces, society and the economy. According to the 2013 National Mental Health Report, total spending on mental health services by the major funders in Australia in 2010-11 was $6.9 billion, representing 7.7% of total government health spending. The major funders are the Australian government ($2.42 billion or 35.2% of spending), state and territory governments ($4.19 billion or 61.0% of spending) and private health insurers ($257 million or 3.7% of spending). These figures reflect the cost of operating the mental health service system. A recent report by the Nous Group for Medibank Private estimated that total direct non-health expenditure to support people with mental illness was $14.8 billion in 2010-11. This included expenditure by the Australian and state/territory governments and private insurers on support payments and service provision. The Disability Support Pension ($3,913 million) and insurance payments for total and permanent disability ($1,045 million) accounted for over two thirds of total support payments and the largest element of expenditure on service provision was expenditure on social housing ($1,506 million).

Mental disorders also have large economic impacts in other areas including out-of-pocket personal expenses, carer/family costs, lost productivity and costs to non-government organisations. These costs are estimated to be greater than total government expenditures. Having a mental disorder reduces the likelihood of completing school or higher education, working full-time, working in a highly paid professional career and decreases quality of life. Moreover, mental illness may impact on personal relationships, and connection to and participation in the community.
Analysis of data from the 2010 SHIP study (and from government and non-government organisation sources) estimated the average annual costs of psychosis to society to be $77,297 per affected individual, comprising $40,941 in lost productivity, $21,714 in health sector costs, and $14,642 in other sector costs. Health sector costs are 3.9 times higher than those for the average Australian. Psychosis costs Australian society $4.91 billion per annum, and the Australian government almost $3.52 billion per annum. Comparison with the first Australian study of high impact psychosis conducted in 2000, revealed minimal change in the average costs. While there were increases in the average annual cost per person for ambulatory care, non-government services and pharmaceuticals and supported accommodation costs, these increases were offset by over a halving of mental health inpatient costs and an 85% decrease in crisis accommodation costs. It is significant to note that productivity losses changed minimally between the surveys.

Australians with mental disorders are more likely to be unemployed and to rely on welfare payments than those without these disorders. Analysis of data from the longitudinal Household, Income and Labour Dynamics in Australia (HILDA) survey showed that poor mental health is associated with an increased risk of subsequent unemployment. On average, men and women who experienced symptoms of common mental disorders spent greater time over the next four years unemployed than those with better mental health. In a recent report, Degney et al estimated that mental disorders in young men aged 12–25 cost the Australian economy $3.27 billion per annum, with the Australian Government bearing 31% of this cost via direct health costs, disability welfare payments, unemployment benefits and the direct costs of imprisonment.

Schofield et al used 2009 data from the Australian Bureau of Statistics' Survey of Disability, Ageing and Carers to quantify the personal cost of lost income and the cost to the state from lost income taxation, increased benefits payments and lost GDP as a result of early retirement due to mental health conditions in Australians aged 45-64. Their results showed that those who retired early due to depression had 73% lower income then their full time employed counterparts and those retired early due to other mental health conditions had 78% lower incomes. They also estimated that, in 2009 alone, the cost to government due to this early retirement equated to $278 million in lost income taxation revenue, $407 million in additional transfer payments and around $1.7 billion in GDP. Further analyses showed that both men and women who were out of the labour force due to depression or other mental health problems had at least 97% less savings and retirement income by age 65 that those who remained employed full-time.

It should be noted that the majority of studies on the economic costs of mental disorders relate to schizophrenia and depression. There is relatively little evidence for the costs of other disorders, particularly in Australia, and those studies that do exist have methodological weaknesses.

### 4.1.4 Mental disorders and workplace productivity

A number of Australian studies have attempted to assess the impact of mental disorders on workplace productivity. Lim et al, using data from the 1997 NSMHWB, showed that having a current mental disorder was associated with an average of one lost day from work per month, and three days per month of reduced performance. They concluded that anxiety and affective disorders were associated with more than 20 million work impairment days annually (among those in the full-time workforce). Results from the Work Outcomes Research Cost-benefit (WORC) project involving over 60 000 employees in 58 organisations in the Federal, state and local governments sectors and the private sector showed that, in any given month, 4.5% of full-time employees had high levels of psychological distress. Data also showed that high psychological distress led to an 18% increase in absenteeism in blue collar workers but not white collar workers, equating to an annualised loss of 8.8 weeks. There was also a 6% increase in presenteeism (attending work while ill but not
functioning to usual capabilities) in both blue and white collar workers. The researchers estimated that psychological distress produced a $5.9 billion reduction in employee productivity in 2009. Degney et al. reported that, on average, young men with mental disorders have 9.5 days out of role per year and that Australia loses over 9 million working days per annum to young men with mental illness.

### 4.1.5 Mental disorders and educational attainment

Mental disorders have been shown to increase secondary school drop-out rates in Australia. Data from the 2007 NSMHWB show that early onset mental disorders were significantly associated with the termination of secondary education, particularly early onset substance use disorders such as alcohol, cannabis and stimulant use. These disorders were most likely to disrupt completion in the middle years of high school (year 10 completion). This is of concern as evidence suggests that those who fail to complete high school are less likely to be employed in higher skilled occupations and to obtain other (non-school) educational qualifications.

Mental health problems have also been shown to affect both exam performance and higher education drop-out rates, with an estimated 86% of individuals who have a psychiatric disorder withdrawing from college prior to completion. In an Australian study, Stallman found that Australian students experiencing very high levels of distress were, on average, unable to work or study for eight days within the previous four weeks and had another nine days of reduced capacity for work.

### 4.1.6 The costs of inaction

As mentioned above, the worldwide burden of mental and substance use disorders increased by 37.6% between 1990 and 2010. In the case of mental disorders, while prevalence rates have remained largely stable over time, population growth and ageing has contributed to this increase in burden. Thus, it is likely that without concerted action in the areas of prevention and treatment of mental disorders, the projected ageing of the Australian population is likely to lead to an ever-increasing burden of disease. A study undertaken for the World Economic Forum estimated that the cumulative global effect of mental disorders in terms of lost economic output could amount to US$16 trillion in the next 20 years. This is equivalent to 25% of global GDP in 2010.

In a 2007 report for the Productivity Commission, LaPlagne and colleagues used data from HILDA to estimate the effects on the future probability of participation in the labour force of averting or preventing six health conditions. Their modelling showed that, averted a mental health or nervous condition had the largest positive impact on labour force participation (ranging from a 17 to 30 percentage point increase in labour force participation for men and a 17 to 25 percentage point increase for women).

Studies in other countries also provide insight into the costs of inaction. A United Kingdom study designed to estimate mental health expenditure in England until 2026 calculated future prevalence and cost estimates for depression, anxiety disorders, schizophrenic disorders, bipolar disorder/related conditions, eating disorders, personality disorder, child/adolescent disorders and dementia. The authors concluded that the number of people in England who experience a mental health problem will increase by 14.2% with service costs estimated to increase by 45% to £32.6 billion in 2026 (at 2007 prices). In Canada, Smetanin et al modelled the current and future life and economic outcomes associated with mood disorders, anxiety disorders, schizophrenia, childhood and adolescent mental disorders, cognitive impairment (including dementia) and substance use
disorders. They reported that, by 2041, the number of people living with a mental illness is expected to increase by 31% and that total cumulative costs could exceed $2.5 trillion dollars. Thus, failing to adequately prevent, manage and treat mental disorders results in considerable costs that must be borne not only by the health system but also by broader society, including individuals, families, workplaces, society and the economy.

4.2 What evidence should the Tasmanian Government take into consideration in planning for a comprehensive, integrated and responsive mental health care system that is: multi-sectoral; takes a life-course approach; promotes human rights; reflects recent scientific evidence and/or best practice; and empowers mental health consumers?

4.2.1 Multi-sectoral

Mental health care in Tasmania is delivered by a broad array of service providers, including those outside the state government funded specialist sector. For example, in 2010-11 6.1% of the Tasmanian population accessed Medicare subsidised mental health services from general practitioners, psychiatrists and allied health providers, while 2.0% of the population received state mental health services. A ‘multi-sectoral’ approach refers to any involvement of more than two sectors in mental health care. It has been difficult to meet the breadth of consumers’ needs due to the division of mental health care from other service providers, such as alcohol and drug services, housing, and criminal justice services. As demonstrated by the policy review in Chapter 3, recent national and state policies have, however, focused on the need for multi-sectoral integration in the provision of mental health services to holistically meet the support needs of people with mental illness.

In providing guidance as to what is needed for multi-sectoral integration between mental health and other services, we have focused on linkages between mental health and three important sectors with respect to the needs of people with mental health problems: the community services sector (including housing, employment, income support/entitlements); the drug and alcohol services sector; the general health care sector. For the purposes of this report, we defined ‘integration’ between the mental health sector and these three sectors the same way it was defined in a recent Australian review of integration in primary health care. ‘Integration’ is defined as structural or system/service wide strategies to integrate or coordinate health care; in contrast, ‘coordination’ is defined as informal arrangements initiated by health care providers rather than the system.

4.2.1.1 The community services sector

Individuals with a mental illness experience varying levels of severity of illness, defined by a combination of diagnosis, the intensity of symptoms, duration of illness and degree of disability experienced. Analysis of epidemiological data from the 2007 National Survey of Mental Health and Wellbeing indicates that of Australians identified as having a mental disorder in the survey, 46% were classified as having a mild illness, 33% as having a moderate illness, and 21% as having a severe illness. Severe disorders have the most impact on the individual, their support networks and the
broader community, in terms of both health services and social costs. Within this group of people with severe illness, those with persistent illness experience the greatest ongoing disability.

People with severe and persistent mental illness represent the core target population for Tasmanian Government-funded specialised clinical services (bed-based services and community services/teams) and mental health community support sector services. Individuals with these disorders tend to experience considerable impact on daily functioning, with an inability to cope with the demands of life. For these individuals, clinical treatment should be provided alongside community support to improve their social functioning and overall quality of life. Using prevalence estimates derived from multiple national and international sources, it has been estimated that 12% of adults with severe mental disorders (0.4% of the adult population) rely upon services from multiple agencies.

Ensuring the non-clinical needs of people with severe and persistent mental illness living in the community are met has long been identified as a necessary part of improving consumer outcomes. With an increased emphasis on the need to meet the non-clinical needs of people with mental illness, the recent growth in the community services sector has been met with significant investment in this sector in Tasmania. Nevertheless, integration between the mental health and community support sectors has often been impeded by systemic barriers, with responsibilities for the funding and delivery of services separated into different portfolios and levels of government.

Numerous studies have been published on mental health service integration. However, the most important aspect of this literature for policy makers and service planners is in determining which strategies are effective to achieve positive outcomes for consumers and services. A recent Australian review examined 40 studies for descriptions of linkages between the mental health and non-clinical community sectors (commonly including housing, employment, income support/entitlements, and in some cases including justice and other diverse sectors), as well as the barriers and facilitators to integration. The paper focused on identifying which integration mechanisms were linked to positive outcomes. The study found that formal linkages generally lead to positive system level outcomes (e.g., improved interagency communication, understanding and respect, reduced bureaucracy and improved service efficiency) and consumer outcomes (e.g., clinical functioning and employment prospects).

Sixteen of the 40 included studies focused specifically on integration with employment services, where the evidence based supports individual placement and support models as having the best outcomes. A key part of these models is the integration of vocational staff into community mental health teams through co-location and/or being employed directly by the mental health service.

The remaining studies were heterogeneous but some general conclusions could be drawn. Briefly, the report identified that positive system level and consumer level outcomes were promoted through the use of the following mechanisms: joint service planning through interagency committees or interface workers; formal interagency collaborative agreements; a single care plan across agencies; cross-training of staff; shared information systems; blended funding initiatives; joint service provision through multi-agency teams; co-location of services; and administration by a single lead agency. The review also identified barriers to the introduction of multi-sectoral integration, including: lack of adequate funding and technology; unrealistic workloads; ‘turf issues’ between service providers; ensuring consumer confidentiality when information sharing; implementing strategies as planned; and maintaining stakeholder engagement.

Most of the mechanisms identified in the literature review are relevant for the Tasmanian context. Some mechanisms may be difficult to implement, such as having a single information system,
administration by a single lead agency, or co-location of mental health and community services, particularly in rural areas. However, the review found that other mechanisms which may be more feasible for the Tasmanian context, such as shared care plans, formalised partnerships, and regular communication between agencies, produce many of the same benefits. These provide promising mechanisms to increase multi-sectoral integration between mental health services and services within the community sector.

*Services Connect* provides a recent example of a multi-sectoral approach between services provided in the mental health sector and the community services sector at the organisational level. In 2013, the Victorian government introduced *Services Connect*, an integrated human services model designed to connect clients with complex needs with support across different government and non-government services (including mental health treatment services, alcohol and drug treatment services, housing, and child and family services), with one key worker as a single point of contact. This client-centred approach aims to streamline the access of information and services, identification of needs, planning and delivery of services through adopting a flexible, three-tiered support model that consists of 1) self-support, 2) guided support and 3) managed support.\(^{115}\)

### 4.2.1.2 The drug and alcohol services sector

As noted in Chapter 3, most jurisdictions are currently working to develop and strengthen links between the mental health and drug and alcohol services sectors. Integration between these services needs to be strengthened because the two have until recently administered and funded separately in Australian states and territories, with these sectors separated into distinct silos.\(^{116}\) This is despite the high prevalence of dual diagnosis, defined as the presence of both a mental disorder and a substance use disorder in the same individual. Data from the 2007 National Survey of Mental Health and Wellbeing indicated that 38.6% of males and 48.5% of females with a substance use disorder had at least one co-occurring affective or anxiety disorder, and 20.3% of males and 23.7% of females with an affective or anxiety disorder had a co-occurring substance use disorder.\(^{117}\) These data provide a broad national picture for common mental disorders. The 2010 Survey of High Impact Psychosis (SHIP) study provided similar data on people with psychosis who are in contact with specialised mental health services, indicating that within this more severe group 50.5% had a lifetime alcohol use disorder and 54.5% had a lifetime drug use disorder in addition to their psychosis.\(^{118}\) Therefore the co-occurrence of mental health and substance use disorders is common, and is typically associated with complex and varied mental, physical and psychosocial needs.\(^{116}\)

Evidence suggests people with dual diagnosis are still not well serviced in Australia.\(^{119}\) An integrated care approach has been promoted to improve service delivery for individuals with dual diagnoses.\(^{119}\) Integrated care is defined as interventions or services that integrate both mental health and substance use treatments by the same service provider, and generally takes the form of a specialised dual diagnosis service. Integrated care may be implemented in outpatient, inpatient, residential or criminal justice settings (for more information, see \(^{120-123}\)). Where this is not possible or practical, mechanisms of integration between mental health and drug and alcohol services have been promoted, such as collaborative partnerships between services, a ‘no wrong door’ approach to treatment, and clear delineation of the responsibilities of each service.\(^{124}\)

Controlled studies generally support the effectiveness of integrated treatment approaches for people with severe mental illness and substance use disorders, demonstrating improved consumer outcomes in domains such as psychiatric symptoms, substance use, hospitalisation, housing, arrests, functional status, and overall quality of life.\(^{125}\) An example of an intensive model of outpatient integrated care, Integrated Dual Disorders Treatment (IDDT), has been associated with reduced improved psychosocial functioning and reduced substance use in studies from the United States.\(^{125}\)
However, clinical studies vary widely in their inclusion of treatment settings and types of psychiatric and substance use disorders, leading to ongoing disagreement about the superiority of integrated treatment over more traditional treatment for all people with dual diagnoses.\textsuperscript{121,122} A meta-analysis of 13 studies of integrated psychiatric and substance abuse care in the United States found mixed results; integrated treatment led to modest, non-statistically significant improvements in consumer-level psychiatric outcomes and alcohol use, but not drug use.\textsuperscript{127}

A recent review of dual diagnosis treatment service models within Australia suggested that many systems-level, clinical and attitudinal barriers to optimal service provision are related to the separation of the mental health and drug and alcohol service systems.\textsuperscript{126} The Tasmanian Government might consider introducing mechanisms to better integrate mental health and drug and alcohol services, such as staff training and access to consultation, the provision of integrated care and shared care arrangements, and strategies to improve communication. The use of consistent terminology and conceptual frameworks, more consistent screening and assessment tools, and a general improvement in awareness of the presence and complexity of comorbidity across these sectors have been identified as ways to improve communication and coordination between service providers.\textsuperscript{116} Where practical, integrated dual diagnosis services may provide the best outcomes for consumers. However, in the absence of separate dual diagnosis services, some of the above strategies may improve the provision of integrated care for people with dual diagnosis.

4.2.1.3 The general health care sector

This section considers coordination between the mental health care sectors and the general health care sectors in relation to physical health. GP-specialist mental health care collaboration in relation to mental health care is considered elsewhere in the report (see Section 4.3.2.4).

The life expectancy gap for people with mental illness has been widening since 1985, and in 2005 males with a mental illness were expected to live 15.9 years less, and females 12.0 years less than the general population. Importantly, 77.7\% of these excess deaths have been attributed to physical health conditions such as cardiovascular disease and cancer.\textsuperscript{128} A number of factors may contribute to the poor physical health of people with mental illness, including poor lifestyle behaviours, substance abuse and the side effects of psychiatric medications. People with mental illness have also been found to receive fewer preventive health interventions, to access screening less, and to receive little monitoring for the metabolic side effects of medications.\textsuperscript{129,130}

Coordination and communication between physical and mental health services and clinicians is poor,\textsuperscript{131} despite the fact that the connectedness between mental and physical health has been well documented.\textsuperscript{132} The policy documents reviewed in Chapter 3 generally acknowledge the importance of integration of mental health services with general health services. Training programs provided by the mental health sector for health professionals, including general practitioners and nurses, are also identified as important in national and state and territory policy documents. Strategies to improve the integration of mental health and general health care services identified in the literature include:\textsuperscript{133}

- Integrated teams (a single interdisciplinary team provides comprehensive mental and physical health care);
- Collaborative care (both the mental health specialist and the general health care provider are highly involved in the care of the consumer as orchestrated through an agreed-upon set of protocols, which may include one case manager responsible for coordinating the consumer’s mental and physical health care);
- Co-location (locating mental and physical health care services in one setting).
The significant heterogeneity in the definition and components of integration has resulted in a lack of definitive evidence supporting its overall effectiveness. However, general mechanisms for improving integration with the general health care sector include broadened treatment paradigms (e.g., a holistic approach by both mental health care and physical health care providers), assessment of the individual’s health status, introduction of medical monitoring protocols (especially for antipsychotic medications, which have established metabolic effects), primary care providers with responsibility for individual consumers, and effective communication mechanisms between mental health and primary care providers.

Collaboration between mental health specialists and the primary health care sector is of critical importance, given estimates that 85% of people with a mental disorder using services are seen by Commonwealth funded (Medicare and Department of Veterans’ Affairs) and other health services outside of the state and territory specialist mental health sector.

There is evidence that integration between mental health specialist care and primary care is associated with positive results at the system and consumer levels. Trials of integrated, co-located physical and mental health services in the United States have shown positive outcomes, including higher rates of preventive medical care, greater improvements in physical health and no significant difference in health care costs compared to standard care. In Australia, locating a part-time general practice clinic within a mental health service in the Northern Territory was found to improve coordination between general practitioners and mental health staff, and increase the delivery of physical health care services and health promotion interventions to consumers. Fuller and colleagues examined the evidence from 119 studies of the effectiveness of service linkages in primary mental health care. The most common linkages in studies with a positive effect were care management, enhanced communication, consultation liaison and local protocols. Most of the studies used a combination of linkage types and these were grouped into four broad linkage categories: direct collaborative activities, agreed guidelines, communication systems and service agreements. Analysis by the smaller number of broad linkage categories revealed that the most common combination with positive outcomes was: direct collaborative activities plus agreed guidelines plus communication systems. Studies using this combination reported a high proportion of positive clinical (81%) service delivery (78%) and economic (75%) outcomes. A lower proportion of studies that used linkages from a single broad category showed positive outcomes, compared to those studies that used linkages from multiple broad categories. Of all the broad categories, a ‘service agreement’ was the only one not associated with any positive outcome. The authors also reported that most evidence of effectiveness came from studies of depression, with long term benefits attributed to medication concordance and the use of case managers with a professional background who received expert supervision. There were fewer randomised trials related to collaborative care of people with psychosis and there were almost none related to collaboration with the wider human service sectors.

Additional mechanisms identified by a recent review of the integration between mental health and primary health care within the United States include co-location of physical and mental health care services, common funding sources to facilitate referrals and reimbursement, providing adequate compensation for integration, and communication networks that facilitate information sharing between the two sectors.

The two best options for coordinated physical and mental health care appear to be through making mental health services more accountable for the physical health of consumers with severe mental illness through treatment protocols and better coordination with primary care services, or by co-
locating primary health care and specialised mental health services within the one facility. Co-location of services has been consistently demonstrated to improve the integration of mental health and primary health care services. In a Cochrane review, Harkness and Bower\textsuperscript{141} concluded that mental health workers working onsite in primary care to deliver psychological therapy and psychosocial interventions led to a significant reduction in primary care provider behaviours such as consultations, prescribing, and referrals to specialist care.

Going forward, the Tasmanian Government might consider the adoption of integrated care models to improve multi-sectoral integration between mental health and the primary health care sector. In a companion paper to the study described above, Fuller and colleagues\textsuperscript{142} outlined five relevant areas of strategy for policymakers. These include the need to address organisational level support, joint clinical problem solving, local joint care guidelines, staff training and supervision and feedback. However, it should be noted that some models of care, particularly co-location of services, may not be possible in remote areas where service provision is scarce (see Section 4.5). Thus, a single model for coordinated care may not suit all areas, but a range of integration models may be suitable or adaptable to local circumstances.

4.2.2 Takes a life-course approach

Mental health services are required across all developmental periods across the lifespan. Results of large longitudinal studies linking risk factors in early childhood (e.g., low birth weight and late attainment of developmental milestones) to mental illness in later life underscore the importance of taking a life-course approach in planning for a responsive and targeted mental health care system.\textsuperscript{143,144} Policy documents analysed in Chapter 3 also frequently identify the importance of a life-course approach.\textsuperscript{145}

The life-course approach takes a long-term view of the causes, contributing and protective factors involved in the maintenance of mental health and development of mental illness. This approach focuses on the long-term pathways or trajectories to mental illness that often include lagged effects (delay between exposure and onset), reciprocal effects, and/or cyclical effects. The life-course approach also emphasises family trajectories, which are the whole sequence of family events during the life-course of early adults (i.e., unions, childbearing and later career) and their influence on mental health outcomes.\textsuperscript{146}

Within the life-course approach, there is a significant focus on the lagged effect of early adversity, such as childhood trauma, abuse and neglect, or divorce and poor socio-economic status. Mitigating factors and resources are also described, such as good parental relationships and moves to mitigate economic hardship. The life-course model also has implications for the recovery approach,\textsuperscript{147} with clinical studies on major depressive disorder show that higher social support predicts a shorter recovery time.\textsuperscript{148-150} Existing clinical studies typically focus on shorter periods of time and fail to adequately capture the complexities of trajectories over the life-course.\textsuperscript{117,118} Nonetheless, existing research demonstrates several areas to be salient in the development of mental illnesses:  

- Mental illness in youth tends to persist into adulthood\textsuperscript{151} and is widely identified as a significant predictor of poorer adult outcomes, including lower educational attainment,\textsuperscript{152} lower occupational status and income,\textsuperscript{153} higher rates of divorce\textsuperscript{154} and earlier parenthood.\textsuperscript{152}
- Children’s early experiences have an impact on their lifelong mental health outcomes.\textsuperscript{155-158} Negative events and traumas in childhood such as parental loss, child abuse and neglect have been associated with poorer mental health outcomes in later life.\textsuperscript{118,159} Individual childhood risk factors including aggressive behaviour, depressive symptoms, and peer and academic difficulties have been demonstrated to have a significant impact on mental health.
outcomes in adolescent and adulthood. The trajectories across the life-course can be varied and upward mobility and other protective factors (such as stable relationships) in adulthood can ameliorate negative experiences or low socio-economic status in childhood.

- A number of studies have examined the extent to which children of parents with mental illness are vulnerable (excluding genetic vulnerability and focussing on the social vulnerabilities). These studies mainly focus on the effect of mothers with affective disorders on their offspring, and document strong relationships between mothers' mental illness and mental health problems among their children. This relationship could be fully or partially mediated by neglect/abuse, poor parenting, and problems with other interpersonal relationships.

The life-course approach highlights the need for mental health promotion and mental illness prevention and early intervention programs, particularly for children at risk of developing mental illness. Interventions in early childhood and adolescence within Australia and internationally have been demonstrated to produce positive mental health and overall outcomes in later life. The long-term benefits of these interventions are difficult to capture due to the typically short time frames of clinical studies. Nevertheless, several programs have been demonstrated to be effective and provide examples of how such targeted interventions could be implemented. These include targeted programs such as Triple-P, and universal programs such as the Healthy Kids Check.

Triple-P is a multilevel parenting programme provided over 1-4 months for children with behavioural, emotional, and developmental problems, delivered (unless self-directed) by psychologists/nurses with accreditation training. Meta-analyses have demonstrated the program to be effective in improving parent-child interactions and children's behaviour problems. These improvements have been found to be maintained over time, with some studies reporting further improvements after 3-4 years.

While Triple-P is targeted at families with identifiable problems which may place children at risk of poor outcomes, the Medicare Benefits Schedule Healthy Kids Check is a universal program targeted at the whole population, which aims to promote early detection of lifestyle risk factors, delayed development and illness, and provides the opportunity to introduce at-risk children to early intervention strategies. By providing a mechanism for early identification of emerging developmental problems, the Healthy Kids Check has the potential to play a key role in producing positive mental health and overall outcomes in later life.

Given that adolescence and young adulthood has been identified as a developmental period of importance within the mental health trajectory through the life course, an effective transition between child and adolescent mental health services to adult mental health services is needed to provide continuity of care and maximise the mental health outcomes for transition-age youth (ages 16-25 years). Chronological age demarcations between child and adolescent services and adult services may act as barriers to achieve continuity of care. An example of an evidence-based transition mental health program is Headspace. Evolved as a community-based model of care, this program aims to address gaps in service delivery while providing integrated, holistic care for Australian youth aged 12-25 years. This transition model comprises of service delivery sites (communities of youth services) with a range of healthcare providers (e.g. general practitioners, psychologists, addiction counsellors and social workers) and explicitly aims to have an impact on service reform in relation to service coordination and integration within communities, and at an Australia and state/territory government policy level. Preliminary evaluation data on the program support its efficacy as a transition program including increased access and help-seeking among young people, and improvements in referral pathways.
For young people with more severe conditions, the Early Psychosis Prevention and Intervention Centre (EPPIC) model delivers specialised early intervention to youth who have experienced their first episode of psychosis. This program aims to 1) reduce the period of time between the onset of psychosis and the commencement of treatment, and 2) bring about symptomatic recovery and restore the normal developmental trajectory as early as possible. Longitudinal studies of EPPIC report positive clinical and functional (e.g. social/vocational outcomes) outcomes. A national scaling-up of the EPPIC model was implemented from early 2012, providing 16 high-fidelity early psychosis services based on the EPPIC model across Australia. At the time of preparing for this report, our review indicates no publicly available evidence regarding its implementation.

Mental health morbidity associated with the perinatal period (i.e. conception to the end of the first postnatal year) has recently been recognised as a major area of reform in Australia. To address problems with low rates of detection and treatment of depression of postpartum women, the National Perinatal Depression Initiative (2008-2013) was implemented to enable the introduction of a specific perinatal mental health Medicare stream (under the Access to Allied Psychological Services initiative) and the development of national clinical practice guidelines for depression and related disorders in the perinatal period. Preliminary evaluation indicates implementation of the NPDI to be uneven among Australian maternity hospitals with barriers including insufficient personnel, per-client time requirements, insufficient clarity about screening protocols, difficulties modifying the medical record, few referral options, and a lack of training resources. A recent evaluation of the Healthy Start Depression Initiative in the US indicates that screening for postpartum depression needs to accompany with appropriate further diagnostic and treatment procedures. Given the majority of screening procedures for the NPDI were handled by midwives, maintaining continuity of care beyond the perinatal periods is important to translate into improved patient outcomes.

Given the importance of the protective and risk factors during early childhood and adolescence on mental health outcomes at later life, there is a strong rationale for the investment and roll-out of early intervention models. Based on the existing evidence, it would seem to be desirable for the Tasmanian Government to take a life-course approach in the provision of mental health services, recognising early childhood and adolescence and continuity of care as specific areas of focus while at the same time ensuing equitable access to service delivery across the lifespan. Childhood and adolescence, especially for at-risk groups, should be a particular focus for mental health promotion, prevention and early intervention programs delivered by the Tasmanian Government.

4.2.3 Promotes human rights

Human rights are an important issue in mental health. There is a delicate balance between duties of care and protection by mental health service providers and the right of the consumer to self-determination. A widely cited article on the intersection of human rights and mental health outlines the rights and freedoms owed to all persons and the duties placed on government to respect them, and explains the interplay between human rights and mental health: people are more able to contribute to society when their mental health is good, and their mental health is more likely to be good when their rights are protected. Government intervention may be beneficent towards individuals, families and society; however, it requires due process and fair application.

In Australia, there remain ongoing concerns about the delivery of services in a way that promotes the human rights of service users. The Not for Service report in 2005 identified examples of neglect in the service system, and concluded that the process of deinstitutionalisation had not been accompanied by the provision of adequate supports in the community, resulting in a situation where people with mental illness, while no longer institutionalised, remained marginalised and unable to
participate meaningfully in society.\textsuperscript{180} Consumers’ experience of discrimination and marginalisation was also highlighted in the National Mental Health Commission’s \textit{Report Card}.\textsuperscript{181} The rights of people with mental health problems to have input into the development of services and policy has been reinforced by groups such as the People’s Health Movement,\textsuperscript{182} which advocates for consumer participation in the development of health services. In line with these views, and international agreements (e.g., consensus statements on human rights in mental health developed by the World Health Organisation and the Council of Europe), the national Australian policy documents identified in Chapter 3 emphasise that the rights and responsibilities of people with mental illness must be acknowledged and respected.

Some people and groups are particularly vulnerable to human rights violations, stigma and discrimination, which can increase the likelihood of developing mental health problems and reduce the utilisation of services. Examples of vulnerable groups relevant to the Australian context include people fleeing persecution and violence\textsuperscript{183} and sexual and physical violence,\textsuperscript{184} and people experiencing the pervasive effects of poverty and discrimination.\textsuperscript{184} Governments therefore have a responsibility to identify these people and to adopt specific measures in order to safeguard and realise their rights, including their right to mental health.\textsuperscript{183}

Approaches to the human rights of people with mental illness cover a broad range of areas, including the development of global and national charters of human rights, drafting of mental health legislation, medical duty of care, and the use of involuntary treatment practices within routine mental health service provision. For the purpose of this report, we have focused our detailed review on the latter, within the framework of existing human rights and mental health legislative frameworks. The following section reviews the evidence on two areas of human rights within routine mental health services in Australia: involuntary inpatient treatment, seclusion and restraint; and community treatment orders.

\textbf{4.2.3.1 Involuntary inpatient treatment, seclusion and restraint}

It is a commonly accepted view that adults with serious mental illnesses, such as schizophrenia, bipolar disorder and severe depression, may not be autonomous when they are acutely ill and may be at risk of harm to themselves or others.\textsuperscript{185} These individuals may be subjected to compulsory psychiatric treatment. Involuntary admission and treatment in mental health inpatient settings is used both to treat or help the individual (e.g., when their capacity to make decisions about their treatment is deemed to be impaired) and to protect the safety of others (e.g., when an individual threatens or is violent towards health staff, other consumers, family or members of the community).

Seclusion refers to the involuntary confinement of a consumer alone in a secured room or area from which free exit is prevented. Restraint involves restricting another’s freedom of movement, and can be mechanical (e.g., keeping someone in a chair using bed sheets), physical (e.g., staff holding someone down) or chemical (e.g., medication or sprays). Restraint and/or seclusion may be experienced by people with mental illness in a range of settings, including in hospital wards, emergency departments, or during transport to mental health facilities. The primary aim of these practices is to reduce the risk of traumatic experiences or injuries for both consumers and staff.\textsuperscript{186}

With the increased recognition of consumer autonomy and responsibility in medical decision making, debate regarding the usage of involuntary treatment continues. Admitting a person involuntarily results in a serious restriction of their civil liberties, a loss of control and privacy, and the administration of treatment to which they may object. A review of five qualitative studies of consumers’ experiences of involuntary admission and treatment identified several negative and some positive aspects.\textsuperscript{187} Negative aspects included the restriction of autonomy, no participation in
decision-making about treatment, and feeling powerless and dehumanised. On a positive note, some consumers reported that they participated in treatment planning, were informed of their rights, collaborated with health professionals, and felt safe and looked after. Almost half of consumers who are admitted involuntarily for mental health treatment do not agree retrospectively with the appropriateness of the admission.\textsuperscript{188, 189}

Systematic reviews have concluded that there is insufficient evidence to determine the efficacy of either seclusion or restraint as interventions in psychiatric inpatient settings.\textsuperscript{190-192} However, reviews have identified negative psychological effects on service users resulting from seclusion and restraint, such as anxiety, feelings of powerlessness and being degraded, a sense of injustice, feeling the interventions were overused and not always justified, and harm to the therapeutic alliance.\textsuperscript{186, 192}

It may be impossible to provide acute mental health treatment programs for individuals with severe mental illness without the use of any involuntary treatment, seclusion or restraint.\textsuperscript{186} However, there are alternative evidence-based interventions which may minimise the need for these involuntary practices. Reducing the use of seclusion and restraint was formally endorsed as a priority for mental health in 2005 in the \textit{National Safety Priorities in Mental Health: A National Plan for Reducing Harm}.\textsuperscript{193} The Council of Europe consensus statement recommends that all instances of involuntary admission have a therapeutic aim, and the World Health Organization consensus statement recommends that involuntary admission be limited to cases where there is a risk of significant or serious deterioration, or if judgment is impaired, to a need for treatment to improve health.\textsuperscript{194} The use of involuntary treatment, seclusion and restraint in mental health facilities also does not align easily with human rights principles.

There is evidence that advance directives (also known as joint crisis plans) may reduce the need for involuntary admission and treatment for some consumers of mental health services. These are written statements about future care which allow people with a mental illness to appoint a proxy decision maker and make choices about desired treatments should they become incapable of making decisions for themselves.\textsuperscript{195} Advance directives which are negotiated in collaboration with a consumer’s mental health treating team are more likely to be implemented during an acute episode of mental illness.\textsuperscript{196} Randomised controlled trials of the use of advance directives have shown that their implementation results in less involuntary admissions to hospital and improved consumer satisfaction, sense of involvement and control compared to usual care.\textsuperscript{196-198}

A recent review of 16 studies on interventions for reducing the use of seclusion identified that common features of successful programs include leadership, the monitoring of seclusion episodes, staff education, and changing the therapeutic environment to increase collaboration between consumers and staff.\textsuperscript{199} Training in the prediction and prevention of violence and post-incident debriefing for staff and consumers have also been found to contribute to the reduction of seclusion and restraint.\textsuperscript{186} Comfort rooms, which include comfortable furniture, soothing colours, soft lighting, quiet music and other sensory aids aimed at assisting consumers to calm down in a voluntary and non-restrictive environment, have also been found to improve consumer satisfaction with services and to lower the use of seclusion and restraint.\textsuperscript{200} The National Mental Health Seclusion and Restraint Project (2007-2009) was established as a collaborative initiative to reduce seclusion and restraint in Australian public mental health facilities, and several of these project sites reported significant reductions in the use, and/or duration of seclusion.\textsuperscript{201} Nationally, seclusion rates within public sector mental health hospital services have fallen, from 15.6 events per 1,000 bed days in 2008-09 to 10.6 events in 2001-12\textsuperscript{201}. The rate of seclusion events in Tasmania fluctuated between 11.5 to 19.7 days (per 1,000 bed days) in the years 2008-09 to 2012-13. There is a lack of national comparable data on the use of restraint in Australian mental health services due to a lack of agreement over definitions.
Going forward, the Tasmanian Government should be aware of the clinical implications of the use of involuntary inpatient treatment, seclusion and restraint within mental health services, including their negative psychological effects on mental health staff and consumers. Mechanisms that have been demonstrated to contribute to reduction of these practices, such as advance directives, increased collaboration between staff and consumers, staff training in de-escalation, debriefing after incidents, comfort rooms, and ongoing monitoring of their use should be considered.

4.2.3.2 Community treatment orders

Community treatment orders (CTOs) refer to a legal order that permits involuntary treatment in the community for a person with mental illness. CTOs offer a less restrictive, community-based environment for involuntary treatment when compared with the inpatient setting. Legislation that permits involuntary treatment generally requires a medical practitioner, with the support provided by a psychiatrist, to certify that the person has a mental illness that requires treatment either to protect that person or others. This policy assumes that the person’s condition is treatable and that they will benefit from being treated.

The use of CTOs remains controversial. Substantial variation in the rate of use of CTOs across jurisdictions has led to criticism that their use is arbitrary and poorly related to clinical need. Due to the difficulty associated with assessing community-based interventions, there is a lack of high-quality experimental evidence to suggest whether CTOs lead to improved consumer-level outcomes. A Cochrane review identified only two randomised controlled trials, both conducted in the United States, that examined the cost-effectiveness and clinical outcomes of CTOs. Neither study demonstrated significant differences in service use, social functioning, quality of life or cost effectiveness between CTOs and standard care. Similarly, a more recent large scale randomised controlled trial on CTOs for consumers with psychosis reported that the use of CTOs did not reduce readmissions. Without clearly demonstrable clinical outcomes, researchers argue that the continued use of CTOs, which curtail the consumer’s right to self-determination, remains problematic.

CTO use in Australia has been consistently high compared to international rates of use. A 2005 review of CTO use internationally reported that more people were being placed under CTOs in Australia than in Canada, with varied numbers in the United States. CTO use varies across Australian jurisdictions, with Tasmania showing the lowest rate of usage of 30.2 persons per 100,000 population, and Victoria showing the highest at 98.8 per 100,000. Light et al also observed a uniform increase in the usage of CTOs in states where there were previously available figures (New South Wales, Victoria, Queensland, Western Australia). It is important for the Tasmanian Government to recognise the scientific and human rights concerns surrounding the use of CTOs by mental health services. Given that trials on CTOs demonstrate a lack of benefits at the consumer level, the Tasmanian Government should consider reducing reliance on CTOs and ongoing monitoring of their use.

4.2.4 Reflects recent scientific evidence and/or best practice

4.2.4.1 Evidence-based service planning

Increasingly, policy-makers and planners are tasked with developing more strategic and coordinated approaches to mental health planning and service delivery that are designed to address the burden associated with mental disorders. In addition, there is increasing pressure from consumers and other stakeholders to ensure that the bases for mental health planning decisions are transparent.
To achieve this, good mental health policy must be underpinned by an evidence-based approach to mental health planning. An evidence-based approach to health planning has been defined as the ‘application of the best available information derived from clinical, epidemiological, administrative, demographic and other relevant sources and consultations to clearly describe current and desired outcomes for an identified population or organisation’. This section provides an overview of the role of evidence and best practice in the various stages of the planning process, based on an examination of selected health and mental health planning models and examples.

We identified a number of published health planning models, as well as two real-world examples of mental health service planning in the Australian context. Each of these provides a detailed breakdown of the steps involved in applying a population-based planning approach. Broadly speaking, the planning process can be divided into two phases. The first is service development planning, which involves modelling service requirements for a ‘should be’ scenario in which total need is met using optimal treatment strategies, irrespective of practical constraints regarding access, availability and resources. It is this stage in which evidence and best practice play a critical role. The second stage is implementation planning, which refers to the implementation of a service development plan in a particular context (e.g., a geographical area). This is a more practical stage in which resource and other considerations influence the types and levels of services that can be implemented. This section focuses on service development planning, rather than the practical considerations of implementation planning.

Notwithstanding some variations, evidence should be used to inform service development planning in four areas:

1. Estimating mental health treatment need in the population
2. Identifying the services/interventions required to most optimally meet population need
3. Mapping the optimal services/interventions to a framework of services
4. Estimating the resources and costs to deliver the required interventions to meet the identified population need, and setting resource targets.

**Estimating mental health treatment need in the population:** Health need can be conceptualised from a variety of perspectives, each of which has its own strengths and weaknesses, and there is no consensus on how mental health need should be defined and measured. However, in contemporary needs assessment approaches, health need is often based on the burden of illness associated with levels of severity of illness and type of mental disorder. This approach is consistent, for example, with the *Fourth National Mental Health Plan* and has most recently been applied in the National Mental Health Service Planning Framework. Evidence is then required to quantify that need. In practice, this usually involves a combination of demographic and socioeconomic data, epidemiological data, hospital and service activity data, and qualitative data about consumer’s needs, perceptions and preferences.

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2 Various classifications of health need exist. A recently proposed classification by Ardal et al (2006) is: health need as a medical necessity (determined by an expert authority); health need as burden of illness (reflecting the severity and disability associated with the illness); health need as a comparative deficit (as per comparative need); and health need as capacity to benefit (population’s ability to benefit from health care).

3 Jointly led by the New South Wales Ministry of Health and Queensland Health, the National Mental Health Service Planning Framework was funded by the Australian Government Department of Health and Ageing with the aim of developing a nationally consistent approach to the planning of mental health services for people deemed to be in need of these services, informed by evidence based practice and epidemiological data.
Epidemiological data describing the prevalence and incidence of mental health problems in the relevant population(s), as well as risks and determinants of mental health, is the main tool. In Australia, under the National Mental Health Strategy, a series of cross-sectional epidemiological surveys known collectively as the National Survey of Mental Health and Wellbeing (NSMHWB) have been conducted. These included surveys of common mental disorders in adults (conducted in 1997 and again in 2007), low prevalence disorders (in particular, psychotic illnesses) in adults (1997 and 2010), and the mental health of children and adolescents (1998 and 2013). Together, these provide a picture of the number of people affected by mental illness in the Australian population, and how mental illness impacts on their lives. Other surveys, although not specifically designed to assess mental illness, also provide useful information; these include the Australian Health Survey and the Survey of Disability Ageing and Carers, both conducted by the Australian Bureau of Statistics (ABS). Mortality data, also reported by the ABS, is a further source of information about health status in the population; suicide rates being of particular concern in mental health.

The available epidemiological data is nonetheless subject to some limitations. For example, there may be gaps in the data required for a specific application - it might not encompass the full range of mental disorders or problems of interest, and may not cover the entire lifespan. By way of example, although the NSMHWB includes surveys of adults, children and adolescents, and people living with psychotic illnesses, variations in methodology, and differences in age and disorder coverage limit the extent to which they can be combined. In addition, data might not be available for a desired geographic region - for example it may be available at a national level but not at a state of region level, although the latter is where much service planning takes place. Another limitation is that surveys vary in the ways that the levels of severity of disorder and the level of disability an individual experiences; this is problematic because severity and disability are important determinants of level of need and how services are utilised. The reality is that, as illustrated by previous efforts to construct a complete picture of mental disorder epidemiology and service utilisation in Australia, planners often resolve these problems by interpolation of data from other sources.

Health service activity collections, and quantitative and qualitative data and findings from research studies and program evaluations play a complementary role to epidemiological data in determining a picture of need in the population. Although health services data only provides information about people in contact with services, it often affords a more detailed picture of the type, quantity and patterns of service use than can be obtained from epidemiological data. For example, an analysis of current level of service provision and trends in provision can be used to identify departures from usual practice compared to other places and to monitor progress against targets. Similarly research and evaluation studies can provide more detailed information about the determinants of health care use and factors affecting the success of programs target populations with specific need profiles.

**Identifying the services/interventions required to most optimally meet population need:** Planning also requires an assessment of the available, or potentially available, mental health services and treatments in terms of their capacity to meet population need. Evidence regarding the effectiveness and cost-effectiveness of interventions is usually obtained from individual, high quality research studies or literature reviews that synthesise the results across multiple studies on a given topic. Evaluations describing the effectiveness of interventions as implemented in real world service environments and information regarding adherence to best practice guidelines and standards are particularly valuable, but less common. In the absence of evidence, expert consensus is commonly used. The latter approach was used, for example, in the Tolkien II project, an Australian modelling exercise that aimed to estimate the costs and resource requirements for the optimal treatment of 15 mental disorders. In Tolkien II, stepped care pathways for each disorder, disaggregated by
severity or disability as appropriate, were developed on the basis of research evidence supplemented by disorder-specific experts as necessary to address gaps in the research evidence.

**Establishing a framework of services:** Once effective and cost-effective interventions have been identified, these need to be mapped to a service delivery framework, that is, a schema showing where in the system these interventions will be provided. This requires the development of a taxonomy of the mental health care system that encompasses the scope of the mental health services to be planned (as per the evidence base, which may not correspond exactly to the existing service system), and that enables services and interventions to be grouped into meaningful units for planning purposes (e.g., the full-time staff equivalents required to deliver a specified number of hours of clinical care, the number of inpatient beds required to provide a specified number of bed days, the number of residential places to support a required number of consumers, etc.). These service groupings should be supported by definitions and descriptions of the services provided. Although numerous taxonomies of mental health services exist, mapping the evidence to the service system can be a challenging task, given that research evidence is typically presented at the level of specific interventions that address specific types of mental disorders (e.g., cognitive behavioural therapy for depression). Planners and policy-makers, by contrast, are usually tasked with allocating resources to specific programs (e.g., early intervention for psychosis services) or for aggregated service types (e.g., primary care or acute inpatient services) and often irrespective of disorder type.

**Estimating the resources and costs to deliver the evidence-based services to meet the identified population need, and setting resource targets:** Estimating the resources required to deliver the optimal interventions to the population in need within an agreed service delivery framework, and converting these resources into costs, requires information about the unit costs of the relevant resources (e.g., beds, clinical full-time equivalent staff). These may need to be collected or calculated if not readily available. Using this information, a gap analysis comparing current and optimal treatment at varying levels of treatment coverage can be conducted. Using this approach, for example, the Tolkien II project estimated that a 30% increase in budget could treat 60% more people and produce a 90% increase in health gain.

Given the finite nature of health resources, addressing the gap between what is and what should be requires priorities to be set and progress towards achieving these priorities to be measured quantitatively and reviewed over time. As highlighted by a previous review, relatively few mental health plans in Australia or elsewhere publish resource targets. The absence of nationally-agreed planning targets for mental health services is explicitly acknowledged in the Fourth Plan, however progress has been made at a national level (via the National Mental Health Service Planning Framework) and in some jurisdictions.

**4.2.4.2 Evidence to guide the balance of investment**

There has been increasing investment in recent years in mental health community sector services, with the sector’s share of the mental health budget increasing from 2.1% to 9.3% from 1992-93 to 2010-11 nationally, and from 3.2% to 13.5% in Tasmania over the same period. It is recognised that an appropriate balance needs to be achieved by state and territory governments in investing in specialist clinical mental health services, such as inpatient units and community mental health teams, as well as community mental health sector support services. It is difficult to define what this balance should be, as jurisdictions across Australia have different models for delivering services across these sectors. However, previous work has defined planning estimates for the mental health community support sector in Queensland which may be useful in other jurisdictions such as
Further, the recently developed National Mental Health Service Planning Framework which has been provided to all Australian governments, provides a national consensus guide as to optimal resource allocation across the full range of mental health services, including the community sector.

4.2.5 Empowers mental health consumers

A 2010 statement by the World Health Organization Regional Office for Europe on mental health consumer empowerment specified that in a mental health context, empowerment refers to the amount of choice, influence and control that mental health consumers can exercise over events in their lives. Mental health consumers have historically been excluded from the decision-making processes in mental health services. They are also at greater risk of experiencing marginalisation and discrimination in many facets of life.

Consumer empowerment, or disempowerment, has also been shown to be linked with outcomes. Broadly, disempowerment has been demonstrated to lead to poorer physical and mental health outcomes, with exposure to enduring hardship and chronic stressors linked to the development of a range of mental health problems. A system which disempowers mental health consumers may further exacerbate existing mental health problems. Certain experiences which may occur as part of psychiatric treatment, such as involuntary treatment or restraint, may add to the disempowerment of mental health consumers. Conversely, empowering initiatives, for example mechanisms to increase community participation, have been demonstrated to lead to overall better health outcomes.

The need for greater consumer and carer participation and decision making about both the development of services and about individuals’ own treatment was identified in the original National Mental Health Plan. This recognition has provided consumers more responsibility and allows them to demonstrate their ability to contribute to improving service delivery. The introduction of individual funding mechanisms may also increase the sense of control and empowerment of consumers.

Objectives and guiding principles such as increased social and economic participation, stigma reduction and social inclusion of people with mental illness, having person-centred and individualised approaches, carer and consumer participation, and identification of peers as part of the mental health workforce have been adopted at the national and state and territory level in Australia. These objectives may empower consumers though creating equal opportunities to help people with mental illness attain life goals, and were reviewed in Chapter 3.

Consumer empowerment can occur at multiple levels, acting to foster both individual and social empowerment. Changes at the legislative and policy level can be made to create equal opportunities, while changes at the service provider and individual consumer level can contribute to individual empowerment. A 2006 literature review on the discourses surrounding empowerment in mental health identified a range of methods for enabling empowerment:

- Inclusion of mental impairment within disability legislation, making it illegal to deny employment or services based on mental impairment;
- Provision of financial and organisational change within educational establishments to support people with mental health problems through issues of stress tolerance and discrimination;
- Campaigning for less discriminatory and prescriptive treatment by consumer groups; services should collaborate with these groups in a genuine partnership and government should provide funding and endorsement to legitimate consumer groups;
• More formalised mechanisms to ensure access to information and genuine service choices for consumers; and
• Collaborative partnerships between practitioners and consumers that adhere to a recovery approach, focusing on individual strengths and resources and future capacity to use these, which hopefully would enable consumers to set treatment agendas.

For the purpose of this report, we have focused on reviewing the latter two methods, which can be implemented at the service level by mental health service planners and managers to empower consumers at the individual level. Therefore the following section reviews the evidence on the practices most relevant to consumer empowerment in mental health at the service provider and individual consumer level: peer support and consumer-operated services; and increased consumer participation.

4.2.5.1 Peer support and consumer-operated services

At the service provider level, peer support services (identified as support or services provided to people with mental illness by others with lived experience of mental illness) have been promoted as a way to promote self-efficacy and hope through sharing experiential knowledge and coping strategies.\(^{241}\) The potential for reciprocal support (explicit in mutual support groups and implicit in peer relationships) may empower both consumers and providers of these services.\(^{242}\) In line with the United Kingdom and the United States, peer support services are expanding across Australia, particularly in community-based mental health settings.\(^{243}\) Briefly, there is currently a lack of experimental evidence to support the clinical outcomes of peer support for people with severe mental illness over traditional treatment methods. However, in regards to empowerment, a recent systematic review and meta-analysis of randomised controlled trials of peer support services noted that while heterogeneity across treatment settings may have resulted in relatively inconsistent outcomes, these services generally increase the levels of empowerment experienced by consumers.\(^{242}\) Two studies investigated maintenance of the levels of empowerment following intervention, and demonstrated that the significant and positive effect of empowerment also persisted at 6-month follow-up.\(^{244},^{245}\)

Specific programs run by and for consumers in mental health service delivery, commonly called consumer-operated service providers (COSPs), have also been linked to the empowerment of mental health consumers. Due to, at least in part, the feelings of disenfranchisement and powerlessness among mental health consumers from a perceived lack of choice and control over their treatments, these programs typically share a clear focus on empowerment.\(^{246}\) A recent study\(^{246}\) examined the difference in consumer-reported empowerment between consumers who were or were not exposed to one of three types of COSPs (drop-in programs, peer support and mentoring programs, and education and advocacy programs) and found generally positive improvements in empowerment for those who used COSPs. Due to the variability between program sites, some programs were more successful at increasing empowerment than others. Notable differences between program sites included local geography, program resources and the way in which the interventions were conducted. It is important to note that due to the diverse nature of the programs (as well as characteristics of service recipients), there is currently a lack of systematic research or empirical evidence about the clinical outcomes of COSPs in mental health settings.

Some of the barriers to peer provided services, including COSPs, include inadequate infrastructure and resources for consumer positions, poorly defined roles, and stresses associated with the lack of role clarity.\(^{247},^{248}\) Given the lack of numbers, peer workers might be relatively isolated in teams or services and therefore not be adequately supported.\(^{249}\) The heterogeneity in peer provided services,
including COSPs, has also been identified as contributing to the variability in producing measurable clinical outcomes.\textsuperscript{242, 246}

Increasing the use of trained mental health peer support workers has been identified as an action in national policy documents. A new Certificate IV in Mental Health Peer Work has been developed to formalise the knowledge and skills required to work as consumer and carer workers within the mental health sector. In Tasmania, mentoring opportunities have been identified as a workforce development strategy. The role for paid consumers and carer consultants in relevant services was also identified among several stigma reduction initiatives. Going forward, the Tasmanian Government might consider the infrastructure and resources available to consumer workers to promote recruitment, training and retention of peer workers in mental health settings. Accreditation of the Certificate IV in Mental Health Peer Work should be further explored in the Tasmanian context, as it may provide a mechanism to formalise and standardise the knowledge and skills of consumer and carer workers. Such accreditation may also assist peer workers to integrate into the existing mental health workforce. The Tasmanian Government should also consider the role of evidence-based COSP programs within the mental health sector. While formalising and providing oversight of COSPs may strengthen the clinical outcomes of these programs, such input may impact on the sense of empowerment service users experience from these services.

4.2.5.2 Increased consumer participation

At the individual consumer level, increased consumer participation can lead to greater sense of personal empowerment. Historically, consumers have not been involved in the decision making process in mental health settings. Following deinstitutionalisation, the evolution of service delivery has been accompanied by increased opportunities for consumers to contribute to decisions in the planning, development, and delivery of services.\textsuperscript{250}

Lack of understanding of treatment regimens, especially for chronic disorders, may lead to perceived coercion among consumers, resulting in consumer disempowerment and undermining the partnership between clinicians and consumers.\textsuperscript{251} Strategies such as designing treatment programs that meet consumers’ personal goals have been suggested to foster collaboration between clinicians and consumers and promote consumer empowerment.\textsuperscript{251} Changing the therapeutic environment to increase collaboration between consumers and staff has also been identified as a strategy to decrease the use of involuntary treatment and prevent further disempowerment experienced by consumers.\textsuperscript{237} In addition, the promotion of mental health literacy (i.e., knowledge and beliefs about the recognition, management or prevention of mental disorders) among consumers, typically through psycho-education, may also assist them in making decisions about individual treatment options.\textsuperscript{252}

An Australian qualitative study identified that, from the perspective of consumers, mental health reforms have allowed them to experience greater control over their own lives and the service system they have used.\textsuperscript{250} However, consumers also noted that their participation has been challenged by a lack of acceptance by service providers, and felt that the expectation of government policy for service providers to encourage consumer participation had resulted in a degree of tokenism.\textsuperscript{250}
4.3 What contemporary models of care does the literature suggest regarding the most appropriate service streams and clinical service priorities to ensure that we provide the best overall mental health care for all Tasmanians?

4.3.1 Taxonomy of service components and scope

A taxonomy of mental health service components and service types was developed based on the review of mental health policy documents described in Chapter 3 (see Tables 1 and 2). Four service components were identified, namely universal promotion and prevention services (including suicide prevention services), primary care and/or general health services, specialised clinical services (general and special populations) and mental health community support sector services. Within each service component, a range of mental health service types were identified, as shown in Figure 1.

For the purpose of describing contemporary models of care, we have defined ‘contemporary’ as representing current best practice, and focused the scope of the review on those mental health service types likely to be delivered by the Tasmanian Government, primarily within specialised clinical services, but also with some consideration of support service types which may be contracted out to, or delivered in partnership with, non-government agencies.
4.3.2 Specialised clinical services (general and special populations)

Specialised clinical services can be broadly grouped into four service types – bed-based mental health services, psychiatric emergency care services, community mental health services, and mental health consultation-liaison services. These services are generally provided directly by state and territory governments and are usually targeted broadly to consumers with a mental disorder, often organised by age group (children and/or youth, adults and older persons). In addition, targeted services under one or more of these service types may also be provided for special populations, such as people in contact with the justice system or Indigenous people.

4.3.2.1 Bed-based mental health services

Contemporary models of mental health service delivery include a core of bed-based services for consumers requiring intensive 24-hour support. Despite an increasing shift towards community mental health services, there is an ongoing need for inpatient mental health care for some consumers in times of high need. The most well established bed-based services are acute psychiatric inpatient units and non-acute or extended care units. Acute units are required to provide short term, high intensity treatment for people with acute and severe mental illness, to provide stabilisation of mental state in crises and prevent risk of harm to self or others. As a long-standing and core part of most mental health service systems, it is surprising that there has been little research into the effectiveness of acute psychiatric inpatient units as a service type. Nonetheless they are considered an essential part of the spectrum of mental health services. Non-acute units provide longer term rehabilitation in a bed-based environment, and are considered to be appropriate only for a small group of people with severe disability caused by their mental illness who are not able to live in a less restrictive environment at the present time.

There has been a strong push over the last half century towards the deinstitutionalisation of mental health care in order to treat consumers in their local community where possible. As hospital admissions decrease, alternative accommodation options in the community have expanded. Sub-acute and non-acute residential and supported accommodation services delivered in community settings provide an alternative to hospital admission and a stepped care approach to mental health treatment and rehabilitation in the least restrictive environment.

There is increasing evidence from several reviews that community based sub-acute residential facilities provide an effective, consumer-preferred and lower cost treatment option for some people who would otherwise be admitted to an acute inpatient unit. Sub-acute units are 24-hour staffed home-like facilities which provide community-based care to consumers in crisis. Some examples of these facilities are the Prevention and Recovery Care (PARC) units rolled out extensively in Victoria, and community crisis houses, such as Acmena House in Queensland. These services can provide a ‘step-up’ for consumers in the community experiencing an acute exacerbation of their illness with the aim to avert an inpatient admission, or a ‘step-down’ or transitional arrangement for inpatients whose illness has stabilised enough to allow discharge from inpatient care but who still require a residential level of care, support to find housing, and develop living skills and community connections. Although evaluations of these community sub-acute services show very positive results, they may not be suitable for consumers with particularly severe or complicated disorders, first admissions, or those in need of involuntary treatment, and therefore they are not a complete replacement for acute inpatient units. Sub-acute facilities can be delivered through a partnership model between clinical mental health services and non-government sector providers, allowing consumers to receive both clinical treatment and psychosocial support in the one setting.
For longer term, non-acute mental health care, contemporary models of care promote providing this care in the community wherever possible, allowing consumers to maintain contact with family, friends and the local community.260 There is also evidence from many studies that community-based long-term residential care and supported accommodation are an effective alternative and are more cost-effective than extended care in a hospital-based setting.260 A range of residential services should be provided to suit individual needs, including long-stay community residential units such as Community Care Units (CCUs), and supported accommodation packages providing housing, clinical and non-clinical support to people in need of assistance to live successfully in the community, such as the Housing and Accommodation Support Initiative (HASI) in New South Wales, the Housing and Support Program (HASP) in Queensland, and the Housing and Accommodation Support Partnership (HASP) program in South Australia. Evaluations of these supported accommodation programs have shown success in reducing the frequency and duration of hospital admissions and emergency department attendances, reducing the incidence of involuntary treatment, maintaining or improving symptoms and psychosocial functioning, maintaining housing tenancy and reducing the overall cost of mental health care.261-263

4.3.2.2 Psychiatric emergency care services

The initial point of contact for people experiencing a mental health crisis is often a first responder, such as the general hospital emergency department, police or ambulance service. Specialised mental health services can play an important role in ensuring that people in mental health crises receive appropriate and timely assessment and treatment in these situations, while being treated with respect and dignity. Strategies include providing mental health training to first response staff, and providing consultation and/or intervention in these settings by specialised mental health staff. There are a number of alternative models of care for people who present to an emergency department with a mental health problem. General health providers working in the emergency department often lack mental health expertise, and studies have found that the involvement of specialised mental health staff in the emergency department improves the quality and timeliness of mental health care provided to consumers in this setting.264,265 This can be achieved through the availability of psychiatric consultation liaison staff to provide consultation and/or assessment in the emergency department on an on call basis. However, some issues with this approach include delays in the availability of staff and a lack of continuity of care, and evaluations provide limited information about the effect on consumer outcomes.266 Contemporary models of care in larger hospitals with a high frequency of mental health-related emergency department attendances include specialised psychiatric emergency care centres, which have dedicated psychiatric emergency beds and specialised psychiatric staff embedded within or co-located near the emergency department.266,267 This model of care provides the most advantages for consumer safety and timeliness and appropriateness of care.268-270 However, these centres can be very expensive compared to standard care, and some have expressed concern that they segregate mental health emergency care from general health services.266 Where practical considerations prevent the establishment of psychiatric emergency care centres, such as in smaller hospitals, mental health liaison staff (particularly nurses) embedded within the emergency department can provide timely and quality care at a lower cost, while also supporting and educating general emergency staff to better deal with psychiatric emergencies.266 Further, when mental health consultation staff are not available to the emergency department at all, training of general health staff in mental health and de-escalation techniques, and other small changes in practice and the emergency department environment may lead to improvements in consumer care.271

It is also important that police and ambulance services are able to respond to psychiatric emergencies in the most efficient and effective way. Contemporary models of care in this area focus on providing mental health training to police officers and paramedics, collaboration and linkages
with mental health crisis staff, and the ready availability of mental health crisis services to which police or ambulance services can transport individuals experiencing a mental health crisis. Core elements of training programs include information about the symptoms of mental illness, suicide prevention interventions, and appropriate techniques for interacting with people with a mental disorder. A more specialised model involves providing more extensive mental health training to a team of police officers who are then the first point of contact in psychiatric crises in order to de-escalate the situation and provide transport to mental health services as necessary. Partnerships between police and mental health services have also been implemented and evaluated in many jurisdictions. In Australia, joint specialised mental health, police and ambulance response models have been developed, with examples including Queensland’s Mental Health Intervention Program, Victoria’s Police, Ambulance and Clinical Early Response (PACER) trial, and New South Wales’ Mental Health Police Crisis Intervention Team pilot program. The various types of programs discussed here have been found to lead to less imposition on police officers’ time and facilities, lower arrest rates, and more timely access to mental health assessment and treatment.

### 4.3.2.3 Community mental health services

Contemporary models of mental health care rely on multidisciplinary community mental health teams to deliver outpatient care and provide ongoing support and relapse prevention to people with severe and often chronic mental illness. Within community mental health services, case management is the widely used standard model of care, targeting consumers who require maintenance treatment and relapse prevention from specialised mental health services. General case management models involve the provision of treatment planning, direct clinical care, monitoring and linkage with other support services by a mental health professional operating within the community mental health team. Staff caseloads are typically in the range of 30 or more consumers, with contacts usually provided at clinics. There is mixed evidence on the effectiveness of case management for consumer outcomes, but it has been found broadly to reduce dropout from mental health services, and provide some improvement in symptoms and social functioning.

Reviews of the evidence have found that the effectiveness of case management increases as it aligns more closely to assertive community treatment (ACT) models of care (see below).

Contemporary examples of community mental health services which have a stronger supporting evidence base include ACT, crisis assessment and treatment teams (CATTs), and youth early psychosis services. ACT services provide intensive mobile treatment to people with severe and persistent mental illness with a history of frequent hospitalisation within a standardised model of care, which includes small caseloads and team-based care. In addition to traditional case management functions, ACT teams offer are more comprehensive array of rehabilitation services. Compared to standard care, ACT has been found to result in fewer and shorter hospital admissions, reduce treatment costs and improve satisfaction for people with severe and persistent mental illness who are frequent users of inpatient care. Some reviews also suggest that ACT has positive effects on housing stability, symptoms, quality of life and employment outcomes. ACT services are best suited for consumers who do not achieve good outcomes with less intensive forms of case management and are frequent users of inpatient mental health services.

CATTs are provided by an increasing number of state/territory mental health services in Australia. These teams provide mobile 24-hour assessment and emergency treatment in response to consumers experiencing an acute mental health crisis, usually in a person’s home or other community location. CATTs can also initiate a course of short-term community treatment, or admission to an acute inpatient unit as required for the individual. This community-based crisis response approach has been found to be more acceptable and less disruptive to consumers and their families than acute inpatient treatment.
Early psychosis services for young people have received increasing attention in recent times. These services provide assessment, treatment and support for young people with first presentation of a psychotic disorder, generally for a limited period. There is no clear evidence for the optimal duration of treatment for early psychosis services and more research is needed, although studies suggest that for most consumers treatment intensity should be maintained for the first five years. Consumers who have completed treatment with an early psychosis service and transition to care from general mental health services may experience disruptions to the continuity of care and reduced levels of support available. However, due to funding constraints, established early psychosis services in Australia and internationally tend to provide services for a maximum of 18 months to 3 years. The age group of focus is usually young people aged in their mid-teens (15 or 16 years) to mid-twenties (24 or 25 years). Australian and international studies show benefits of early psychosis services over standard care, including reduced morbidity, better social and vocational functioning, better engagement with services and reduced hospitalisation. However, the evidence for any effect on longer term outcomes for people with psychosis after contact with early psychosis services ceases is unclear. Some studies have shown that early intervention may be more effective and less expensive over an 8 year period compared to usual care, but others have found that the benefits of early psychosis services may diminish after transition back to usual care. Given the positive outcomes from early interventions services and the difficulties with short term programs and transition back to usual care, it is therefore recommended that early intervention type service models should be part of mainstream mental health service delivery rather than a stand-alone specialised service, in order to ensure the best possible care is delivered to all consumers.

Finally, although community mental health services play a very important role in the care of people with severe and persistent mental illness, these consumers require a range of services, including clinical treatment, stable housing, and psychosocial support services, to ensure they can live well in the community. As part of community mental health care, case managers should ensure that consumers with complex needs have a single care plan and coordinated care across agencies involved in their support.

4.3.2.4 Mental health consultation-liaison services

Psychiatric consultation-liaison (CL) services provide education, training and expert advice to providers outside of the mental health specialised sector as well as direct assessment and treatment planning for individuals under the care of these other providers. Contemporary models of mental health care include the provision of CL services to a range of settings, but particularly within general hospital wards and to primary care providers. CL and collaborative care with professionals in community settings such as schools and nursing homes are also a crucial part of providing mental health services for children and adolescents and older adults. These CL services are important in providing good quality mental health care, education for non-mental professionals, and a stepped system of care where individual consumers are treated in the least restrictive environment suitable to their needs. Where consumers can be treated successfully in general health and community settings, CL services can play a role in assisting these services to manage their care successfully so that more intensive specialised services are not required.

Within general hospital settings, the main goals of CL are to improve the physical and mental health care of admitted individuals, reduce the length of hospital stay and associated costs, and educate non-mental health professionals. There is some evidence that CL services to general hospital wards are cost effective and reduce the length of hospital stay when mental health staff are involved early in the admission. However, there is limited available evidence with which to judge the efficacy of
CL services, particularly around the effect of CL on consumer outcomes, and further research is required. Under the introduction of activity-based funding for hospital-related services in Australia, the financing of mental health consultation liaison services is a potentially problematic area which requires close scrutiny and a considered approach. As many mental health CL service consultations do not result in a mental health diagnosis being assigned to the consumer, there is the potential for a loss of mental health funding in this area if it is not carefully addressed.

CL to primary care providers is another area of contemporary mental health service delivery which requires further research. There is very little evidence that CL alone has a positive impact on consumer outcomes in primary care. However, there is more evidence for the clinical effectiveness of collaborative care models between mental health services and primary care, in which a case manager also works with consumers, primary care staff and psychiatrists to improve the quality of mental health care. More collaborative models of care have shown positive effects on health, satisfaction and treatment compliance. Evaluation of the Consultation-Liaison in Primary-Care Psychiatry (CLIPP) model developed in Melbourne has found that it is possible to transition some stable consumers from specialised community mental health care into primary care with CL/collaborative care with no negative impact on outcomes. Successful candidates for the CLIPP program tend to be consumers with some insight, social support, and a clinically stable disorder.

4.3.3 Mental health community sector services

Specialised clinical services are the core area of responsibility for the Tasmanian Government in delivering mental health services. However, they are not sufficient alone to achieve optimal outcomes for people with severe and persistent mental illness. For people with severe and persistent mental illness, who are the core population utilising state/territory specialised mental health services, a range of coordinated services are required, including clinical treatment, appropriate housing, and community support services. Mental health community support sector services are an important part of contemporary mental health service delivery, providing support for consumers to live successfully in the community, improving functioning, aiding recovery, and supporting families and carers in their caring roles. Core service types in this area which are likely to be financed by state and territory governments include family and carer support, personalised support, group support, and mutual support and self-help services. Education, employment and training services and care coordination provide important supports for people with severe mental illness, but in Australia are provided or funded largely by the Australian Government.

Studies have shown that mental health community support sector services provide benefits to consumers and their families or carers. A systematic review of personalised support services delivered by mental health professionals and peer workers noted their effectiveness in reducing illness acuity and improving satisfaction for people with severe and persistent mental illness. Group support services such as psychosocial clubhouses may improve consumer empowerment and quality of life. Mutual support and self-help groups have been found to improve social participation and symptom management in a range of studies. Family and carer support, including family services delivered to the consumers and their families, and group and mutual support services for families and carers, have a good evidence base for improving carer outcomes such as understanding of mental illness, social networks, and coping skills.
4.4 What are the attributes of a mental health workforce that would support the delivery of a comprehensive, integrated and responsive mental health care system?

We have interpreted this question as relating to qualities, characteristics or skills (terms which we use interchangeably) of the mental health workforce that would support the delivery of a comprehensive, integrated and responsive mental health care system. The Tasmanian Workforce Development Plan 2012-2015 identifies three priority areas for action in order to achieve a sustainable workforce: increasing and retaining their current and future workforce; building workforce development and planning capacity across the sector; and raising and updating the skills of the workforce across the sector. Therefore, the review provided in this section informs the third priority area in that it focuses on identifying the skills required by the mental health workforce in order to engage with consumers in a manner that facilitates optimal and responsive mental health outcomes for consumers.

4.4.1 Who comprises the mental health workforce?

Before describing the attributes of the mental health workforce, it is necessary to understand who the individuals that comprise the mental health workforce are. The mental health workforce encompasses nurses (mental health, general and enrolled), psychiatrists, general and other medical practitioners, psychologists, social workers, occupational therapists, vocationally qualified mental health workers, consumer and carer workers (also referred to as peer workers), Aboriginal mental health workers and Aboriginal health workers. Overall, there appears to be consensus within national policy documents about disciplines or groups comprising the workforce, although there is variation to some extent. For example, the National Practice Standards for the Mental Health Workforce document emphasises nurses, occupational therapists, psychiatrists, psychologists and social workers but concedes that other disciplines and workers apart from these five professions are also an important part of the mental health workforce. We use the term ‘mental health practitioners’ inclusively to refer to all potential individuals comprising the mental health workforce.

4.4.2 Health Workforce Australia (HWA)

An additional point to note prior to considering the attributes of the mental health workforce is the remit of Health Workforce Australia (HWA), which is a Commonwealth statutory authority that delivers a national, coordinated approach to health workforce reform. HWA was established in 2010 by the Council of Australian Governments (COAG) in response to the challenges of providing a ‘skilled, flexible and innovative health workforce that meets the needs of the Australian community’ [https://www.hwa.gov.au/about-us]. Of particular relevance to this review is HWA’s body of work in relation to the reform of Australia’s mental health workforce, which is aligned with the National Mental Health Workforce Strategy. This work aims to inform the development and support of a ‘skilled and sustainable mental health workforce that delivers safe, high-quality, recovery-oriented, mental health services.’ HWA’s mental health workforce projects include:

- The Mental Health Workforce study which is currently in progress and aims to provide quantitative evidence on workforces delivering services to mental health consumers, to understand the existing workforce and support future workforce planning.

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4 It should be noted that at the time of the development of this report, the Australian Government announced the abolition of Health Workforce Australia, consolidating its functions into the Department of Health
• The Mental Health Peer Workforce study was completed in September 2013. The study included a range of information-gathering activities, including site visits and interviews to compile case studies of peer workers from around Australia; a literature scan; and an online survey of mental health peer workers. The draft mental health peer workforce study has been completed\textsuperscript{118} and the HWA website indicates that the report will be published early in 2014.

• The Mental Health Capabilities project identifies and describes expected workforce behaviours across the range of mental health services and workforce roles. Its purpose is to ensure the mental health workforce across Australia has consistent skills and works to the same high standards. Drawing on HWA’s National Common Health Capability Resource and the revised National Practice Standards for the Mental Health Workforce, the draft National Mental Health Core Capabilities were tested with potential users to obtain feedback from the sector in November 2013. A number of focus group workshops enabled the capabilities to be refined, and validated the work that has already been undertaken. Workshops were held with mental health services, educators and trainers, service planners, consumers and carers, managers and leaders. The draft National Mental Health Core Capabilities (NMHCC)\textsuperscript{319} was recently available for consultation, with a closing date of 2 May 2014.

Certain features of these projects are elaborated as relevant throughout this review.

4.4.3 Mental health workforce attributes

4.4.3.1 National Practice Standards for the Mental Health Workforce

The National Practice Standards for the Mental Health Workforce (NPSMHW)\textsuperscript{314} describe values and attitudes as well as practice standards that are intended to complement the discipline-specific contributions of each profession. Values and attitudes influence the manner in which mental health services are delivered and received, with the following values and attitudes considered to underpin how mental health practitioners apply skills and knowledge when working with people, families, carers and communities:

• **Respect**: Mental health practitioners respect the person, their family and carers, their experience, their values, beliefs and culture, including diversity among people.

• **Advocacy**: Mental health practitioners strive to uphold the human rights of people, families and carers, including full and effective participation and inclusion in society.

• **Recovery**: Mental health practitioners support and uphold the principles of recovery-oriented mental health practice outlined in the National Standards for Mental Health Services 2010.

• **Working in partnership**: Mental health practitioners foster positive professional and authentic relationships with people, families, carers, colleagues, peers and wider community networks. Safe and professional boundaries are maintained. Mental health practitioners work constructively to resolve tensions that may arise between partners in care. The professional diversity that can exist within teams is respected and valued and there is always endeavour to work in positive and collaborative ways that support multidisciplinary and interdisciplinary practice. Mental health practitioners believe that quality service provision is enhanced and underpinned by effective working relationships within the service, with partner agencies and communities.

• **Excellence**: Mental health practitioners are committed to excellence in service delivery, personal development and learning (e.g., reflective practice, ongoing professional development, lifelong learning).
Thirteen national practice standards that describe the capabilities that mental health practitioners should achieve in their work have been outlined under the guidance of the Mental Health Workforce Advisory Committee (MHWAC) and include the following:

- **Standard 1 – Rights, responsibilities, safety and privacy**: Privacy, dignity and confidentiality are maintained, and safety is actively promoted. Mental health practitioners implement legislation, regulations, standards, codes and policies relevant to their role in a way that supports people affected by mental health problems and/or mental illness, as well as their families and carers.

- **Standard 2 – Working with people, families and carers in recovery-focused ways**: In working with people and their families and support networks, mental health practitioners support people to become decision-makers in their own care, implementing the principles of recovery-oriented mental health practice.

- **Standard 3 – Meeting diverse needs**: The social, cultural, linguistic, spiritual and gender diversity of people, families and carers are actively and respectfully responded to by mental health practitioners, incorporating those differences into their practice.

- **Standard 4 – Working with Aboriginal and Torres Strait Islander peoples, families and communities**: By working with Aboriginal and Torres Strait Islander peoples, families and communities, mental health practitioners actively and respectfully reduce barriers to access, provide culturally secure systems of care, and improve social and emotional wellbeing.

- **Standard 5 – Access**: Mental health practitioners facilitate timely access to services and provide a high standard of evidence-based assessment that meets the needs of people and their families or carers.

- **Standard 6 – Individual planning**: To meet the needs, goals and aspirations of people and their families and carers, mental health practitioners facilitate access to and plan quality, evidence-based, values-based health and social care interventions.

- **Standard 7 – Treatment and support**: To meet the needs, goals and aspirations of people and their families and carers, mental health practitioners deliver quality, evidence-informed health and social interventions.

- **Standard 8 – Transitions in care**: On exit from a service or transfer of care, people are actively supported by mental health practitioners through a timely, relevant and structured handover, in order to maximise optimal outcomes and promote wellness.

- **Standard 9 – Integration and partnership**: People and their families and carers are recognised by mental health practitioners as being part of a wider community, and mental health services are viewed as one element in a wider service network. Practitioners support the provision of coordinated and integrated care across programs, sites and services.

- **Standard 10 – Quality improvement**: In collaboration with people with lived experience, families and team members, mental health practitioners take active steps to improve services and mental health practices using quality improvement frameworks.

- **Standard 11 – Communication and information management**: A connection and rapport with people with lived experience and colleagues is established by mental health practitioners to build and support effective therapeutic and professional relationships. Practitioners maintain a high standard of documentation and use information systems and evaluation to ensure data collection meets clinical, service delivery, monitoring and evaluation needs.

- **Standard 12 – Health promotion and prevention**: Mental health promotion is an integral part of all mental health work. Mental health practitioners use mental health promotion and primary prevention principles, and seek to build resilience in communities, groups and individuals, and prevent or reduce the impact of mental illness.

- **Standard 13 – Ethical practice and professional development responsibilities**: The provision of treatment and care is accountable to people, families and carers, within the boundaries prescribed by national, professional, legal and local codes of conduct and practice. Mental
health practitioners recognise the rights of people, carers and families, acknowledging power differentials and minimising them whenever possible. Practitioners take responsibility for maintaining and extending their professional knowledge and skills, including contributing to the learning of others.

4.4.3.2 National Mental Health Core Capabilities

As noted above, HWA is in the process of developing a description of core capabilities for the mental health workforce. The final list of capabilities is intended to complement the national practice standards for the mental health workforce, the National Standards for Mental Health Services and the National Framework for Recovery-Oriented Services. As part of the National Core Mental Health Capabilities project, a consultation paper was available in April 2014, which sought feedback from various stakeholders about the core capabilities. The capabilities are classified according to six domains and include:

- **Values**: Respect; advocacy; recovery; working in partnership; excellence.
- **Diversity and whole of person focus**: Diversity; working with Aboriginal and Torres Strait Islander people, families and communities; prevention and promotion of wellbeing; whole of person focus.
- **Professional, ethical and legal approach**: Ethical and legal practice; scope of practice and accountability; communication, documentation and conflict management; self-management and care.
- **Collaborative practice**: Shared responsibility with people using services, and their families and carers; inter-professional collaboration (vision and objectives; collaboration within and across team; collaborative interpersonal decision-making); collaborating across time and place (transfer of care; follow-up and referral, including clinical handover; integrated care)
- **Provision of care**: Access and engagement; assessment; performing health care activities (individual planning; deliver care; monitor, evaluate and revise plans); supporting processes and standards (evidence-based practice; quality care provision and general safety; dignity of risk).
- **Life-long learning**: Holistic learning and development; self-reflection; professional support relationships; feedback and peer assessment.

Further details about the core capabilities are available in HWA’s consultation paper. The capabilities address core elements of common mental health practice across the mental health workforce. They are intended to complement the valuable, discipline specific contributions of each work force group, and to address the shared capabilities, values and attitudes required when working in an interdisciplinary mental health service. The capabilities are intended to inform: workforce and service planning; workforce and service redesign; individual and organisational development; education and training; and recruitment, selection and induction.

The capabilities then specify observable or measurable actions expected of the workforce when performing each activity. These behaviours are specified at four levels: essential or level 1 behaviours, practitioner or level 2 behaviours, team leader/experienced practitioner or level 3 behaviours and leader/systems responsibility or level 4 behaviours. The final draft of the NMHCC is currently in preparation and is a potentially useful resource for workforce development, the mental health workforce itself and for consumers and carers.

4.4.3.3 International core competencies for integrated practice

In the United States, the Substance Abuse and Mental Health Services Administration and the Health Services Administration commissioned the Center for Integrated Health Solutions to identify and
disseminate core competencies on integrated practice relevant to behavioural health and primary care providers.\textsuperscript{322} Some or all of these competencies may be of relevance to the attributes of the mental health workforce that we are considering and include the following:

- **Interpersonal communication**: The ability to establish rapport quickly and to communicate effectively with consumers of health care, their family members and other providers.
- **Collaboration and team work**: The ability to function effectively as a member of an inter-professional team that includes behavioural health and primary care providers, consumers and family members.
- **Screening and assessment**: The ability to conduct brief, evidence-base and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.
- **Care planning and care coordination**: The ability to create and implement integrated care plans, ensuring access to any array of linked services, and the exchange of information among consumers, family members and providers.
- **Intervention**: The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.
- **Cultural competence and adaptation**: The ability to provide services that are relevant to the culture of the consumer and their family.
- **Systems oriented practice**: The ability to function effectively within the organisational and financial structures of the local health care system.
- **Practice-based learning and quality improvement**: The ability to assess and continually improve the services delivered as an individual provider and as an inter-professional team.
- **Informatics**: The ability to use information technology to support and improve integrated health care.

Common themes across these various standards and competencies include respecting rights, working in partnership (including with other service providers and consumers and carers), meeting diverse needs/cultural competence and quality improvement.

### 4.4.4 Peer workers

We understand that peer workers and their role in the mental health workforce are of particular interest to the Tasmanian Government. Peer workers are a relatively recent addition to the mental health workforce both nationally and internationally. Peer workers are also be referred to as ‘consumer companions’, ‘consumer support workers’, ‘peer support workers’, ‘peer educators’, ‘carer support worker’s, ‘consumer workers’ or ‘carer workers’.\textsuperscript{313}

Peer workers are people who have lived experience of mental illness, either directly, or within their family, and are employed specifically to share this experience and knowledge to help other people and families experiencing mental illness. Peer workers are employed in Australia in a range of different ways. Roles may include peer support, advocacy, health promotion, coordination or education. Peer workers may be employed in either a paid or voluntary capacity in outreach services, inpatient units, day programs, and telephone services, amongst other service types. Currently, the peer workforce in Australia appears to be small, and often there is a lack of role clarity and workplace supports for these workers.\textsuperscript{318}

#### 4.4.4.1 HWA’s Mental Health Peer Workforce study

The purpose of HWA’s Mental Health Peer Workforce study is to inform the national adoption of a Mental Health Peer Workforce model, which aims to reduce the current burden on the mental
health system. Its secondary objective is to provide policy advice on training, regulatory and practice changes required to establish a career pathway for mental health peer workers into the mental health workforce. The study proposes a more systematic approach to the adoption of the mental health peer workforce, for example through the establishment of National Mental Health Peer Workforce Development Guidelines.  

### 4.4.4.2 Mental health peer workforce capacity and skills development

The draft mental health peer workforce report provides a set of recommendations that are aligned with the five domains for action identified in the National Health Workforce Innovation and Reform Strategic Framework for Action 2011 (WIR Framework). The five domains for action are: health workforce reform for more effective, efficient and accessible service delivery; health workforce capacity and skills development; leadership for the sustainability of the health system; health workforce planning; and health workforce policy, funding and regulation. HWA’s draft recommendations in relation to the second domain for action, health workforce capacity and skills development, which are of relevance to the present review are:

- Promote the national rollout of the Certificate IV in Mental Health Peer Work including the implementation of the national training resources.
- Support the development and implementation of Recognition of Prior Learning tools that recognise existing peer worker training and experience.
- Build awareness of traineeships and scholarships to support entry into the mental health peer workforce.
- Develop national guidelines for the effective mentoring, coaching and supervision of the mental health peer workforce.
- Define the career pathway options into and beyond mental health peer workforce.
- Develop training resources for mental health and health practitioners outlining the role of the MHPW in supporting recovery, and potential benefits at a personal, service and system level.

However, the evidence-base in relation to consumer outcomes produced by peer support remains ambiguous. To this end, we have identified three recent systematic reviews of the evidence. Pitt and colleagues conducted a systematic review of randomised controlled trials assessing the effects of employing consumers of mental health services as providers of statutory (public services, those required by statute or law, or public services involving statutory duties) mental health services to consumers. Inclusion criteria for the trials were that they compared either consumers versus professionals employed performing the same role within a mental health service, or mental health services with and without consumer-providers as an adjunct to the service. Eleven trials (rated as being of moderate to low quality) involving 2,796 people were included. The authors concluded that involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for consumers that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services. The authors also suggested that there is low quality evidence that involving consumer-providers in mental health teams results in a small reduction in consumers’ use of crisis or emergency services. Compared to professionals, consumer-providers were found to spend more time face-to-face with consumers (and less time in the office, on the telephone, with the consumer’s family and friends, or at provider agencies). The authors determined that the overall quality of the evidence is moderate to low and provide recommendations for strengthening the quality of future trials. They further conceded that there is presently no evidence of harm associated with involving consumer-providers in mental health teams.
The second review is a systematic review and meta-analysis of randomised controlled trials of non-residential peer support interventions (mutual peer support, peer support services, or peer delivered mental health services) conducted by Lloyd-Evans and colleagues. Eighteen trials including 5,597 participants were included. These comprised four trials of mutual support programs, eleven trials of peer support services, and three trials of peer-delivered services. There was substantial variation between trials in participants’ characteristics and program content. Outcomes were incompletely reported; there was high risk of bias. There was little or no evidence that peer support was associated with positive effects on hospitalisation, overall symptoms or satisfaction with services. There was some evidence that peer support was associated with positive effects on measures of hope, recovery and empowerment at and beyond the end of the intervention, although this was not consistent within or across different types of peer support. It was concluded that there is little evidence from current trials about the effects of peer support for people with severe mental illness. Although there are few positive findings, the review provided important implications for policy and practice: current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programs. Further peer support programs should be implemented within the context of high quality research projects wherever possible. Deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions.

The third review involved a meta-analysis that focused specifically on the efficacy of peer support interventions for people with depression. This review reported that randomised controlled trials indicate that peer support interventions improve depression symptoms more than usual care alone, and that such effects may be comparable to those achieved through group cognitive behavioural therapy.

4.5 What contemporary models of care will support the achievement of a mental health system that meets the National Mental Health Standards and that promotes equitable access to services in a state such as Tasmania, with its rural and dispersed population?

To answer this question, we describe models and approaches to mental health service delivery that have been used in rural and remote areas, and consider the extent to which these models and approaches align with the National Standards for Mental Health Services.

4.5.1 Mental health in rural populations

There is no evidence that living in a rural or remote community affects the incidence or prevalence of mental health problems, or that it predicts the type of mental health difficulties that an individual may develop, although suicide rates have been found to be higher in rural than in metropolitan areas. When mental health problems do occur for people in rural and remote areas, factors specific to residential location may impact on wellbeing. Lack of access to mental health services can be a major difficulty for Australians in rural and remote parts of the country, although there is evidence that there have been some improvements in this regard in recent times (e.g., the Access to Allied Psychological Services (ATAPS) program has improved access to mental health care for rural residents with depression and anxiety). Cultural differences in rural areas can also act as barriers
to seeking mental health care. These include stigma, concerns about confidentiality and a culture of self-reliance.

### 4.5.2 Delivering mental health care to rural populations

For people with severe and persistent mental illness living in rural or remote locations, access to specialised mental health services represents a major challenge. The provision of public mental health care across geographically large regions with relatively low population densities creates significant challenges for specialised mental health services. Travel, accommodation and communication logistics present barriers to clinicians accessing rural sites. In addition, the fee-for-service model through which private mental health clinicians are funded means that many prefer to practice in metropolitan areas where the number of potential consumers is larger and practice is more financially rewarding. This has led to a scarcity of private mental health clinicians in many rural communities. Additionally, many NGOs are located in metropolitan regions and those that serve rural communities must address logistical challenges similar to those faced by specialised mental health services.

Because of the difficulty accessing specialised mental health services, a general practitioner is likely to be the first or only local medical contact for those in rural communities who do seek treatment and support for mental health problems. However, accessing a general practitioner can be difficult in some localities and general practitioners may vary in their level of experience with the treatment of psychological distress or mental illness. Using national data, Caldwell et al.\(^{329}\) found lower rates of general practice encounters for psychological problems in residents of most non-metropolitan areas. Additionally, general practitioners prescribed mental health medications at half the rate for residents of remote areas than capital cities. Waiting lists, lack of treatment options or the need to travel to access health care services may result in many people with mental illness who do not access support services, or who are not seen until their condition has deteriorated significantly. Some communities have only periodic access to specialised mental health workers, who may visit the area from a nearby regional centre. This can create difficulties in regard to early intervention, the building of positive consumer-clinician relationships, and the continuity and effectiveness of treatment.

As outlined in Chapter 3, the need for targeted solutions for the delivery of specialised mental health services to people living in rural and remote areas is acknowledged in a number of mental health policy documents from Australia and other countries, notably Canada. Several difficulties are highlighted in these documents, including providing services to small, geographically dispersed populations, recruitment and retention of the mental health workforce, and the unique needs of rural populations, including Indigenous populations and farmers.

### 4.5.3 Models and approaches that have been used in rural and dispersed populations

Harte and Bowers\(^{330}\) conducted a review of the literature in order to inform Queensland Health about the development of a framework for mental health service delivery to rural and remote parts of the state. They outlined a number of models of mental health care delivery in rural and remote areas of Australia including South Australia’s Rural and Remote Mental Health Service (which used a consultation-liaison model), New South Wales’ Far West Area Health Service Mental Health Integration Project (which involved community mental health teams, general practitioners and other agencies who were provided with clinical and broader support services by consultant psychiatrists from public and private sectors), Victoria’s Aged Persons Mental Health Services (which were based
at regional hospitals in Victoria and offered outpatient and outreach services), and South Australia’s Coordinated Aboriginal Mental Health Care project.

After reviewing these models and the evidence underpinning them, Harte and Bowers concluded that:

- A one size fits all approach is not appropriate, and models of care should be adapted to specific regions utilising the facilities, other resources and unique aspects of these regions as well as engaging with community members;
- Models should be multi-disciplinary and inter-sectoral, utilising both formal and informal community networks and particularly sectors outside of health to optimise the use of human and financial resources;
- Models should centre on wide and ongoing community consultation;
- Service delivery needs to be well coordinated through one central agency, with some autonomy at the regional level, and a sound communication strategy should be intrinsic to this coordination; and
- Models should provide services which are complementary, such as the hub and spoke with outreach services covering prevention, promotion, primary health and acute care services supplemented by tele- and e-health services.

They also reported that the three main components of the most appropriate and successful models were as follows:

- Mental health services in primary care including mental health services in general hospitals;
- Visiting community mental health services and specialised mental health services; and
- Self-care, informal community mental health care and community development.

We focus on elements of each of these components – collaboration with primary care, the provision of specialised mental health services, and community development – because these are likely to be central to the development of policies to promote equitable access to services for people in rural Tasmania.

4.5.3.1 Collaboration with primary care

Several studies have considered challenges to good collaboration between primary care providers and specialised mental health services in Australia. Lockhart examined the collaboration and referral practices of general practitioners and community mental health workers in rural and remote Western Australia and found that meaningful collaboration was prevented by a combination of a poor communication, a lack of shared assessment or follow-up strategies between services and disagreements regarding mental health classifications and consumer care. Bambling et al focused on rural Queensland and examined the views of rural practitioners concerning issues and challenges in mental health service delivery. Their results revealed significant problems with inter-service communication and liaison, and led to the conclusion that better integration, including more active collaboration between general practitioners, community organisations and mental health services, shared case management and communication between sectors would form a critical part of any effective solution. Fuller et al conducted consultations with rural stakeholders about primary mental health care in South Australia and identified difficulties with service access, acceptability and teamwork. They also found that the availability of local human service workers led to their use as first-level mental health contacts, but these workers were neither skilled nor supported for this. They pointed to the need to pay attention to the boundaries between different service providers which can otherwise create inflexibility and service gaps and outlined a program for collaboration through regional interagency task groups, networking groups for local human service workers and
the position of a regional mental health coordinator in order to overcome these difficulties and to operationalise service partnerships.

The above three studies emphasised the barriers to collaboration, but Fuller et al\textsuperscript{139} considered how these barriers might be overcome. They conducted a review of the literature on the effectiveness of service linkages in primary mental health care and concluded that there is strong evidence to support collaborative primary mental health care for people with depression when linkages involve direct collaborative activity, as well as agreed guidelines and communication systems. In a companion paper, they outlined five areas of strategy for policymakers that address organisational level support, joint clinical problem solving, local joint care guidelines, staff training and supervision and feedback.\textsuperscript{142}

4.5.3.2 Provision of specialised mental health services

Telepsychiatry and e-health are described in the literature as key vehicles for improving provision of specialised mental health services in rural and remote areas. We use the term telepsychiatry to refer to a range of mental health services which utilise different forms of telecommunications such as email, fax, telephone, still images and videoconferencing. We use the term e-health to refer to interventions delivered via the internet.

In recent years, advances in technology, particularly in internet and mobile-based technologies, have led to a growing interest in telepsychiatry and e-health for improving access to mental health services. These technologies can extend access to mental health care in several ways: by enhancing the reach to priority populations, addressing system capacity issues, supporting training, improving clinical decision making, lowering the ‘consumer’s threshold’ for treatment, delivering preventive mental health services, speeding innovation and adoption, and reducing cost barriers to treatment.\textsuperscript{334}

Telepsychiatry, in particular video teleconferencing, is used to treat a variety of disorders and is capable of allowing providers to reliably assess, diagnose, and treat many mental health and substance abuse concerns from a distance. Several studies have shown psychiatry via video teleconferencing to be comparable to face-to-face interventions, with benefits including improved functioning, a reduction in hospital referrals, improved convenience, decreased number of missed appointments, a reduction in travel time as well as time spent waiting for specialty services, reduced level of stigma, and enhanced access to treatment.\textsuperscript{335}

A number of studies have also shown the benefits of emergency telepsychiatry in rural practice. In cases where consumers in rural locations need care in a tertiary hospital, collaborative care may be further complicated due to the need for cooperation between primary and tertiary care settings and other occupational groups such as police and ambulance officers who may be involved in transferring people to treatment settings in urban areas. The consultation and liaison model has been developed in order to address the needs of people in rural communities for specialised mental health services. Specialists, working in tertiary settings, provide acute inpatient care, but they ensure overall continuity of care for consumers through liaison relationships with local key workers (general practitioners or community mental health team members) through a telepsychiatry system. These relationships provide support, information and consultation, ensuring that the consumer is able to stay in the home community, with appropriate support, for as long as possible. In a study designed to document the experiences of mental health consumers travelling from the country to the city for acute care, Taylor et al\textsuperscript{336} interviewed consumers, country professional and occupational groups and tertiary providers. Results showed that the distance consultation and liaison model provided by the rural and remote mental health services was highly regarded by research.
participants. The authors concluded that extending the use of this model to other primary mental health care providers and tertiary facilities would improve transfer of care.

Saurman et al\textsuperscript{337} evaluated a rural emergency telepsychiatry program, the Mental Health Emergency Care-Rural Access Program, which aimed to improve access to emergency mental health care for communities in rural New South Wales. They used service activity data to assess change and trends over time. Their results showed that the program was well established and achieved acceptable levels of service activity, continuing to be as used as intended.

The above examples involve the use of telepsychiatry for adult consumers. While as not as widespread as in adult populations, the use of telepsychiatry for children in rural areas is growing\textsuperscript{338}. It has been implemented in various areas including treatment of depression, anxiety, substance abuse, ADHD, eating disorders, and general mental health promotion with high parent, provider, and consumer satisfaction.\textsuperscript{335} Telepsychiatry has been shown to improve rural health care for children and may also reduce the burden on families (including by limiting their need to travel long distances for care) and provide a shorter waiting time for treatment. Determinants of satisfaction with services include an established provider-consumer relationship and high quality audio and video transmission. Barriers to using telepsychiatry for children in rural areas include the cost of implementation, complexity of hardware, difficulty assessing non-verbal communication, and the longer time taken to establish rapport with some children.\textsuperscript{339}

In their review of adult collaborative mental health care for people in rural locations with severe and persistent mental illness, Lee et al\textsuperscript{340, p73} concluded that ‘innovative use of telepsychiatry models in conjunction with outreach education and training offers a key model to deliver effective collaborative care to rural and remote Australians’. They noted that the outreach component is key to the exchange of information and to establish professional trust and a relationship between telepsychiatry and rural staff. In addition to models focusing on collaborative care and telepsychiatry it is likely that the growing use of effective internet and mobile phone delivered interventions can also assist in promoting equitable access to services and improving health outcomes in the rural Tasmanian population.

There is growing evidence that e-health interventions are effective in the treatment of mental health problems, particularly depression and anxiety disorders.\textsuperscript{341} Two of the best-known Australian web-based interventions are the depression information website BluePages (www.bluepages.anu.edu.au), and the cognitive-behavioural therapy (CBT) skills training website MoodGYM (www.moodgym.anu.edu.au). There is evidence that larger effects are achieved with greater therapist contact, particularly in cases of clinical depression.\textsuperscript{342} Such treatments offer a less-intensive, cost-effective way to deliver empirically validated treatments for a variety of psychological problems and may be particularly relevant to delivery in rural and dispersed populations.

**4.5.3.3 Community development**

Informal community mental health care and community development have also been identified as central to the provision of health care in rural populations. This may involve improving the mental health skills of rural support workers who are available as an essential service to rural people (such as in agriculture, finance and drought support). These workers may play a role in providing informal care as they are often the first point of contact for rural populations, notably farmers. An example of an intervention that may be used to build community skills is Mental Health First Aid (MHFA) training (www.mhfa.com.au). Sartore et al\textsuperscript{343} assessed the effectiveness of MHFA training in drought-affected rural and remote Australia, as part of a strategy to improve capacity among farming communities in New South Wales to provide early intervention for mental health problems.
After attending the courses, the ability of rural support workers and community volunteers to identify high prevalence disorders and endorse evidence-based interventions for both high and low prevalence disorders increased, as did their confidence in their ability to provide appropriate help.

4.5.4 Alignment of proposed models and approaches with the National Standards for Mental Health Services

The aim of the National Standards for Mental Health Services is to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services. The current Standards were introduced in 2010 and reflect the changes in service provision that have occurred since the first Standards were introduced in 1996. The Standards focus on:

- How services are delivered;
- Whether they comply with policy directions;
- Whether they meet expected standards of communication and consent; and
- Whether they have procedures and practices in place to monitor and govern particular areas—especially those which may be associated with risk to the consumer, or which involve coercive interventions.

The Standards have been developed to be applied across the broad range of mental health services. This includes bed-based and community mental health services, those in the clinical and non-government sectors, those in the private sector and also those in primary care and general practice. The Standards are as follows:

- The rights and responsibilities of people affected by mental health problems and/or mental illness are upheld by the mental health service and are documented, prominently displayed, applied and promoted throughout all phases of care;
- The activities and environment of the mental health service are safe for consumers, carers, families, visitors, staff and its community;
- Consumers and carers are actively involved in the development, planning, delivery and evaluation of services;
- The mental health service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care;
- The mental health service works in partnership with its community to promote mental health and address prevention of mental health problems and/or mental illness;
- Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery;
- The mental health service recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness;
- The mental health service is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services;
- The mental health service collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers; and
- The mental health service incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

The models and approaches discussed above (improved collaboration with primary care, provision of telepsychiatry and e-health in specialised mental health services, and community development) all align with the direction and content of the National Mental Health Standards. In particular, they
address the rights of rural and remote consumers to comprehensive and integrated mental health care, ensuring that they are not disadvantaged by living outside a regional or metropolitan area.

4.6 What additional evidence would influence the commissioning of services that ensure a focus on promotion, prevention and early intervention?

Mental health is not simply the absence of mental illness, but is a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and is able to make a contribution to his or her community. Mental health and mental disorders arise as a result of complex interplay between individual and environmental factors. Opportunities that enable people to exercise control over their lives, to use their skills and to engage in supportive social interactions are critical to mental health. Having a valued social position, an adequate income and physical security are also fundamental to mental health. Mental health and mental illness (and the role of programs and services) are conceptualised as occurring across a continuum from prevention through early intervention and treatment to continuing care.

4.6.1 Definitions

4.6.1.1 Mental health promotion

Mental health promotion is any action taken to optimise mental health and wellbeing in individuals and communities. It aims to protect, support and sustain the emotional and social wellbeing of the population by promoting the factors that enhance mental health. Mental health promotion is relevant across the continuum of care and entire spectrum of interventions, that is, before, during and after the onset of mental health problems and mental disorders.

The Ottawa Charter for Health Promotion and the Jakarta Declaration are central to work in the area of mental health promotion. The key elements of the Ottawa Charter are to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services towards promotion, prevention and early intervention.

4.6.1.2 Mental illness prevention

Prevention refers to interventions that occur before the initial onset of a disorder to prevent the development of the disorder. The prevention of mental health problems relies on reducing the risk factors for mental disorders, as well as enhancing the protective factors that promote mental health. As noted in Chapter 3, prevention interventions are usually considered in terms of universal, selected or indicated interventions. Universal interventions target the whole population, selective interventions target population subgroups at increased risk and indicated prevention targets individuals at high risk. Indicated prevention overlaps with early intervention while universal prevention overlaps with health promotion, particularly where the focus is on behaviour change.

4.6.1.3 Early intervention

Early intervention comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental disorder, and people developing or experiencing a first episode of mental disorder. Early identification of people with
emerging signs and symptoms of mental health problems and mental disorders plays a key role in the provision timely, effective and appropriate treatment in order to prevent diagnosable illness and reduce the disability associated with symptoms. Early intervention overlaps with indicated prevention while universal prevention overlaps with health promotion, particularly where the focus is on behaviour change.

4.6.2 The importance of promotion and prevention

The recent release of the 2013 National Mental Health Report, the prime vehicle for monitoring the mental health system reform agenda outlined in the National Mental Health Strategy, offers the opportunity to consider the progress of that agenda. There have been some gains including increases in health expenditure and workforce, increases in access to treatment, reductions in the use of licit and illicit drugs that contribute to mental illness, a decrease in the suicide rate and improvements in mental health literacy. However, it is notable that the prevalence of mental disorders remains unchanged, and that employment participation rates have either decreased (from 64% to 62% for employment participation among working age Australians with a mental illness) or remained stable (employment and education participation rates for Australian aged 16-30 with a mental illness).

Reducing the prevalence of mental illness involves both primary prevention and an increase in access to effective services to reduce the duration of illness in those who already have symptoms. It is notable that the increases in expenditure have largely focused on clinical services which typically provide early intervention. This can be seen in the section of the National Mental Health Report that outlines the key actions taken under the Prevention and Early Intervention priority area. The great majority of the resources are targeted towards headspace and early psychosis youth centres, which, valuable though they may be, are oriented towards treatment rather than prevention. A recent survey further highlights the gap between mental health-related research funding and the priorities of stakeholders such as researchers, policymakers, consumers and carers. The divergence was most pronounced in the area of prevention/promotion, which, despite being the top-ranked priority for stakeholders, received a low amount of funding, an amount which has actually diminished over the past 10 years.

A promising area for investigation arises as a result of the growing evidence that mental disorders and major physical disorders such as cardiovascular disease and cancer have common risk factors. This evidence points to the need for greater integration of physical and mental health promotion and prevention, and the inclusion of mental health outcome measures into evaluations of physical health promotion interventions. The overlapping nature of the risk factors for physical and mental disorders also offers those working to prevent mental disorders opportunities to learn from the successes and failures of decades of research in prevention of physical disorders, as exemplified by the role of tobacco control in the prevention of cardiovascular disease and cancer.

In order to reduce the prevalence of mental illness, it is argued that there is a need for considerably greater investment in the area of mental health promotion and prevention. If successful, this investment has the potential to reduce the future demand for mental health services.

4.6.3 Reviewing the evidence

Health promotion and prevention interventions are typically targeted towards particular settings (such as schools, workplaces or cities) or towards identified population groups (such as older adults or young people). Many programs and strategies cross boundaries and target both.
Because the influences on mental health and mental disorders occur in the events and settings of everyday life, mental health promotion, prevention and early intervention typically take place beyond the health sector. It is recognised that, in order to improve population mental health, work in this area needs to extend across all relevant sectors to encompass all those people, groups, services, organisations, policies and practices that impact on the everyday life events that influence mental health. However, in keeping with the scope of the current project, this section outlines the evidence base for services that focus on promotion, prevention and early intervention that rest with the health sector. It does not cover those that may be provided by other sectors.

The evidence presented in this review draws on work done for the National Mental Health Service Planning Framework. It largely focuses on interventions for which there is ‘sufficient evidence’ according to the framework outlined by Mihalopoulos and colleagues\textsuperscript{352} (i.e., interventions which have been shown to be effective in systematic reviews of relevant randomised controlled trials, by at least one properly designed randomised controlled trial, by well-designed pseudo-randomised controlled trials (alternate allocation or some other method), by comparative studies with concurrent controls, or by cohort studies or case-control studies.

### 4.6.3.1 Mental health promotion

#### 4.6.3.1.1 Creating supportive environments: Reducing bullying in schools and workplaces

Being bullied every few weeks or more often during a term at school is a fairly common experience, affecting 27\% of Year 4 to Year 9 Australian students.\textsuperscript{353} Bullying has been associated with an increased risk of mental health problems including depression and suicidal ideation.\textsuperscript{354, 355} Vreeman and Carroll\textsuperscript{356} conducted a systematic review of rigorously evaluated school-based interventions to decrease bullying, including curriculum interventions, multidisciplinary or ‘whole-school’ interventions, social skills groups, mentoring and social worker support. The results showed that only four of the 10 curriculum studies showed decreased bullying, but three of those four also showed no improvement in some populations. Of the 10 studies evaluating the whole-school approach, seven revealed decreased bullying, with younger children having fewer positive effects. Three of the social skills training studies showed no clear bullying reduction. The mentoring study found decreased bullying for mentored children. The study of increased school social workers found decreased bullying, truancy, theft, and drug use. They concluded that many school-based interventions directly reduce bullying, with better results for interventions that involve multiple disciplines. However, curriculum interventions were less likely to affect bullying behaviours.

Almost 7\% of workers experience bullying in any 6-month period.\textsuperscript{357} Workplace bullying has been linked to an increased risk of mental health problems, including depression and anxiety disorders.\textsuperscript{358, 359} In a recent review, Iling et al\textsuperscript{360} concluded that there is an association between poor work climate, managers with poor interpersonal skills and bullying. They also noted that interventions were more likely to be successful when part of a strategic approach to tackling bullying at the organisational level, involving senior management support, structural support and resources, proactive and empowered staff, publicity, and readiness for change. The role of leaders and managers was crucial, particularly in relation to the following: lending support and credibility to interventions, modelling appropriate behaviours, driving and maintain change, and creating a culture in which negative behaviours are challenged. There was limited evidence on the effectiveness of therapeutic and supportive interventions directed at individuals, although some benefit was reported in case studies on coaching and mentoring and informal support. However, the quality of included studies was low, with many reporting case studies and using small sample sizes.
4.6.3.1.2 Strengthening community action: Reducing stigmatising attitudes towards people with mental illness

People with mental illness are among the most disadvantaged in society, and many experience social and economic hardship as a direct result of their illness. They must cope with the symptoms of their illnesses and also with the limitations of community understanding of mental illness, that is, the erroneous beliefs, stereotypes and prejudice that result from misconceptions about mental illness. These stigmatising attitudes are often nominated as a central concern for people with mental illness. The 2010 SHIP study reported that 37.9% of participants (46.9% of females and 31.8% of males) said they had experienced stigma or discrimination in the past year as a result of their mental disorder. Fear of discrimination stopped 22.7% of participants doing some of the things they had wanted to do, while 20.3% said that it was the actual experience of stigma or discrimination that had stopped them. Stigma was nominated by 11.6% of participants as one of their top three challenges for the coming year.

Anti-stigma initiatives typically take three main approaches: education to challenge inaccurate stereotypes, interpersonal contact with a person with a mental illness, and social activism or protest. Interventions may be considered in terms of the target population (whole of community or individuals within particular population groups, such as culturally and linguistically diverse communities), the mode of delivery (in-person or web-based) and the intervention setting (workplaces, schools, tertiary education institutions). Most commonly, anti-stigma initiatives take the form of community-based campaigns, psycho-education initiatives and web-based provision of information, all of which are discussed below.

Evidence suggests that short-term (e.g., 3-week) community-based campaigns are not likely to be effective, while longer-term campaigns may be effective in reducing stigmatising attitudes and reducing experiences of discrimination. Evaluation reports from the largest national campaign ever undertaken, the Time to Change (TTC) campaign, have recently made a significant contribution to the literature on whole-of-community anti-stigma interventions. Time to Change is the largest-ever program in England designed to reduce stigma and discrimination against people with mental disorders (http://www.time-to-change.org.uk/). It involved a mass media strategy, a one-day event designed to facilitate social contact with people with a mental illness and sports-related programmes. Changes in public attitudes measured every year from 2008 to 2012 revealed a mixed picture: there were improvements in intended behaviour and a non-significant trend for improvement in attitudes, but no significant improvements in knowledge or reported behaviour. Encouragingly, one of the most marked changes between 2008 and 2011 was the significant overall reduction in the levels of experienced discrimination reported by people using mental health services.

There is sufficient evidence to suggest that psycho-education interventions improve knowledge and reduce stigmatising attitudes, particularly when they include face-to-face interpersonal contact with a person with mental illness. In Australia, the best-known psycho-education initiative is Mental Health First Aid (MHFA). MHFA was developed to address the fact that although many people have contact with people with mental illness, they often lack mental health first aid knowledge and do not feel confident in providing assistance. MHFA takes the form of a training course for members of the public on how to assist someone who is developing a mental illness or in a mental health crisis situation, has been shown in a number of studies to reduce desire for social distance from people with mental disorders. In a recent review of MHFA intervention studies, Jorm and Kitchener found that participants in six studies had increased help provided to others while participants in 12 studies had increased confidence in providing help to others. MHFA has also been found to reduce stigmatising attitudes in culturally and linguistically diverse populations.
A number of Australian studies have assessed the effects of web-based, anti-stigma interventions and, while there is limited evidence to suggest that they are effective, longer-term effects are unknown. In their simplest form, these interventions provide information on psychiatric disorders, both to increase public understanding of them and as a means of offering assistance to people with mental illness and their carers. Websites may be provided by governments, non-profit organisations, corporations, and private individuals. These sites allow information to be provided at little or no cost to anyone with an Internet connection. The information is easily accessible and can be viewed anonymously, which may be important for those concerned about the stigma surrounding psychiatric disorders.

The relatively rapid increase in the amount of health information on the Internet has been closely followed by discussions about its quality, and the impact that poor quality information might have on the health of those who access it. In the area of psychiatric disorders, poor quality information may increase the risk that someone who needs treatment might delay or avoid it, use inappropriate or ineffective treatments, or not adhere to treatment. The provision of online mental health information is very common. A recent review of the quality of online mental health information found this to be generally poor, although the quality of information on affective disorders may be improving. However, there is very little understanding of the influence of website quality on user behaviour.

Any social change, including the reduction of stigmatising attitudes towards people with mental illness is likely to require action at multiple levels. Population interventions may be appropriate for most members of the community, whereas more intensive interventions will be justified for those in higher risk groups or who are more likely to have contact with people with mental disorders. There is evidence that educational and contact interventions are effective in reducing stigmatising attitudes in many types of health professionals in the short term. However, evidence for long-term effects is inconclusive.

4.6.3.1.3 Promotion of help-seeking attitudes and behaviours: Mass promotion and structured psycho-education

Mass promotion interventions to improve help-seeking attitudes and behaviours may incorporate media campaigns, websites, books, brochures, videos, TV advertisements, billboards, and telephone information services. There is evidence that, while short term campaigns have limited effects on help-seeking intentions, longer term campaigns may lead to 5-25% increases in willingness to seek professional help (depending on the source). A number of studies have assessed effects on help-seeking behaviours, including a Canadian study of a suicide awareness week promotion that led to a <10% increase in calls to suicide prevention centres and number of admissions to hospital. Two Australian studies have shown increases in help-seeking in response to community campaigns, one found a 14.6% increase in treatment-seeking rates in states with a high exposure to beyondblue, compared to a 6.0% increase in low exposure states, and the other found increases in help-seeking in response to a youth mental health community awareness campaign in two regions of Victoria.

In a Norwegian study, a mass promotion campaign for the general public, schools and general practitioners about how to recognise psychosis was run in two areas of Norway between 1997 and 2000. The study also incorporated an early detection team that could be contacted by anyone. During the intervention, the median duration of untreated psychosis in the intervention areas was five weeks, while in regions without the campaign, it was 16 weeks. Between 2002 and 2004 the information campaign was stopped, while the early detection team continued to operate. As a
result, the duration of untreated psychosis increased to a median of 15 weeks, supporting the conclusion that the information campaign was critical to the success of the intervention.

Structured psycho-education interventions are more targeted than mass promotion campaigns, and deliberately directed at those who might benefit from mental health care. In a recent review, Gulliver et al.386 examined randomised controlled trials targeting help-seeking attitudes, intentions or behaviours for depression, anxiety, and general psychological distress. They identified six published studies of randomised controlled trials investigating eight different interventions for help-seeking. The majority of trials targeted young adults. Their results showed that mental health literacy content was effective in improving help-seeking attitudes in the majority of studies at post-intervention, but had no effect on help-seeking behaviour.

### 4.6.3.1.4 Social and emotional learning

Social and emotional learning interventions include classroom-based interventions, interventions for parents and whole of school policy development. Most have explicit goals and focus on active learning and skills development. In a recent review and meta-analysis of 213 studies, Durlak et al.387 found that compared to controls, social and emotional learning intervention participants demonstrated significantly improved social and emotional skills, attitudes, behaviour, and academic performance. Although they were somewhat reduced in magnitude, gains were still seen at 6-month follow-up. Programs delivered by teachers were more effective than programs delivered by others.

### 4.6.3.1.5 Positive psychology

Positive psychology interventions include mindfulness, positive writing, hope therapy, positive reminiscence, gratitude, happiness programs, wellbeing therapy, positive psychotherapy and cognitive behaviour therapy. Sin and Lyubomirsky388 conducted a meta-analysis of 51 such interventions, and found that positive psychology interventions significantly enhanced wellbeing and decreased depressive symptoms. Effects were greater in people with depressive symptoms.

### 4.6.3.2 Prevention of mental illness

Most of the evidence on prevention of mental illness relates to prevention of depression, anxiety disorders, eating disorders and other body image problems, and externalising disorders. Promising interventions for each of these are discussed below.

#### 4.6.3.2.1 Depression and anxiety disorders: Universal prevention programs for children and adolescents delivered in schools and on the internet

In a recent review, Christensen et al.389 identified 21 randomised controlled trials of universal, school-based prevention programs designed to prevent anxiety in children or adolescents. Of the trials identified, 62% reported significant differences in anxiety symptoms between the intervention and control conditions at post intervention or follow-up. The majority of effective programs employed cognitive behavioural therapy, with classroom teachers, mental health professionals and graduate students leading these programs. One of the most effective programs for both children and adolescents was found to be the FRIENDS program, which was developed in Australia, is targeted towards both children and adolescents and involves 10 sessions of 50 to 70 minutes per session and two booster sessions.390, 391 Another effective program is the Stress Inoculation Training (SIT)
program, which was developed in the United States, is targeted towards adolescents and involves 5-10 sessions of 50 to 70 minutes.  

Christensen et al also identified 32 randomised controlled trials of universal prevention programs designed to prevent depression in children or adolescents in the school setting. Of the trials identified, 47% reported significant differences in depressive symptoms between the intervention and control conditions at post intervention or follow-up. The majority of effective programs were based on cognitive behavioural therapy and led by classroom teachers, mental health professionals and graduate students. The two depression programs with the most research evidence supporting their effectiveness are the Penn Resiliency Program and the Interpersonal Psychotherapy - Adolescent Skills Training programs, both of which were developed in the United States and target both children and adolescents. The most effective Australian programs are the FRIENDS program and the Resourceful Adolescent Program.

The results of a Cochrane systematic review also support the conclusion that universal depression prevention programs may prevent the onset of depressive disorders in children and adolescents. There is also support for the effectiveness of internet-based intervention programs for anxiety and depression in children and adolescents. The typical web-based intervention draws on the principles and methods of cognitive behavioural therapy and can be delivered without support.

4.6.3.2.2 Depression: Universal prevention programs for adults delivered in the workplace

As mental disorders can also arise later in life in reaction to traumatic events, loss-related events, chronic illness or chronic stress, prevention planning also needs to consider evidence that interventions in adulthood can prevent mental disorders. An important consideration for such interventions is the ability to access the adult population. With many adults in part or full-time work, the workplace can be access point for support and therefore plays a critical role in planning preventive strategies for mental and physical wellbeing. There is good quality evidence that universally delivered workplace mental health interventions can reduce the level of depression symptoms among workers, particularly when these involve cognitive behavioural therapy approaches.

4.6.3.2.3 Depression and anxiety: Indicated/selective prevention programs for children and adolescents delivered in schools

In the review cited above, Christensen et al also identified 17 randomised controlled trials of indicated/selective prevention programs delivered in schools that were designed to prevent anxiety in children or adolescents. Of the trials identified, 59% reported significant differences in anxiety symptoms between the intervention and control conditions at post intervention and/or follow-up. The review also identified 24 randomised controlled trials of indicated/selective prevention programs designed to prevent depression in children or adolescents. In total, 54% of these reported positive effects. As above, the Australian FRIENDS program was among the more effective interventions.

4.6.3.2.4 Depression and anxiety: Indicated/selective prevention programs for adults delivered face-to-face and over the internet

The strongest evidence for prevention in adulthood is for indicated cognitive behavioural therapy interventions to prevent depression and, to a lesser extent, anxiety disorders. There is also some evidence that web-based cognitive behavioural interventions may be effective in the prevention of depression (particularly therapist-supported interventions).
4.6.3.2.5 Eating disorders and body image issues: Universal and selective prevention programs for children and adolescents delivered in schools and other settings

Body dissatisfaction/weight and shape concerns, dieting and negative affect are the most consistently identified risk factors for eating disorders. Prevention interventions largely aim to reduce the impact of these risk factors in order to reduce the risk of eating disorders. In a recent review of eating disorder prevention programs, Stice et al found that 51% of the interventions reviewed resulted in significant reductions in at least one established risk-factor for eating pathology, such as body dissatisfaction and 29% of the prevention programs resulted in significant reductions in eating pathology. They also found that larger effects occurred for programs that were selective (versus universal), interactive (versus didactic), multisession (versus single session), solely offered to females (versus both sexes), offered to participants over 15 years of age (versus younger participants), and delivered by professional interventionists (versus endogenous providers).

A number of studies have examined the impact of school-based prevention programs. Yager et al reviewed universal-selective, classroom-based programs run with adolescents, and found 16 eligible intervention programs. Seven of these programs were effective in improving body image on at least one measure, from pre to post test, though effect sizes were small. These effective programs were conducted among younger adolescents and included activities focusing on media literacy, self-esteem, and the influence of peers. There is also evidence that we-based prevention programs targeted towards university students are effective in improving body image. There is also evidence that parental involvement in prevention interventions significantly improves child outcomes on measures of body dissatisfaction or disordered eating.

4.6.3.2.6 Externalising problems: Universal and selective prevention programs for children delivered in schools and other settings

Externalising problems include aggression, oppositional defiance disorder (ODD), conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD). ODD and CD develop through an interaction of neurobiological vulnerability and environmental/parenting factors. ADHD has a strong genetic influence and non-genetic risk factors include low birth weight and maternal smoking, followed by poverty, lead exposure, maternal alcohol drinking during pregnancy, and psychosocial adversity.

There is some evidence that parent training can reduce behavioural problems in children. Bayer et al reviewed preventive interventions for young children’s behaviour and emotional problems. They found that that most programs were targeted to children with environmental or indicated behavioural risks and concluded that, despite some methodological weaknesses in the studies, The Incredible Years group format and Triple P individual format programs were found to be likely to be beneficial. In a Cochrane review, Barlow et al examined the use of group-based parenting programs to improve the emotional and behavioural adjustment of young children (maximum mean age of three years eleven months), concluding that there was some support for such interventions. However, they also noted that evidence of effectiveness for primary prevention was insufficient and that data concerning the long-term outcomes was lacking. There is also limited evidence for the effectiveness of web-based programs.

In the previously-mentioned review by Christensen et al, the authors assessed 12 school/classroom-based interventions or components of multifaceted studies. While methodological differences between studies made it difficult to draw conclusions, they recommended the following programs as effective in reducing aggression and conduct problems:
Good Behavior Game, PeaceBuilders and Responding in Peaceful and Positive Ways. In a 2007 meta-analysis, Wilson and Lipsey examined 249 experimental and quasi-experimental studies of school-based programs that aimed to address aggressive and/or disruptive behaviour. They found positive overall intervention effects, with the most common and most effective approaches being universal programs and targeted programs for selected/indicated children. Effects were larger for better-implemented programs and those involving students at higher risk for aggressive behaviour.

4.6.3.3 Prevention of suicide and suicidal behaviour

Most suicide prevention strategies tend to be multi-faceted and advocate for a range of universal, selective and indicated interventions. Systematic reviews have examined the evidence for some of the more commonly used interventions, including restriction of access to means, general practitioner education, gatekeeper training, suicide prevention in schools, responsible media reporting of suicide, and web-based programs for reducing suicidal ideation. The evidence for each of these is reviewed briefly below.

4.6.3.3.1 Restricting access to means

There is evidence that restricting access to means can have a preventive effect, with, for example, tightening of gun laws, improvements in paracetamol packaging and barriers on bridges leading to reductions in suicide rates. Restricting access to means is seen as a useful intervention, particularly when the suicide method being targeted is common and has a high case fatality rate. Restricting access to means is seen to be successful because it ‘buys time’, allowing the individual to think through their actions and choose a more desirable alternative and/or allowing a third party to intervene. There is good evidence that even where substitution of means occurs there is still a net gain in terms of reduced suicide rates.

4.6.3.3.2 Education of general practitioners

Most people who die by suicide have contact with a general practitioner in the months, weeks and even days before their death. General practitioners are not always optimally equipped to detect suicidality and some of the clinical risk factors that are associated with it, however; depression and other mental disorders are under-recognised and undertreated in the primary care setting. Improving general practitioners’ knowledge about suicidality and depression through dedicated training efforts may assist in preventing suicide. A number of studies in this area have reported promising results with respect to reductions in suicidal ideation, suicide attempts and competed suicide. However, there is also evidence that the effect diminishes over time and booster training sessions may be needed to ensure long-term maintenance of preventive effect.

4.6.3.3.3 Gatekeeper training

Suicide prevention interventions often focus on educating and improving the skills of people who are likely to come into contact with people at risk of suicide. These gatekeepers may include health professionals (e.g., pharmacists, aged care providers) and those employed in institutional settings like schools and prisons. Evidence from a number of reviews suggests that gatekeeper training may yield positive results, at least in terms of gatekeepers’ knowledge, skills, and attitudes regarding suicide prevention.

4.6.3.3.4 Suicide prevention in schools

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Robinson et al\textsuperscript{421} conducted a systematic review of suicide prevention, early intervention and postvention programs in school settings. They concluded that, while the evidence was limited and hampered by methodological concerns, the most promising interventions for schools were gatekeeper training and screening programs.

4.6.3.5 **Responsible reporting in the media about suicide**

There is evidence that irresponsible media reporting of suicide can increase the risk of imitative behaviour. This has promoted the widespread development of guidelines for the media reporting of suicide, including in Australia under the Mindframe initiative (http://www.mindframe-media.info/). Bohanna and Wang\textsuperscript{422} conducted a systematic literature review of the evidence concerning the use and effectiveness of media guidelines for reporting on suicide. They concluded that guidelines can change reporting style and prevent imitative suicide, but that approaches centred on consultation, collaboration, media ownership, and training are likely to achieve the greatest success.

4.6.3.6 **Web-based programs for reducing suicide ideation**

Recently, several web-based interventions aiming to reduce suicidal ideation have emerged.\textsuperscript{423} In a randomised controlled trial, van Spijker et al\textsuperscript{424} tested the effectiveness of unguided online self-help program to reduce suicidal thoughts. The intervention group showed a small significant effect in terms of reduced suicidal thoughts, with effects more pronounced for those with a history of repeated suicide attempts. There was also a significant reduction in levels of worrying.

4.7 **What guidance does the literature provide regarding evaluation of the mental health service system?**

The quality, effectiveness and efficiency of mental health systems are increasingly under scrutiny, not least because consumers, carers and other stakeholders are making themselves informed and are demanding a system that meets community need. Since its inception, the National Mental Health Strategy has had a focus on evaluation to ensure that effectiveness and efficiency are achieved. Throughout the evolution of the Strategy, evaluation and monitoring have remained strong themes in each of the four *National Mental Health Plans*. This section provides an overview of reporting and evaluation of the National Mental Health Strategy. It also considers other efforts to evaluate the mental health system in Australia, and considers the directions recommended by the evaluation literature more broadly.

There are few other areas of health subject to the level of reporting required of mental health under the Strategy. The *National Mental Health Report* is the main vehicle for publicly monitoring and reporting progress towards agreed goals and initiatives under the Strategy. The most recent 2013 *National Mental Health Report*\textsuperscript{5} monitors progress in mental health reform under the Strategy from 1993 to 2011. Consistent with the increased emphasis on monitoring outcomes under the *Fourth Plan*, the 2013 report provides data against a suite of outcome-oriented indicators agreed for monitoring progress of the *Fourth Plan* as well as qualitative information about the progress of the actions agreed under the five priority areas of the *Fourth Plan*. Data are reported at both a national and jurisdiction level. In addition to the *National Mental Health Report*, data on the mental health system are currently published in several other reports including: the *Mental Health Services in Australia* report series,\textsuperscript{425} prepared annually by the Australian Institute of Health and Welfare; the Productivity Commission’s annual *Report on Government Services*,\textsuperscript{426} the National Mental Health Commission’s *National Report Card on Mental Health and Suicide Prevention*,\textsuperscript{181} and the *Roadmap for National Mental Health Reform 2012-2022*.\textsuperscript{22}
In addition to ongoing reporting and monitoring, evaluations and reviews have been conducted at key points during the Strategy, and these have informed its ongoing directions. Briefly:

- The evaluation of the First National Mental Health Plan in 1997 reported improvements in areas such as the relative mix of inpatient and community services, and inter-sectoral links between mental health and housing and employment services. However it also highlighted a need to expand the scope of reform from a focus on the structural reform of specialised mental health services to incorporating a broader population-focused approach, inclusive of primary care and less severe mental disorders.\(^4^\) In response to the evaluation recommendations the scope of the Second National Mental Health Plan (1998-2003),\(^4^\) released in 1998, was expanded to encompass a broader range of services (including mental health promotion, mental illness prevention and destigmatisation) and disorders (namely the more prevalent conditions such as depression and anxiety).

- The findings from a two-stage review of the Second National Mental Health Plan\(^4^\) showed that although significant progress had been made in mental health reform, consumer dissatisfaction and unmet need were still high, and further work was needed to ensure full and meaningful participation for consumers and carers, continuity of care, a focus on priority populations, and on service quality and monitoring. These findings underpinned the explicit adoption of a population health approach in the subsequent Third Plan. Areas of focus for reform centred on promotion and prevention, access and responsiveness (particularly for indigenous populations, forensic populations and people with complex needs), strengthening service quality and fostering innovation.

- The summative evaluation of the Third National Mental Health Plan\(^4^\) made key recommendations for the development of the next mental health plan, including on workforce development, service models, performance monitoring, consumer and carer participation, the recovery orientation and a coordinated whole-of-government approach. The findings from this evaluation influenced the Fourth National Mental Health Plan which was released in the following year. The Fourth Plan specified priorities for collaborative government action, identifying 34 reform actions to be undertaken across five priority areas, namely: social inclusion and recovery; prevention and early intervention; service access, coordination and continuity of care; quality improvement and innovation; and accountability.

- The 2013 National Mental Health Report\(^5\) notes that an evaluation of the Fourth Plan will be undertaken, and an evaluation framework is under development.

The Fourth National Mental Health Plan has included ‘Accountability: Measuring and Reporting on Progress’ as one its five priority areas. The Fourth Plan sets out four actions to be achieved, most of which have been touched on already: regular national reporting on mental health reform; the development of indicators to monitor system performance; further development of mental health information; and an evaluation of the Fourth Plan. The development of mental health information encompasses a range of activities designed to fill gaps in, or further develop, comprehensive reporting on mental health services including: the development of national minimum dataset to enable consistent data collection about the mental health sector; the development of instruments for measuring consumer and carer experiences of mental health care and consumer social inclusion; development of a classification of mental health interventions; and a review and further development of the National Outcomes and Casemix Classification (NOCC).

The National Mental Health Strategy has sought to advance the collection of outcomes and casemix data as a means of tracking at a ‘big picture’ level the extent to which people receiving mental health treatment are benefiting from it. Australia was one of the first countries to implement routine outcome measurement and has continued to pioneer technical developments in the field.
NOCC is managed by the Australian Mental Health Outcomes and Classification Network (AMHOCN) on behalf of the Australian Government, and provides leadership to the mental health sector to support the sustainable implementation of routine outcomes and casemix measure collection. AMHOCN regularly reports outcome data at a national level, partitioned by age group and service setting, initially via a suite of ‘standard reports’ and later via a reports portal which provides users with greater flexibility to tailor reports to their requirements. AMHOCN has supported states/territories to utilise their own outcome data and to benchmark against each other for identify opportunities or system improvement.

Alongside this, other efforts are also underway. Currently, the most notable of these is the National Mental Health Commission’s Review of Mental Health Services and Programmes (http://www.mentalhealthcommission.gov.au/our-work/review-of-mental-health-services-and-programmes.aspx). The review aims to ‘assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community’. Its scope encompasses government, private and non-government sectors. Data is being gathered via a number of methods. A major component of the data gathering strategy was a public call for stakeholder submissions (opened on 24 March 2014 and closed on 14 April 2014) which ‘sought input on service gaps, duplication, inefficiency, unnecessary red tape and solutions’. The final report is expected to be submitted to the Government by 30 November 2014.

Of course, Australia is not the only country to have emphasised evaluation of its policy reform agenda. The World Health Organization’s monograph on Monitoring and Evaluation of Mental Health Policies and Plans sets out a staged approach to policy evaluation, stating that: ‘First, the process of developing the policy and plan and the contents must be evaluated. Second, the plan should be monitored to ensure that its implementation proceeds according to a defined set of activities, timetable and budget and to assess whether the outputs are being realised. Third, if the plan is not being implemented as intended, an evaluation may be needed to understand the reasons for this. Fourth, at the end of a policy period it is important to assess whether the objectives set have been realised (page 5).’ From here, a detailed five-step process for conducting evaluations is outlined.

The World Health Organization’s approach is consistent with the broader evaluation literature which recognises that evaluations of complex systems require innovative approaches based on clear organising principles (e.g., such as program logic approaches which allow the hierarchy of objectives of given programs and policies to be teased out and assessed), the use of multiple perspectives and data sources to triangulate the findings, the assessment of standardisation and treatment fidelity to ensure an intervention is implemented as intended across heterogeneous treatment settings, and a multi-dimensional approach to outcome measurement matched to the hypothesised factors contributing to the success of an intervention, or the barriers to its success.

As noted in Chapter 3 of this report, individual states and territories have taken a range of approaches to monitoring and evaluation, and the extent to which the results of these evaluations are made publicly available or appear to be incorporated into the ongoing review of policy (as recommended by the World Health Organization) is highly variable.
5 Conclusions and recommendations

Mental disorders have a substantial impact on individuals, families, workplaces, society and the economy. Recently published data from the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 highlight the extent of the impact of mental and substance use disorders, providing evidence that these disorders are the leading cause of non-fatal burden of disease worldwide. Moreover, the burden of disease has increased over time, largely due to population growth and ageing, rather than increases in prevalence. Thus, it is likely that without concerted action in the areas of prevention and treatment of mental disorders, the projected ageing of the Australian population is likely to lead to an ever-increasing burden of disease. Failing to adequately prevent, manage and treat mental disorders will increasingly result in considerable costs that must be borne not only by the health system, but also by broader society, including individuals, families, workplaces, society and the economy.

In recognition of these challenges and in order to drive change, federal and state governments in most developed countries have produced and implemented health policies and plans that aim to meet the needs of their populations. The Tasmanian Department of Health and Human Services (DHHS), through the Mental Health, Alcohol and Drug Directorate is developing a new long-term Plan for mental health. The scope of the plan will include publicly-funded clinical mental health services, including inpatient, extended treatment and forensic mental health services, community mental health care provided primarily by the community sector, as well as effective coordination of linkages between primary care and providers within the private health system.

We have reviewed relevant local, national and international mental health policies and related literature in order to inform the development of this new Plan for Tasmania. There is remarkable consistency across policy documents in terms of their objectives and guiding principles, their service scope and the types of specialised services that they identify, their emphasis on collaboration with a range of sectors that are likely to influence outcomes and recovery for people with mental illness, and their focus on populations with particular service delivery needs. The literature suggests that the broad frameworks provided by other policies are sound, and that there is evidence that particular strategies and interventions might be helpful in operationalising these frameworks. On this basis, we make the following recommendations:

1. Tasmania’s new Plan should include the following themes and priority areas: whole-of-government approach; person-centred care; recovery approach; rights of consumers; carer and consumer participation; social and economic participation; enhanced access to services; coordination and continuity of care; quality of care and safety; workforce development; differences across the lifespan; recognition of diversity; research and innovation; evidence based service delivery; promotion, prevention and early intervention; and stigma reduction.

The thematic analysis of the objectives and priority areas of relevant policy documents outlined in Section 3.2 identified these recurring themes, which can be used to inform the objectives and priority areas of the Tasmanian plan. These should be viewed in light of the unique circumstances of Tasmania.

2. The scope of Tasmania’s new Plan should be in line with contemporary Australian policy documents.

Tasmania’s new Plan should conceptualise the scope of its services in a similar fashion to that used in other mental health policies, emphasising specialised clinical services and mental health community support sector services as those which the Tasmanian Government will be most closely
involved in funding and managing (see Sections 3.3 and 3.4). It should also consider the interface between specialised mental health services and primary care and general health services, with a view to making access to and movement between components of the system as seamless as possible for consumers. Although suicide prevention is covered under a separate strategy, the new plan should recognise the importance of mental illness as a risk factor for suicide and should acknowledge the role of the mental health sector in suicide prevention. Similarly, the new Plan should recognise the extent to which mental illness and substance use disorders occur comorbidly and should promote collaboration between the two sectors.

3. Tasmania’s new Plan should maintain a whole-of-government approach and should have an enhanced focus on inter-sectoral collaboration

A number of the identified objectives and priority areas outlined in Section 3.2 are reflected in Tasmania’s previous mental health policy documents, including the need for a whole-of-government approach, with strong leadership from the mental health sector. This should be continued.

Tasmania’s new Plan should consider the myriad ways in which coordination across different sectors is achieved, ranging from high level governance and planning arrangements, to local pilot studies (see Section 3.5). There should be a focus on the development and implementation of multi-sectoral approaches, as well as on the barriers to and facilitators of success. Inclusion of mental health, substance abuse and general health services within family services, or services co-located with housing are commonly found methods of inter-sectoral collaboration, and should be considered. Partnerships with the clear devolvement of responsibilities, for example in emergency services and housing, are likely to lead to better outcomes for mental health consumers and should be considered.

Partnerships in the area of training and workforce development are found in most jurisdictions, and provide an actionable, quick-acting method of intervention, however the continued presence of stigma amongst mental health services suggests that ongoing evaluation of the effectiveness of some training and capacity building initiatives may be necessary. The new Plan should include partnerships with services within the employment sector as it enables people with mental illness to remain employed or return to employment.

4. Tasmania’s new Plan should have an enhanced focus on social and economic participation, to encourage a recovery focused approach

Social and economic participation and recovery-focused approaches were identified as objectives or guiding principles in many Australian and overseas plans (see Section 3.2.7). Increased social and economic participation usually encompasses stable housing and education, training and employment for people with mental health problems and mental illness. As these are all the responsibility of sectors outside health, social and economic participation is linked closely to a whole-of-government approach. Social and economic participation and inclusion should be considered as important goals in clinical services as well as other aspects of the mental health system.

5. Tasmania’s new Plan should take a life-course approach to the provision of mental health services, and recognise early childhood and adolescence as specific areas of focus

Equitable access to service delivery across the lifespan should be ensured, but at the same time particular consideration should be given to childhood and adolescence (see Section 4.2.2). There is evidence that early intervention and screening programs can be cost-effective and lead to positive outcomes in both the short- and long-term.
6. The Tasmanian Government should be aware of the implications of human rights legislation for mental health system reform

Recent trends in mental health law reform towards use of capacity and treatability tests, treatment in the interests of health rather than safety, and regular reviews of treatment orders, among other things, provide guidance on ensuring that human rights are respected (see Section 4.2.3).

While national Australian policy documents identified in Section 3 emphasise that the rights and responsibilities of people with mental illness should be acknowledged and respected, practices used within mental health settings such as involuntary admission and treatment, seclusion, restraint, and community treatment orders have the potential to infringe upon the human rights of consumers. There is currently a lack of evidence to support the efficacy of these practices in mental health settings. The Tasmanian Government should be aware of the implications of the use of these practices on the human rights of people with mental disorders and limit their use where possible within the mental health system. Recent trends in mental health law reform towards the use of treatment in the interests of health rather than safety focus on using evidence-based practice and regular reviews of treatment orders, and provide guidance in ensuring that human rights are respected. People with mental illness should be consulted and included in the planning and policy process.

7. People with lived experience, their families and carers, should be consulted and included in the planning and policy process

Policy documents at the national and state and territory level emphasise various objectives that assist in empowering mental health consumers at both the community and individual levels (see 3.2.12). Tasmania’s previous key policy document had the action ‘Cost and implement the Consumer and Carer Participation Framework’ and identified the need for consumer and carer participation in governance and partnerships in mental health services and community sector organisations.

Current models at the service provider level such as peer support workers and consumer-operated service providers (COSPs) have been demonstrated to result in increased empowerment for consumers (see 4.4.4). However, due to the diverse nature of these interventions, there is currently a lack of evidence to support the clinical outcomes of these interventions. The Tasmanian Government should be aware that variability between projects will affect intervention results, and that while these interventions may increase consumer empowerment, their direct effect on clinical outcomes is not established. The recently established Certificate IV in Mental Health Peer Work provides a mechanism to formalise and standardise the knowledge and skills of peer workers, and may lead to better clinical outcomes for these interventions in the future. The role of the Certificate IV in Mental Health Peer Work in the mental health sector should be further explored in the Tasmanian context.

Consumers have reported an increased sense of empowerment following mental health reforms. However, barriers to consumer participation at the service provider level suggest that it is important for the Tasmanian Government to ensure empowerment is well understood by health care providers and policy makers and results in actions rather than rhetoric or tokenism.

8. Models of service delivery used in other jurisdictions but not currently used in Tasmania should be considered for future implementation in Tasmania

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In the development of the new Plan for Tasmania, consideration should be given to the range of existing and emerging mental health service types being delivered in other jurisdictions, particularly similar Australian states and territories (see Section 4.3). Where models of service delivery being embraced by other jurisdictions are not currently part of the spectrum of mental health services in Tasmania, and are both feasible for the Tasmanian context and supported by research evidence, they should be considered for future implementation in Tasmania in order to achieve the most efficient mental health system and the best consumer outcomes. For example, based on the mental health services outlined in the Tasmanian Mental Health Services Strategic Plan 2006-2011, there may be scope to expand sub-acute transitional mental health beds, supported accommodation options in the community, and youth specific bed-based and community services.

9. The increasing emphasis on population prevention and promotion, early intervention and stigma reduction should be maintained in Tasmania’s new Plan

Prevention, promotion, early intervention and stigma reduction are significant features of policies in most jurisdictions (see Section 3.3). In order to reduce the prevalence of mental disorders there is arguably a need for considerably greater population health action. This action should consider the developmental origins and risk factors over the life-course and should begin with support for families during pregnancy and early childhood and continue with interventions that aim to promote help-seeking attitudes and behaviours; reduce stigmatising attitudes towards people with mental disorders; promote wellbeing through social and emotional learning and positive psychology interventions; and reduce school bullying (see Section 4.6).

Interventions that have been shown to be promising in preventing suicide include restriction to means, general practitioner education, gatekeeper training, responsible media reporting of suicide and some school-based programs. Web-based interventions have been shown to reduce suicidal ideation. Mental health promotion in workplaces, community and the aged care sector is likely to play a key role in preventing mental disorders in adults. Action in these settings is also critical to addressing stigmatising attitudes towards people with mental disorders thereby improving participation in work and access to stable housing. Investment in population mental health strategies is cheap compared to the costs of specialised mental health services, and if successful is likely to reduce the future demand for these services.

Effective universal prevention strategies must also be able to reach the broader population.\(^ {436}\) Thus, decisions about implementation need to be informed by the generalizability and scalability of such interventions. With the increasing popularity of digital media, the internet also offers a promising mode of delivery for interventions to prevent mental disorders.\(^ {398}\)

10. The increasing emphasis on workforce development, including the development of peer support workers, should be maintained in Tasmania’s new Plan

Workforce development has been prioritised in a number of national plans and the previous Tasmanian policy was unique in that it was one of few to identify the importance of mentoring opportunities as a workforce development strategy, which may help recruit and retain professionals. Tasmania’s new Plan should ensure that the mental health workforce meets all relevant standards, capabilities and guidelines, which may be used to inform job descriptions, orientation programs, supervision and performance reviews (see Section 4.4.3). They can also be used as a resource for educators as they develop education and training programs for the mental health workforce. However, awaiting the final report on HWA’s workforce capabilities project is recommended so that these important findings can be taken into consideration.
Other jurisdictions, with significant rural and remote populations have identified the use of communication technologies, such as the internet to promote recruitment, training and retention. Such strategies could be increasingly useful for Tasmania.

11. The needs of priority populations should be further considered in Tasmania’s new Plan

Tasmania has already identified several priority populations, including populations across the lifespan, people with multiple-comorbidities, people that have experienced trauma, Aboriginal people, forensic, LBGTI, drug and alcohol misuse disorders, culturally and linguistically diverse groups, and carers in its discussion paper. Given that the Aboriginal and Torres Strait Islander population appears to be increasing in Tasmania, greater consideration of mental health and suicide prevention policy documents devoted to this population may be warranted. Men as a priority population should also be considered, as men are particularly vulnerable in conditions of economic instability and with the decline of traditional industries (see Section 3.6).

12. Equitable access to services in rural populations should be enhanced in Tasmania’s new Plan

The rurality of Tasmania is also a consideration for service delivery, and rural and remote populations should be considered a priority population in the new Plan, which should focus on the following: mental health services in primary care including mental health services in general hospitals; visiting community mental health services and specialised mental health services; and self-care, informal community mental health care and community development (see Section 4.5.3). Delivering effective collaborative care to the rural population may be most effectively done through the use of telepsychiatry models in conjunction with outreach education and training. It is also likely that the growing use of effective internet and mobile phone delivered interventions can also assist in promoting equitable access to services and improving health outcomes in the rural Tasmanian population.

13. Collaboration with research institutions should be further explored in the Tasmanian context in order to provide an avenue for ongoing collaborative access to evidence-based research

The increasing requirement for evidence-based services is a promising development for mental health outcomes. Collaboration with research institutions identified in several policy documents should be further explored in the Tasmanian context, as it may provide an avenue for ongoing collaborative access to evidence-based research (see Section 3.2.14).

14. Tasmania’s new Plan should include measurable indicators or desired outcomes in order that success or progress can be evaluated

Evaluation is critical part of policy development. However, the review of policy documents showed that individual jurisdictions have taken a range of approaches to monitoring and evaluation, and the extent to which the results of these evaluations are made publicly available or appear to be incorporated into the ongoing review of policy is highly variable (see Section 3.7).
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