Australian Health Ministers' Conference

Council of Australian Governments National Action Plan for Mental Health 2006-2011

Progress Report 2006-07

This report was prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council and endorsed by Australian Health Ministers.

February 2008

Foreword

The Council of Australian Governments (COAG) National Action Plan on Mental Health, endorsed in July 2006, represents a landmark in the development of mental health services in Australia. For the first time, government leaders focused on the issue of mental health and agreed to a national plan of action to reform mental health services. Backing this agreement, a total of $4.1 billion was committed to a wide range of initiatives over the 2006-11 period, with a further $935 million committed subsequently. This represents the largest collective investment in mental health by Australian governments to date.

The Action Plan is also unprecedented in that it addresses not only health needs, but makes commitments to activities in the other key areas of housing, employment, education and correctional services, all of which have an important part to play in addressing the mental health needs of Australians. A network of state-based mental health groups has been established to coordinate this work both across sectors and between governments.

This is the first in the series of annual reports stipulated by COAG as a requirement for monitoring implementation. It describes the progress made in 2006-07, the commencement year of the Action Plan. The report presents information about allocations to date in each of the priority areas, along with details of additional funding commitments made by jurisdictions since the Action Plan was signed.

The report also brings together the most current data relevant to 12 progress indicators agreed by COAG for measuring the outcomes of the Action Plan. As such, the report provides important information on key areas targeted for reform and, importantly, sets the baseline for monitoring change over the next four years. It shows that the number of people accessing mental health services in 2006-07 (5% of population) is far less than the known rates of mental illness in the community, suggesting high levels of unmet need. Readmissions to hospital and rates of community follow-up after discharge vary substantially between jurisdictions, suggesting major differences in practices. Workforce participation rates for working age Australians who have a mental illness are only half those for people of comparable age who do not have a mental disorder. These indicators highlight the need for all governments to maintain the effort that has been commenced through the Action Plan.

Reports such as this require considerable work and coordination between governments. The cooperation that has been evident in developing the current report has been strong. It is much to the credit of all governments in Australia and their respective administrations that the report has been produced within the tight timeframes.

The Hon. Stephen Robertson
Chair, Australian Health Ministers' Conference 2008
Minister for Health, Queensland
February 2008

Contents

PART A
National overview

This section of the report summarises the first year of progress in implementation of the National Action Plan, along with initial data available on agreed outcomes.

Chapter 1 Overview of the National Action Plan

Action Plan in summary

In July 2006, the Council of Australian Governments (COAG) agreed to the National Action Plan on Mental Health 2006-2011, recognising the need for a change in the way governments respond to mental illness. The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers, aimed at building a more connected system of health care and community supports for people affected by mental illness.

The Action Plan outlines a series of initiatives that will be implemented between 2006 and 2011, described in Individual Implementation Plans prepared by each government. A total of 145 separate initiatives are described in the Individual Implementation Plans, with a combined value of $4.1 billion.

While most initiatives represent additional commitments to expand ongoing programs, many are new and take the delivery of services for people with mental illness into areas beyond the boundaries of traditional health care. Key human service programs operating outside the health system that have major responsibilities under the Plan include housing, employment, education and correctional services. Additionally, the initiatives funded under the Plan emphasise the role of the non-government sector in the delivery of a wide range of community support services. These provide the services needed by many people affected by mental illness, complementing the role of health services.

The Plan identifies five 'Action Areas' for combined government action, with specific policy directions within each area. The Action Areas provide an organising framework for grouping and understanding the relative investments by governments.

Governments also committed to four outcomes by which the success of the Plan can be assessed. The Action Areas and outcomes are summarised below.

Figure 1: COAG Action Plan agreed Action Areas and outcomes

Action Areas agreed in the COAG Plan	Agreed outcomes
• Promotion, prevention and early intervention • Integrating and improving the care system • Participation in the community and employment, including accommodation • Increasing workforce capacity • Coordinating care ('Coordinating care' and 'Governments working together')	• Reducing the prevalence and severity of mental illness in Australia • Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent long term recovery • Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention • Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

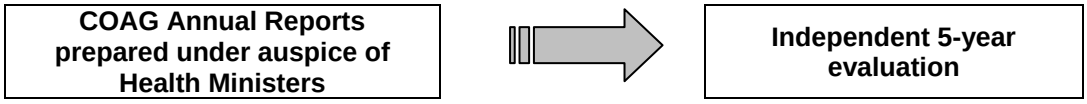
Commitment to annual monitoring and independent evaluation

Heads of Governments agreed to the discipline of annual reporting, stipulating regular monitoring of the implementation of the Action Plan and progress against agreed outcomes. Responsibility for this function is assigned to Health Ministers. Governments also agreed to an independent evaluation and review of the Plan after five years.

The primary role of the annual reports is to chart progress made under the Action Plan, and monitor the extent to which the agreed initiatives are taking place, addressing the question of 'Are we doing what we said we would'? Additionally, annual reports will present interim data on Action Plan outcomes, where data are relevant and available.

The five-year independent evaluation will be the primary vehicle for assessing the impact of the Action Plan and its success in achieving the agreed outcomes. While the annual reports will serve as key building blocks for the evaluation, it will also draw on a range of other evidence, including evaluations of major initiatives undertaken by each jurisdiction. A national evaluation framework to guide the evaluation is currently being developed and will be designed to address four key questions, shown below.

Figure 2: Roles of Action Plan annual reports and independent 5-year evaluation



"Are we doing what we said we would?"

Designed to give information about:

- implementation progress
- updated information about developments within each jurisdiction including funding allocations
- updates on Action Plan outcome indicators where available

"Have we achieved the outcomes we expected?"

Designed to address four questions:

1. To what extent have the agreed policy directions as specified in the Action Plan been implemented in each of the five Action Areas?
2. How effective has the Action Plan been in achieving the agreed outcomes?
3. To what extent did the structural arrangements established by the Action Plan contribute to a coordinated government approach to improving mental health care in Australia?
4. What opportunities exist for further cross-government collaboration to build on progress achieved through implementation of the Action Plan?

Action Plan in context

In monitoring the progress of the Action Plan, Health Ministers believe that it is important to recognise that the new COAG funding commitments are being directed to bolster an established specialist health sector that has been the subject of an ongoing national reform framework (the National Mental Health Strategy) since 1992. Substantial growth in services has occurred under the Strategy, with spending of approximately $3.9 billion annually. This is equivalent to $19,880 billion over the course of the Action Plan.

A total of $4.1 billion in new funding has been committed by governments, on signing of the Action Plan, on 14 July 2006. This represents an increase of 17-18% of total spending on mental health over the 2006-11 period. It should be noted that further commitments have been subsequently announced by most jurisdictions.

The Action Plan adds much needed impetus to accelerate reforms and focuses on areas that have not progressed sufficiently under the National Mental Health Strategy. As the Plan continues to be implemented, it will be necessary to not only monitor the progress of the new initiatives, but also ensure that base commitments pre-dating the Action Plan are maintained.

Monitoring base spending is outside the scope of this report but will be achieved through other national reports prepared regularly on mental health, in particular the National Mental Health Report.

Chapter 2 Progress in implementation

Action Plan commitments and first year allocations

Original commitments made by governments totalled $4.1 billion. While most of the committed outlays were targeted at ongoing service delivery, funding commitments by several governments included substantial capital components, largely directed at building new facilities and expanding or upgrading hospitals and community care centres.

Subsequent to the release of the Action Plan, most governments have made further commitments to mental health in one or more of the Action Areas, announced through recent budgets. The combined value of the additional commitments announced last year is $935 million, taking the total value of Action Plan initiatives to $5.01 billion, 23% above the original commitments.

Table 1: Action Plan funding commitments 2006-11 and allocations 2006-07 (millions)

	Funding commitments 2006-11			New funding allocated 2006-07
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11	
Australian Government	1,855.1	20.0	1,875.1	218.7
New South Wales	938.9	42.6	981.5	230.9
Victoria	472.2	69.3	541.5	104.4
Queensland	366.4	528.8	895.2	109.3
Western Australia	252.5	144.1	396.6	51.3
South Australia	116.1	117.0	233.1	29.5
Tasmania	43.0	-	43.0	9.0
Australian Capital Territory	20.7	12.9	33.5	3.4
Northern Territory	14.5	0.6	15.1	2.9
Total	**4,079.3**	**935.3**	**5,014.6**	**759.4**

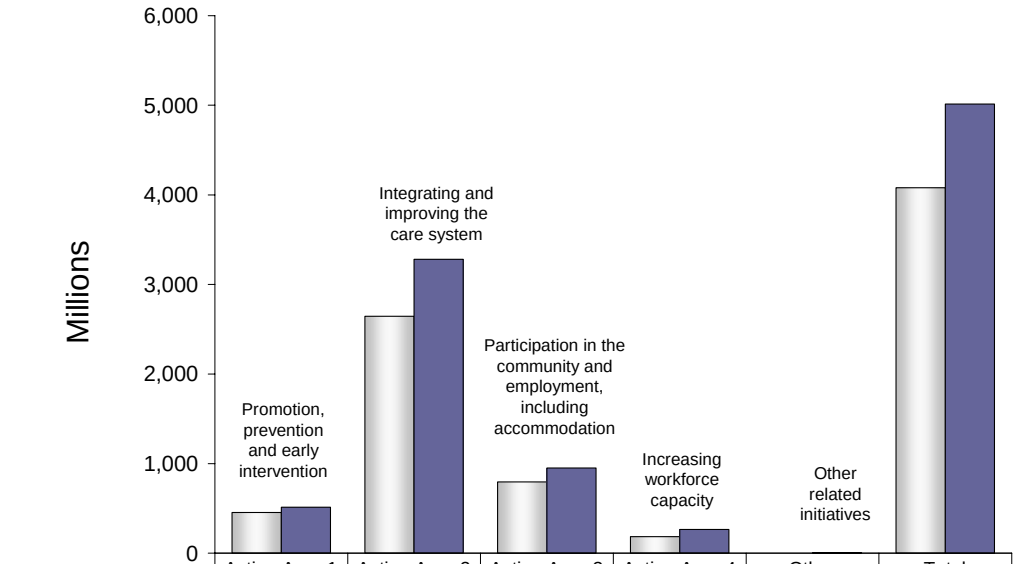
Combined allocations of $759 million were made in 2006-07. For all governments, spending in 2006-07 is less than anticipated in future years because, as the first year of implementation, programs were only being established and not operational for the full year. It is expected that spending under the Plan will 'ramp up' substantially in 2007-08, the first year of full operation for most of the new and expanded programs.

All governments have provided summaries of their progress in 2006-07, each focusing on the main developments in the year. These are presented in Part B of the report. Additionally, in keeping with the requirements of the Action Plan, governments have submitted details of their funding commitments, allocations made in 2006-07, and any new commitments made since the Action Plan was agreed in July 2006. These are presented in Appendix 1.

Funding commitments made under the Action Plan are spread across four of the five Action Areas, with about two thirds directed to Area 2 (Integrating and Improving the Care System). The relative balance of investment in the Action Areas varies across the jurisdictions,

reflecting both differences between states and territories in the range and scale of services in place prior to the Action Plan, as well as differences in how specific initiatives are classified.

Figure 3: Funding commitments by Action Area 2006-11, original and revised



	Action Area 1	Action Area 2	Action Area 3	Action Area 4	Other	Total
Initial commitments	454.3	2,645.3	794.8	185.0	0.0	4,079.3
Revised commitments	513.8	3,279.6	950.6	265.8	4.8	5,014.6

Action Area 1: Promotion, prevention and early intervention

Figure 4: Promotion, prevention and early intervention – Action Plan policy directions

- Building resilience and coping skills of children, young people and families
- Raising community awareness
- Improving capacity for early identification and referral to appropriate services
- Improving treatment services to better respond to the early onset of mental illness, particularly for children and young people
- Investing in mental health research to better understand the onset and treatment of mental illnesses

COAG agreed that promotion, prevention and early intervention are critical to enabling the community to better recognise the risk factors and early signs of mental illness and to find appropriate treatment. The Action Plan identifies this area as requiring increased investment, based on growing evidence that mental illnesses are less severe, of shorter duration, and less likely to recur when identified and treated early.

The Plan spells out five policy directions to guide future investments in promotion, prevention and early intervention (Figure 4).

Governments originally committed a combined total of $454 million additional funding to initiatives grouped under Action Area 1, increasing to $514 million when more recent government budget announcements are included. Funding directed to promotion, prevention and early intervention represents 10% of the total revised Action Plan commitments.

Based on the first year progress reports, $80 million new funding was allocated in 2006-07.

Table 2: Action Area 1 - funding commitments 2006-11 and allocations 2006-07 (millions)

	Funding commitments 2006-11			New funding allocated 2006-07
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11	
Australian Government	158.4	0.3	158.7	17.6
New South Wales	102.2	19.5	121.7	32.0
Victoria	80.3	10.0	90.3	13.1
Queensland	6.9	9.4	16.3	0.5
Western Australia	60.7	12.6	73.3	11.3
South Australia	39.5	7.6	47.1	4.1
Tasmania	2.0	-	2.0	0.2
Australian Capital Territory	3.3	-	3.3	0.5
Northern Territory	1.0	0.3	1.3	0.5
Total	**454.3**	**59.6**	**513.8**	**79.8**

Action Area 2: Integrating and improving the care system

Figure 5: Integrating and improving the care system – Action Plan policy directions

- Resourcing adequately health and community support services to meet the level of need
- Developing ways of coordinating and linking the range of care that is provided across the continuum of primary, acute and community services by public, non-government and private sector providers

Action Area 2 of the Plan promotes future investment in mental health towards two policy directions. The first concerns resources and aims to increase current provision of health care and community support services to a level where the needs of the Australian population are being met. Reducing the high level of unmet need for mental health care is paramount and is the focus of one of the key outcome indicators COAG set for monitoring the overall success of the Plan (Indicator 5 - see Chapter 3).

The second policy direction targets the need to better integrate and connect services by private, public and non-government health and community providers who deliver care to people affected by mental illness.

Concerns about coordination between services accessed by people with mental illness were at the forefront of a number of major reports on mental health care in Australia in the lead up to the Action Plan. The Plan promotes improvements in all arrangements, both within the health sector as well as between health and community service providers, such as accommodation and employment services. Better coordinated and integrated services are aimed at preventing people in need from 'slipping through the care net', and experiencing the adverse consequences that can follow such as unplanned readmissions to hospital, homelessness, imprisonment or suicide

To give prominence to the role of coordination, governments committed to two 'flagship' initiatives to better coordinate and link the range of care across the continuum of primary,

acute and community services, provided by public, non-government and private sector providers. 'Care coordination' and 'Governments working together' are described under Action Area 5.

Governments originally committed a combined total of $2.65 billion additional funding to initiatives grouped under Action Area 2, increasing to $3.28 billion when more recent government budget announcements are included. Funding directed to initiatives to integrating and improving the care system represents 65% of the total revised Action Plan commitments. Based on the first year progress reports, $548 million new funding was allocated in 2006-07.

Table 3: Action Area 2 - funding commitments 2006-11 and allocations 2006-07 (millions)

	Funding commitments 2006-11			New funding allocated 2006-07
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11	
Australian Government	1,196.9	19.7	1,216.6	161.9
New South Wales	699.7	23.1	722.8	183.4
Victoria	284.8	57.7	342.5	64.0
Queensland	289.1	345.8	634.9	78.5
Western Australia	53.6	116.4	170.0	26.4
South Australia	75.6	68.2	143.8	24.3
Tasmania	21.1	-	21.1	5.1
Australian Capital Territory	11.5	3.5	15.0	2.3
Northern Territory	13.0	-	13.0	2.0
Total	**2,645.3**	**634.4**	**3,279.6**	**547.9**

Action Area 3: Participation in the community and employment, including accommodation

Figure 6: Participation in the community and employment, including accommodation – Action Plan policy directions

- Enhancing support services for people with mental illness to participate in the community, education and employment
- Enabling people with mental illness to have stable housing by linking them with other personal support services
- Improving referral pathways and links between clinical, accommodation, personal and vocational support programmes
- Expanding support for families and carers including respite care

Action Area 3 of the Plan gives emphasis to the role played by services that operate outside the health sector in promoting recovery from mental illness. People affected by mental illness have the same requirements as other people for stable housing, home support, recreation, employment, education and family relationships. When their disorder results in disability, they may require access to a range of supports to live independently and participate fully in community life.

The Action Plan recognises that reform of the specialised mental health sector alone will not produce the broader change required to improve services for mental health consumers

in these areas. Four policy directions are identified to accelerate the development of support services in the community, with a special focus on employment, accommodation and services to assist carers (Figure 6).

Governments committed a combined total of $795 million additional funding to initiatives grouped under Action Area 3, increasing to $951 million when more recent government budget announcements are included. Funding directed to 'participation in the community' initiatives accounts for 19% of the total revised Action Plan commitments.

Based on the first year progress reports, $107 million new funding was allocated in 2006-07.

Table 4: Action Area 3 - funding commitments 2006-11 and allocations 2006-07 (millions)

	Funding commitments 2006-11			New funding allocated 2006-07
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11	
Australian Government	370.0	-	370.0	26.2
New South Wales	113.8	-	113.8	12.1
Victoria	102.7	1.7	104.4	26.5
Queensland	64.3	98.1	162.4	28.9
Western Australia	129.4	12.7	142.1	10.8
South Australia	-	38.1	38.1	-
Tasmania	11.3	-	11.3	2.0
Australian Capital Territory	2.8	5.0	7.8	-
Northern Territory	0.5	0.3	0.8	0.4
Total	**794.8**	**155.9**	**950.6**	**106.8**

Action Area 4: Increasing workforce capacity

Figure 7: Increasing workforce capacity – Action Plan policy directions

- Increasing the mental health workforce
- Improving its ability to meet patient needs across Australia, particularly in rural and regional areas and for Aboriginal and Torres Strait Islander people
- Supporting the non-government and private sector to provide quality services to people with mental illness

The Action Plan recognises that shortages across the mental health workforce are a key limiting factor to improving mental health services. Additionally, distribution of the workforce, particularly across rural and regional areas, needs priority attention.

The nature of the workforce providing mental health care in Australia has changed substantially over the last decade. Complementing the specialist public mental health services managed by states and territories, primary care is now acknowledged as a critical element of comprehensive mental health services. New and expanded roles have also developed for private and non-government providers. The skill mix to deliver quality services is diverse and requires

adequate numbers of psychiatrists, nurses, psychologists, social workers, occupational therapists, other allied health providers, general practitioners and Aboriginal and Torres Strait Islander health workers.

The Action Plan sets four policy directions to target governments' future workforce investments (Figure 7), all aimed at building capacity in terms of supply, distribution and skills.

A combined total of $185 million additional funding to initiatives grouped under Action Area 4, increasing to $266 million when more recent government budget announcements are included. Funding directed to workforce initiatives accounts for 5% of the total revised Action plan commitments.

Based on the first year progress reports, $25 million new funding was allocated in 2006-07.

Table 5: Action Area 4 - funding commitments 2006-11 and allocations 2006-07 (millions)

	Funding commitments 2006-11			New funding allocated 2006-07
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11	
Australian Government	129.8	-	129.8	13.0
New South Wales	23.2	-	23.2	3.4
Victoria	4.4	-	4.4	0.8
Queensland	6.1	70.8	76.9	1.5
Western Australia	8.8	2.4	11.2	2.9
South Australia	1.0	3.2	4.2	1.0
Tasmania	8.6	-	8.6	1.7
Australian Capital Territory	3.1	4.4	7.5	0.6
Northern Territory	-	-	-	-
Total	**185.0**	**80.8**	**265.8**	**24.9**

Action Area 5: Coordinating care

Figure 8: Coordinating care - Action Plan policy directions

- Coordinating care
- Governments working together

The Action Plan contains two flagship initiatives directed at providing more seamless and coordinated health and community services for people with a mental illness. It was anticipated that work in this area would be undertaken within existing resources with no funding earmarked in the Action Plan.

Governments working together

Premier or Chief Minister Departments in each State and Territory and the Australian Government Department of Health and Ageing have convened COAG Mental Health Groups to provide forums for oversight and collaboration in planning and implementing initiatives under the Action Plan. The groups include representatives from government departments with

responsibility for implementation of initiatives. Non-government organisations, the private sector, and consumer and carer representatives are also engaged.

On average, each group has met and continues to meet quarterly. In total, there have been over 90 meetings and stakeholder consultations since July 2006 demonstrating the commitment of all jurisdictions to work under the Action Plan, and also the effort required to ensure that work on the Action Plan proceeds collaboratively across portfolios.

Coordinating care

Through the Action Plan COAG committed to ensuring that care is coordinated for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system. This group of people have persistent symptoms and significant disability, have lost social or family support networks and often need the support of multiple health and community services to maintain their lives within the community. In particular, access to clinical care needs to be complemented by access to accommodation support to ensure stable housing, and a range of community support services focused on employment, income support, education and social and family support. When one or more of these needs is not met, the person's recovery and their capacity to live in the community is jeopardised.

The aim was a new system, building upon existing coordination arrangements, whereby care coordinators, with the support of clinical providers, will ensure the person is connected to these services.

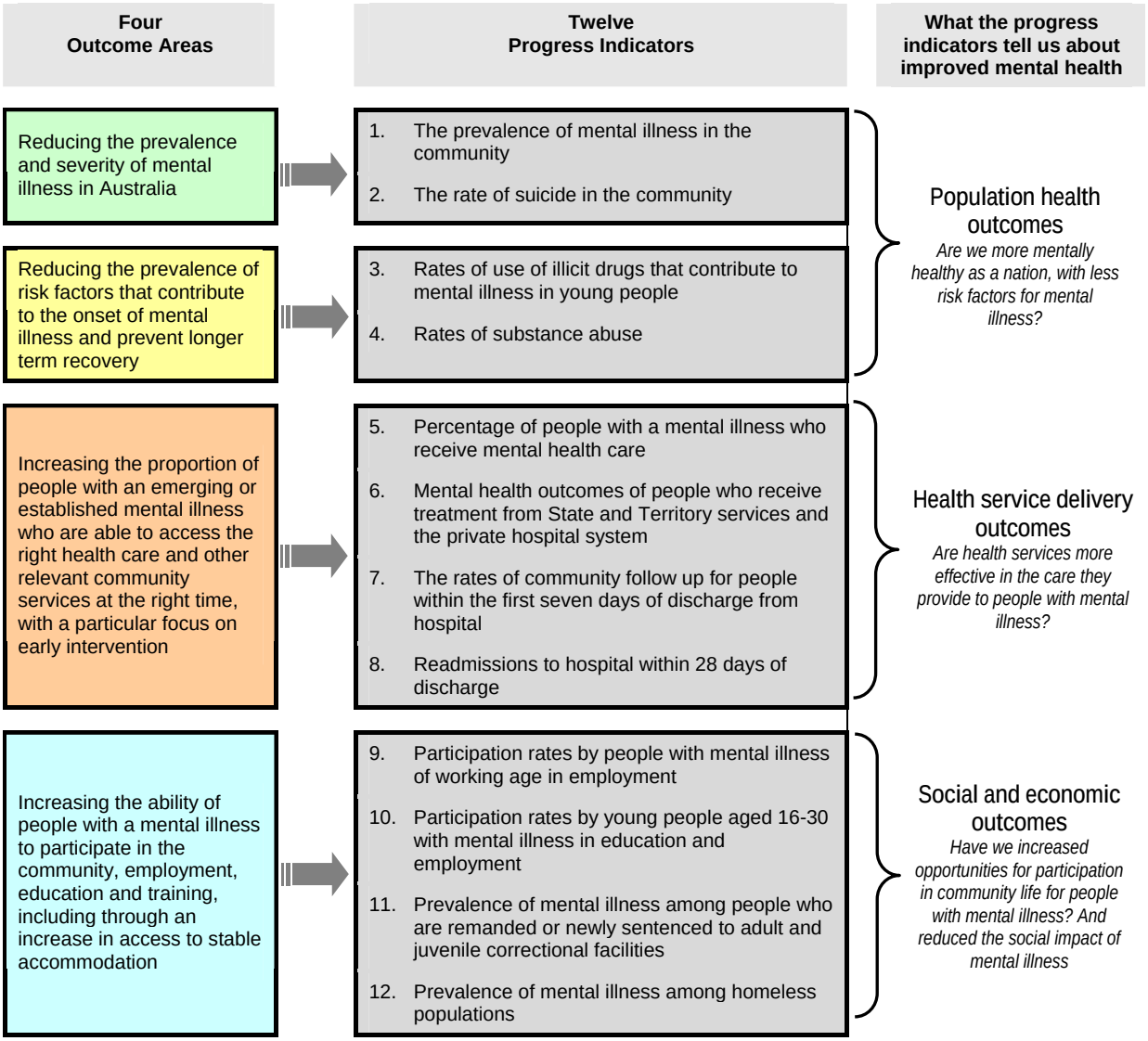
A set of high-level principles and implementation guidelines have been developed to guide the work. The implementation by each jurisdiction is, however, flexible reflecting local systems.

Work is progressing on the development of state-based care coordination models in all states and territories through care coordination sub-groups of the state-based COAG Mental Health Groups. The Australian Government has also undertaken extensive consultations in the development and initial implementation of the Personal Helpers and Mentors initiative, which sees the Australian Government complementing the services provided by states and territories.

Chapter 3 Progress towards outcomes

The Action Plan identifies four outcome areas targeted for long term change. Collectively, the actions committed by governments aim to improve the status of the population's mental health, stimulate better outcomes from health services, as well as achieve improvements at the broader social and economic level. A total of 12 progress indicators are identified to track improvements across the agreed outcome areas. The indicators are representative rather than comprehensive, and are designed to provide a snapshot of progress in key areas.

Figure 9: COAG Action Plan outcome areas and progress indicators



This section of the report presents information for the 12 progress indicators, drawn from currently available data. Not all indicators are suitable for reporting annually. Primary data sources for only five of the indicators are collected on an annual basis (Indicators 2, 6, 7, 8, 12), while the remainder are collected periodically (3 to 5 yearly) through special, sampled collections.

OUTCOME AREA 1:
Reducing the prevalence and severity of mental illness in Australia

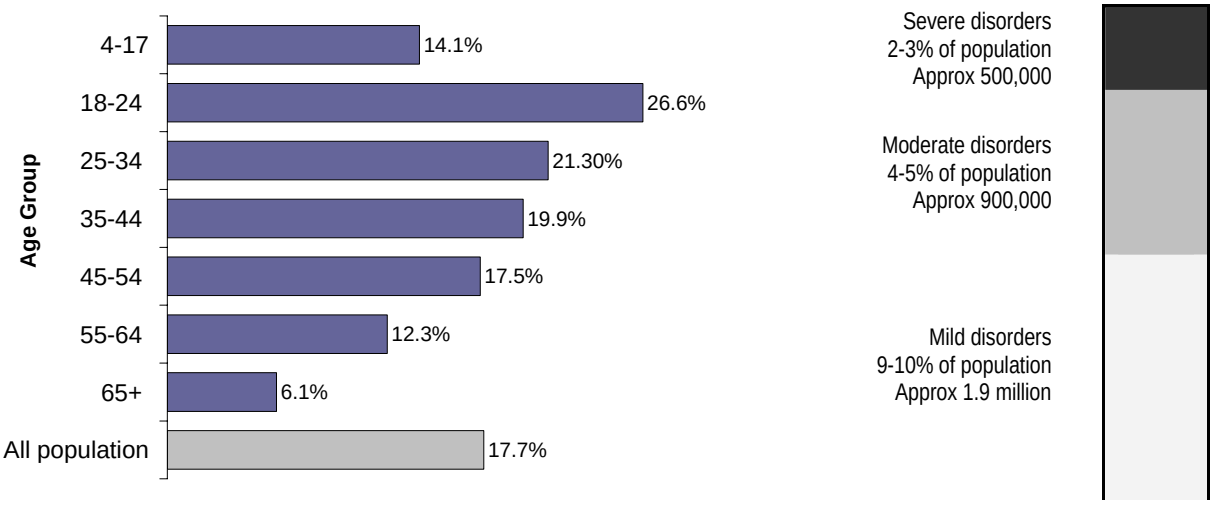
Indicator 1: Prevalence of mental illness in the community

Mental disorders are common in the Australian population, affecting the lives of individuals, their carers and wider community. Awareness of the scale of mental illness and its extensive social impact has increased substantially over the past decade, both within governments and in the community.

National surveys undertaken in 1997 and 1998 provided the first comprehensive assessment of mental disorders in Australia. These found that about 18% of the population – or 3.3 million individuals – are affected by a mental disorder in any one year. One in four individuals were found to experience more than one mental disorder, most commonly some combination of anxiety, depression or substance abuse. The challenges of providing services where individuals present with both a mental disorder and substance abuse are well recognised. Just under a half also had a chronic physical illness.

Severity is judged according to the type of disorder (diagnosis), the intensity of symptoms, the length of time symptoms have been experienced, and the degree of disablement that is caused to social, personal and vocational functioning. An estimated 2-3% of Australians have severe disorders, representing about half a million Australians. About half of these people have a psychotic illness, primarily schizophrenia or bipolar disorder.

Figure 10: Prevalence of mental disorders in the Australian population



The prevalence of mental illness varies across the life span. Rates are higher in the early adult years, the period during which many people first experience symptoms of illness, reinforcing the need to strengthen early intervention services targeting younger Australians.

The Action Plan aims to reduce both the prevalence and severity of mental illness. Reduction in prevalence may be brought about by preventive efforts to stop an illness occurring in the first place, or by increasing access to effective treatments for those in whom the illness has begun. Reducing the severity of mental illness requires a range of services designed to alleviate the disablement that may be caused to a person's social, personal and vocational functioning. A substantial proportion of the Action Plan initiatives have targeted these areas.

A second national population survey on mental health, taking place in 2007, will provide more current estimates of the prevalence of mental illness. Results from the survey will be available for the 2009 progress report.

OUTCOME AREA 1:
Reducing the prevalence and severity of mental illness in Australia

Indicator 2: Rate of suicide in the community

While suicide accounts for only a relatively small proportion (1.6%) of all deaths, it accounts for a much greater proportion of deaths in certain cohorts, in particular 20% of deaths for males aged from 20 to 34 years. Each represents not only a loss of a life, but also affects family and friends left behind and the community as a whole.

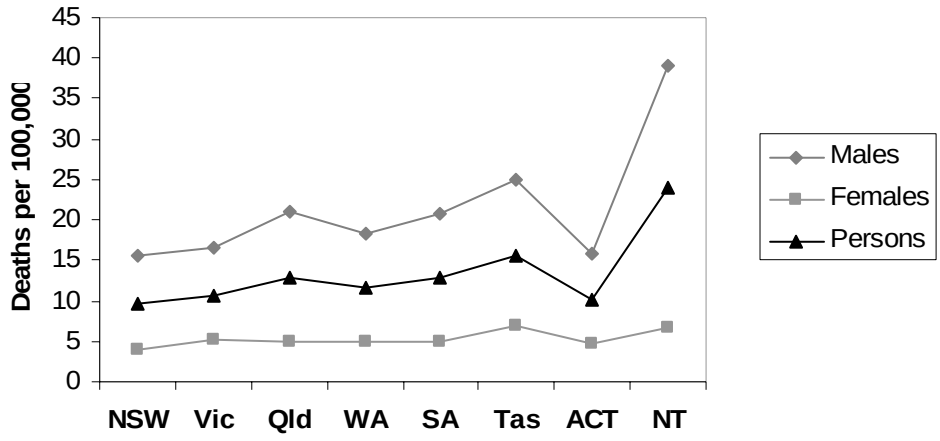
Table 6: Suicide by state or territory, number of deaths 2001-2005

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2001	785	541	499	269	207	64	46	43	2,454
2002	692	528	537	242	170	70	26	55	2,320
2003	640	540	466	226	193	69	35	44	2,213
2004	587	521	453	194	178	88	26	51	2,098
2005	549	505	459	203	231	74	35	45	2,101

There were 2,101 deaths in 2005 and 80% of these were males. The age-standardised rate for Australia as a whole was 10.3 per 100,000. The age-specific suicide death rates were highest for males aged 30 to 34 years (27.5 per 100,000 compared to 16.4 per 100,000 across all ages), while for females it is for those aged 35-39 years (6.9 per 100,000 compared to 4.3 per 100,000 across all ages).

Suicide rates fluctuate across time, often greatly within smaller jurisdictions due to the relatively small numbers of suicide registered annually. There are also significant variations across jurisdictions in the finalisation of coronial processes. Data are therefore combined across five years to allow more reliable comparison.

Figure 11: Suicide by state or territory age-standardised rate 2001-2005



Source: Australian Bureau of Statistics, Suicides Australia 2005

Figure 2 shows that the rates for the Northern Territory (24 per 100,000) are a major concern, more than double the national rate of 11.2 per 100,000. Tasmania had rates 39% above the national rate (15.6 per 100,000), and Queensland and South Australia were 14% above the national rate (12.8 per 100,000). New South Wales, Victoria and ACT all had rates below the national average. Higher proportions of rural areas and Indigenous peoples contribute to these differences.

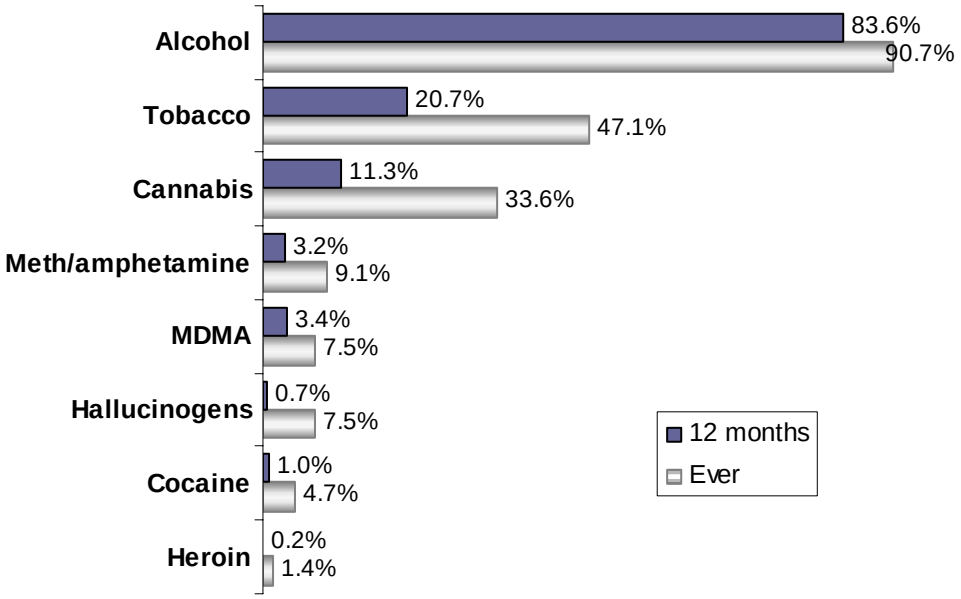
OUTCOME AREA 2:
Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery

Indicator 3: Rates of use of illicit drugs that contribute to mental illness in young people

Indicator 4: Rates of substance abuse

The National Action Plan reflects concern at both a government and broader community level about substance abuse and the effects of this in terms of both the prevalence of mental illness and demands upon health services. While national programs have been initiated under the National Drug Strategy further targeted efforts are required in reducing substance abuse, particularly the use of illicit drugs that have shown to contribute to mental illness, and in dealing with the challenges of providing services to people presenting with comorbid mental health and substance abuse problems.

Figure 12: Prevalence of drug use in Australia, 2004



Cannabis and methamphetamines are the most widely used illicit drugs in Australia with an estimated 34% and 9% of the population having ever used these drugs. This high level of usage is of particular concern due to mental health problems often associated with their use. This compares to 91% of the population consuming alcohol.

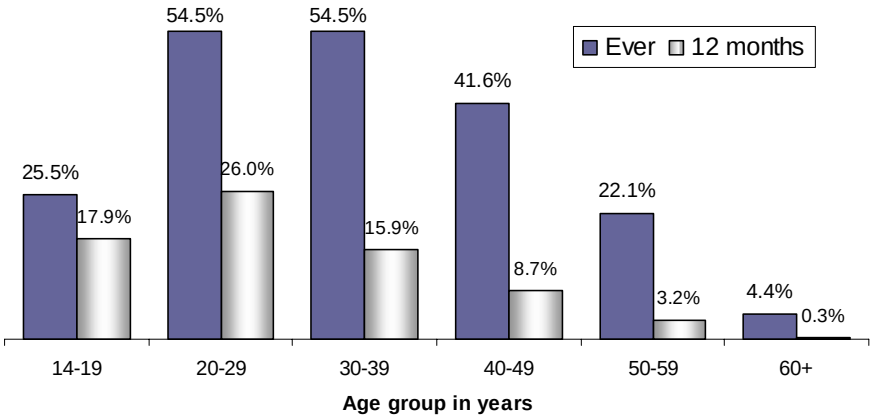
Alcohol

Alcohol is a major cause of death, injury and illness in Australia. In 2004, almost 10% of people aged 14 years and over drank at risk or high-risk levels for long-term health problems (including liver cirrhosis and cardiovascular disease). This is the result of high level regular daily patterns of drinking. While 35% drank at risky or high-risk levels (associated with drinking on a single day) for short-term risk such as injury, acute pancreatitis and even death. The proportion who had drunk at levels considered risky or high risk in both the short term and long term was 9%.

Cannabis

Cannabis remains the most widely used illicit drug in Australia. In 2004, 34% of the population aged 14 years and over had ever used cannabis, with 11% having used it in the preceding 12 months. Males are more likely than females to use cannabis, to use with greater frequency and to use the more potent parts of the plant. Recent (past year) cannabis use is most common among males in the 20-29 year age group.

Figure 13: Prevalence of lifetime and 12-month cannabis use by age, 2004



Although lifetime use of cannabis has reduced among 14-19 year olds from 45% in 1998 to 26% in 2004, adolescents are still more likely to have tried cannabis than tobacco (16%).

The demand for interventions for cannabis-related problems is increasing with around one in five alcohol and drug treatment episodes being for a primary cannabis use disorder.

Cannabis use may precipitate schizophrenia in people who have a personal family history of the disorder. There is also some research evidence that cannabis increases the risk of experiencing psychotic symptoms for those who have a vulnerability to psychosis. Cannabis use may also exacerbate symptoms of schizophrenia, but it remains unclear whether or not cannabis causes additional cases of schizophrenia.

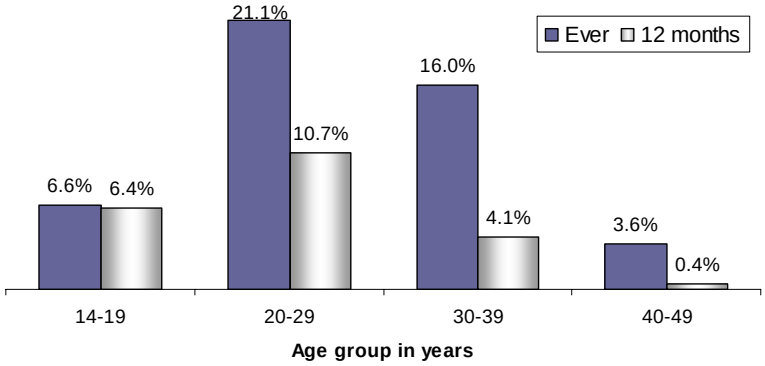
Cannabis use also poses a moderate risk for later depression, with heavy cannabis use possibly posing a small additional risk of suicide.

Methamphetamine use

Although the prevalence of methamphetamine use has stabilized in recent years, increased up-take in the 1990s, coupled with recent increases in the use of crystalline methamphetamine, has been associated with an increase in problems from the drug. Symptoms of psychosis are one of the particularly worrying consequences of methamphetamine use and dependent methamphetamine users also suffer from a range of comorbid mental health problems.

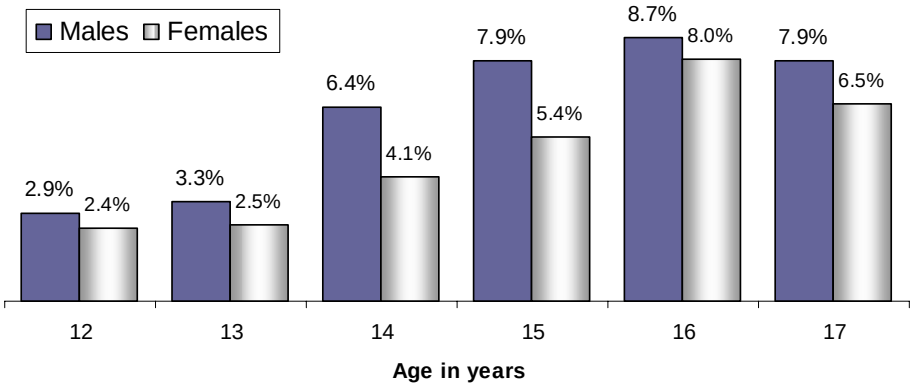
Conversely, users who have schizophrenia, mania or other psychotic disorders are more likely to experience the recurrence of psychotic symptoms, or more severe symptoms, making treatment substantially more difficult.

Figure 14: Lifetime and 12 month prevalence of meth/amphetamine use for selected age groups, 2004



Statistics on the overall prevalence of meth/amphetamine use in the general community mask the worryingly high prevalence among young adults in Australia. Among those aged 20-29 years, 21% have used meth/amphetamine in their lifetime, and 11% have taken the drug recently. Most people who take these drugs do so infrequently (that is 89% use monthly or less often) and are unlikely to experience substantial harm related to use. Harm from usage is seen disproportionately among people who use these drugs weekly of more often.

Figure 15: Lifetime prevalence of meth/amphetamine use among 12-17 year olds by gender, 2004



Early onset of drug use is an important predictor of later problematic use patterns. The onset of meth/amphetamine use typically occurs in the mid-to-late teens, and this is reflected in the lifetime prevalence of 8% among 16-17 year old secondary school students.

Meth/amphetamines can induce paranoid psychosis in some people who take the drug. Indeed, among methamphetamine users who take the drug monthly or more often, the prevalence of psychosis is 11 times higher than among the general population. The symptoms usually last hours to days, and in severe cases, can lead to hospitalization and require sedation and/or antipsychotic medication. In rare cases, the condition can last weeks to months, or can remit and recur over a longer period of time, contiguous with drug use and other life stressors.

Depression, increased aggression, anxiety disorders (including post traumatic stress disorder), and personality disorders also frequently co-occur with meth/amphetamine use.

OUTCOME AREA 3:

Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention

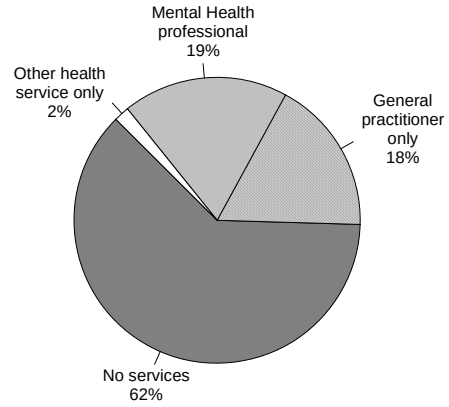
Indicator 5: Percentage of people with a mental illness who receive mental health care

Widespread concern about access to mental health care and the need for better coordinated services were key main factors that placed mental health as priority issue on the COAG agenda.

First insights into the gap between need for mental health services and services actually delivered were provided by national population surveys undertaken in 1997 and 1998. The surveys revealed that only 38% of adults and one quarter of children and younger people with a mental disorder received treatment from a health service. The proportion of people with a disorder who accessed care was half that for comparable physical illnesses. Of those who received services, the overwhelming majority (77%) consulted their general practitioner, although about 60% also attended another health service (Figure 16).

The implication is that, ten years ago, 11% of Australians had a mental disorder but received no treatment from any part of the health system. While these estimates are high, similar findings estimates have been reported in other comparable countries.

Figure 16: Health services used by adults with a mental disorder, 1997



'General practitioner only' does not include an additional 11% who saw both a GP and another health service.

Other evidence suggests that treatment rates varied according to the severity of the person's condition. Approximately 90% of those with severe disorders received some level of service, albeit of variable quality. About 29% of people with moderately severe disorders and only 16% of people with milder (but still clinically significant) disorders were estimated to receive mental health care.

Low treatment rates for people with mental illness may be a function of several factors. These include unavailability of services, lack of awareness by the person that they have a problem or that effective treatments are available, negative experiences of previous service use, and stigma associated with mental illness. Additionally, it may not be appropriate for all people to be treated by a health service. Some will elect not to seek help, or seek assistance outside the health system and many with mild conditions will recover without health intervention. While a combination of factors is likely, the surveys of the late 1990s revealed that potential demand for mental health care is high and was not being met by either the specialist or general health system.

If the findings of a decade ago are generalised to today, the number of Australians with untreated mental illness would comprise 2.3 million individuals. However, substantial service growth has taken place in the ten years preceding the Action Plan. The specialist mental health clinical workforce employed by states and territories increased by about one third, coupled with new initiatives by the Australian Government to expand the role of the primary healthcare sector in providing mental health care. Alongside these developments, steps have been taken under the National Mental Health Strategy to increase community

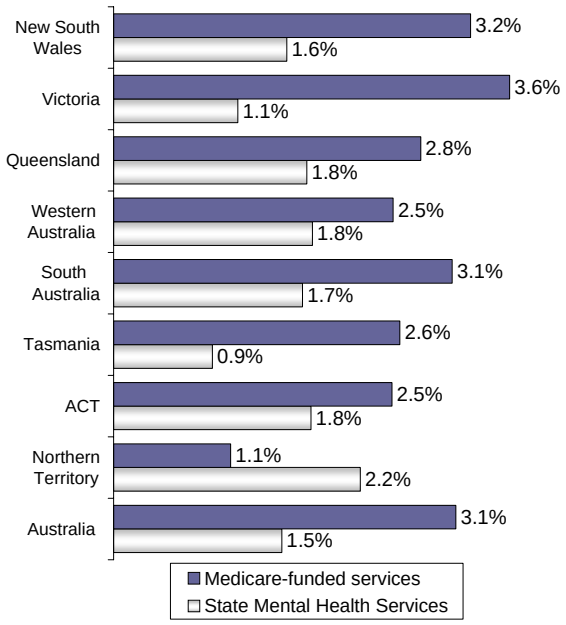
awareness about mental illness and the availability of effective treatments. Higher levels of access could reasonably be expected to have resulted from these initiatives.
An updated picture on the extent of unmet need for mental health care is not yet available, and will not be so until the results of the next national population mental health survey are published in late 2008. As an interim measure, health administrations within each jurisdiction agreed to pool related data on the number of people receiving services through all the government-funded clinical mental health care streams. The Private Mental Health Alliance also agreed to contribute data on people treated in private hospitals.

Results for 2006-07, the first year of the Action Plan, are presented below. The figures need to be interpreted carefully, given that most of the Action plan initiatives were not in place for the whole year and do not give a full year picture. For example, the Australian Government *Better Access to Mental Health Care* initiative that expanded Medicare-funded mental health services were only operational for seven months (from November 2006). Comparisons across state and territory services need to be made cautiously because jurisdictions differ in the way in which they count the number of people under care.

Table 7: Percentage of population receiving clinical mental health care, 2006-07

	State Community Mental Health Services	Private hospitals	Medicare-funded services (Nov to July only)				
			Private Psychiatrists	General Practitioners	Clinical Psychologists	Allied Health	All MBS funded services
New South Wales	1.6%	0.1%	1.3%	2.0%	0.2%	0.6%	3.2%
Victoria	1.1%	0.1%	1.5%	2.2%	0.2%	0.8%	3.6%
Queensland	1.8%	0.1%	1.2%	1.7%	0.1%	0.6%	2.8%
Western Australia	1.8%	*	1.0%	1.6%	0.4%	0.2%	2.5%
South Australia	1.7%	*	1.6%	1.6%	0.2%	0.4%	3.1%
Tasmania	0.9%	*	1.0%	1.7%	0.3%	0.5%	2.6%
ACT	1.8%	*	1.0%	1.6%	0.2%	0.5%	2.5%
Northern Territory	2.2%	*	0.4%	0.7%	0.1%	0.2%	1.1%
Australia	**1.5%**	**0.1%**	**1.3%**	**1.9%**	**0.2%**	**0.6%**	**3.1%**
No. of people seen	318,756	17,720	272,194	399,051	45,895	122,621	648,891

Figure 17: State and territory summary of access to clinical mental health care, 2006-07



Comparisons of relative coverage between states/territories and Medicare-funded services also need to take account of differences in the type and intensity of services provided across these sectors, with states and territories having their main focus on severe mental disorders.

The figures for the first year of the Action Plan do, however, suggest important observations. Approximately one million people, or 5% of the population, received clinical mental health care in the year, if we assume no overlap between the state/territory and Medicare-funded services. This suggests a continuing gap between service coverage and estimated need. Further service growth arising from COAG initiatives is expected to reduce the gap over the life of the Plan.

OUTCOME AREA 3:

Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention

Indicator 6: Mental health outcomes of people who receive treatment from state and territory services and the private hospital system

Establishing a system for the routine monitoring of consumer outcomes has been the focus of extensive activity in state/territory-funded mental health services and the private hospital sector, with support from the Australian Government. The goal has been to develop standard measures of a consumer's clinical status and functioning and apply these at entry and exit from care to enable change to be measured. For consumers who require longer term care, the measures are applied at three monthly review points. The outcome measures provide both clinician and consumer perspectives on the extent to which services are effective in achieving improvements.

The concept is simple but ambitious because it requires major overhaul of clinical information systems as well as extensive training of the clinical workforce in the use of the new outcome measures. More significantly, few precedents have been available to guide Australia. No other country has established routine consumer outcome measures comprehensively across their publicly and privately funded mental health services.

First steps to put these arrangements on the ground were taken in 2001, and are continuing across all jurisdictions. Routine measurement of consumer outcomes is now in place in an estimated 85% of public mental health services and 98% of private hospitals. Over 12,000 clinicians have received training. Systems have also been established to enable pooling and analysis of the information at the national level.

The information gathered to date is providing important insights.

- For state and territory mental health services, it is clear that, for most consumers, acute inpatient care achieves a significant reduction in the symptoms that precipitated hospitalisation. Data from private hospital psychiatric care also shows a substantial reduction in symptoms and distress in patients treated. Notwithstanding the changes in symptoms, most patients remain symptomatic at discharge, pointing to the need for continuing care in the community.
- There is less change in symptoms for those treated in the community, reflecting the long term nature of many mental disorders.

While the new measures hold great potential, further work is needed before they can be applied within a performance indicator context. Data quality and conceptual issues need to be resolved to produce reliable indicators that are suitable for presentation to COAG. As there are no international precedents to guide the work, Australia needs to 'grow the evidence' from which any quantitative indicators will emerge.

Over the next 12 months, work will continue to resolve the conceptual, data quality and technical issues to enable quantitative data to be included in future annual reports on Action Plan progress.

OUTCOME AREA 3:

Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention

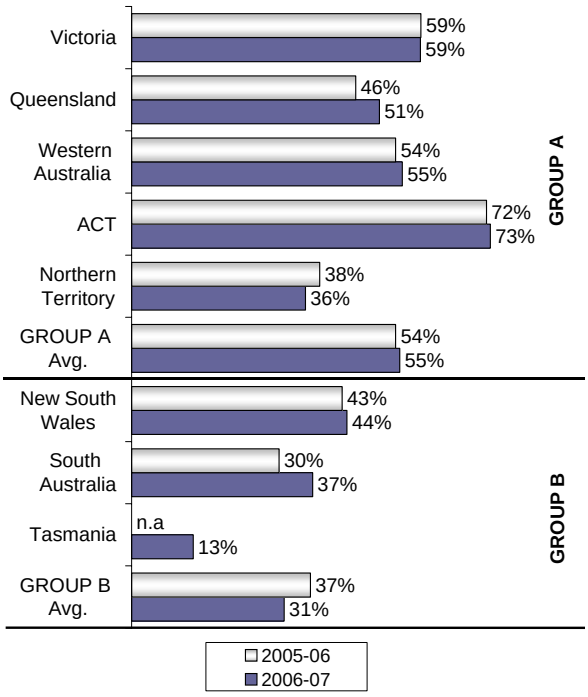
Indicator 7: Rates of community follow up for people within the first seven days of discharge from hospital

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened vulnerability and, without adequate follow-up, may relapse or be readmitted. It is also a period of great stress and uncertainty for families and carers.

Evidence gathered in recent years from a number of consultations around Australia suggests that the transition from hospital to home is often not well managed. The inclusion of this indicator as a measure of progress under the Action Plan targets the performance of the overall health system in providing continuity of care, recognising the need for substantial improvement in this area. The standard underlying the measure is that continuity of care involves prompt community follow-up in the vulnerable period following discharge from hospital.

Results for the first year of the Action Plan, and the year immediately preceding are shown in Figure 18 for state and territory-funded mental health services. They reveal substantial variation. Across the jurisdictions, one-week post discharge follow-up rates range from a low of 13% to 73%. Equivalent data for the private and Medicare-funded sectors are not available for comparison.

Figure 18: Percentage of discharges receiving 7-day community follow up, state and territory mental health services



* Group B jurisdictions differ from those in Group A by having less capacity to track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers or data matching systems. This factor can contribute to an appearance of lower follow-up rates for these jurisdictions.

Recent work undertaken as part of an Australian Government-funded initiative to support benchmarking in public mental health services is providing learnings about why organisations, and jurisdictions, may vary on one week post discharge follow-up rates. Accuracy of information systems in tracking the movement of people between hospital and community care, particularly across organisations, is critical. Lower follow-up rates may also be the result of some consumers being managed outside the state/territory public system (e.g., GPs, private psychiatrists, or Aboriginal/remote health services in the Northern Territory). These activities are not captured by existing mental health information systems.

Overall, the variation in post-discharge follow-up rates suggests important differences between mental health systems in their practices.

OUTCOME AREA 3:

Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention

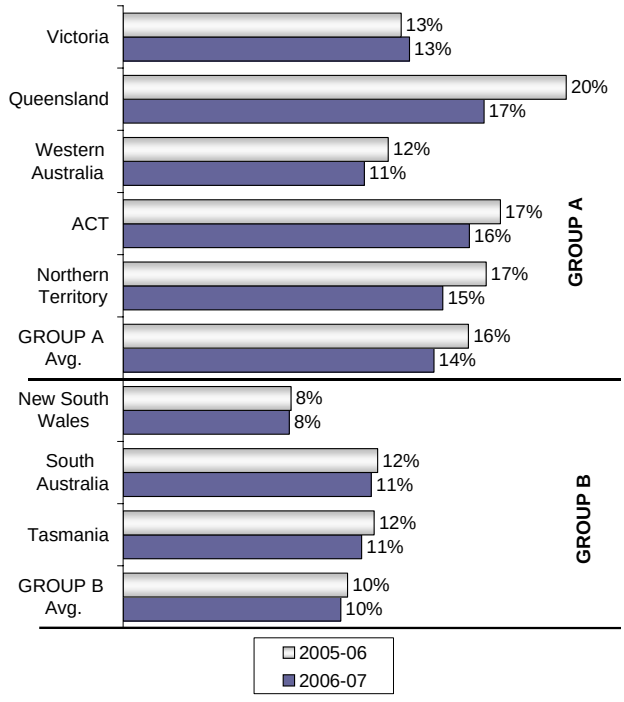
Indicator 8: Readmissions to hospital within 28 days of discharge

Readmission rates can be regarded as a non-specific indicator of the overall functioning of health systems. High rates may point to deficiencies in hospital treatment or community follow-up care, or a combination of the two.

Readmission rates are also affected by other factors, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the health system. Notwithstanding the complexity of the indicator, it is used by many countries to monitor health system performance. It has special relevance to areas of health care that involve provision of services to people with longer term illnesses who need a combination of hospital and community-based treatment. The underlying standard is that, while multiple hospital admissions may be necessary over the course of a lifetime for some cases, unplanned readmissions occurring shortly after discharge largely reflect failures in the care system.

The greatest risk period for re-admission is in the month following discharge. Unplanned readmissions following a recent discharge may indicate that treatment provided during the inpatient stay was incomplete or ineffective, or that follow-up community care was inadequate to maintain the person out of hospital.

Figure 19: Percentage of discharges readmitted within 28 days of leaving hospital, state and territory mental health services



* Group B jurisdictions differ from those in Group A by having less capacity to track readmissions that occur between hospitals, due to the lack of unique patient identifiers or data matching systems. This factor can contribute to the appearance of lower readmission rates for these jurisdictions.

Figure 19 shows the results for state and territory-funded mental health services in the first year of the Action Plan and the year immediately preceding. As with the post-discharge follow up indicator, variation between jurisdictions is evident, with 28-day readmission rates ranging from 8% to 20%. Comparable data for the private and Medicare-funded sectors are not available.

Accurate monitoring of 28-day readmission rates depends on unique identifier information systems that track the movement of people between hospitals. Not all jurisdictions have this capacity at this stage, compromising the comparability of the data.

Reasonable targets for readmission rates have not yet been identified, and are likely to differ within subspecialities (adult, aged, child and adolescent and forensic mental health services). Ongoing work at the national level to promote benchmarking within the mental health industry is expected to contribute to better understanding of good practice targets over the next few years.

OUTCOME AREA 4:
Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

Indicator 9: Participation rates by people with mental illness of working age in employment

Mental illness can reduce participation in the workforce in two broad ways. For those in employment, untreated mental illness can diminish the person's engagement and activity in the workplace. Annual losses to national productivity caused by untreated mental illness in the Australian workforce have been estimated at $10 billion. For those not in the workforce, mental illness can act as barrier to the person gaining or holding a job.

A range of Australian evidence points to the scale of the problem. Population surveys conducted in 2003 showed that only 44% of people with a mental disorder who are of working age participate in the workforce, about half the participation rate for those people of comparable age who do not have a mental disorder. Participation in the workforce decreases in proportion to the severity of the disorder. For people affected by psychotic illnesses, only 25% were in the labour force. Recent analysis by the Productivity Commission suggests that, of six major health conditions (cancer, cardiovascular, major injury, mental disorder, diabetes, arthritis), mental disorders are associated with the lowest likelihood of being in the labour force.

Table 8: Labour force participation rates for people of working age with a mental disorder, 2003-04

	Percent in labour force
Working age Australians with a mental disorder	
Anxiety disorders	53%
Depression	44%
Psychotic disorders	25%
Any mental disorder	44%
Working age Australians without a mental disorder	81%

An implication of these findings is that approximately 1.4 million working age Australians who have a mental disorder are not in the workforce, and account for about 40% of the working age population not in employment or looking for work. The estimates highlight the importance of COAG initiatives to improve participation in the workforce by people affected by mental disorders.

Of the 700,000 people on Disability Support Pensions (DSP) in 2006-07, 27% had a mental disorder recorded as the principal condition necessitating government income support. The current statistics indicate that, for every 1,000 adults of working age, 13 are on a disability pension due to mental illness. Rates vary across the states and territories.

Across all categories of government income support recipients, the 1997 population survey data indicated that almost one in three had a mental disorder, 66% higher than the prevalence among Australian adults not receiving income support. For those who are not in the workforce, the absence of meaningful vocational roles is likely to compromise their recovery. It can also increase their need for health care because poor vocational outcomes can compound the person's clinical condition through the continuation of social exclusion, welfare dependency, unstable housing and long-term poverty. An increasing body of evidence is accumulating that vocational outcomes for people affected by mental illness can be improved substantially, leading to better health outcomes.

The national population survey on mental health, taking place in 2007, will provide an updated picture of workforce participation for people with mental disorders.

OUTCOME AREA 4:

Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

Indicator 10: Participation rates by young people aged 16-30 with mental illness in education and employment

Mental disorders are more prevalent in early adult years (see Indicator 1), frequently having their onset in late adolescence or early adulthood. For those affected, education can be disrupted causing premature exits from school or tertiary training, or disruptions in the transition from school to work. When this occurs, the impact can be long lasting, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime.

Relatively little data are currently available that directly address this indicator. However, research conducted using the Australian Bureau of Statistics' 2003 Survey of Disability, Ageing and Carers provides preliminary insights into the extent of the problem. One third of young people aged 15 to 29 who have a mental disorder are neither in education nor participating in the labour force. Rates for healthy comparable aged groups were not available for this report.

Table 9: Education and labour force participation rates for young people with mental disorders aged 15-29 years, 2003-04

	Still at school / in education	In employment	Looking for work	Not in the labour force
People with mental disorders	11.0%	45.4%	9.4%	34.3%
Healthy Australians	n.a	n.a	n.a	n.a

OUTCOME AREA 4:

Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

Indicator 11: Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities

No national data are currently available, however, studies of the Australian prison population have indicated that around 40% have a mental disorder and that 10-20% are affected by severe disorders.

Better understanding these needs has been identified as a priority with work proceeding over the last year on development of a national prisoner health data collection.

A number of the draft indicators to be included in the collection relate to the prevalence of mental illness among prisoners, both diagnosed by a health professional and self reported. Indicators are also included on self harm and thoughts of self harm, and alcohol and drug use.

This process is likely to take several years to come to fruition, requiring expert input, definitions of the indicators, pilot testing, and endorsement by the public health information groups and data standards committees before agreement is sought from state and territory Corrections Ministers to implement the minimum data set.

OUTCOME AREA 4:
Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

Indicator 12: Prevalence of mental illness among homeless populations

Getting a true picture of the homeless population is difficult. However, evidence suggests that up to 75% of the homeless people aged 18 years and over have a mental disorder and, of these, about a third of these (approximately 29,000 people) are affected by severe disorders.

A snapshot survey conducted in March 2006 in seven jurisdictions indicated that 43% of people occupying an acute psychiatric bed could be discharged if suitable housing or accommodation support was available. Provision of these services is also key in reducing frequency of hospitalisation.

The Supported Accommodation Assistance Program (SAAP) provides crisis accommodation and related support services to people who are homeless or at imminent risk of becoming homeless. Data are routinely collected on SAAP clients through a national minimum dataset.

Table 10: SAAP clients with mental health, substance use and comorbid problems

	Mental illness		Substance use		Comorbidity		Total	
	%	No.	%	No.	%	No.	%	No.
Males	**5.1**	**5,400**	**7.9**	**8,400**	**3.7**	**3,900**	**39.9**	**42,400**
0–24 years		1,400		2,100		900		13,500
25–44 years		2,700		4,500		2,300		19,500
45–64 years		1,100		1,600		600		7,400
65+ years		100		100		<50		1,100
Females	**7.6**	**8,100**	**5.3**	**5,600**	**2.6**	**2,800**	**60.1**	**63,900**
0–24 years		2,500		2,100		1,100		23,200
25–44 years		4,100		2,900		1,400		30,600
45–64 years		1,100		400		200		7,200
65+ years		100		<50		<50		1,000
Total Clients	**12.7**	**13,500**	**13.2**	**14,100**	**6.3**	**6,700**	**100.0**	**106,500**

Note: All figures rounded to nearest hundred.

In 2005-06, there were 106,500 users of SAAP services. Of these, 13,500 SAAP clients (or around 13%) were deemed to be seeking assistance due to mental health issues. These included clients who were referred from a psychiatric unit; reported psychiatric illness and/or mental health issues as reasons for seeking assistance; were in a psychiatric institution before or after receiving assistance; and/or needed, were provided with or were referred on for support in the form of psychological or psychiatric services. Another 14,100 (also around 13%) reported problematic drug, alcohol and/or substance use as a reason for seeking assistance and/or were provided with or were referred on for support in the form of drug and/or alcohol support or intervention. A further 6% of clients were considered to have both mental health and substance use problems (comorbidity).

It should be noted that research suggests that this data significantly under-reports the number of clients of SAAP services that actually have mental health problems. Clients may not identify mental health as a reason for seeking assistance for a number of reasons, including the well-documented stigma attached to mental illness and the fact that gaining assistance for this problem may not be the most pressing issue at the time.

PART B
Jurisdiction reports on progress of Individual Implementation Plans

This section of the report presents summary highlights, prepared by each jurisdiction, of the first year of implementation of the National Action Plan.

Australian Government

During 2006-07, the Australian Government portfolios of Health and Ageing (DoHA), Family and Community Services and Indigenous Affairs (FaCSIA), Employment and Workplace Relations (DEWR), Education, Science and Technology (DEST) and Veterans' Affairs (DVA) all made significant progress in the implementation of the *Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011*.

ACTION AREA 1: PROMOTION, PREVENTION AND EARLY INTERVENTION

Expanding Suicide Prevention Programmes: Funding for the initiative provided for more than 55 community-based and national projects to enhance community capacity in suicide prevention by improving community understanding of suicide, building community resilience and increasing access to support those at risk of suicide. In addition, a national consultation was conducted to update the *Living Is For Everyone – A Framework for Prevention of Suicide and Self-Harm in Australia.* This framework will to provide direction for suicide prevention activities over the next five years.

Alerting the Community to Links Between Illicit Drugs and Mental Illness: A review of the latest evidence relating to illicit drug and mental illness comorbidity is being undertaken by the National Drug and Alcohol Research Centre as a first step in development of a major community awareness campaign in 2008.

New Early Intervention Services for Parents, Children and Young People: The Australian Government is developing national resources to assist childhood workers engaged in mental health promotion, prevention and early intervention for young children. Early Childhood Australia has recently commenced consultation that will help guide this development with resources expected to be available in 2008. In addition, a framework for a new Australian Child and Adolescent Trauma, Loss and Grief Network has been developed.

Community Based Program to help Families Coping with Mental Illness: A series of workshops is being developed by the Mental Health Council of Australia to support carers. Additional funding has also been provided to seven family relationship support services to continue their work focussing on families coping with mental illness.

ACTION AREA 2: INTEGRATING AND IMPROVING THE CARE SYSTEM

Better Access to Psychiatrists, Psychologists and General Practitioners (GPs) through the Medicare Benefits Schedule (MBS): The Better Access initiative introduced new Medicare items on the Medicare Benefits Schedule (MBS). The November 2006 launch by the Australian Government saw a substantial increase in access to treatment for those who require mental health care in the Australian community. Since the introduction of the Better Access initiative, more than 400,000 people have benefited from access to these services, including around 100,000 people in rural and remote areas.

In the first eight months of these new services almost 300,000 GP mental health care plans had been developed, around 600,000 services by clinical and registered psychologists had been subsidised, and almost 50,000 new psychiatry services had been rebated. Around 1.2 million mental health services were rebated through Medicare Australia over the November 2006 to June 2007 period.

Information on the Better Access initiative was developed and distributed to support GPs and allied mental health providers through peak professional organisations and the Australian General Practice Network. Over 10,000 allied mental health providers were registered with Medicare Australia to provide Better Access services.

New Funding for Mental Health Nurses: The initiative provides an incentive payment to community based general medical practices, private psychiatrist services and other appropriate organisations who engage mental health nurses to assist in the delivery of clinical care for people with severe mental disorders. The program formally commenced on 1 July 2007. Over 200 applications had been received from organisations wishing to participate.

Mental Health Services in Rural and Remote Areas: The initiative was expanded by a further $30 million to provide funding to drought affected communities. In 2006-07, funding agreements with 15 auspice organisations were finalised to enable greater access to mental health services for people living in rural and remote Australia.

Improved Services for People with Drug and Alcohol Problems and Mental Illness: $8.2 million was provided to expand the National Comorbidity Initiative, which was originally established in 2003-04.

Funding for Telephone Counselling, Self-help and Web-based Support Programmes: The initiative provided Lifeline Australia and Kids Help Line with funding of $18 million over five years, and $5.035 million over two and a half years respectively to expand and enhance their national services. Funding has also been allocated to six web-based support programmes to enhance, or develop, mental health support services that will be provided free of charge to the Australian public via the internet.

New Personal Helpers and Mentors Program: 28 demonstration sites have been operational since May 2007 in 17 metropolitan and 11 rural, regional and remote locations. The first funding round was in excess of $32 million over three years. Collectively, these sites will provide a total of 160 places in the new program. A second funding round, to select up to a further 49 sites, was advertised in May 2007. These additional sites are expected to be operational from November 2007.

Veterans' mental health care - improving access for younger veterans: In the 2006 Budget, the Department of Veteran's Affairs announced funding of $20 million. In 2006-07, a veterans' suicide prevention strategy *Operation Life* and a range of mental health awareness programs were developed, and a partnership with the Australian General Practice Network was established.

ACTION AREA 3: PARTICIPATION IN THE COMMUNITY AND EMPLOYMENT INCLUDING ACCOMMODATION

Helping People with a Mental Illness enter and remain in Employment: 2,500 additional *Personal Support Programme* places were released in 2006-07. Measures to increase Employment in Jeopardy and Intermittent Support for the *Disability Employment Network* programme were implemented; Job in Jeopardy places were increased and an Intermittent Post Placement Support Fee was introduced for the *Vocational Rehabilitation Services* programme; additional information on mental health and employment assistance was provided through the JobAccess website; and mental health and employment related research and evaluation activities commenced.

Support for Day-to-day living in the Community: Extensive planning was undertaken with state and territory governments to identify suitable sites for new services, based on need, linkages to clinical and community support services and capacity of the non-government sector in each area. Applications for funding for the 2007-09 period were sought during February and March 2007, with 51 non-government organisations receiving a total of $19 million funding. The programme was formally launched in July 2007, providing a total of 6,427 new funded day program places for people with severe mental illness.

Helping Young People stay in Education: The Youth Pathways initiative was implemented on 1 January 2007. Approximately 1,900 young people with potential mental health issues were assisted to remain engaged in education over January to July 2007.

More Respite Care Places to help Families and Carers: In 2006-07, 54 centres were funded a total of $66 million over four years to provide respite services for carers of people with a mental illness, psychiatric disability or intellectual disability. The program will provide a total of 244,000 respite hours per year.

ACTION AREA 4: INCREASING WORKFORCE CAPACITY

Additional Education Places, Scholarships and Clinical Training in Mental Health: 431 higher education places in mental health nursing and 210 in clinical psychology were included in higher education providers' 2007 Commonwealth Grant Scheme Funding Agreements. In 2006-07, a total of 58 (36.5 FTE) mental health nursing and 47 (38.5 FTE) clinical psychology scholarships were awarded under the Mental Health Postgraduate Scholarship Scheme.

Mental Health in Tertiary Curricula: Funding agreements were signed with six health profession accreditation bodies to review undergraduate course accreditation requirements in relation to mental health content. The professions involved are social workers, occupational therapists, osteopaths, dietitians, dentists and chiropractors.

Improving the Capacity of Workers in Indigenous Communities: An Expert Advisory Group of key stakeholders from the Aboriginal and Torres Strait Islander (ATSI) health and mental health sectors was formed to guide the implementation of the measure. Significant planning was completed to develop a mental health training program targeting 840 Aboriginal Health Workers and a culturally appropriate mental health first aid training program for 350 transport and administration workers in ATSI health services. Five of the 25 additional scholarships for ATSI students studying a health discipline were awarded for the 2007 academic year in medicine, nursing, community counselling, community welfare and health science.

ACTION AREA 5: COORDINATING CARE

Coordinating Care

The Australian Government contributed to the development of national principles and implementation guidelines to guide planning and inform consistent evaluation approaches for the care coordination models through the state-based COAG Mental Health Groups in each jurisdiction.

Governments Working Together

Throughout 2006-07 Australian Government was an active participant on all state-based COAG Mental Health Groups and used these as forums for seeking advice to assist with the development of specific programs including the Mental Health Services in Rural and Remote Areas, Support for Day-to-day living in the Community and the New Personal Helpers and Mentors initiatives.

The Australian Government convenes a COAG Mental Health Implementation Interdepartmental Committee (IDC) with membership comprising those portfolios with responsibility for implementing the COAG National Action Plan, namely DoHA, FaCSIA, DEWR, DEST and DVA. The Departments' of Prime Minister and Cabinet, Treasury and Attorney-General's are also members of the IDC. The IDC continues to meet quarterly to discuss issues in relation to implementation, monitoring and evaluation of the Australian Government initiatives

New South Wales

ACTION AREA 1: PROMOTION, PREVENTION AND EARLY INTERVENTION

Expanding Early Intervention Services for Youth. A prototype NSW Youth Mental Health Service Model is being developed and evaluated in one Area Health Service. This model will provide an integrated co-located service for young people with mental health problems to improve access to general practitioners, drug and alcohol services, vocational support and other services. Nine clinical staff and two project staff were recruited for the multidisciplinary team, and the service will commence treating clients in July 2007. The model will be progressively implemented across Area Services, and will be adapted as necessary for rural areas.

Specialist Assessment of the Needs of Older People. Enhancements were made to the Specialist Mental Health Services for Older People program to respond to the needs of older people with complex mental health problems in a community setting. In addition, Behavioural Assessment and Intervention Services were improved to increase capacity to provide assessment, consultation /liaison services and case management for identified clients. Funding in 2006/07 was allocated to Area Health Services for the establishment of 39 positions covering old age psychiatrists, specialist psycho-geriatric nurses and allied health professionals with expertise in this area.

ACTION AREA 2: INTEGRATING AND IMPROVING THE CARE SYSTEM

Enhancing Community Mental Health Emergency Care. This program will increase the provision of 24 hour, seven day a week mental health services in the community, and the provision of emergency and community care outside of normal business hours. Funding was allocated to Area Health Services in 2006/07, with 19 specially trained professionals recruited to deliver out of hours emergency and acute community responses.

Expansion of Community Forensic Mental Health Services. Enhancements were made to state-wide Adult and Adolescent Forensic Mental Health Services in 2006/07, with funding used to employ two additional clinical staff in each service. The Adult Service is focused on providing support for existing mental health teams, and is developing a Clinical Risk Management Consultation Liaison Service model. The adolescent court liaison service has been expanded to Parramatta Children's Court. It is now providing psychiatry services to metropolitan community clinics. Service provision and coordination of psychiatry input to rural custodial clinics in Wagga and Orange has also increased.

Better Integration of Mental Health Services with Drug and Alcohol Services. A range of initiatives were introduced to better integrate mental health services and drug and alcohol services to meet the complex needs of people with coexisting mental health and substance use disorders: establishment of methamphetamine treatment trials in two areas catering to 148 clients; Drug and Alcohol Consultation Liaison services to area mental health services, emergency departments and hospital wards in two non-metropolitan areas; establishment of after-care workers in four areas for clients leaving a treatment program; enhancements to the four existing cannabis clinics to develop integrated service delivery models that bring together drug and alcohol and mental health specialists; trial of an early intervention model for young people experiencing co-morbidity issues; and workforce development initiatives.

Increasing Mental Health Beds, building new facilities and refurbishing and relocating mental health facilities. Ongoing implementation of the mental health capital works

program has resulted in the establishment of 380 new mental health beds since 1 July 2001. The provision of a further 360 beds by 2011 has also been approved.

In 2006/07, major projects under construction included: a new 135 bed forensic hospital at Long Bay Correctional centre; new adult, child and adolescent units at Lismore incorporating 23 additional beds; 20 bed non-acute units at Shellharbour and Coffs Harbour; and a 15 bed older persons unit at Wollongong.

In addition, a number of major mental health hospital redevelopments are underway including: transfer of facilities at Rozelle Hospital to purpose built facilities at Concord; the replacement of the James Fletcher Hospital at Newcastle with a new 96 bed mental health facility containing10 additional adult beds and 82 extra beds from the Bloomfield Hospital units.

Specialist Mental Health Services for Older People. Work commenced on the clinical service redesign for seven 16-bed units. These will mainly operate as short-medium stay specialist assessment and treatment facilities for older people with severe and persistent challenging behaviours associated with dementia and/or mental illness.

Establishing Psychiatric and Emergency Care Centres. Nine Psychiatric Emergency Care Centres (PECCs) are being established in the following hospitals: Liverpool, Nepean, St George's, St Vincent's, Hornsby, Wyong, Blacktown, Campbelltown and Wollongong. Twenty four beds were established, with seven locations providing 24-hour, 7-days per week, psychiatric emergency care services with dedicated mental health staff. A further two locations are providing psychiatric services in emergency departments while the PECCs are under construction. Preliminary evaluation findings are that PECCs are improving patient flow and access to care (eg 74% of PECC admitted patients were in an emergency department for less than 8 hours, and Emergency Access Performance for PECCs was on average 15% better than in other units).

ACTION AREA 3: PARTICIPATION IN THE COMMUNITY AND EMPLOYMENT

Housing and Accommodation Support Initiative (HASI). HASI is a partnership between NSW Health, the Department of Housing, the NGO sector and consumers and carers. It assists people with a mental illness to participate in the community, maintain successful tenancies and improve their quality of life. HASI places range from lower support to very high support.

This initiative has funded 850 places for people with a mental illness. A two-year longitudinal evaluation of the first stage of HASI conducted by the Social Policy Research Centre at the University of New South Wales identified positive outcomes for participants: 94% had established friendships; 85% had maintained their tenancy; 83% were participating in social and community activities; almost 50% were working and or studying; and 68% reported an improvement in symptoms, social and living skills and reduced psychological distress. Time spent in hospital also decreased by 81%.

Community Rehabilitation Services. This initiative includes extra clinical rehabilitation specialists to provide assessment and rehabilitation options for people at the earliest stages of their treatment with a mental health service. Funding in 2006/07 was provided for the employment of 29 clinical rehabilitation clinicians and Vocational Educational, Training and Employment (VETE) clinicians. A trial has shown very positive outcomes. For example, clients achieved 67% employment outcomes with a 78% retention rate, and 60% of clients maintained enrolments at TAFE or university.

In addition, tenders were called for NGOs to provide Recovery and Resource Services. These services will support people with a mental illness by providing access to community leisure and recreational opportunities, and linkages to education and employment options.

Enhance Family and Carer Mental Health Program. This state-wide program provides a comprehensive range of supports and services for families and carers of people with a mental illness through strengthening existing partnerships between families and carers, NGOs and area mental health services. Workforce development initiatives are also underway to ensure that clinicians effectively engage with families and carers in frontline services. Funding was allocated in 2006/07 for one NGO in each Area Health Service to provide education and training, and individual support services for families and carers of people with a mental illness.

ACTION AREA 4: INCREASING WORKFORCE CAPACITY

Mental Health Workforce Program. NSW Health is offering 350 scholarships in 2007 for mental health nurses interested in further studies, in addition to the 119 scholarships offered in 2005/06. Furthermore, 96 nurses have taken up mental health related jobs as a result of the NSW Mental Health Reconnect programs for nursing and allied heath. Fourteen doctors have elected to move into psychiatry in addition to the 204 already in training.

Aboriginal Mental Health Workforce Program. This program employs Aboriginal people in mental health services, and supports their participation in recognised degrees. It has resulted in the employment of 18 Aboriginal mental health worker trainees to improve the mental health and wellbeing of the Aboriginal population across NSW. A statewide coordinator for the program has also been appointed.

ACTION AREA 5: COORDINATING CARE

The NSW COAG Mental Health Working Group, chaired by the Department of Premier and Cabinet, was established in August 2006, initially focussing on development and implementation of the care coordination demonstration project. On 28 November 2006, the NSW Group held a consultation meeting on care coordination with representatives from peak NGOs, consumer and carer groups, and health professions. The eight Care Coordination demonstration sites in NSW correspond to the sites for the first round of the Personal Helpers and Mentors Program (PHAM): Inner City Sydney, Parramatta, Campbelltown, Ryde, Central Coast, Wollongong, Newcastle, and Orange. Workshops with PHAM providers have been held in each Area Health Service to develop local arrangements for care coordination. Area Advisory Committees are currently being established as part of the agreed governance framework for the demonstration project.

VARIATIONS AND ADDITIONAL FUNDING COMMITMENTS

Additional funding of $41m for mental health services has been committed. This includes $23.4m in new monies in 2007/08 allocated in the NSW State Budget, and $16m for a Youth Clinical Mental Health Facility at the University of Sydney.

CHALLENGES

There are a number of challenges to the implementation of care coordination and other mental health initiatives. These include increasing pressure on workforce supply, particularly for the non-government sector, coupled with uneven distribution of the workforce compared to need, (which sees particular shortfalls in regional, rural and remote areas). There are challenges to be addressed in relation to infrastructure and capacity issues faced by NGOs as they take a key role in the delivery of many initiatives.

Victoria

At the commencement of the National Action Plan in July 2006 the Victorian Government committed funding over the five years of at least $472.4 million across activities within the four action areas. The Government's commitment to a strengthened mental health service system in Victoria includes a new Ministerial portfolio of Mental Health and the creation of a new Division of Mental Health and Drugs within the Department of Human Services. The 2007-08 State Budget committed a further $69.3 million which included further initiatives in three of the five action areas. Implementation highlights during 2006-07, as well as identification of new and expanded commitments, are summarised below.

Promotion, Prevention and Early Intervention

- **Expanding youth early psychosis programs** (YEP) (originally $16.9 million, now $26.9 million) YEP programs are being rolled out in each area mental health service. Ten services are operational, and the 2007-08 Budget committed additional funding of $9.97 million over the next four years, which will complete implementation of the program.
- **Expanding conduct disorder programs ($8.4 million**). Conduct disorder programs are being expanded through child and adolescent mental health services (CAMHS) in partnership with schools. Six services are now operational **.**
- **Support for children of parents with a mental illness ($2.4 million**). The Families with Parents with a Mental Illness (FaPMI) Strategy will build capacity of both specialist mental health services and universal services in recognizing and targeting needs of all family members, including dependent children and parents. In 2006-07, FaPMI coordinators were appointed in 7 area services to train and support clinical staff working with families.
- **Postnatal depression support services ($4.9 million).** Three hospital-based mother and baby units have been funded to work with maternal and child health services to provide additional postnatal depression support in outer metropolitan suburbs in Melbourne's growth corridors. The **New Centre for Women's Mental Health ($1.1 million)** at the Royal Women's Hospital (RWH) has increased capacity to deliver mental health consultation and liaison in obstetric services, as well as to other particularly vulnerable client groups, including women with substance abuse problems, young mothers and indigenous women.
- **Expanding counselling in Community Health Services ($2.6 million**). In 2006-07, additional funding was provided for 19 Community Health Services in areas with greatest unmet demand for services for people with mild to moderate mental health problems. This provides for 7.5 FTE counsellors .
- **Expanding primary prevention and promotion programs ($36 million**). VicHealth focuses on mental health primary prevention and promotion in its mental health strategy and research program. During 2006-07, a new Centre for the Promotion of Mental Health and Community Wellbeing (the McCaughey Centre) was established and new programs were funded to improve mental health and wellbeing.
- **Mental Health research ($8.0 million**). This funding enables the relocation of the Mental Health Research Institute (MHRI) to the Australian Centre for Neuroscience and Mental Health Research. The centre was launched on 22 February 2007, with anticipated building completion in 2010.

Integrating and Improving the Care System

- **Expand community mental health services –** (originally $47.3 million, **now $51.9 million**). Community treatment capacity of area mental health services has been expanded across all age groups. Southern Health, in conjunction with the Butterfly Foundation, were funded to establish a new specialised eating disorder day program for young people up to

24 years of age, in addition to extra positions across CAMHS services. The 2007-08 Budget has committed additional funding of $4.57 million to provide counselling, referrals and treatment for patients with a mental illness through the Craigieburn Health Service.

- **Expanding dual diagnosis services ($8.9 million).** Victoria's dual diagnosis initiative involves expanding education and training and psychiatrist capacity across mental health and drug and alcohol services. During 2006-07, a reciprocal rotation project commenced.
- **Improve hospital care and alternatives –** Expansion of mental health teams in hospital emergency departments (originally $15.6 million**, now $23.9 million**). This initiative provides enhanced mental health responses in emergency departments; nine hospitals were funded in 2006-07. From 2007-08, an additional 17 mental health positions will be established across 15 health services. The 2007-08 Budget has provided additional funding of $8.3 million over the next four years for this initiative.
- **Supporting transition to community for long-term residents of extended care facilities ($6.6 million).** Three consortia comprising several non-government organisations and area mental health services have been funded to provide transitional support for residents transferring from extended bed-based clinical care to the community, to allow a minimum of 12 consumers to receive individualized intensive support packages.
- **Expanding capacity in bed-based forensic mental health services ($21.1 million).** An additional 18 interim forensic beds at Thomas Embling Hospital were opened in May 2007.
- **Additional step-up/step-down PARC sub-acute places** (originally $25.1 million, **now $30.9 million**). Victoria has progressively funded clinical services which partner with PDRSS to deliver sub-acute services since 2005. Currently, 38 prevention and recovery care (PARC) places are operational and 40 more have been funded. The 2007-08 State Budget includes additional funding of $5.8 million over the next four years to support operation of a new 20-bed facility at Deer Park.
- **Hospital demand management** ($17.4 million). A range of initiatives are being implemented to support quality care and treatment for mental health consumers presenting to emergency departments. These include the development of a short-stay model for mental health patients presenting to emergency departments, including opening four short-stay beds for mental health patients at the Royal Melbourne Hospital.
- **Increasing acute mental health bed capacity** (originally $39.9 million, **now $42.4 million**). Victoria is expanding adult acute inpatient capacity in public hospitals. The 2007-08 Budget provides additional funding of $2.5 million over the next four years to open five new adult acute beds at Maroondah Hospital.
- **Improve information flow – Improving triage practice** ($2.8 million). All area mental health services have now established '1300' telephone numbers to provide 24/7 access to a mental health clinician for consumers and providers.
- **Building better mental health facilities - Heidelberg, Shepparton, Bouverie Centre relocation** (originally $20.5 million, **now $22.0 million**). Development of the new facilities is progressing, with the 2007-08 Budget providing a further $1.5 million for works associated with the redevelopment of the Veterans' Mental Health facility at the Heidelberg Repatriation Hospital. Construction of a new community care unit has commenced at Ambermere (Shepparton), with completion due in March 2008. The Bouverie Centre relocation is also under construction and due for completion in September 2007.
- **Building better mental health facilities – Northern Hospital, Deer Park, Preston, Broadmeadows** (**new commitment of $25.6 million**). The 2007-08 State Budget provides $25.6 million to build 25 additional acute inpatient beds at the Northern Hospital,

and to develop new sub-acute Prevention and Recovery Care (PARC) services at Deer Park (20 beds), Preston (10 beds) and Broadmeadows (10 beds).

- **Improving access to mental health residential aged care beds** (**new commitment of $1.6 million**). The 2007-08 State Budget has provided funding of $1.6 million over the next four years to support 15 newly constructed aged persons mental health residential beds at the Grace McKellar Centre in Geelong.
- **Improving services** (**new commitment of $7.5 million**). In 2006-07 an additional $7.5 million was provided to improve the amenity and safety of mental health services provided by non-government organizations, and to enhance their capacity to comply with standards, accreditation and reporting requirements. In addition to this commitment, a further 4.0 million was also provided in 2006-07 to services for a variety of service enhancement initiatives across both the specialist and NGO sectors.

Participation in the community and employment, including accommodation

- **Growing psychiatric disability rehabilitation support services** (originally $38.6 million, **now $40.3 million**). In 2006-07 $1.3 million was provided to expand Home Based Outreach Services (HBOS), and an additional $500,000 provided to maintain and enhance capacity in the Mutual Support and Self Help program. The 2007-08 Budget provided additional funding of $1.7 million over four years to improve access to services in areas of high need, including additional rehabilitation beds at the Regina Coeli facility in North Melbourne.
- **Expanding community care units** ($7.5 million). This initiative includes funding the equivalent of 14 additional beds in Community Care Units (CCU), with ten beds under construction in Central East (Box Hill) and due for completion in November 2007.
- **Supported accommodation for vulnerable people** ($40.4 million). Victoria is improving the viability of pension-level Supported Residential Services (SRS) and their capability to meet accommodation and personal support needs of residents with psychiatric and other disabilities by approving eight community service organizations across Victoria to manage funding on behalf of 69 pension-level SRS.
- **Homelessness and mental health initiatives** ($8.0 million). This initiative will provide stable and affordable housing pathways for people with a mental illness and improve post discharge housing support from adult acute inpatient and extended care facilities. Pathway services have been established in all nine DHS regions, which provide up to 320 episodes of support to consumers annually. Training for facility providers commenced in April 07.
- **Enhanced support for carers** (**new commitment of $0.24 million**). The 2007-08 Budget has provided $0.24 million over the next four years to increase the capacity of the *Network for Carers of People with a Mental Illness* to provide systemic advocacy, policy and service development advice to carers of people with a mental illness.

Care co-ordination

Cross-sectoral care co-ordination planning. During 2006-07, forums were organized to consider issues such as the MBS **mental health items and continuing care.** Non-recurrent funding was provided to support locally based partnerships across agencies providing care to clients served by multiple agencies. Further development of the framework and process of care co-ordination is continuing.

Increasing workforce capacity

- **Enhancing workforce capacity** ($4.4 million). This initiative aims to progressively fund specialist graduate nurse and allied health positions and postgraduate nursing scholarships through area mental health services. During 2006-07, 37 postgraduate scholarships and six graduate positions were funded.

Queensland

On 14 July 2006, Queensland Government announced its initial contribution of $366.2m to the COAG *National Action Plan on Mental Health 2006-2011* (NAP). This initial investment has been increased by an additional $528.8m over four years as part of the 2007-2008 State Budget that further expands the programs outlined in the NAP (Table 1). This has resulted in an unprecedented investment in mental health of $895m over five years by the Queensland Government.

Table 1: Queensland Government investment under the COAG NAP 2006-11

Areas of Investment	2006-11[1]	2007-2011[2]	2006-2011
Promotion, prevention and early intervention	$6.9m	$10.15m	**$17.05m**
Integrating and improving the care system	$289.0m	$330.61m	**$619.61m**
Participation in the community	$64.3m	$98.09m	**$162.39m**
Coordinating care		$4.77m	**$4.77m**
Workforce, quality, information and safety	$6.1m	$85.14m	**$91.24m**
TOTAL	**$366.2m**	**$528.8m**	**$895.06m**

The highlights of Queensland's implementation of the NAP include: major achievements in the areas of supported social housing, employment, independent living and social support services; service hub development in a range of high need areas across Queensland; and enhancement of community mental health services including those specialist community mental health services targeted at people with a dual diagnosis, from a culturally and linguistically diverse background, those in prison, and those that are homeless. In addition, Queensland has made progress toward the statewide implementation of care coordination for people with severe mental illness and complex care needs.

The Queensland Housing and Support Program (HASP) has made available 80 social housing options, through the Department of Housing, for people with mental illness and psychiatric disability. The program provides non-clinical support through funding from Disability Services Queensland and Queensland Health. In the first 12 months, 80 people have been referred to the program of whom 60 have successfully moved into their initial social housing allocation. In the 2007-08 State Budget, the Queensland Government has expanded this program by committing a further $40m capital and $22.45m operating expenditure for support services over four years to assist an additional 160 people with mental illness into supported social housing. In total, 240 supported social housing places will be provided to people with a mental illness through the HASP over five years.

In the area of employment, Queensland allocated $5m over five years through the Department of Employment and Industrial Relations (DEIR) to provide approximately 100 places each year for people with mental illness in the Community Jobs Program (CJP). In 2006/07 this enabled 100 people with mental illness to gain 24 weeks of open employment, paid at the award wage, and resulted in 63% of participants gaining long term employment or entering further education. This program could be further complemented if this employment program targeted at people with mental illness was recognised as an employment outcome which generates a payment for the DEN provider. To further support employment

[1] The initial funding was committed in 2006/07 over 5 years
[2] The second funding commitment was announced in 2007/08 over 4 years

opportunities for people with mental illness, Queensland Health has allocated one-off funding of $450,000 in total to six District Mental Health Services to engage employment specialists within community mental health teams to assist them in accessing appropriate employment options.

The non-government sector in Queensland has been expanded with 20 organisations across Queensland receiving funding to provide independent living and social support services to people with mental illness residing in the community. This initiative complements the HASP program and includes a component devoted to Indigenous specific services and sector development. The initial allocation of $5m each year for five years has been further enhanced in the 2007-08 State Budget with an additional $35.64m over four years to the non-government sector. These additional funds will purchase a range of accommodation and personal support services including: residential recovery places; consumer operated crisis/respite services; personal support packages for people residing in hostels; boarding houses and their own homes; and support services for people with a mental illness transitioning from correctional facilities to accommodation in the community.

The Queensland Government has committed to providing services to people in high areas of need through the development of service delivery hubs in a range of locations across Queensland. In 2006/07, the Department of Communities has established Early Years Service Centres, Blueprint for the Bush Service Delivery Hubs and Indigenous Domestic and Family Violence Counselling Services. These hubs are designed to provide a comprehensive range of services, including mental health services, with a focus on children and families, rural communities, and Indigenous communities.

Queensland has increased community public mental health services with funding for an additional 179 new positions targeted at children and young people, adults, and older persons across the state. In addition, funding was provided for programs that target people with a dual diagnosis; those from a culturally and linguistically diverse background; those in prison; and those that are homeless. This initial investment in clinical community mental health services has been significantly expanded in the 2007-08 with an additional 479 community mental health positions over three years covering generic and specialist community mental health services.

Queensland's implementation of the COAG "flagship" initiative of care coordination for people with severe mental illness and complex care needs has been considerably progressed in 2006/07. In September 2006, a model which identified the target group and the eligibility criteria was agreed by the Qld COAG Mental Health Group. In October 2006, a range of initiatives where identified to support the implementation of the agreed model at a stakeholder workshop. Queensland Health has committed to the establishment of 20 Service Integration positions located across Queensland to operationalise the agreed model of care coordination for the target group across all agencies. Queensland's commitment to implementing this flagship initiative of the NAP has been reinforced by the allocation of $4.77m in the 2007-08. The strategy for implementing the care coordination model in Queensland includes: the establishment of the 20 Services Integration positions; the development of Memoranda of Understanding and Local Partnership Agreements between all key stakeholders across. government, non-government and private sectors; the development of local referral pathways, protocols and guidelines for the operationalisation of care coordination; the establishment of a local governance structure to oversee and support implementation; and the implementation of a cross-sector training and professional

development strategy. Of critical importance to the implementation of care coordination is the development of systems that address the differing access criteria, employed by various agencies, so that people in the target group do not fall through gaps in service provision.

Queensland has provided considerable advice and support to help the local implementation of the various Commonwealth Government measures. Specifically, Queensland has provided advice to FaCSIA about priority locations for the Personal Helpers and Mentors program; information about existing respite services in Queensland and disseminated information about the Community measure to relevant stakeholders to ensure an adequate uptake by Queensland agencies. Similarly, support has been provided to DoHA in the identification and selection of successful locations and organisations for the Rural and Remote Allied Health measure; the Day-to-Day Living in the Community measure and information disseminated about the Drug and Alcohol and Mental Illness measure to relevant non-government agencies to ensure an adequate uptake by Queensland agencies.

In 2006/07, Queensland developed a position paper entitled *Enhancing Consumer Choice* that aims to better integrate public mental health services with primary care and private specialist mental health providers, with a focus on the new *Better Access* MBS items . Resources have been established to support District Mental Health Services and Divisions of General Practice in the implementation of best practice models identified in the position paper. In addition, Queensland Health has allocated $640,000 for the implementation of the *Partners in Mind Framework* in seven locations across Queensland which provides an agreed framework for the establishment of an integrated primary mental health care sector. This framework, together with the *Enhancing Consumer Choice* paper and the *Connecting Healthcare in Communities* initiative provide an environment for establishing and strengthening the relationship between general practitioners and public mental health services.

Queensland has recognised the added pressure that has been placed on the various non-government organisations as a result of the numerous tenders being advertised for the various measures. Following consultation with a range of peak agencies, funding of $150,000 has been allocated between the Queensland Alliance and the Queensland Aboriginal and Islander Health Council to support their members and other organisations in the tender processes. This measure enables Queensland non-government organisations to compete for available funds. The two agencies are currently putting in place a range of measures to assist non-government organisations in the tendering process.

The Queensland decision to include a broader range of stakeholders on the Qld COAG Mental Health Group, in addition to the relevant Queensland and Commonwealth government agencies, has proved to be positive. This membership ensures that consultation occurs regularly with key stakeholders including the non-government and private sectors, professional bodies and associations and consumers and carers. The composition of the group has led to an increased level of accountability and transparency, and the ability to raise and address issues of concern with various stakeholders. The cross-sectoral governance structure has ensured that Queensland is driving implementation of the various Queensland and Commonwealth Government initiatives in an integrated way. This approach has been complemented with a comprehensive communication and marketing strategy which includes regional visits, organisation of consultation forums, the establishment of one-off and ongoing sub-groups. The production of a Queensland COAG Mental Health Group *Communiqué* which is distributed bi-monthly to approximately 1000 key stakeholders throughout the state has assisted local engagement.

Western Australia

Mental Health reform in Western Australia gained impetus with the commitment of $173.4M in additional funding by the State Government through the WA Mental Health Strategy 2004-2007. The WA State Government's commitment to the National Action Plan on Mental Health 2006-2011 (NAP) is a continuation of growth and reform commenced under the State's Mental Health Strategy. The following details the highlights, variations to funding and key barriers related to Western Australia's individual implementation plan as outlined in the National Action Plan on Mental Health 2006-2011.

HIGHLIGHTS

Action Area 1: Promotion, Prevention and Early Intervention

The initiatives under Action Area 1 focus on populations particularly at risk of developing serious mental illness. Services are aimed at enhancing existing community mental health services and addressing service gaps for specific population groups. These include young people at risk of developing mental illness, women at risk of mental health problems during and after pregnancy, individuals who are difficult to keep in treatment and have had multiple psychiatric admissions, and vulnerable adults and young people who are homeless.

The following initiatives have been implemented:

- Two **Multi-systemic Therapy (MST) Teams for young people** (12 - 16 years) in the metropolitan area;
- **Community-based Post-natal Depression (PND) Services** have been extended Statewide through non-government community organisations;
- **Assertive Community Care teams** have been introduced in the metropolitan area, providing mobile intensive treatment for people with severe and persistent mental illness;
- **A community mental health service for young people (15 – 24 years)** has been established, for young people who are at risk of developing complex mental health problems, and also have accommodation and other psychosocial needs.

Action Area 2: Integrating and Improving the Care System

The initiatives under this Action Area focus on the key components of mental health emergency department liaison services in the metropolitan area, after hours psychiatric services in rural locations and access to inpatient services. Specialised emergency department mental health liaison services provide early assessment and management, as well as timely access to appropriate psychiatric interventions. The integration of specialised mental health services into emergency departments ensures appropriate care is provided. Additional psychiatric cover in rural and remote areas of WA increases access to psychiatric services in both community and inpatient settings and enables services to be maintained at optimum levels. The following initiatives have been implemented:

- **Emergency Department mental health liaison nurses** and **On-duty Registrars** at eight metropolitan hospitals and Emergency Department mental health liaison nurses have been appointed in a regional general hospital.
- **18 new mental health Emergency Department observation beds**;
- **Additional psychiatrists** have been recruited at four rural locations.

- **Additional inpatient beds** in Graylands, King Edward Memorial and Armadale Hospitals.

Action Area 3: Participation in the Community and Employment, including Accommodation

The initiatives under Action Area 3 are provided for people with a persistent mental illness who require support to participate in community life. **Intermediate Care Units** offer an alternative model to acute inpatient care through the provision of intensive rehabilitation and recovery programs, to ensure easier transition to community living. Community-based **Day Treatment Programmes** provide rehabilitation and support to those at risk of relapse, reducing the likelihood of readmission. **Psychosocial and clinical support programs** assist people with mental health problems who require support to maintain stable accommodation and participate in the community. The combined service approach to **community supported residential accommodation** is based on a partnership model between the Department of Housing and Works, non-government organisations, and Area Mental Health Services.

The following initiatives have been progressed:

- A 16-bed **intermediate care unit** opened in December 2006;
- **Day Treatment programmes** are fully operational at six metropolitan locations;
- **Supported accommodation** facilities are under construction in rural areas for a total of 35 residents.
- The personal care subsidy to **support residents in licensed private psychiatric hostels** was increased to improve the quality of care;
- Additional **psychosocial support services** have been provided to assist people to continue to live in the community in their own homes;
- The construction of a **Community Options accommodation facility** for eight residents has commenced to provide accommodation for people with high support needs.

Action Area 4: Increasing Workforce Capacity

Western Australia continues to increase the capacity of the mental health workforce through workforce and safety initiatives, recruitment and retention strategies, and implementing national practice standards.

The following Workforce and Safety Initiatives have been implemented in all public mental health services:

- Guidelines for the Management of disturbed/violent behaviour;
- Upgraded safety measures including additional duress alarms.

The following **Workforce Development and Expansion initiatives** have been implemented:

- An overseas (UK) recruitment drive took place in June 2007;
- Recruitment incentives through the provision of overseas and interstate relocation costs;
- Thirty-four scholarships awarded for a Postgraduate Diploma of Mental Health.

The following initiatives related to **Standards and Monitoring** have been delivered or implemented across Western Australia:

- Statewide orientation/induction programme for all new staff;

- Clinical Supervision Framework and training package;
- Management and Leadership course for senior mental health staff;
- Cultural competency training package and audit tool for mental health services;
- Implementation and monitoring of service standards for non government organisations who provide community support services

VARIATIONS AND ADDITIONAL FUNDING COMMITMENTS

The WA State government has increased its funding commitment to the NAP by $144.10 million, which represents a significant increase on the original $252.5 million over the period of the Action Plan. The additional funding includes increased investment in the capital and operational components of the following programs:

Action Area 1: Promotion, Prevention and Early Intervention
WA State government has increased funding by $12.56m over the period of the NAP, which particularly addresses the gap in services for young people, and women with post-natal depression.

Action Area 2: Integrating and Improving the Care System
WA State government has increased funding by $116.41 over the period of the NAP. An amount of $9.07m addresses the increased demand for Emergency Department mental health liaison services and better access to psychiatric services in rural and remote communities; and $107.34m to provide additional **Acute Inpatient Facilities** to address the increase in demand for inpatient services.

Action Area 3: Participation in the Community and Employment, including Accommodation
WA State government has increased funding by $12.74m over the period of the NAP to further expand mental health specific supported accommodation, and intermediate care services.

Action Area 4: Increasing Workforce Capacity
WA State government has increased funding by $2.39m over the period of the NAP to further expand workforce development and safety initiatives.

KEY BARRIERS TO IMPLEMENTATION

Western Australia faces two key barriers to the implementation of its commitment to the NAP. The barriers include the recruitment and retention of appropriately trained and skilled mental health professionals, and the skills shortage in the building industry that is adversely impacting on WA's capital works and infrastructure programs.

The WA State government is committed to addressing these barriers through the development and implementation of a range of workforce strategies to recruit and retain staff, including ongoing international recruitment campaigns and scholarships and incentives for people to enter the WA mental health workforce. In addition, a collaborative partnership between Health and the Department of Housing and Works has been established to jointly plan the construction of the supported community residential accommodation program.

South Australia

Highlights over the previous year

During 2006-07 South Australia achieved a number of outcomes to improve mental health services: These included:

- Completed a report by the Social Inclusion Board regarding mental health reform. The recommendations of the report culminated in an additional $107.9 million to implement a new stepped model of care and other associated mental health reforms.;
- Completed the recruitment of over 100 additional mental health professionals to assist in the delivery of mental health services to consumers. The additional staff were recruited to areas such as emergency departments, assertive care, hospital at home, child and adolescent services, co-morbidity services, emergency triage for country hospitals, peer support and assessment and crisis intervention services.
- Implemented the Health Young Minds initiatives to provide early intervention services for children and young people to reduce the social, health and economic impact of mental illness. Program funding allocated was $10.2 million over fours years and provides for 26 mental health professionals, which included:
  - an additional 20 community outreach workers and three psychiatrists for Child and Adolescent Mental Health Services.
  - an outreach service for adolescents with mental illness and substance use issues, which includes two specialist mental health workers and a Consultant Psychiatrist.
  - the extension of mental health cover at the Women's and Children's Hospital to ensure a 24-hour 7-day service for children and young people in crisis.
- Completed implementation arrangements with the South Australian Division of General Practice to employ 30 allied-health workers – such as psychologists, occupational therapists, social workers, as well as nurses – to work with GPs across the State to assist people with mental illness, and to also provide much needed support for our GP workforce. Funding of $9.7 million was allocated over 4 years. 14 workers will be placed in country locations.
- Completed contractual arrangements with beyondblue to develop promotion and prevention strategies, enhance professional training, commission and support research and promote partnerships across mental health and other sectors..

Information on variations to, and any additional funding commitments and allocations that may have occurred during the previous year

At the time the National Action Plan was prepared in July 2006, the South Australia Government advised that it could only include funding until 2009-10 due to its 4 year budget cycle. The recent State Budget has provided an additional of $23.5 million to continue many of these initiatives as well as funding for a new service model until 2010-11 and accounting for minor changes in initial commitments.

The South Australia Government also made other recent significant announcements during 2006-07 regarding mental health funding and provided an additional $93.5 million for the period of the National Action Plan. Details of this additional funding are as follows:

Establishment intermediate care facilities - $17.6 million
Funding of $18.2 million was provided over 5 years for 90 new intermediate care beds, 60 at four centres across metropolitan Adelaide and 30 in country facilities. The funding for the period of the Action Plan is $17.6 million. South Australia currently does not have any facilities of this type. The new facilities will be for people who are becoming unwell or people with a mental illness who are leaving hospital, but still need support before returning home. The facilities will provide:

- access to specialist mental health staff 24 hours a day, 7 days a week.
- relapse prevention services, including crisis support planning where necessary, individually tailored recovery care planning and implementation, which may involve existing treatment services;
- support for daily living and practical experience;
- day to day support, supervision and monitoring;
- access to group and individual services including linkage with supports that can be sustained on discharge.

Establishment of 73 supported accommodation beds - $20.46 million
Funding of $20.46 million was provided for facilities for an extra 73 supported accommodation beds across Adelaide. South Australia has very few beds of this type. The beds will assist people who struggle, for a variety of reasons, to maintain their tenancies. The initiative will provide clustered housing–usually single bedroom units–with staff on site 24 hours a day. The focus of the service is rehabilitation and recovery.

Smooth transition between the current system and the five new tiers - $1.84 million
Funding provides $1.84 million to allow a smooth change over between the current system and the new five tiers of care in the "Stepped Care" model.

Provision of priority access to services for approximately 800 people with chronic and complex needs - $1.47 million
Funding provided for priority access to services for about 800 people with chronic and complex needs, including those who also have drug and alcohol problems, a history of homelessness or who may be involved in the criminal justice system.

Eight mental health nurse practitioners in regional areas - $1.6 million
South Australia has provided $1.6 million to place eight mental health nurse practitioners in regional areas over the next four years to increase mental health services in regional locations

Non-clinical community support funding to NGOs for people with a mental illness - $36.8 million
Funding has been allocated to non government organisations to provide non-clinical based community rehabilitation and support services for people with a mental illness through rehabilitation and continuing support packages, day programs, respite places and other support services. These packages will assist in reducing unplanned or emergency readmissions to hospital.

Establishment of a team to provide outreach services to young people experiencing their first episode of mental illness - $1.6 million.

Funding has been provided to establish a dedicated team of specialists for early intervention support and act as a hub for young people and adolescents experiencing the first symptoms of mental illness.

Establishment of six community mental health centres across Adelaide over the next four years - $12.1 million

Funding of $25.9 million has been approved over the next 6 years with $12.1 million applicable for the period of the National Action Plan for the construction of 6 new community mental health centres across the metropolitan area. These centres will provide a range of specialist assessment and treatment mental health services, offering consulting and rehabilitation space for consumers and a range of specialist health professionals. These centres will bring mental health facilities closer to the communities where consumers live, with a key aim of providing increased access to early intervention and recovery services, leading to a reduction in the number of hospital referrals. The centres will also enable better interaction for the delivery of mental health services between the public health sector, general practice and the non-government sector.

Total new funding for South Australia to 2010-11 is now $117.0 million and increases the overall commitment to approximately $233 million over the period of the National Action Plan.

Barriers faced in implementation.

Recruitment and retention of mental health professionals is an issue that challenges all mental health jurisdictions, both nationally and overseas. Increasing workforce capacity, ensuring an appropriately skilled workforce and ensuring long-term workforce retention and sustainability are key issues for the Australian and South Australian Governments across both government and non-government mental health sectors. There are workforce shortages across most mental health professional groups from time to time. Governments need to continue to develop recruitment and retention strategies to ensure an available workforce that will sustain all services into the future.

Given the diversity of approach in the allocation of funding by jurisdictions, the challenge for Government will be to ensure that all people experiencing mental health issues across Australia whether living in metropolitan, rural or remote areas have equal access to and are able to benefit from the Australian Government's and the South Australian Government's mental health reform packages. It is vital that strong coordination mechanisms and partnership arrangements are developed and maintained at a strategic and operational level in order to maximise recovery outcomes for mental health consumers, families and carers, minimise unmet need and ensure that mental health consumers do not fall through the gaps.

Tasmania

In 2004, the Tasmanian Government commenced a four year funding commitment of over $47 million to Mental Health Services (MHS) allocated in response to the Bridging The Gap review.

The Tasmanian strategies contained in the COAG National Action Plan on Mental Health build upon initiatives arising from the Bridging The Gap report by continuing to focus strategically on service reform priorities and specific areas of need.

In response to the requirement for ensuring coordinated care for people with severe mental illness and complex needs who are at risk of falling through the gaps in the system, and to ensure the full effectiveness of the plan, Mental Health Services has established a collaboration forum comprising key government and non-government stakeholders, and representation from consumers and carers.

This forum, which has met twice over the initial year of implementation of the Plan, is coordinated with the COAG Mental Health Group, convened by Department of Premier and Cabinet in Tasmania, and involving relevant Commonwealth and State Government representation. Issues from the COAG Mental Health Group are referred to the collaborative forum, and issues arising from the forum are referred to the COAG Mental Health Group.

The establishment of a Care Coordination Model for Tasmania that enhances partnership between Commonwealth, Tasmanian government, non-government and private sector organisations, is an example of how the collaborative forum and COAG Mental Health Group is working effectively to harmonise service delivery. The partnership involves working to establish demonstration programs in support of the Personal Helpers and Mentors Program, the Day-to- Day Living initiative and the Mental Health Services in Rural and Remote Areas incentive program, synchronised with existing Tasmanian community based strategies such as Packages of Care and Recovery packages.

Promotion, Prevention and Early Intervention

Kids in Mind Tasmania was developed using a collaborative, evidence based project design approach and focuses on the needs of children and young people in families where a parent has a mental illness, with the overall goal of improving outcomes for these children through interventions that support the child and family.

The guiding principles underpinning the Kids in Mind project are that interventions have an emphasis on prevention and early intervention, be evidence-based and cost-effective and strengthen the service system and promote integration and collaboration between agencies both within and external to government. A total of $400,000 per annum for five years has been allocated commencing in 2006/07 to deliver programs in support of this program including Champs Camps and the Taz Kidz Club. An independent review of the program undertaken during this financial year considered possible changes in future years as a way of ensuring the services delivered are consistent with the principles of the National Action Plan on Mental Health 2006-2011 and the Mental Health Services Strategic Plan 2006-2011.

During the 2006/07 financial year a total of 73 children from across the state participated in Taz Kidz Clubs with a further 155 attending Champs Camps.

Improved Alcohol and Drugs Programmes

The public pharmacotherapy program in Southern Tasmania relocated to its new premises in July 2006.Progressive recruitment to key specialist medical, nursing and pharmacy positions has enabled admission of new patients to the public program and commencement of a public dispensing program in the south. In line with the directions of Future Health -Tasmania's Health Plan and in recognition of the immediate need to begin to address some of the urgent issues identified through the current ATOD service review, the Alcohol and Drug Service has been allocated an additional $1.5 million in the 2007/08 budget.

There are a range of key initiatives which the Agency will implement in 2007/08.The initiatives include:

- Key medical and other clinical staff will be recruited to improve the capacity of the sector to address urgent issues in opiate substitution pharmacotherapy, consult and liaise with the acute health, primary health and general practice services;
- A clinical expert with training expertise will be recruited to support the professional development of both government and non government sectors;
- Training and other professional development packages are to be developed for clinical staff working in the acute health and primary health sectors, other health services, and general practice settings;
- The Alcohol, Tobacco and Other Drugs Council will be provided with a three year funding agreement and the Department of Health and Human Services will work with them on projects to enhance the capacity of the non-government sector; and
- Staff with clinical expertise in working with youth and alcohol and other drug issues are to be recruited to enhance the relationships between the alcohol and other drug treatment services, youth justice and child and family services.

Secure Mental Health Unit

The Wilfred Lopes Centre brings Tasmania in line with other Australian States and international human rights conventions relating to the incarceration and treatment of people with mental illnesses. Opened early in 2006, at full capacity this 35 bed secure mental health unit houses both long term and short term mental health patients in a purpose built modern facility. It provides patients with modern, professional and highly specialised psychiatric care and treatment based on individually tailored programs designed to support independence and dignity, and minimise the ill effects of long-term care.

Bed occupancy at the centre has progressively increased in line with targets set for the phased opening of the Unit (from 6 to current bed occupancy of 20).The recruitment strategy in place over the past year has proved successful in securing a sufficient number of qualified staff to open 20 beds at staffing levels that meet the agreed Nursing Hours Per Patient Day (NHpPD) model.

The challenges of establishing and maintaining a new forensic inpatient model have been significant. Strong proactive leadership, and a skilled workforce supported by effective orientation, training, policies and procedures, has ensured success, and additionally has resulted in the minimal occurrence of incidents and minimal use of seclusion. The annual recurrent budget for this facility is $6.8 million.

Improved Access to Acute Psychiatric Care, including Emergency, Crisis, Acute Inpatient and Community Services

A Mental Health Helpline was introduced in October 2006 as a key element of the ongoing reform of mental health service delivery in Tasmania and in support of the Mental Health Services Strategic Plan 2006 – 2011. This 7-day a week, 24-hour a day service provides crisis advice and assists consumers, carers and other service providers to access other services and handled in excess of 10,000 calls during the first 4-months of operation. This new service is providing people experiencing serious mental illness better coordinated treatment and care options through a convenient statewide 1-800 telephone Triage service. The MHS Helpline is a point of contact for General Practitioners and other agencies referring a client to MHS and provides a clear pathway for the provision of care for people with a mental health condition.

Improved Youth Health Services - Child and Adolescent Mental Health Services (CAMHS)

The Bridging The Gap report specifically identified key developmental areas relating to the provision of service to Children and Adolescents. A primary aim was strengthening clinical resources in the community with a focus on child and adolescent teams. Significant progress towards the recruitment of additional clinical resources has been made in relation to the target of recruiting 48 additional full time equivalent direct clinical service delivery staff. Of this total number, 26 of these staff are in the area of Children and Adolescent Mental Health Services distributed across the state.

This injection of resource has enabled the child and adolescent services to provide a more responsive service to young people experiencing mental health issues. An integrated service response is being achieved through the effective coordination of service provision to ensure continuity of care in the least restrictive environment and with a focus on recovery.

Additional Accommodation for People with Mental Illness

The Bridging the Gap Review also identified the need to establish one new Mental Health Services residential facility in each of the South, North and North West regions of Tasmania. In the second half of 2006 a community based residential rehabilitation service was commissioned in the North West of the state in Ulverstone comprising twelve Level 3 supported beds and operated by a non-government organisation.

During the 2006/2007 financial year, planning commenced for the establishment of a 15 bed Northern Extended Care facility will be built in Launceston. Currently the timeframe for completion of construction is March 2008 with an estimated infrastructure cost of $ 2 million dollars. This project will have a recurrent cost of $2 million dollars (net) annually. A twelve-bed facility is now fully operational in Hobart and is also operated by the non-government sector.

Support to the Non-Government Sector to Provide Quality Services to People with Mental Illness

Funding is being provided to the non-government sector to provide recovery based services for people experiencing serious mental illness consisting of rehabilitation and recovery services, supported accommod ation and packages of care. As at 30 June 2007, a total of 91 out of 144 rehabilitation places are being provided across the state with all existing places allocated in the North and North-West of the state.

Australian Capital Territory

Mental health service delivery and prevention activity in the ACT is guided by the population mental health framework of the *ACT Mental Health Strategy and Action Plan 2003 – 2008*. The strategy describes the local service picture and priorities for the territory. The prioritising of mental health by CoAG has enabled a number of ACT priorities to be brought forward. The actions in the ACT section of the CoAG Action Plan for mental health emerge from the alignment of local priorities with the areas identified for action in the CoAG plan. In the 2006-07 Budget the ACT Government committed $20.4 million, in addition to existing base funding, to be spent on mental health in the key action areas over the 5 years of the Plan. This included: Mental Health Promotion Prevention and Early Intervention $3.2 million, Integration and Improving the Care System $11.5 million, Participation in the Community and Employment $2.8 million and Increasing workforce Capacity $3.1 million.

The ACT Government recognises that to meet the mental health needs of the ACT community within the CoAG National Action Plan framework will require a commitment to incrementally resourcing the sector. The ACT Government has committed to increasing the funding the mental health sector during the next 5 years. The ACT Government is exploring options to achieve 12% of the overall Health budget by 2012, but realises this is a challenging goal. In the ACT 2007-08 Budget the Government committed an additional $12.86 million to the implementation of the ACT initiatives.

Mental Health Promotion Prevention and Early Intervention ($3.2 million)

Perinatal and infant mental health services expansion - this initiative is designed to enhance the capacity of mental health services to participate in an integrated model of early childhood health care, and provide an early intervention approach to service delivery. The expanded service has been launched and is ongoing.

Community Education – this initiative aims to increase the capacity of community agencies to provide mental illness education to the ACT community through schools and other agencies. Services are based on a 'consumers and carers as educators' model. The expanded service has been funded. During 2006-07, with the enhanced funding, the provider delivered a 10% increase in secondary school mental health education programs, 50% increase in the youth resilience programs and a 20% increase in mental health education sessions to community & emergency service agencies, targeted professional groups and tertiary students.

Children of Parents with a Mental Illness development and delivery of Training Program– this initiative provides for the development and delivery of a training program for professionals and community workers across sectors to enhance skills in working with children of parents with a mental illness (COPMI). The program has been implemented and is ongoing.

Workplace mental health promotion program development and delivery – this initiative aims to facilitate the ACT working in partnership with *beyondblue* and other agencies to support the development of mental health promotion programs in workplaces throughout the ACT. The tender process is completed and the successful tenderer will be announced when contract negotiations are finalised.

Early Recovery Support– to provide intensive early recovery support for people who have experienced an episode of mental illness and hospitalisation, to overcome the barriers to re-engagement with the community and rehabilitation program. Early recovery support workers have been recruited and the program implemented.

Integration and Improving the Care System ($11.5 million)

Improving the general health of people with mental illness– this program improves the physical health outcomes for persons with serious mental illness through improved referral and access for clients of Mental Health ACT to GP practices. The service has been implemented and is ongoing with recurrent funding.

Increase capacity for carer and consumer participation in service planning – to provide additional part-time carer and consumer consultant positions to improve the level of consumer and carer contribution to the development of mental health services that better meet their needs. Recruitment to the positions is underway.

Mental health legislation review– to ensure compatibility with the *ACT Human Rights Act* and consistency with current best practice for mental health. The review is being conducted in full consultation with consumers, carers and all other key stakeholders. The review has commenced and is expected to be finalised in the second half of 2008. During 2006-07 the Review progressed through the release of a Discussion Paper and a public consultation process. The consultation process led to the development of an Options Paper, which will be released for consultation in 2007-08.

Mental Health Services Plan– to guide the future development and operation of government and community agency mental health services, including redevelopment of inpatient services to meet the special needs of groups such as women and adolescents and culturally and linguistically diverse communities.

Intensive Treatment and Support Program for People with dual disability– this initiative provides a comprehensive additional service for an identified group of clients aged 17 and over who have an intellectual disability and a mental disorder with complex behavioural problems and who are at significant risk of entering the criminal justice system. The program includes a step-up short-term purpose-built accommodation to be used for some within this client group requiring intensive support. This service has commenced and is ongoing.

Participation in the Community and Employment including Accommodation ($2.8 million)

Youth supported accommodation – to increase capacity to provide 24-hour supported accommodation and outreach services to youth with mental illnesses, which is an identified area of need in the ACT. The tender process has been completed. The successful tenderer and ACT Health are currently negotiating appropriate residential accommodation for the program.

Increasing Workforce Capacity ($3.1 million)

Additional medical workforce positions - to provide medical officer positions for the ACT public mental health system to help to improve access to specialist mental health services in the ACT. As a result of this initiative, additional medical positions have been recruited.

ACT 2007-08 BUDGET: AN ADDITIONAL $12.86 MILLION OVER 4 YEARS

The most recent commitments by the ACT Government in the 2007-08 Budget towards mental health services were announced in June 2007 and include the following initiatives.

24-hour "Step up/Step down" & Outreach program for Adults with serious mental illness ($3.97 million over 4 years) – The "step-up-step-down model of care" complements existing services and provides alternative options for acute admission, early intervention and improved options for support, subject to the level of need assessed by the consumer. The initiative provides outreach transitional support for those returning to their usual community accommodation. This will ensure continuity of care for clients so that those exiting the program (stepping down) are supported and reliably linked into other appropriate community support programs to maintain their living skills in the community.

Additional mental health clinical positions and enhanced training ($3.8 million over 4 years) – new clinical mental health positions in the hospital Emergency Departments and the mental health inpatient unit will improve consumer services and safety. Specialist mental health educators will be contracted to provide targeted training packages.

Enhanced mental health community sector quality improvement and sector development ($0.56 million over 4 years) – to provide investment in the mental health peak body supporting enhanced carer and consumer participation and non-government organisation service and workforce development.

Additional funding committed in the 2007-08 budget towards 2006-07 initiatives includes the following:

- **Mental Health Facilities Development ($3.49 million, during 2007-08)** – to plan and design the redevelopment of acute inpatient services and the development of secure services as directed within the Mental Health Services Plan
- **Youth supported accommodation (additional $1.04 million over 4 years).**

Northern Territory

1. Suicide Prevention and Response ($1.0 million)

Funding was provided to increase suicide prevention and response activities including creation of a Suicide Prevention Coordinator position. Additional funding has also been provided to improve early identification of mental health problems.

Progress to date:

Suicide Prevention

- Suicide Prevention Coordinator appointed in June 2006. Review of current suicide prevention and response activities undertaken in the NT and establishment of a cross Government Suicide Prevention Coordinating Committee (NT SPCC). First meeting of the NT SPCC took place in March 2007. This committee will progress the NT Strategic Framework for Suicide Prevention, monitor current trends and guide future activity. The Committee is developing a suicide prevention action plan for the Northern Territory in consultation with non-Government and community representatives.
- Funding to expand the Life Promotion Program to Tennant Creek.
- Funding to Lifeline Central NT to continue provision of the crisis counselling services and coordinate suicide prevention training in the Central Australian region for a further 2 years.
- Anglicare NT has received additional funds to ensure that their suicide prevention-training program can continue in the Top End for a further 12 months (previously funded by DoHA). This program will be reviewed prior to June 2008.
- A bereavement support group has been funded in Darwin for people affected by a completed suicide.

Early Intervention

- A new Primary Health Care Service within the public Mental Health Services in Central Australia has been funded.
- Increased funding for Young Carers Resilience Workshops for young people with parents with a mental illness or disability.
- Funding for perinatal training for professionals working in perinatal and infant mental health in the NT.

2. Sub-acute Beds ($5.5 million)

24 hour supported community based services as an alternative to hospital admission or to facilitate intensive support following discharge from hospital.

Progress to date:

- A trial program to provide intensive support for clients who are at risk of relapse and possible hospital admission, or, to provide post-discharge support was established in

September 2005. This program is provided by public mental health services in partnership with NGOs. An evaluation of these programs and the final report is expected by October 2007.

- Funding for sub-acute beds will compliment this program, providing 24 hour supported beds in Darwin and Alice Springs for people who are unable to be intensively supported in their own home, including people from rural and remote areas. Plans have been approved and building works have commenced on an 8-bed facility in Darwin. It is anticipated this service will be operational in October 2007.
- A more flexible model is planned for Alice Springs. Four sub-acute beds are currently available - two 24 hour supported beds and a two-bedroom unit.

3. Rural and Remote Services ($4.0 million)

Increased services to rural and remote communities, including additional adult and child and adolescent clinical positions for rural and remote areas, increased funding to Aboriginal Mental Health Worker Programmes and Visiting Psychiatrist Services (in addition to MSOAP funding).

Progress to date:

- New child and adolescent positions have been funded in public mental health services to provide services to rural and remote communities and visiting child and adolescent psychiatrist services to Katherine, Nhulunbuy, Alice Springs and Central Australian communities have commenced.
- Increased clinical staff have been funded in rural and remote adult teams to increase the frequency and duration of visiting services.
- Visiting psychiatrist programs have been expanded to all major remote communities in the Top End and Central Australia via NT Government funding and Australian Government Medical Specialist Outreach Program (MSOAP).
- Increased funding to Top End Division General Practice Aboriginal Mental Health Worker Program and Tiwi Mental Health Program.

4. Prison In-reach Services ($3.5 million)

Increased forensic mental health and disability in-reach services to people in Alice Springs and Darwin prisons who have a mental illness, intellectual disability or acquired brain injury.

Progress to date:

- Additional community nursing, allied health, Aboriginal Mental Health Worker and part-time forensic psychiatrist positions have been funded in the Darwin and Alice Springs Forensic Teams.
- Training program for correctional staff has commenced.
- Facilities modifications to Darwin Correctional Centre to accommodate a full time forensic mental health presence in the prison have been completed.

5. Rehabilitation and Recovery Services ($0.5 million)

Increased funding for rehabilitation and recovery and carer support services provided by the non-government sector.

Progress to date:

- Increased funding to various NGOs to increase rehabilitation and recovery services and expand regional services for consumers, carer support and community education. Programs include outreach and recovery, supported accommodation, self help groups and carer support. Funding has exceeded the initial commitment.

6. Care Coordination

One of the main aims of the NAP is to improve the Care Coordination process for people with severe mental illness and complex needs.

Progress to date:

- An NT Care Coordination Working Group has been established. The objectives of the group are to ensure collaboration and align Australian and Territory Government efforts, improve the responsiveness of the mental health system and pursue opportunities to work across portfolios, departments and service systems to improve mental health outcomes.
- A draft NT Care Coordination Policy Paper has been circulated for comment.
- To inform the NT Care Coordination Working Group and progress care coordination at the operational level, two subgroups have been established. One sub-group to develop improved care coordination for people who are in contact with the criminal justice system and who have mental health and alcohol and other drug problems has been established in the Top End. It is currently proposed to establish a similar sub-group in Tennant Creek. A second sub-group to develop improved care coordination between primary health, specialist mental health and non-government rehabilitation and recovery services has been established in Central Australia.

APPENDIX 1 Action Plan funding commitments and allocations

This section of the report presents jurisdictional funding summary tables by Action Area.

Details are included of each government's original commitment, additional funding commitments announced subsequent to signing of the Action Plan (14 July 2006), and funding allocations in 2006-07.

Explanatory notes to Appendix 1 tables

The tables in this appendix present data on funding commitments and allocations for the individual initiatives listed by each jurisdiction in the Action Plan, grouped into four 'Action Areas'. Data prepared by jurisdictions also allowed for reporting of new additional mental health funding allocations in areas where the activity is directly relevant to the Action Plan objectives and where the associated additional funding commitments were announced subsequent to signing of the Plan (14 July 2006).

For all funding data, the amounts shown are in millions, rounded to two decimal places, and reported in current year prices relevant to the reference year. To aid the readability of the tables, cells in which the value is zero are shown as blank.

Action Plan funding commitment 2006-11

Figures entered in this column list the total funding commitment as specified in the Action Plan for each initiative, recognising that for some jurisdictions, the amounts include allocations in years prior to the first year of the Plan (2006-07) or do not extend across the full 2006-11 period.

Subsequent additional mental health funding commitments 2006-11

Figures in this column present aggregate amounts for any new funding commitments covering the period 2006-11 in areas that are directly relevant to the Action Plan objectives, and where those funding commitments have been announced by the relevant government subsequent to signing of the Action Plan (14 July 2006). The amounts reported show the cumulative total funding commitment over 2006-11.

Funding allocated 2006-07

This column provides details, for each initiative, of the funding expended or provided to services by the relevant government in the 2006-07 year. Given the tight timelines for preparation and submission of this report, funding allocations may be preliminary estimates, based on funds committed. Adjustments will be made in subsequent progress reports where annual reconciliation and/or acquittal processes provide more accurate data on actual allocations in previous years.

Cumulative funding allocations from July 2006

This column provides details, for each initiative, of the cumulative funding allocations since 1 July 2006. For most jurisdictions, this equals the amounts reported for 2006-07. For those jurisdictions that included pre-COAG agreement funding commitments (i.e. years prior to 2006-07) in their Individual Implementation Plans, pre-1 July 2006 allocations are included.

Other new mental health funding allocations relevant to COAG Action Plan objectives

Any initiatives grouped in this category present information relating to new funding commitments made subsequent to 14 July 2006 that are directly relevant to the Action Plan but cannot be grouped under one of the four Action Areas.

Australian Government

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Expanding suicide prevention programmes	62.38		10.28	10.28	
Alerting the Community to Links between Illicit Drugs and Mental Illness	21.60		3.01	3.01	
New Early Intervention Services for Parents, children and young people	28.14	0.30	1.90	1.90	
Community based programmes to help families coping with mental illness	45.22		2.23	2.23	
Increased funding for the MHCA	1.04		0.20	0.20	
Total Action Area 1	***158.38***	***0.30***	***17.61***	***17.61***	
Action Area 2: Integrating and Improving the Care System					
Better Access to Psychiatrists, Psychologists, GPs through MBS	538.00	-30.70	131.45	131.45	a
New Funding For Mental Health Nurses	191.60		2.06	2.06	
Mental Health Services in Rural and Remote Areas	51.70	30.70	5.35	5.35	
Improved Services for People with Drug and Alcohol Problems and Mental Illness	73.90		1.64	1.64	
Funding for Telephone Counselling, Self-help and Web based Support Programmes	56.93		7.02	7.02	
New Personal Helpers and Mentors	284.77		5.08	5.08	
Veterans' mental health care - improving access for younger veterans		19.72	7.29	7.29	
Total Action Area 2	***1,196.90***	***19.72***	***161.90***	***161.90***	
Action Area 3: Participation in the Community and Employment, including Accommodation					
Helping People with a Mental Illness Enter and Remain in Employment	39.80		6.51	6.51	
Support for Day to Day Living in the Community	45.96		5.38	5.38	
Helping Young People Stay in Education	59.53		6.13	6.13	
More Respite Care Places to Help Families and Carers	224.66		8.16	8.16	
Total Action Area 3	***369.95***	***0.00***	***26.18***	***26.18***	
Action Area 4: Increasing Workforce Capacity					
Additional Education Places, Scholarships and Clinical Training in mental health	103.48		9.67	9.67	
Mental Health in Tertiary Curricula	5.60		1.26	1.26	
Improving the Capacity of Health Workers in Indigenous Communities	20.75		2.12	2.12	
Total Action Area 4	***129.83***	***0.00***	***13.05***	***13.05***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***1,855.07***	***20.02***	***218.74***	***218.74***	

***Notes to Australian Government table*:**

a. Under the Better Access initiative $126.37 million was paid in Medicare benefits during 2006-07 for mental health care by GPs, psychiatrists, psychologists and other allied mental health professionals. A further $2.37 million was allocated for expected additional costs of prescriptions to the Pharmaceutical Benefits Scheme arising from the Better Access initiative. This replaces a total of $3.87 million estimated expenditure in 2006-07 on Medicare items for mental health care that have been replaced by Better Access (i.e. 3-Step Mental Health Process and Chronic Disease Management Allied Health Services). Some elements of Better Access expenditure on Medicare rebates are notionally offset by the cost of services that would otherwise have resulted in Medicare claims but for the Better Access initiative, however, these offset services are general medical services and not specifically for the provision of mental health care. Other than the $3.87 million referred to above, the Commonwealth's expenditure on Better Access Medicare rebates is not 'netting off' other Commonwealth mental health expenditure.

New South Wales

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Expanding university based research	10.00		7.90	7.90	a
Expanding early intervention services for youth	28.60		1.40	1.40	
Specialist assessment of the needs of older people	37.30		4.00	4.00	
State wide 24 hour mental health access by telephone	26.30		2.65	2.65	
Safe Start - Maternal & Infant Care		3.50			
Expanding University Based Research - Grants to Brain & Mind at Institute University of Sydney		16.00	16.00	16.00	
Total Action Area 1	***102.20***	***19.50***	***31.95***	***31.95***	
Action Area 2: Integrating and Improving the Care System					
Enhancing Community Mental Health Emergency Care	51.40		6.76	6.76	
Expansion of community forensic mental health services	6.50		1.30	1.30	
Better integration of mental health services with drug and alcohol services	17.60		5.60	5.60	
Supporting people with Mental Illness in the prison system	5.00		1.00	1.00	
Further increasing the number of acute and non acute mental health beds	151.70		19.10	19.10	
Building and operating new forensic facility at Long Bay Prison	171.60		67.60	67.60	b
Expansion of community based professional mental health services including child and adolescent services	14.30		1.50	1.50	
Specialist mental health services for older people	10.80		2.15	2.15	
Improving mental health clinical information and accountability	7.60		1.50	1.50	
Building new facilities to accommodate new mental health beds including works at Lismore, Illawarra and Bloomfield Hospital	117.00	1.70	29.70	29.70	
Redevelop and integrate mental health services with drug and alcohol services at St Vincent's Hospital	23.00		23.00	23.00	
Refurbishing and relocating mental health facilities at Concord, Gosford, Newcastle, and Orange Hospitals	117.40		19.40	19.40	c
Establishing Psychiatric Emergency Care Centres	5.80	1.50	4.80	4.80	
Eating Disorders		4.10			
Child & Adolescent mental Health Outpatient Services		15.80			
Total Action Area 2	***699.70***	***23.10***	***183.41***	***183.41***	

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 3: Participation in the Community and Employment, including Accommodation					
Housing Accommodation and Support Initiative	58.80		6.80	6.80	
Community Rehabilitation Services	41.50		3.80	3.80	
Enhance NSW Family and Carer Mental Health Programme	13.50		1.50	1.50	
Total Action Area 3	***113.80***	***0.00***	***12.10***	***12.10***	
Action Area 4: Increasing Workforce Capacity					
Mental Health Workforce Programme	11.00		1.90	1.90	
Aboriginal Mental Health Workforce Programme	12.20		1.50	1.50	
Total Action Area 4	***23.20***	***0.00***	***3.40***	***3.40***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***938.90***	***42.60***	***230.86***	***230.86***	

***Notes to New South Wales government table*:**

a. These grants were provided in May 2006 for service enhancements to be delivered in 2006-07.

b. The commitment to build a new forensic facility is occurring through a Public Private Partnership (PPP). This return is based on 70% construction completion in 2006-07.

c. The commitments at Orange Base Hospital and the Newcastle Mater Hospital are occurring through Public Private Partnerships (PPPs). This return is based on: Orange - approximately 10% of total project value being the Mental Health component; Newcastle Mater - approximately 25% of total project value being the Mental Health component.

.

Victoria

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Expanding early psychosis programs	16.90	9.97	2.84	2.84	
Expanding conduct disorder programs	8.40		1.39	1.39	
Support for children of parents with a mental illness	2.40		0.35	0.35	
Postnatal depression support services	4.90		0.65	0.65	
New Centre for Women's Mental Health	1.10		0.19	0.19	
Expanding counselling in community health services	2.60		0.50	0.50	
Expanding primary prevention and promotion programs	36.00		7.20	7.20	
Mental Health Research	8.00			0.00	
Total Action Area 1	***80.30***	***9.97***	***13.11***	***13.11***	
Action Area 2: Integrating and Improving the Care System					
Expand child and adolescent, adult and aged specialist community services	47.30	4.57	8.12	8.12	
Expanding dual diagnosis services	8.90		1.50	1.50	
Expansion of mental health teams in Hospital Emergency Departments	15.60	8.31	2.98	2.98	
Supporting transition to the community for long term residents of extended care facilities	6.60		0.66	0.66	
Expanding capacity in bed-based Forensic Mental Health Services	21.10		2.59	2.59	
Additional step up/down PARC Sub-acute Places	25.10	5.78	1.19	1.19	
Hospital Demand Management	17.40		3.32	3.32	
Increasing the acute mental health bed capacity	39.90	2.53	8.13	8.13	
Improving triage practice	2.80		0.64	0.64	
Building better mental health facilities - Heidelberg, Shepparton, Bouverie Centre relocation	20.50	1.50	4.57	4.57	
Cost growth in forward estimates over the 5 years of the Plan	79.60		15.12	15.12	
Building better mental health facilities - Northern Hospital, Deer Park, Preston & Broadmeadows		25.60	1.50	1.50	
Improving access to mental health aged care residential beds		1.66	0.05	0.05	
Improving services		7.50	13.64	13.64	
Enhanced support for carers		0.24			
Total Action Area 2	***284.80***	***57.69***	***64.01***	***64.01***	
Action Area 3: Participation in the Community and Employment, including Accommodation					
Growing Psychiatric Disability Rehabilitation Support Services	38.60	1.66	7.20	7.20	
Expanding Community Care Units	7.50		0.91	0.91	
Supported Accommodation for vulnerable people	40.40		11.00	11.00	
Homelessness and mental health initiatives	8.00		5.77	5.77	
Cost growth in forward estimates over the 5 years of the Plan	8.20		1.59	1.59	
Total Action Area 3	***102.70***	***1.66***	***26.47***	***26.47***	

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 4: Increasing Workforce Capacity					
Enhancing workforce capacity	4.40		0.84	0.84	
Total Action Area 4	***4.40***		***0.84***	***0.84***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***472.20***	***69.32***	***104.43***	***104.43***	

Queensland

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Early Years Service Centres	4.90				
Prevention strategies in schools (reprioritising budget to allow development)	0.00				
Dual Diagnosis Positions	0.80		0.29	0.29	
Transcultural Mental Health Workforce	1.20		0.24	0.24	
Qld Centre for Promotion, Prevention & Early Intervention		4.97			
Promotion of innovative technologies in mental health promotion, prevention and early intervention		0.50			
Cross-sectoral strategies to reduce suicide risk		2.91			
Perinatal & infant mental health hub		0.97			
Total Action Area 1	***6.90***	***9.35***	***0.53***	***0.53***	
Action Area 2: Integrating and Improving the Care System					
Blueprint for the Bush Service Delivery Hubs	1.80		0.08	0.08	
Indigenous Domestic and Family Violence Counselling	1.20				
Child Safety Therapeutic and Behaviour Support Services	17.60		9.00	9.00	
Health Action Plan - Existing Service Pressures	58.10		11.60	11.60	
Community Mental Health Services - Enhancement	114.50		18.00	18.00	
Dual Diagnosis Positions	4.70	2.92	1.62	1.62	
Mental Health Intervention Teams	4.10		1.30	1.30	
Forensic Mental Health Services	14.80	10.50	3.60	3.60	
Transcultural Mental Health Positions	6.80	1.80	1.36	1.36	
Area Clinical Mental Health Networks	7.70		1.50	1.50	
Alternatives to Admission	17.50		4.50	4.50	
Responding to Homelessness	19.70		11.50	11.50	
Mental Health Services in Prisons	8.60		2.40	2.40	
Mental Health Capital	12.00	121.55	12.00	12.00	
Primary care liaison coordinators		3.24			
Implementation of "Partners in Mind"		1.42			
Consumers Consultants		2.97			
Child and Youth Mental Health Services		37.78			
Adult Community Mental Health Services		9.44			
Older Person's Community Mental Health Services		18.70			
Mobile Intensive Treatment Services		11.55			
Extended Hours Acute Care		27.47			
Consultation Liaison		9.63			
Centre for Rural and Remote		2.36			
ATSI Mental Health		5.15			
Administrative support staff		5.70			
District leaders, supervisors and quality & safety staff		15.32			
Intellectual disability & mental health		0.97			
Eating Disorders		2.71			
Sensory impairment and mental health		1.12			
Implementation of Butler recommendations		53.48			
Total Action Area 2	***289.10***	***345.78***	***78.46***	***78.46***	

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 3: Participation in the Community and Employment, including Accommodation					
Housing Capital	20.00	40.00	20.00	20.00	
Health Action Plan Non-Government Organisation Funding	25.00		5.00	5.00	
Disability Services Respite and Sector Capacity Building	12.00		2.40	2.40	
Employment and Training	5.00		1.00	1.00	
Mental Health Services in Prisons	2.30		0.50	0.50	
DSQ - NGO personal support & accommodation		35.64			
DSQ- Personal support in social housing		22.45			
Total Action Area 3	***64.30***	***98.09***	***28.90***	***28.90***	
Action Area 4: Increasing Workforce Capacity					
Increased Workforce Remuneration	5.80		1.16	1.16	
Mental Health Transition to Practice Nurse Education Programme	0.30		0.30	0.30	
Workforce development & research		8.06			
Growth funding		43.00			
Information management		19.76			
Total Action Area 4	***6.10***	***70.82***	***1.46***	***1.46***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Care Coordination		4.77			
Total Other initiatives relevant to Action Plan		***4.77***			
Total funding commitments/allocations	***366.40***	***528.81***	***109.34***	***109.35***	

Western Australia

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Multi-systemic Therapy for Adolescents	10.50	2.65	1.90	4.30	
Post-natal depression services	2.00	2.90	0.70	1.70	
Assertive case management systems	45.20	1.50	7.80	15.20	
Homeless clinical services	1.00	1.64			
Intensive community youth services	2.00	3.87	0.90	1.40	
Total Action Area 1	***60.70***	***12.56***	***11.30***	***22.60***	
Action Area 2: Integrating and Improving the Care System					
ED mental health liaison nurses and on-duty registrars	24.50	4.33	4.00	9.20	
Acute observation ED Beds	20.10	2.20	2.40	6.70	
Rural and Remote medical cover	9.00	2.54	1.70	3.40	
Increase in Acute Inpatient Facilities		107.34	18.31	37.67	
Total Action Area 2	***53.60***	***116.41***	***26.41***	***56.97***	
Action Area 3: Participation in the Community and Employment, including Accommodation					
Intermediate care units	25.00	9.21	3.25	3.60	
Day treatment programme	29.00	1.04	4.30	7.81	
Supported community residential units	27.20	8.51	1.00	1.00	
Licensed psychiatric support expansion	10.00	-2.52	1.00	3.00	
NGO Psychosocial Support Expansion	10.00	-3.50	1.00	3.00	
Clinical rehabilitation teams	28.20		0.20	2.00	
Total Action Area 3	***129.40***	***12.74***	***10.75***	***20.41***	
Action Area 4: Increasing Workforce Capacity					
Workforce and Safety Initiatives	2.30	1.56	1.20	2.00	
Workforce development and expansion	5.50	-1.50	0.20	0.20	
Standards and implementation monitoring	1.00	2.33	1.45	1.45	
Total Action Area 4	***8.80***	***2.39***	***2.85***	***3.65***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***252.50***	***144.10***	***51.31***	***103.63*** *(a)*	

***Notes to Western Australia government table*:**

a. The reported WA cumulative funding allocation from July 2006 is greater than reported funding allocated for 2006-07 because, for some initiatives, expenditure prior to July 2006 was included in the Individual Implementation Plan.

South Australia

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Promoting mental health	1.10		0.56	0.56	
Preventing mental illness by building resilience	29.60	5.09	2.96	2.96	
Early intervention with young people	8.80	2.52	0.61	0.61	
Total Action Area 1	***39.50***	***7.61***	***4.13***	***4.13***	
Action Area 2: Integrating and Improving the Care System					
Shared care with general practitioners	10.00	2.89	0.74	0.74	
Improving services to people with mental illness and drug and alcohol issues	3.50	0.99	0.75	0.75	
24 hour mental health access by telephone	8.00				
Enhancing emergency department responses	6.70	1.73	1.59	1.59	
Improving access to acute and community-based clincial services	22.70	5.69	5.69	5.69	
Increased services for people in country areas	7.60	1.90	1.90	1.90	
Extra support for Aboriginal and Torres Strait Islander people	5.10	1.28	1.28	1.28	
Community support	12.00		12.00	12.00	
New Model of Care		1.50	0.38	0.38	
Provision of priority access to services for approximately 800 people with chronic and complex needs		1.47			
Smooth transition between the current system and the five new tiers		1.84			
Non-clinical community support funding to NGO's for people with a mental illness		36.80			
Establishment of six community mental health centres across Adelaide over the next four years		12.08			
Total Action Area 2	***75.60***	***68.16***	***24.33***	***24.33***	
Action Area 3: Participation in the Community and Employment, including Accommodation					
90 New intermediate care beds, 60 at four centres across Adelaide and 30 in country hospitals		17.60			
73 supported accommodation beds		20.46			
Total Action Area 3	***0.00***	***38.06***	***0.00***	***0.00***	
Action Area 4: Increasing Workforce Capacity					
Peer Support Workers	1.00		1.00	1.00	
Eight mental health nurse practitioners in regional areas		1.60			
Establishment of a team to provide outreach services to young people experiencing their first episode of mental illness		1.60			
Total Action Area 4	***1.00***	***3.20***	***1.00***	***1.00***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***116.10***	***117.03***	***29.45***	***29.45***	

Tasmania

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Kids in Mind Tasmania	2.00		0.18	0.18	
Total Action Area 1	***2.00***		***0.18***	***0.18***	
Action Area 2: Integrating and Improving the Care System					
Improved Alcohol and Drugs programmes	2.00		0.40	0.40	
Secure Mental Health Unit	12.50		2.50	2.50	
Improved access to acute psychiatric care, including emergency, crisis, acute inpatient and community services	1.50		0.28	0.28	
Improved youth health services (CAMHS)	5.10		1.90	1.90	
Total Action Area 2	***21.10***		***5.08***	***5.08***	
Action Area 3: Participation in the Community and Employment, including Accommodation					
Additional accommodation for people with mental illness	6.30		1.40	1.40	
Support to the non government sector to provide quality services to people with mental illness	5.00		0.57	0.57	
Total Action Area 3	***11.30***		***1.97***	***1.97***	
Action Area 4: Increasing Workforce Capacity					
Improve the working conditions and remuneration for doctors and allied health professionals	8.60		1.72	1.72	
Total Action Area 4	***8.60***		***1.72***	***1.72***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***43.00***		***8.95***	***8.95***	

Australian Capital Territory

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Perinatal and Infant Mental Health Services	0.90		0.18	0.18	
Community Education	0.40		0.07	0.07	
Children of Parents with a Mental Illness	0.30		0.05	0.05	
Workplace Mental Health Promotion	0.70				a
Early Recovery Support	1.00		0.18	0.18	
Total Action Area 1	***3.30***		***0.48***	***0.48***	
Action Area 2: Integrating and Improving the Care System					
Improving the General Health of People with a Mental Illness	0.80		0.13	0.13	
Increase Capacity for Carer and Consumer Participation in Service Planning	0.40		0.07	0.07	
Mental Health Legislation Review	0.20		0.06	0.06	
Mental Health Services Plan	0.08	3.49	0.06	0.06	b
Intensive Treatment and Support Programme for People with a Dual Disability	10.00		2.02	2.02	
Total Action Area 2	***11.48***	***3.49***	***2.34***	***2.34***	
Action Area 3: Participation in the Community and Employment, including Accommodation					c
Youth Supported Accommodation	2.80	1.04			c
Adult 'Step-up Step-down' Supported Accommodation and Outreach		3.97			d
Total Action Area 3	***2.80***	***5.01***			
Action Area 4: Increasing Workforce Capacity					e
Additional Medical Workforce Positions	3.10		0.62	0.62	
Mental Health Community Sector Quality improvement and sector development		0.56			
Additional mental health clinical positions and enhanced training		3.80			
Total Action Area 4	***3.10***	***4.36***	***0.62***	***0.62***	
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***20.68***	***12.86***	***3.44***	***3.44***	

***Notes to ACT government table*:**

a. The tender and contract negotiations for Workplace Mental Health Promotion Development initiative will be finalised in August 2007.

b. The 2007-08 ACT Budget committed additional funds to the ACT Mental Health Service Plan.

c. The tender and contract negotiations for the Youth Supported Accommodation initiative concluded in May 2007. The 2007-08 ACT Budget committed additional funds to the Youth Supported Accommodation.

d. The Budget committed new funds for the Adult Step-up - Step-down Supported Accommodation and Outreach initiative.

e. The 2007-08 ACT Budget committed funds to the mental health clinical workforce initiative including mental health clinicians in the Public Hospital Emergency Departments. The Budget also funded a new initiative for the NGO mental health sector to develop quality improvement frameworks through the NGO local mental health peak body.

Northern Territory

	$MILLIONS				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Cumulative funding allocations from July 2006**	**Note**
Action Area 1: Promotion, Prevention and Early Intervention					
Suicide Prevention and early intervention	1.00	0.27	0.47	0.47	
Total Action Area 1	***1.00***	***0.27***	***0.47***	***0.47***	
Action Area 2: Integrating and Improving the Care System					
Sub-acute Beds	5.50		0.75	0.75	
Rural and Remote Services	4.00		0.80	0.80	
Prison In-reach Services	3.50		0.45	0.45	
Total Action Area 2	***13.00***	***0.00***	***2.00***	***2.00***	
Action Area 3: Participation in the Community and Employment, including Accommodation					
Rehabilitation and Recovery Services	0.50	0.29	0.39	0.39	
Total Action Area 3	***0.50***	***0.29***	***0.39***	***0.39***	
Action Area 4: Increasing Workforce Capacity					a
Total Action Area 4					
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Total Other initiatives relevant to Action Plan					
Total funding commitments/allocations	***14.50***	***0.56***	***2.86***	***2.86***	

***Notes to Northern Territory government table*:**

a. The Northern Territory has previous funding commitments to enhancing mental health workforce capacity which are currently not explicitly mapped against this Action Area, but which aim to develop relevant capability.

APPENDIX 2
Technical Notes

This section of the report presents explanatory notes for the indicators and statistics presented in Chapter 3 of the report.

Indicator 1 – Prevalence of mental illness in the community

Prevalence estimates for people aged 18 years and over are based on the 1997 National Survey of Mental Health and Wellbeing, as published by the Australian Bureau of Statistics. Estimates for children and young people in the age range 4-17 years are based on a parallel survey of children and adolescents, conducted by the University of Adelaide.

It is important to note that the 'all population' prevalence estimate of 17.7% is based on the more common ('high prevalence') disorders that are found in the population, primarily anxiety, depression and alcohol/drug related disorders. These disorders are amenable to accurate enumeration in large-scale population surveys that use lay interviewers. The estimates do not include a range of less prevalent conditions, such as schizophrenia and other psychotic illnesses, eating disorders, personality disorders and a number of other conditions. Collectively, these add an additional 2-3% to the total number of Australians affected by mental disorders. When these are added to the group of people affected by the more common disorders, it is estimated that 20-22% of the total Australian adult population are affected by one or more mental disorders in any given year.

Splits by severity levels are based on population planning norms published by New South Wales. New South Wales estimates are derived from extensive definitional work and epidemiological studies completed in the United States, and incorporate data gathered in the Australian National Survey of Mental Health and Wellbeing (1997).

Sources:

Australian Bureau of Statistics (1998), *Mental Health and Wellbeing: Profile of Adults, Australia 1997*, ABS Cat. No. 4326.0. Commonwealth of Australia, Canberra.

Centre for Mental Health, Department of Health New South Wales (2001) *Mental Health Clinical Care and Prevention Model: A Population Mental Health Model*

Sawyer M, Arney F, Baghurst P et al. (2000) *The Mental Health of Young People in Australia*. Commonwealth of Australia, Canberra

Indicator 2 – Rate of suicide in the community

Source used for all data presented under this indicator:
Australian Bureau of Statistics (2007), *Suicides Australia 2005*. ABS Cat. No. 3309.0. Canberra, Australian Bureau of Statistics.

Indicator 3 – Rates of use of illicit drugs that contribute to mental illness in young people
Indicator 4 – Rates of substance abuse

Sources:

National Drug and Alcohol Research Centre (2007), *Illicit drug use in Australia: Epidemiology, use patterns and associated harm*. Second edition. NDARC.

Australian Institute of Health and Welfare (2007), *Statistics on drug use in Australia 2006*. Drug Statistics Series No. 18. Cat. No. PHE 80. Canberra: AIHW.

White, V and Hayman, J (2006) *Australian Secondary School students' use of over-the-counter and illicit substances in 2005*. National Drug Strategy Monograph Series No 60, Cancer Council, Victoria.

Alcohol risk definitions are sourced from the National Health and Medical Research Council *Australian Alcohol Guidelines 2001*, and are defined as follows:

Long-term risk:
For males, the consumption of up to 28 standard drinks per week is considered 'low risk', 29 to 42 per week 'risky', and 43 or more per week 'high risk'. For females, the consumption of up to 14 standard drinks per week is considered 'low risk', 15 to 28 per week 'risky' and 29 or more per week 'high risk'.

Short-term risk:
Short term risk is the consumption of 7 or more standard drinks for men, or 5 or more standard drinks for women, on any one drinking occasion.

Indicator 5 – Percentage of people with a mental illness who receive mental health care

Estimates of health services used by adults with a mental disorder (Figure 16) are based on the 1997 National Survey of Mental Health and Wellbeing, as published by the Australian Bureau of Statistics.

Source:

Australian Bureau of Statistics (1998), *Mental Health and Wellbeing: Profile of Adults, Australia 1997*, ABS Cat. No. 4326.0. Commonwealth of Australia, Canberra.

Data prepared by jurisdictions used for Table 7 are presented below.

Table 11: Number of people receiving clinical mental health care, 2006-07[a,b]

	State Community Mental Health Services [c, d]	Private hospitals [e]	Medicare-funded mental health services [f]				
			Private Psychiatrists [g]	General Practitioners [h]	Clinical Psychologists [i]	Allied Health [j]	All MBS funded services [k]
New South Wales	107,968	5,300	89,951	140,496	14,974	40,608	222,561
Victoria	58,316	4,620	77,853	114,965	12,723	40,890	185,998
Queensland	72,586	4,020	49,756	69,113	4,754	25,309	115,369
Western Australia	37,607	n.a	20,952	33,478	8,372	5,099	52,871
South Australia	27,062	n.a	24,662	25,628	2,833	6,108	48,519
Tasmania	4,413	n.a	4,779	8,434	1,417	2,676	12,798
ACT	6,037	n.a	3,488	5,353	704	1,611	8,514
Northern Territory	4,767	n.a	753	1,584	118	320	2,261
Australia [l]	318,756	17,720	272,194	399,051	45,895	122,621	648,891

Notes to Table 11:

a. Estimates are based on unique counts of individuals receiving care within the year, within each service stream, where each individual is only counted once regardless of the number of services received. The columns cannot be added to give a total count across jurisdictions because people may be seen by more than one service stream. For example, it is estimated that up to 95% of people treated in private hospital psychiatric units are also treated by Medicare-funded private psychiatrists. Additionally, all people seen by clinical psychologists and allied health providers are included in the counts of persons seen by GPs, because referral by a GP is necessary for these services to be

accepted by Medicare Australia for billing purposes. Options for developing non-duplicated estimates of the number of people receiving mental health care across all service streams will be explored for future years.

b. All estimates are preliminary only. The strict timelines required for Action Plan progress reporting dictated that data submitted by jurisdictions was likely to be in advance of final end-of-year reconciliations, with the possibility that some service utilisation data may not be included. Adjustments to historical data will be made in subsequent progress reports when more complete data are available.

c. Person counts for state and territory mental health services are confined to those receiving one or more contacts provided by ambulatory mental health services. This approach was adopted to improve consistency across the service streams (particularly for comparison of state and territory services and Australian Government-funded Medicare mental health services) as well as picking up most people seen in state and territory inpatient services. All service contacts are counted in defining whether a person receives a service, including those delivered 'on behalf' of the consumer i.e. where the consumer does not directly participate. This approach was taken to ensure that the role of state and territory mental health services, in providing back up as tertiary specialist services to other health providers, is recognised.

d. State and territory jurisdictions differ in their capacity to provide accurate estimates of persons receiving services due to the lack of unique patient identifiers, or data matching systems, in some jurisdictions. New South Wales, Tasmania and South Australia indicated that the data submitted was not based on unique patient identifier or data matching approaches. Additionally, jurisdictions differ in their approaches to counting clients under care.

e. Private hospital estimates are unique counts of individuals receiving specialist psychiatric care within the private hospital service stream, using information submitted to the Private Mental Health Alliance's Centralised Data Management Service by private hospitals with psychiatric beds. Services provided to patients with psychiatric diagnoses by other private hospitals (i.e. those without designated psychiatric beds) are not included. Data for jurisdictions marked by an asterisk have been suppressed for confidentiality purposes.

f. All Medicare funded data are based on year of processing, as provided by the Australian Government Department of Health and Ageing and billing data maintained by Medicare Australia. A significant component of the data includes services provided under the Australian Government *Better Access to Mental Health Care* initiative, which commenced on 1 November 2006. MBS estimates, therefore, are part-year only for these services.

g. Private psychiatrist data represents a unique count of people seen who received one or more consultant psychiatrist attendance items billed to Medicare Australia.

h. General practitioner data represents a unique count of people who received one or more general practitioner attendance items, billed to Medicare Australia, that are mental health specific. These include items under the *Better Mental Health Outcomes* initiative, new items under the *Better Access to Mental Health Care* initiative (available 1 November 2006 onwards) and a small number of other mental health related items (Family Group Therapy). A small proportion of this latter group may also be provided

by other medical practitioners. The count does not include people receiving GP-based mental health care that was billed as a general consultation.

i. Clinical psychologist data represents a unique count of people who received one or more clinical psychologist attendance items, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. These commenced in 1 November 2006.

j. Allied health data represents a unique count of people who received one or more attendance items provided by registered psychologists, social workers or occupational therapists, billed to Medicare Australia, as introduced under the *Better Access to Mental Health Care* initiative. The person count also includes a small number of services provided by allied health professionals provided under the *Enhanced Primary Care Strategy*.

k. 'All MBS funded services' provides a unique count of persons receiving one or more services provided under any of the Medicare-funded service streams described at (g) to (j). Persons seen by more than one provider stream are counted only once.

l. Population rates presented as percentages in Table 10 are calculated using ABS estimates of state and territory populations at December 2006, based on the 2006 census.

Indicator 6 – Mental health outcomes of people who receive treatment from state and territory services and the private hospital system

Estimates of the proportion of state and territory services that have introduced routine outcome measurement are as provided by the Department of Health and Ageing. Estimates of private hospital coverage are based on information provided by the Private Mental Health Alliance, using information submitted to the Centralised Data Management Service by private hospitals with psychiatric beds.

Indicator 7 – Rates of community follow up for people within the first seven days of discharge from hospital

Estimates shown for Indicator 7 (see Figure 18, page 21) are based on source data submitted by jurisdictions, as shown below.

Total number of admitted patient overnight separations from the state/territory psychiatric inpatient services occurring within the reference period		
	2005-06	**2006-07**
NSW	25,823	20,590
Vic	15,664	12,347
Qld	14,805	9,802
WA	7,204	5,062
SA	5,352	4,189
Tas	n.a.	1,733
ACT	1,050	719
NT	799	535

Total number of admitted patient overnight separations for which a community mental health contact was recorded in the seven days immediately following separation		
	2005-06	**2006-07**
NSW	11,104	9,060
Vic	9,256	7,285
Qld	6,777	4,962
WA	3,885	2,800
SA	1,611	1,549
Tas	n.a.	218
ACT	761	527
NT	307	190

Notes to Indicator 7:

a. Based on all 'in scope' separations from state and territory psychiatric inpatient units, defined as those for which it is meaningful to examine community follow-up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge – type change; left against medical advice/discharge at own risk and death

b. Data for 2005-06 reflect full year activity but for 2006-07, the data are based only on the first 9 months of the year (because full year data were not be available within the reporting timeframe).

c. Community mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated. These may be face-to-face or 'indirect' (e.g., by telephone), but not contacts delivered 'on behalf of the client' in which they did not participate (Exception: Northern Territory data includes all contacts, but advised that the impact on the indicator is believed to be marginal). Contacts made on the day of discharge are also excluded.

d. Only community mental health contacts made by state and territory public mental health services are included. Where responsibility for clinical follow-up is managed outside the state/territory mental health system (e.g., by private psychiatrists, general practitioners), these contacts are not included.

e. States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers or data matching systems. Three jurisdictions – New South Wales,

Tasmania and South Australia - indicated that the data submitted was not based on unique patient identifier or data matching approaches. This factor can contribute to an appearance of lower follow-up rates for these jurisdictions.

Indicator 8 – Readmissions to hospital within 28 days of discharge

Estimates for Indicator 8 (see Figure 19, page 22) are based on source data submitted by jurisdictions, as shown below.

Total number of admitted patient overnight separations from the state/territory psychiatric inpatient services occurring within the reference period

	2005-06	2006-07
NSW	25,823	20,590
Vic	15,664	12,347
Qld	14,805	9,802
WA	7,204	5,062
SA	5,352	4,189
Tas	2,381	1,733
ACT	1,050	719
NT	799	535

Total number of admitted patient overnight separations that were followed by a readmission to a state/territory psychiatric inpatient service within 28 days of discharge

	2005-06	2006-07
NSW	2,003	1,579
Vic	2,011	1,633
Qld	3,030	1,634
WA	882	564
SA	629	480
Tas	276	191
ACT	183	115
NT	134	79

Notes to Indicator 8:

a. Based on all 'in scope' separations from state and territory psychiatric inpatient units, defined as those for which it is meaningful to examine readmission rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge – type change; left against medical advice/discharge at own risk and death.

b. Data for 2005-06 reflect full year activity but for 2006-07, the data are based only on the first 9 months of the year (because full year data were not be available within the reporting timeframe).

c. For the purposes of this indicator, a readmission for any of the separations identified as 'in-scope' is defined as an admission to any another public psychiatric unit within the jurisdiction that occurs within 28 days of the date of the original separation.

d. No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.

e. As for Indicator 7, data for this indicator is collected by all states and territories but varies depending on whether the jurisdiction has a system of state-wide unique client identifiers in place, or equivalent data matching systems. Those jurisdictions with

state-wide unique client identifiers or data matching systems have the capacity to track whether a person is readmitted to any hospital in the jurisdiction. Other jurisdictions can only monitor whether a readmission occurs back to the same hospital from which the person was discharged. Different readmission rates will be obtained depending on the method used, reducing the validity of comparison between jurisdictions.

f. Three jurisdictions – New South Wales, Tasmania and South Australia - indicated that the data submitted was not based on unique patient identifier or data matching approaches. This factor can contribute to the appearance of lower readmission rates for these jurisdictions

Indicator 9 – Participation rates by people with mental illness of working age in employment

Estimates of the annual losses to national productivity caused by untreated mental illness are based on unpublished data collected by Whiteford, Hilton and colleagues in the WORC study (Work Outcomes Research and Cost-Benefit). Funded by the Australian Government, this study is being conducted by the University of Queensland in collaboration with Harvard University.

Estimates of workforce participation rates for people with mental disorders (Table 8) are based on analysis conducted by Waghorn and colleagues at the Queensland Centre for Mental Health Research, using information collected in the Australian Bureau of Statistics 2003 Survey of Disability, Ageing and Carers (SDAC). The working age population is defined as those between 15 and 64 years.

The term 'not in labour force' is as defined in the Australian Bureau of Statistics' Labour Force Statistics publications and refers to persons who are were not in the categories 'employed' or 'unemployed' as defined by the ABS.
Recent analysis published by the Productivity Commission, based on the Household, Income and Labour Dynamics in Australia (HILDA) survey corroborate Waghorn and colleagues analyses and suggest that, of those with a mental disorder, only 39% participate in the labour force (cf Waghorn et al – 44%, based on SDAC).

Data on the number of people on Disability Support Pensions (DSP) in 2006-07 is as provided by the Department of Employment and Workplace Relations (DEWR). The number of DSP recipients represents a point in time count of current and suspended Disability Support Pension customers who have identified themselves as having psychological/psychiatric disability as the primary condition. DEWR advised that estimates based on DSP recipients 'primary condition' need to be interpreted cautiously. These clients may have multiple disabilities, including psychological/psychiatric disability.

Estimates of the number of working age Australians with mental disorders who are not in the labour force are based on analysis by the Australian Government Department of Health and Ageing, using prevalence statistics presented in Indicator 1.

Estimates of the prevalence of mental disorders in income support recipients are based on published studies by Butterworth that analysed data collected in the 1997 National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics.

Sources:

Butterworth P (2003) *Estimating the prevalence of mental disorders among income support recipients: Approach, validity and findings*. Department of Family and Community Services Policy Research Paper No. 21, Commonwealth of Australia, Canberra.

Hilton M, Sheridan J, Cleary C, Morgan A, Whiteford H. (2007) The concealed burden of mental health. *Australian & New Zealand Journal of Psychiatry,* 41 [Supplement 1], A32.

Laplagne P, Glover M, Shomos A. (2007) *Effects of health and education on labour force participation.* Staff Working Paper, Productivity Commission, Melbourne.

Waghorn G, Chant D, White P, Whiteford H. (2004) Delineating disability, labour force participation and employment restrictions among persons with psychosis. *Acta Psychiatrica Scandanavica,* 109, 279-288.

Waghorn G, Chant D, White P, Whiteford H. (2005) Disability, employment and work performance among people with ICD-10 anxiety disorders. *Australian & New Zealand Journal of Psychiatry,* 39:55-66.

Indicator 10 – Participation rates by young people aged 16-30 with mental illness in education and employment

Estimates of workforce and education participation rates for people aged 15 to 29 years are based on analysis conducted by Waghorn and colleagues at the Queensland Centre for Mental Health Research, using information collected in the Australian Bureau of Statistics 2003 Survey of Disability, Ageing and Carers (SDAC).

Indicator 11 – Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities

Source:

Mullen P E, Holmquist C L, Ogloff J R P. (2004) *National Forensic Mental Health Scoping Study*. Canberra: Department of Health and Ageing.

Indicator 12 – Prevalence of mental illness among homeless populations

a. Information presented for this indicator is based on analysis of the SAAP National Minimum Data Set 2005-06, conducted by the Australian Institute of Health and Welfare.

b. Quantifying the extent to which people with a mental health problems or problematic substance use issue appear in the SAAP population can be difficult, as there is no single data item that allows easy identification of clients who have these issues. The SAAP client population is divided into four main client groups, defined as follows:

   - Mental health: Clients who were referred from a psychiatric unit; reported psychiatric illness and/or mental health issues as reasons for seeking assistance; were in a psychiatric institution before or after receiving assistance and/or needed, were provided with or were referred on for support in the form of psychological or psychiatric services.

- Substance use: Clients who reported problematic drug, alcohol and/or substance use as a reason for seeking assistance and/or needed, were provided with or were referred on for support in the form of drug and/or alcohol support or intervention
- Comorbidity: Clients who reported at least one of the mental health characteristics and at least one of the substance use characteristics listed above in the same support period.
- Other: Clients who met none of the criteria used above.

c. For the data presented in Table 10:

- Due to errors and omissions in reporting of 'age', the sum of the age groups is less than the totals for both males and females (Number excluded due to errors and omissions in sex and age (weighted) = 3,063)
- Client groups are not mutually exclusive. A client can have more than one support period in a year and their circumstances might vary between support periods. In addition, a client can report mental health, substance use and comorbidity criteria within the same period of support. Consequently, the number of clients in the 'substance use', 'mental health', 'comorbidity' and 'neither' groups will not sum to the total number of clients
- Figures have been weighted to adjust for agency non-participation and client non-consent.