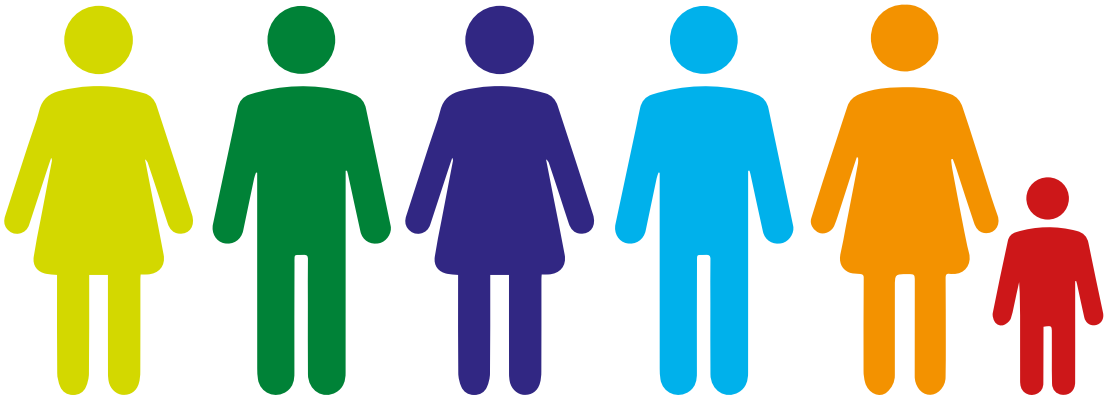
Monitoring mental health and suicide prevention reform

Fifth National Mental Health *and* Suicide Prevention Plan 2020

Progress Report 3



Australian Government
National Mental Health Commission

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- the Australian Institute of Health and Welfare, and the Australian Bureau of Statistics, for providing data to report against the performance indicators.

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Foreword

For many years, people with lived and living experience of mental ill-health, and those who care for them, have been calling for a national and coordinated approach to Australia's mental health and suicide prevention systems.

The *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) committed governments to working together to achieve integration in the planning and delivery of mental health and suicide prevention services. As such, it was an important moment in the nation's mental health and suicide prevention response and laid the groundwork for the tangible systemic reform we are now seeing manifest more clearly.

The mental health sector has undergone significant change in the 3 years since the Fifth Plan was endorsed. In that time we have had the Productivity Commission inquiry into the social and economic benefits of improving mental health, the Royal Commission into Victoria's Mental Health System, the Royal Commission into Aged Care Quality and Safety, the National Suicide Prevention Advisor's advice to the Prime Minister, and the announcement of a National Suicide Prevention Office. There have been catastrophic bushfires, droughts, floods and the start of the COVID-19 pandemic, all of which have negatively affected the mental health of Australians and required rapid policy and program responses from governments.

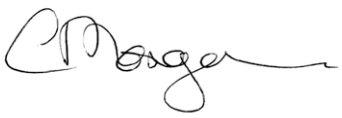
It is good news that, despite the challenging circumstances of 2019–20, 47 of the 66 identified actions and sub-actions within the Fifth Plan were either achieved or were on track. Of the 22 marked as completed, 15 were new additions in 2020.

The Commission commends all governments for their continued focus and commitment to improving the mental health and wellbeing of Australians. However, it is clear that more work is needed across the whole system as well as at the individual, family and community levels to achieve the aims of the Fifth Plan.

In this report, we reviewed the mental health system's performance for 3 significant cohorts: Australians under 25, Australians over 65 and Aboriginal and Torres Strait Islander peoples. The Commission is pleased to report that the use of community mental health care within 7 days of discharge from hospital has increased for all 3 groups and that seclusion rates continue to decline. These are important markers of the improved performance of the mental health system.

Our analysis also shows that the general wellbeing of our youth and older people does not appear to be improving. Similarly, it shows that while access to mental health services has improved for Aboriginal and Torres Strait Islander peoples, their rates of poor wellbeing, and the social determinants that effect these rates, remain mostly unchanged.

The Commission is looking forward to continuing to work with all governments, the mental health and suicide prevention sector and people with lived experience and their carers, to ensure that all Australians receive the benefits of integrated regional planning and service delivery, systems-based suicide prevention, coordinated treatment and supports, reduced stigma and discrimination and a safe, high quality, effective mental health system.



Christine Morgan
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Chair,
National Mental Health Commission

Executive summary

The *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) identifies 8 priority areas and 32 actions designed to improve the transparency, accountability, efficiency and effectiveness of Australia's mental health system. The Fifth Plan also outlines how all governments will work together to integrate mental health care, physical health care and suicide prevention services in Australia. Ultimately, the Fifth Plan aims to improve the lives of people living with a mental illness and the lives of their families, carers and communities.

Reporting on the progress of mental health reform is essential to determine whether the commitments in the Fifth Plan are being met and are making a difference. The National Mental Health Commission (the Commission) has been given responsibility for delivering an annual report on the Fifth Plan's implementation progress and performance against the identified indicators.

This report outlines the progress achieved against the Fifth Plan as at 30 June 2020 and presents the available performance indicators. Citations to the sources of all indicator data used in this report can be found in the accompanying Fifth Plan Performance Indicators Excel workbook.

Implementation progress

Of the 66 actions and sub-actions outlined in the Implementation Plan, 22 were reported as 'completed', including 15 that were reported as completed for the first time this year. A further 25 actions or sub-actions were reported as 'commenced – on track', 7 actions were reported as 'commenced – not on track', and 9 actions were reported as 'yet to commence'. A single rating cannot be reported for Actions 14 and 27, as these actions are being implemented separately by each jurisdiction. One additional action is not scheduled to start until late 2021. A detailed report of the status of implementation progress as at 30 June 2020 can be found at Appendix A.

The 2019–20 implementation and reporting period saw several unexpected and challenging events such as the bushfires, drought, floods and the COVID-19 pandemic. Governments have needed to respond quickly to the physical and mental health impacts and target resources to supporting the wellbeing of their communities during these times. Despite the challenges of 2019–20, progress was made in implementing the Fifth Plan during this period, and the following actions were rated as completed for the first time:

- Publication of the Third National Mental Health Information Priorities (Actions vii and 24).
- Development and release of detailed guidance material to support PHN and LHN regional planning (Actions 1.2, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 16.1, and 16.2).
- Provision of key national data to inform regional level understanding of service gaps, duplication and areas of highest need (Action 1.5).
- Establishment of the Suicide Prevention Project Reference Group to set future directions for planning and investment (Action 3).
- Development of strategies to monitor and report on the accuracy in identifying Aboriginal and Torres Strait Islander peoples within key national mental health data collections (Action 13.2).

Although the implementation of some actions was delayed, the Commission is heartened to see that the majority of Fifth Plan actions are either completed or were progressing on schedule as at 30 June 2020. The genuine commitment of all governments to improving Australia's mental health system is evident in the progress of these reforms under the difficult circumstances of 2019–20.

We know from the Commission's 2020 Consumer and Carer Survey that there is much work to do as many of the Fifth Plan's intended outcomes for consumers and carers are still to be achieved. As such, governments must ensure that all Fifth Plan actions that were not completed at 30 June 2020 continue to be progressed, to ensure the intent of the Fifth Plan is realised.

Executive summary *continued*

Performance against identified indicators

The Fifth Plan performance indicators are designed to collectively provide a picture of the health and wellbeing of Australians and how Australia's mental health system is performing.

The Fifth Plan recognises that health, wellbeing, and experiences of the mental health system vary between population groups. Where possible, the performance indicators include data at both the national level and for different age groups, genders, and for Aboriginal and Torres Strait Islander people.

In the 2019 Progress Report, the Commission presented a national analysis of the health and wellbeing of Australians and the performance of the mental health system. The data that has been released since the 2019 Progress Report does not show any significant changes in health, wellbeing or system performance trends at the national level. As a result, in the current report the Commission has chosen to focus on the health and wellbeing and system performance for 3 particular populations: young Australians (aged under 25), older Australians (aged 65 and over), and Aboriginal and Torres Strait Islander Australians.

Young Australians (aged under 25)

Nationally, some aspects of the mental health system's performance are consistently improving for young people. We have seen improvements in both *seclusion rates* and *community mental health care use within 7 days of hospital discharge*.

However, improvements have not been seen in the proportion of *mental health-related hospitalisations that are followed by rapid readmission,* and fewer people are experiencing significant improvement in their *clinical symptoms* after completing ambulatory care or admitted care. While this change is small, its direction is relatively concerning.

At the national level, some aspects of the health and wellbeing of young Australians have not improved in the last decade, and some are experiencing small, sustained deterioration. We have not seen improvement in:

- the proportion of *developmentally vulnerable children*
- the proportion of people aged 18–24 with *very high levels of psychological distress*
- the proportion of people aged 18–24 with mental illness who *smoked tobacco daily*
- the proportion of youth with a mental illness who *consumed 4 or more standard drinks on a single occasion at least once in the past year*
- the proportion of youth with a mental illness who *used illicit drugs in the previous 12 months*
- the *suicide rate* for people aged 0–14.

There has been an increase in the *suicide rate* for people aged 15–19 (from 8.0 in 2010 to 11.5 suicides per 100,000 population in 2019) and people aged 20–24 (from 11.8 in 2010 to 16.4 suicides per 100,000 population in 2019).

Although there are not enough years of data available to comment on a trend over time, there are disparities between young people with and without mental illness in *long-term physical health conditions, participation in employment, education and training,* and *experience of discrimination*.

Older Australians (aged 65 years and over)

The *seclusion rate* and *the rate of community mental health care following hospital discharge* have improved for older Australians.

Completing inpatient mental health care is associated with improved *clinical symptoms* for almost three-quarters of older Australians (72.6% in 2018–19). However, the effectiveness of the mental health system, as measured by *change in consumers' clinical symptoms following mental health care,* has not consistently improved in the past 10 years. Ambulatory mental health care resulted in significant improvement in *clinical symptoms* for less than half of older people over this time (ranging from 45.2% to 49.7%).

Most performance indicators with data available for people aged 65 years and over show little or no change over time or are unable to identify trends. However, the data cannot tell us whether the lack of change is because mental health reform efforts are having minimal impact for older Australians, or whether a different or expanded set of performance indicators are needed to demonstrate a meaningful change in the mental health of older Australians.

Executive summary *continued*

Aboriginal and Torres Strait Islander peoples

Nationally, the *use of community mental health care following hospital discharge* has improved among Aboriginal and Torres Strait Islander peoples. Reduced *rates of daily smoking* also suggest improving physical health.

However, *suicide rates* have increased in the last decade, and several areas of health and wellbeing have not improved, including:

- the proportion of *children who are developmentally vulnerable*
- the rate of *alcohol consumption*
- the rate of *illicit drug use*
- the proportion of adults with *very high levels of psychological distress*.

Population access to clinical mental health care and the proportion of *mental health-related hospitalisations that are followed by rapid readmission* have not improved.

Conclusion

The data available during the life of the Fifth Plan shows improvement in a number of important areas of mental health system performance, both at the whole of population level and for young people, older people and Aboriginal and Torres Strait Islander peoples specifically. However, the number of indicators of system performance, health and wellbeing that have not improved is a concern. Future reforms must continue to focus on reducing psychological distress, alcohol and other drug use, and childhood vulnerability, as well as eliminating the disparity in wellbeing and community participation between people with and without mental illness.

Introduction

The *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) was endorsed by the Council of Australian Governments (COAG) Health Council in August 2017. Responsibility for implementing the Fifth Plan was assigned to the Australian Health Ministers' Advisory Council (AHMAC), the Mental Health Principal Committee (MHPC) and its subordinate committees, with the intent that implementation would finish in 2022.

This report is comprised of 2 sections. The first outlines the most recent data available for each of the Fifth Plan performance indicators. The second outlines the progress achieved against the Fifth Plan actions as at 30 June 2020.

Performance indicators are measures that concisely describe a system and guide continuous improvement efforts. The Fifth Plan identifies a set of 24 performance indicators designed to collectively measure the health and wellbeing of Australians and the performance of the mental health system for the life of the Fifth Plan and beyond. With this long-term monitoring in mind, the performance indicators include broad measures of the health status of the population and measures of the process of mental health care, rather than measures that closely align with the priority areas or actions under the Fifth Plan. As such, it is not appropriate to use the indicators to analyse the effectiveness of the Fifth Plan in improving Australia's mental health system.

The performance indicator analysis presented in this report is best interpreted in conjunction with the accompanying Technical Report, which contains a detailed description of the scope and rationale for each of the available indicators. Additional data for each available indicator can be found on the Commission's website in an Excel workbook, along with citations to the sources of all indicator data used in this report.

The Fifth Plan includes 32 actions that governments have committed to implementing in order to achieve the aims of the Fifth Plan. To monitor whether these commitments are being honoured, the Commission conducts an annual survey of key stakeholders. The results of this survey are presented in this report. The accompanying Technical Report provides an overview of the development and administration of the implementation progress survey for the 2020 Progress Report.

Performance against the identified indicators

Of the 24 identified indicators, 18 indicators have data sources available and have had their calculation methodologies agreed at the Mental Health Strategy Standing Committee. These indicators are included in this report (Box 1). Information about the 6 indicators still undergoing development can be found in the accompanying Technical Report.

Box 1: Reported performance indicators, by area of monitoring

Reported performance indicators (PI)	
Monitoring health and wellbeing of Australians	**Monitoring performance of the mental health system**
PI 1: *Children who are developmentally vulnerable*	**PI 13:** *Mental health consumer experience of service*
PI 2: *Long-term health conditions in people with mental illness*	**PI 14:** *Change in mental health consumers' clinical outcomes*
PI 3: *Tobacco and other drug use in adolescents and adults with mental illness*	**PI 15:** *Population access to clinical mental health care*
PI 6: *Prevalence of mental illness*	**PI 16:** *Post-discharge community mental health care*
PI 7: *Adults with very high levels of psychological distress*	**PI 17:** *Mental health readmissions to hospital*
PI 9: *Social participation in adults with mental illness*	**PI 18:** *Mental health consumer and carer workers*
PI 10: *Adults with mental illness in employment, education or training*	**PI 22:** *Seclusion rate*
PI 11: *Adult carers of people with mental illness in employment*	**PI 23:** *Involuntary hospital treatment*
PI 19: *Suicide rate*	
PI 24: *Experience of discrimination in adults with mental illness*	

Where possible, the performance indicators include data at both the national level and for community groups or mental health services. This allows performance to be reported for different age groups, genders, and for Aboriginal and Torres Strait Islander peoples.

In the 2019 Progress Report, the Commission presented a national analysis of the health and wellbeing of Australians and the performance of the mental health system. The data that has been released since the 2019 Progress Report does not demonstrate any significant changes at the national level. As such, in this report the Commission has chosen to analyse the performance of the mental health system and the health and wellbeing of young Australians (aged under 25), older Australians (aged over 65) and Aboriginal and Torres Strait Islander peoples.

Limitations of performance indicators

The data for each indicator varies in the number of years of data available and the time period it covers. Some data sources are annually collected administrative data and have more years of data available, while others are national surveys that are collected less frequently, resulting in fewer years of data being available. Some data sources do not currently have enough years of data available to show trends over time, and most do not have data that covers the 2019–20 reporting period. The data included in the report is the most recent data available for each indicator as at 31 December 2020.

Due to limitations in the source data, some indicators cannot be reported on for some groups.

Where trend data is available, performance indicators can show whether there have been improvements in health, wellbeing or system performance. However, performance indicators cannot provide information on why a measure of health, wellbeing or system performance has or has not changed over time, or what is needed to achieve the desired changes.

Young Australians (aged under 25)

Is the health and wellbeing of young Australians improving?

Early life

As children who display poor early learning skills are likely to fall further behind their peers academically, early detection of, and intervention for, developmental vulnerabilities are important to children's longer-term outcomes. Nationally, the proportion of *children who were developmentally vulnerable* (PI 1) did not decrease between 2012 and 2018 (22.0% and 21.7% respectively).

Physical health

Numerous studies have highlighted that people living with a mental illness are more likely to die prematurely. Most of the causes of early death relate to physical illnesses such as cardiovascular disease, diabetes and cancer.[i] In 2017–18, the *presence of a long-term physical health condition* (PI 2) was more than twice as common in people aged 0–14 with a mental illness, than in people without a mental illness (21.6% and 10.5% respectively). Although there are not enough years of data available to identify trends over time, this pattern was present in both 2014–15 and 2017–18 (24.3% and 11.5% for people with and without mental illness respectively in 2014–15). People aged 15–24 with a mental illness were also more likely than people without mental illness to have a physical health condition in both years (32.3% and 21.7% respectively in 2014–15 and 32.4% and 17.2% respectively in 2017–18).

Use of both legal and illicit drugs contributes to poorer health outcomes and decreased life expectancy for people with mental illness in Australia. From 2013 to 2019, a higher proportion of people aged 18–24 with a mental illness *smoked tobacco daily,* compared to all Australians in this age group (24.0% and 13.4% respectively in 2013, 26.8% and 11.6% respectively in 2016 and 20.8% and 9.2% respectively in 2019; PI 3). Although there was a significant reduction in the proportion of all Australians with a mental illness who smoked daily between 2016 and 2019 (23.6% and 19.4% respectively), the proportion of people aged 18–24 with a mental illness who smoked daily was stable.

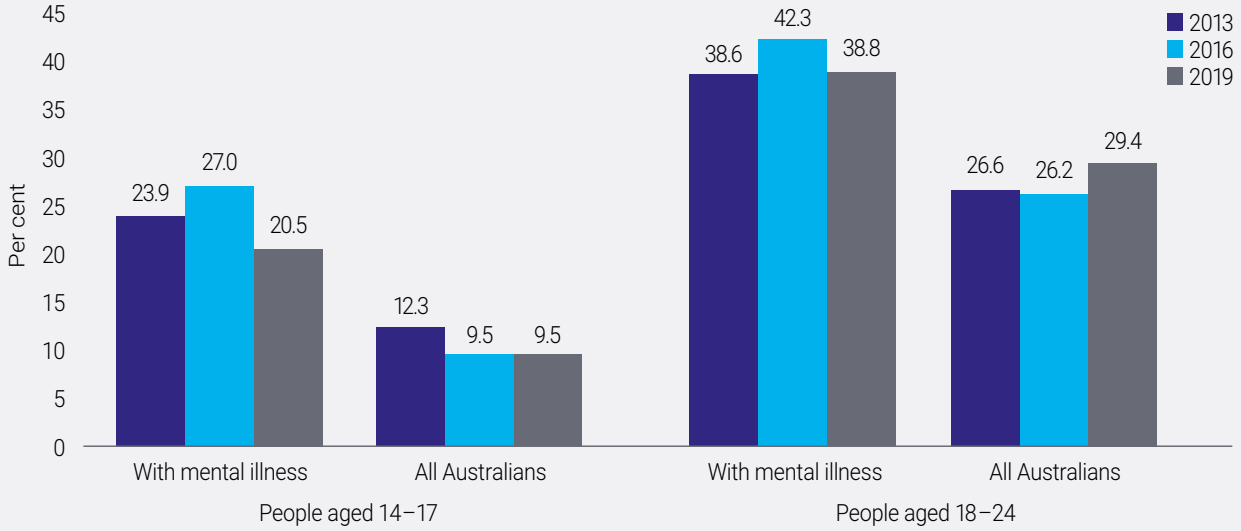
A higher proportion of people aged 14–17 with a mental illness *reported drinking alcohol in the previous 12 months,* compared to all Australians in this age group (50.8% and 30.2% in 2019; PI 3). This pattern was also seen in people aged 18–24 (87.5% of people with mental illness and 81.0% of all Australians in 2019).

Compared to all Australians aged 14–17, a higher proportion of youth with a mental illness *consumed 4 or more standard drinks on a single occasion at least once in the past year* (PI 3) in 2013 (19.5% and 32.8% respectively), 2016 (11.9% and 24.3% respectively) and 2019 (12.6% and 19.7% respectively). In 2016 and 2019, the proportion of people aged 18–24 with a mental illness who *misused pharmaceuticals in the previous 12 months* (PI 3) was almost double that of all Australians aged 18–24 (9.8% and 5.8% respectively in 2016, and 11.2% and 6.3% respectively in 2019).

Between 2013 and 2019 there was no reduction in the proportion of youth with a mental illness *who used illicit drugs in the previous 12 months* (PI 3). Over this time, the proportion of people aged 14–17 with a mental illness who *used illicit drugs in the previous 12 months* was around double that of all Australians in this age group (Figure 1). The proportion of people aged 14–17 and 18–24 with a mental illness who *used illicit drugs in the previous 12 months* was also higher than the proportion of all people with a mental illness, in 2013, 2016 and 2019.

i Council of Australian Governments Health Council. The Fifth National Mental Health and Suicide Prevention Plan. Canberra: COAG Health Council; 2017.

Figure 1: Illicit drug use in the previous 12 months for people with mental illness and all Australians, by age group, 2013, 2016 and 2019



Source: National Drug Strategy Household Survey.

Mental health and mental illness

Very high levels of psychological distress may signify a need for professional help. In both 2014–15 and 2017–18, a higher proportion of people aged 18–24 *experienced high and very high levels of psychological distress* (PI 7), compared to all Australians aged 18 years and over (15.4% and 11.7% respectively in 2014–15; 15.2% and 13.0% respectively in 2017–18).

Mental illness prevalence rates provide a high-level indication of the mental health of Australians. Currently, only a single year of in-scope data is available for the prevalence of mental illness performance indicator, so it will not be possible to comment on change until more data becomes available. The most recent information available from 2013–14 indicates that 13.9% of people aged 4–17 *experienced a mental illness* (PI 6).

While the *suicide rate* (PI 19) for people aged 0–14 remained stable from 2010 to 2019 (ranging from 0.3 to 0.5 per 100,000 population in this period), there was an increase in the *suicide rate* for people aged 15–19 (from 8.0 to 11.5 per 100,000 population) and for people aged 20–24 (from 11.8 to 16.4 per 100,000 population).

Contributing life

All governments are committed to ensuring a contributing life for people with mental illness. This includes an individual's ability to support their own livelihood and contribute to the greater community through employment. In both 2014–15 and 2017–18, a lower proportion of people aged 15–24 with a mental illness were *in employment, education or training* (PI 10) compared to people without a mental illness (82.5% and 93.3% respectively in 2014–15, and 84.6% and 94.0% respectively in 2017–18). In both years, people aged 15–24 with a mental illness were more likely to be *in employment, education or training* than any other age group of people with a mental illness.

For people with a mental illness, experiencing discrimination can increase feelings of isolation and create barriers to seeking help. The proportion of people aged 18–24 with a mental illness who *experienced discrimination* (PI 24) in 2014 was higher than for people without a mental illness (30.8% and 22.4% respectively), and similar to the proportion of all people with a mental illness who have *experienced discrimination* (28.3%).

Is the performance of the mental health system improving for young people?

Seclusion is the confinement of a consumer, at any time of the day or night, alone in a room or area from which free exit is prevented. High levels of seclusion are widely regarded as inappropriate treatment. They may point to inadequacies in the functioning of the overall system and risks to the safety of consumers receiving mental health care. The *rate of seclusion* in public acute child and adolescent mental health hospital services (PI 22) decreased from 17.0 seclusion events per 1,000 patient days in 2008–09, to 9.6 seclusion events per 1,000 patient days in 2019–20.

Involuntary care is a type of restrictive and coercive practice where treatment for mental illness is provided without the person's consent. To understand the amount of involuntary care occurring, the proportion of both hospital separations and patient days that are involuntary should be considered. In 2018–19, most public sector acute mental health separations with specialised mental health care, for people aged 18–24, were voluntary (42.9% involved involuntary care; PI 23a), and 60.2% of public sector acute mental health patient days with specialised mental health care were involuntary (PI 23b) for people aged 18–24. Currently there are not enough years of data available to identify trends over time.

State and territory clinical mental health services aim to reduce symptoms and improve functioning. Clinical mental health services are effective in improving *clinical symptoms* (PI 14) for the majority of consumers aged less than 18 (54.6% of people aged less than 18 experienced significant improvement following inpatient care in 2018–19, and 50.9% experienced significant improvement following ambulatory care). However, between 2007–08 and 2018–19, the proportion of consumers aged less than 18 years who experienced no significant change after completing inpatient care increased from 30.4% to 35.5%. The proportion who experienced significant deterioration increased from 6.5% to 9.9% over the same period. The proportion of consumers aged less than 18 who experienced significant deterioration after completing ambulatory care increased from 3.7% in 2007–08 to 6.4% in 2018–19.

Consumer experiences of care from mental health services are a measure of the performance of the service and are vital to inform ongoing quality improvement efforts. The Your Experience of Service (YES) survey is designed to gather information from consumers about their experiences of care. In New South Wales and Queensland the majority of mental health consumers aged less than 18 and 18–24 years *reported a positive experience* (PI 13) of admitted care in 2018–19 (68.3% and 71.0% respectively in New South Wales, and 82.0% and 55.7% respectively in Queensland). In Victoria, while the majority (59.8%) of people aged 18–24 *reported a positive experience* of admitted care, only 38.7% of people aged less than 18 did. YES survey data for other states and territories is not available.

Community mental health care following hospital discharge is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Nationally, the rate of *community mental health care following hospital discharge* (PI 16), for people aged less than 25, increased from 58.6% in 2012–13 to 71.9% in 2018–19.

Readmission to hospital within 28 days of discharge, also known as *rapid readmission,* may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. Nationally, the proportion of mental health-related hospitalisations for people aged less than 18 or 18–24 that were followed by *rapid readmission* (PI 17) was relatively stable from 2013–14 to 2018–19 (15.9% in 2013–14 and 17.4% in 2018–19 for people aged less than 18; 15.4% in 2013–14 and 15.9% in 2018–19 for people aged 18–24).

Conclusion

Nationally, some aspects of the mental health system's performance are consistently improving for young people, while others remain unchanged. We have seen improvements in:

- *seclusion rates*
- *community mental health care use following hospital discharge.*

Improvements have not been seen in the proportion of *mental health-related hospitalisations that are followed by rapid readmission*. Mental health system performance, as measured by *change in clinical symptoms* after completing ambulatory care or admitted care, has experienced a small, sustained deterioration.

At the national level, some aspects of the health and wellbeing of young Australians have not improved, and some are experiencing small, sustained deterioration. We have not seen improvement in:

- the proportion of *children who are developmentally vulnerable*
- the proportion of people aged 18–24 with *very high levels of psychological distress*
- the proportion of people aged 18–24 with mental illness who *smoked tobacco daily*
- the proportion of youth with a mental illness who *consumed 4 or more standard drinks on a single occasion at least once in the past year*
- the proportion of youth with a mental illness who *used illicit drugs in the previous 12 months*
- the *suicide rate* for people aged 0–14.

There was an increase in the suicide rate for people aged 15–19 and 20–24, from 8.0 in 2010 to 11.5 suicides per 100,000 population in 2019 for people aged 15–19 and 11.8 in 2010 to 16.4 suicides per 100,000 population in 2019 for people aged 20–24.

There are also disparities between young people with and without mental illness in *long-term physical health conditions, participation in employment, education and training,* and *experience of discrimination*. This suggests that more work is needed to support young people with a mental illness in these areas.

Older Australians
(aged 65 years and over)

Is the health and wellbeing of older Australians improving?

Physical health

The proportion of people aged 65–74 with both *a mental health condition and a physical health condition* (PI 2) was stable between 2014–15 and 2017–18 (89.7% and 89.4% respectively). Although the proportion of people aged 75 and over with both *a mental health condition and a physical health condition* (PI 2) appears higher in 2014–15 (95.3%) compared to 2017–18 (89.7%), the 2014–15 estimate has a high margin of error and the apparent difference was not statistically significant. While a higher proportion of older Australians with a mental illness had a physical health condition than older people without a mental illness (89.4% of people aged 65–74 with a mental illness in 2017–18, compared to 78.0% without a mental illness), the difference is smaller than in younger age groups.

People aged 65–74 with a mental illness *smoked daily* (PI 3) at higher rates than all Australians in that age group in 2013, 2016 and 2019 (12.5% and 9.7% respectively in 2013, 14.1% and 8.5% respectively in 2016, and 10.0% and 7.9% respectively in 2019). The rate of daily smokers was stable over that time for both groups.

The proportion of people aged 65–74 and 75 years and over with a mental illness, who *consumed 4 or more standard drinks on a single occasion at least once in the past year* (PI 3) was stable between 2013 and 2019 (19.4% in 2016 and 20.2% in 2019 for people aged 65–74; 9.2% in 2016 and 12.7% in 2019 for people aged 75 and over; the apparent difference for people aged 75 and over was not statistically significant). This rate was comparable to the rate for all Australians in those age groups (18.3% in 2016 and 19.3% in 2019 for people aged 65–74; 8.3% and 10.0% for people aged 75 and over), and was less than half the rate of all people with a mental illness (44.2% in both 2016 and 2019).

The rate of *misuse of pharmaceuticals* (PI 3) among people aged 65–74 years and 75 years and over was similar between people with a mental illness and all Australians in these age groups (6.9% in 2016 and 5.3% in 2019 for people aged 65–74 with a mental illness, compared to 4.2% and 3.8% respectively for all Australians; 8.8% in 2016 and 6.6% in 2019 for people aged 75 and over with a mental illness, compared to 5.6% and 4.0% respectively for all Australians), and stable between 2016 and 2019.

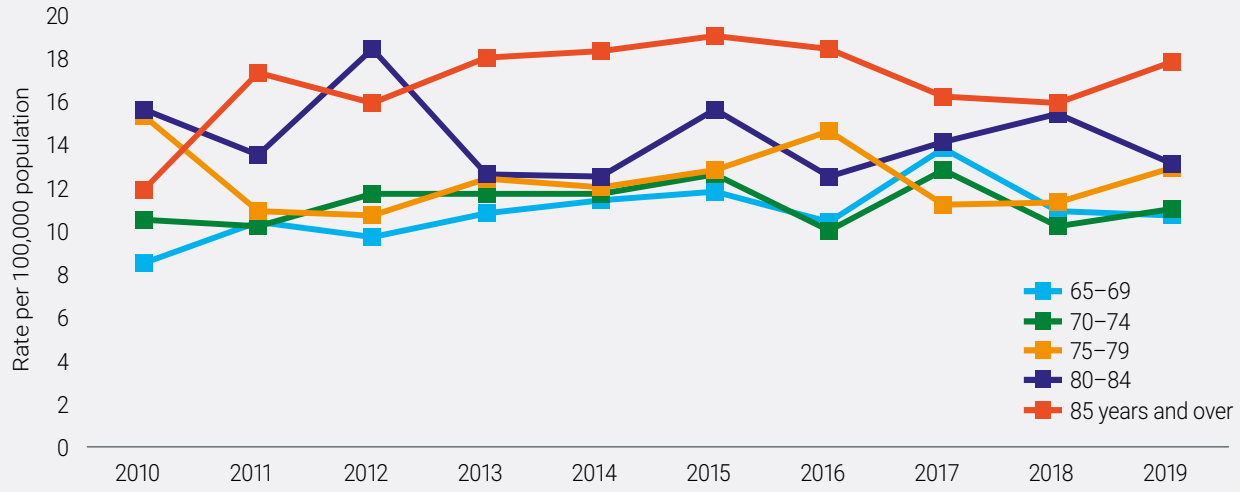
Mental health and mental illness

The proportion of people aged 65–74 and 75 years and over who experienced *high and very high levels of psychological distress* (PI 7) did not decline between 2014–15 and 2017–18 (10.1% in 2014–15 and 10.7% in 2017–18 for people aged 65–74; 9.7% and 8.8% respectively for people aged 75 and over). The rate of *high and very high levels of psychological distress* among older people was lower than the rate for all people aged 18 and over in both 2014–15 and 2017–18 (11.7% in 2014–15 and 13.0% in 2017–18, for all people aged over 18).

In 2007, 8.6% of people aged 65–74 and 5.9% of people aged 75–85 *experienced a mental illness* (PI 6). This compares to a mental illness prevalence of 20.0% for all Australians aged 16–85. Currently, only a single year of in-scope data is available for the prevalence of mental illness performance indicator, so it will not be possible to comment on change until more data becomes available.

The *suicide rates* (PI 19) for each of the 5-year age groups from 65–69 to 85 years and over fluctuated between 2010 and 2019 (Figure 2). None of these age groups have seen a sustained reduction in suicide rates in the past 10 years.

Figure 2: Suicide rates of older Australians, by age group, 2010 to 2019



Source: ABS Causes of Death, Australia, 2019.

Contributing life

While newer data is unavailable, figures from 2014 provide insight into the experience of older Australians with mental illness.

In 2014, similar proportions of people aged 65–74 with and without mental illness had *engaged in social participation in the past 12 months* (94.0% and 95.3% respectively; PI 9). However, a smaller proportion of people aged 75 years and over who had a mental illness *engaged in social participation,* compared to people without a mental illness (79.4% and 90.4% respectively). There are not enough years of data available to identify trends over time.

In 2014, the proportion of people aged 65–74 years, with a mental illness, who had *experienced discrimination* (PI 24) was almost double that of people without a mental illness (15.2% and 8.2% respectively). Older people both with and without mental illness reported experiencing discrimination at lower levels than younger people. Currently, there are not enough years of data available to identify trends over time.

Is the performance of the mental health system improving for older people?

Seclusion rates (PI 22) for public acute mental health hospital services targeted at older people showed a sustained reduction from 2008–09 to 2019–20 (4.0 seclusion events per 1,000 patient days and 0.2 seclusion events per 1,000 patient days respectively).

Of older Australians, people aged 65–69 had the highest rates of *involuntary care* in 2018–19. For this age group, 42.5% of public sector acute mental health separations with specialised mental health care included *involuntary care* (PI 23). In 2018–19, 51.1% of public sector acute mental health patient days with specialised mental health care were involuntary for people aged 65–69. Currently, there are not enough years of data available to identify trends over time.

Inpatient mental health services are effective in improving *clinical symptoms* (PI 14) for the majority of consumers aged 65 years and over (72.6% in 2018–19), but have not made progress in the past 10 years in reducing the proportion of consumers who experienced no significant change (24.7% of consumers in 2007–08 and 22.3% of consumers in 2018–19) or significant deterioration of *clinical symptoms* (7.0% of consumers in 2007–08 and 5.1% of consumers in 2018–19). Ambulatory mental health care is associated with significant improvement in *clinical symptoms* for less than half of people aged 65 years and over (48.4% in 2018–19). There has been no improvement in the past 10 years in the proportion of consumers aged 65 years and over who experienced either no significant change or significant deterioration following care in ambulatory mental health services.

In 2018–19, the majority of people aged 65 years and over in New South Wales, Victoria and Queensland *reported a positive experience* of both admitted and ambulatory mental health care (admitted care in New South Wales 76.3%, 91.7% in Victoria and 54.3% in Queensland; ambulatory care in New South Wales 88.2%, Victoria 73.3% and Queensland 89.2%; PI 13). Currently, there are not enough years of data available to identify trends over time.

Nationally, there was a significant increase in *community mental health care following hospital discharge* (PI 16) for older Australians, increasing from 61.3% in 2012–13 to 75.1% in 2017–18. The proportion of *mental health-related hospitalisations that are followed by rapid readmission* (PI 17) for people aged 65 years and over increased from 9.1% in 2013–14 to 11.9% in 2018–19.

Conclusion

The *seclusion rate* and the *rate of community mental health care following hospital discharge* have improved for older Australians.

Most performance indicators with data available for people aged 65 years and over show little or no change over time or are unable to identify trends. The effectiveness of the mental health system, as measured by change in consumers' clinical symptoms following mental health care, has not improved in the past 10 years. Ambulatory mental health care has remained effective for less than half of older people over this time.

Available data does not provide evidence that mental health reform efforts are creating change for older Australians. However, our conclusions about the impact of reform efforts are limited by the type, amount and quality of data currently collected to assess meaningful change. A different or expanded set of performance indicators could demonstrate meaningful change in the mental health of older Australians but this would require investigation beyond the Fifth Plan indicators.

Aboriginal and Torres Strait Islander peoples

Is the health and wellbeing of Aboriginal and Torres Strait Islander Australians improving?

Early life

The proportion of Aboriginal and Torres Strait Islander children who were *developmentally vulnerable* (PI 1) did not decrease between 2012 and 2018 (43.2% and 41.3% respectively). Over this time, the proportion of Aboriginal and Torres Strait Islander children who were *developmentally vulnerable* was consistently more than double that of non-Indigenous children (20.9% of non-Indigenous children in 2012 and 20.4% in 2019).

Physical health

In 2018–19, the *presence of a long-term physical health condition* (PI 2) was almost twice as common in Aboriginal and Torres Strait Islander peoples with a mental illness than in people without a mental illness (60.3% and 33.8% respectively). There are not enough years of data available to identify trends over time.

Between 2016 and 2019, there was a significant reduction in the proportion of Aboriginal and Torres Strait Islander peoples with a mental illness who *smoked daily* (Figure 3; PI 3). The rate of daily smoking for Aboriginal and Torres Strait Islander peoples with a mental illness became comparable to the rate of all Indigenous Australians in 2019.

Rates of alcohol consumption (PI 3) in Aboriginal and Torres Strait Islander peoples with a mental illness did not decline from 2013 to 2019. In 2013, 46.6% of Aboriginal and Torres Strait Islander peoples reported consuming 4 or more standard drinks on a single occasion at least once in the past year; 46.9% in 2016 and 44.2% in 2019.

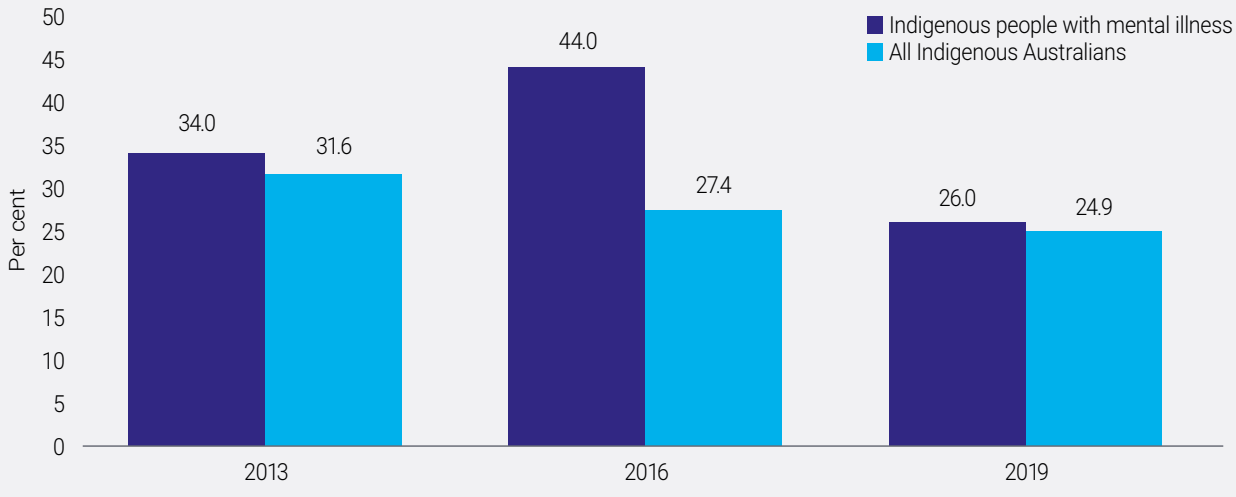
The proportion of Aboriginal and Torres Strait Islander peoples with a mental illness who *used illicit drugs* (PI 3) did not decrease from 2013 to 2019 (25.6% in 2013 and 26.6% in 2019), and remained higher than the rate of illicit drug use among all Indigenous people during that time (20.2% in 2013 and 19.0% in 2019).

Mental health and mental illness

The proportion of Aboriginal and Torres Strait Islander peoples with *high and very high levels of psychological distress* (PI 7) did not decrease between 2012–13 and 2018–19 (29.4% and 31.2% respectively). During this time the rate of *high and very high levels of psychological distress* in Indigenous people was more than double that in non-Indigenous Australians (10.8% in 2011–12 and 13.8% in 2017–18).

In 2010–2014, Aboriginal and Torres Strait Islander Australians had a *suicide rate* (PI 19) around double that of non-Indigenous Australians; this disparity persisted through 2015–2019. The *suicide rate* for Indigenous Australians increased from 21.3 per 100,000 population in 2010–2014 to 24.6 per 100,000 population in 2015–2019. The non-Indigenous *suicide rate* was 11.1 per 100,000 population in 2010–2014 and 12.5 per 100,000 population in 2015–2019.

Figure 3: Daily smoking rates of Indigenous people, by mental illness status, 2013, 2016 and 2019



Source: National Drug Strategy Household Survey.

Contributing life

While newer data is unavailable, figures from 2014–15 provide insight to the experience of Aboriginal and Torres Strait Islander peoples with mental illness.

In 2014–15, the proportion of Aboriginal and Torres Strait Islander peoples with a mental illness who *engaged in social participation* (PI 9) was similar to the proportion of Indigenous people without a mental illness (91.2% and 89.9% respectively). There are not enough years of data available to identify trends over time.

In 2018–19, the proportion of Aboriginal and Torres Strait Islander peoples with a mental illness who were *in employment, education or training* (PI 10) was lower than Indigenous Australians without a mental illness (47.2% and 63.5% respectively). There are not enough years of data available to identify trends over time.

In 2014–15, the proportion of Aboriginal and Torres Strait Islander peoples with a mental illness who *experienced discrimination* (PI 24) was higher than Indigenous people who did not have a mental illness (44.5% and 29.2% respectively). There are not enough years of data available to identify trends over time.

Is the performance of the mental health system improving for Aboriginal and Torres Strait Islander peoples?

Measuring population treatment rates against what is known about the distribution of mental illness in the community gives a broad estimate of unmet need. Data on the prevalence of mental illness in Aboriginal and Torres Strait Islander peoples is not currently available for inclusion in Fifth Plan performance indicator reporting. However, assuming that the prevalence of mental illness is stable, then higher proportions of people accessing clinical mental health care suggest less unmet need. From 2013–14 to 2018–19, the proportion of Aboriginal and Torres Strait Islander peoples *accessing public clinical mental health care* was relatively stable (4.6% in 2013–14 and 5.6% in 2018–19; PI 15). From 2013–14 to 2017–18, the proportion of Aboriginal and Torres Strait Islander peoples accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care increased from 8.1% to 10.6%; data for 2018–19 were not available for reporting.

In 2018–19, 51.1% of public sector acute mental health separations with specialised mental health care, for Indigenous people, included *involuntary care* (PI 23). During this period, 63.8% of public sector acute mental health patient days with specialised mental health care were *involuntary* for Indigenous people. Currently there are not enough years of data available to identify trends over time.

In 2018–19, the majority of Indigenous consumers accessing ambulatory mental health care in New South Wales, Victoria and Queensland, who participated in data collection, *reported a positive experience of service* (72.0%, 72.7% and 79.1% respectively; PI 13). The majority of Indigenous consumers accessing admitted mental health care in New South Wales and Queensland also *reported a positive experience of service* (68.5% and 56.3% respectively). In Victoria, 44.4% of Indigenous consumers *reported a positive experience* of admitted mental health care. Data for other states and territories is not available.

Nationally, the rate of *community mental health care following hospital discharge* (PI 16) for Aboriginal and Torres Strait Islander Australians, increased from 55.0% in 2012–13 to 68.0% in 2018–19.

The proportion of mental health-related hospitalisations for Indigenous Australians that are followed by *rapid readmission* (PI 17) was relatively stable from 2013–14 to 2017–18 (16.6% and 17.6% respectively). Over this time, the rate of *rapid readmission* was similar for non-Indigenous Australians (14.0% in 2013–14 and 14.3% in 2018–19 for non-Indigenous Australians).

Conclusion

Nationally, the use of community mental health care following hospital discharge has improved among Aboriginal and Torres Strait Islander peoples. Reduced rates of daily smoking also suggest improving physical health.

However, suicide rates have increased, and a number of areas of health and wellbeing remain unchanged, including:

- the proportion of *children who are developmentally vulnerable*
- the *rate of alcohol consumption*
- the *rate of Illicit drug use*
- the proportion of adults with *very high levels of psychological distress*.

Population access to clinical mental health care and the proportion of mental health-related hospitalisations that are followed by rapid readmission have not improved.

Performance indicator concluding statement

The data available during the life of the Fifth Plan show that at the national level, we are seeing improvements in:

- *population access to Medicare-subsidised and Department of Veterans' Affairs subsidised clinical mental health care*
- *seclusion rates*
- *employment of consumer and carer workers*
- *post-hospital discharge community mental health care access*
- *rates of daily smoking.*

However, improvements have not been seen in:

- *population access to public and private clinical mental health care*
- the proportion of *mental health-related hospitalisations that are followed by rapid readmission*
- the proportion of consumers who experienced no significant change or significant deterioration of *clinical symptoms* following clinical mental health care
- *alcohol consumption, illicit drug use* and *misuse of pharmaceuticals*
- the proportion of *children who are developmentally vulnerable*
- the proportion of adults with *very high levels of psychological distress.*

However, health and wellbeing, as measured by suicide rates, has deteriorated slightly.

Although there are not enough years of data available to comment on a trend, the disparity between people with and without mental illness in long-term physical health conditions, participation in employment, education and training, and experience of discrimination, suggests that more work is also needed in these areas.

These national patterns are also broadly reflected in the mental health, wellbeing and mental health system performance for young people, older Australians, and Aboriginal and Torres Strait Islander peoples.

While the improvements we've seen in many aspects of mental health system performance are important, the number of indicators that do not show positive change remains concerning. It is clear that sustained attention is needed, through future reforms, to ensure that we change the trajectory of psychological distress levels, alcohol and other drug use, and childhood vulnerability, as well as eliminating the disparity in wellbeing and community participation between people with and without mental illness.

Implementation progress of Fifth Plan actions

To determine the progress of implementing the Fifth Plan, the Commission surveyed stakeholders listed as the Coordination Point of each action or—where a Coordination Point is not identified—the identified lead for the action (Box 2).

Box 2: Surveyed stakeholders

The Commission surveyed the following stakeholders about the implementation status of actions where they are either named as the Coordination Point or are leading implementation of the action:

- the Australian Health Ministers Advisory Council (response provided by the Mental Health Principal Committee on behalf of the Australian Health Ministers Advisory Council)
- the Mental Health Principal Committee
- the National Mental Health Service Planning Framework Steering Committee
- the Mental Health Information Strategy Standing Committee
- the Safety and Quality Partnership Standing Committee
- the Australian Government Department of Health
- state and territory departments of health
- state mental health commissions
- the National Mental Health Commission

The majority of stakeholders provided responses to the implementation progress survey. The South Australia Department for Health and Wellbeing (SA Health) was unable to provide a status update.

Respondents rated the progress of their action as at 30 June 2020. Progress was measured on a 4-point scale:

Yet to commence

Commenced – not on track

Commenced – on track

Completed

These ratings indicate whether actions are progressing according to the milestone date stipulated in the Implementation Plan, or an agreed revised timeline. Respondents were asked to provide relevant context and information about why each rating was given. The combination of ratings and descriptions form the basis of this report. A detailed description of the implementation progress survey process can be found in the accompanying Technical Report.

Implementation progress

Of the 66 actions and sub-actions outlined in the Implementation Plan, 22 were reported as 'completed', including 15 that were reported as completed for the first time. A further 25 actions or sub-actions were reported as 'commenced – on track', including 4 actions that were 'commenced – not on track' last year. Seven actions were reported as 'commenced – not on track', and 9 actions were reported as 'yet to commence'. One additional action is not scheduled to start until late 2021. Two actions (Action 14 and 27) are implemented independently in all jurisdictions and were rated as being at varying stages of progress. A detailed report of the status of implementation progress can be found at Appendix A.

Completed actions

Progress was made in implementing the Fifth Plan during 2019–20 and the following actions were rated as completed for the first time:

- Publication of the Third National Mental Health Information Priorities (Actions vii and 24).
- Development and release of detailed guidance material to support PHN and LHN regional planning (Actions 1.2, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 16.1, and 16.2).
- Making key national data available to inform regional level understanding of service gaps, duplication and areas of highest need (Action 1.5).
- Establishing the Suicide Prevention Project Reference Group to set future directions for planning an investment (Action 3).
- Developing strategies for the ongoing testing and reporting on the accuracy of identification of Aboriginal and Torres Strait Islander peoples within key national mental health data collections (Action 13.2).

Areas of improvement since 2019

A number of actions that were identified as being behind schedule in their implementation on 30 June 2019, were reported as being on track on 30 June 2020. These include:

- **Action 9:** Governments will develop, implement and monitor national guidelines to improve coordination of treatment and supports for people with severe and complex mental illness. This work is expected to be completed in December 2020.
- **Action 13.3:** Governments will strengthen the evidence base needed to improve mental health services and outcomes for Aboriginal and Torres Strait Islander peoples through ensuring future investments are properly evaluated to inform what works. This work is ongoing for the life of the Fifth Plan.
- **Action 18:** Governments will take action to focus on the stigma and discrimination experienced by people with mental illness that is poorly understood in the community. This work is expected to be completed in September 2020.
- **Action 21.1 and 21.4:** Governments will develop a National Mental Health Safety and Quality Framework to guide delivery of the full range of health and support services required by people living with mental illness. The Framework will describe the national agenda and work program for safety and quality over the next 5 years, and will include:
  - identifying new and emerging national safety and quality priorities, and updating the 2005 statement of National Safety Priorities in Mental Health.
  - a process for revising the National Standards for Mental Health Services that accounts for interfaces with other relevant standards such as the National Disability Standards.
- **Action 22:** Governments will develop a mental health supplement to the National Safety and Quality in Health Service (NSQHS) Standards (2nd ed.) which will align the NSQHS Standards and the National Standards for Mental Health Services.

Additional information about the progress made against these actions can be found in Appendix A. The remaining actions that were behind schedule in 2019 were still behind schedule at 30 June 2020. These are discussed in the next section.

Actions that did not progress as expected

The implementation of a number of actions has not progressed as expected and were either yet to commence or not on track at 30 June 2020.

The National Mental Health Policy review was to begin in 2018, to allow governments to renew it during the life of the Fifth Plan and ensure sufficient time for the policy to inform the development of any future National Mental Health and Suicide Prevention Plans (Action iv). As reported in the 2019 Progress Report, the review was delayed in 2018–19 by the commencement of the Productivity Commission Inquiry into Mental Health. It was further delayed in 2019–20 as funding for this project was not agreed because of the review of the former Council of Australian Governments councils and ministerial forums.

The Australian Government committed to commissioning an independent evaluation of the Fifth Plan (Action vi). Although the evaluation of the Fifth Plan was not due for completion until June 2022, the evaluation plan was to be cleared through the Mental Health Information Strategy Standing Committee (MHISSC) by December 2018. As reported in the 2019 Progress Report, work on the evaluation was delayed in 2018–19 by resourcing and capacity issues. In 2019–20 the Mental Health Principal Committee reported that the evaluation has been further delayed by the COVID-19 pandemic and review of the former Council of Australian Governments councils and ministerial forums.

The MHISSC reported that work towards enhancing existing health service data to improve services for Aboriginal and Torres Strait Islander peoples (Action 13.5) was unable to commence under its auspices, as the action may be more appropriately led by the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSIMHSPPRG). This action, which was also reported as 'yet to commence' in the 2019 Progress Report, was due to be completed in 2021.

Commencement of work towards government support of Primary Health Networks and Local Health Networks to develop integrated, whole-of-community approaches to suicide prevention (Action 5), was delayed to await the National Suicide Prevention Strategy (Action 4) and other regional planning work being conducted under the auspices of the National Suicide Prevention Adviser.

Several actions under Priority Area 6: Reducing stigma and discrimination, that were reported as being behind schedule in the 2019 Progress Report, are yet to commence because they are awaiting completion of consultations occurring under Action 18. These consultations, initially due for completion by the end of 2018, and later expected to be held in the first half of 2020, were reported as occurring throughout the COVID-19 pandemic.

Unsurprisingly, during the 2019–20 year, the COVID-19 pandemic caused some disruptions or further delays for several actions, including the:

- consultations necessary to finalise a work plan under Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Difficulty in finalising the work plan resulted in further delays to several actions that were reported as behind schedule in the 2019 Progress Report
- ongoing implementation of Equally Well in Victoria (Action 14)
- drafting of an options paper on physical health monitoring (Action 17)
- implementation of World Health Organization Quality Rights guidance and training tools pertaining to mental health, in Victoria (Action 27)
- development of a plan for ongoing refinement and application of the National Mental Health Service Planning Framework (Action 1.3)
- development of an options paper relating to documenting the roles and responsibilities for supporting the physical health of people with mental illness (Action 16.3). Although it should be noted that this action was not formally scheduled to commence until mid-2020.

Implementation progress concluding statement

The 2019–20 implementation and reporting period saw several unexpected and challenging events such as the bushfires, drought, floods, and the COVID-19 pandemic. Governments have needed to respond quickly to the physical and mental health impacts and target resources to supporting the wellbeing of their communities during these times.

Despite the challenges of 2019–20, the year also saw significant steps toward progress and reform with the interim reporting of the Productivity Commission Inquiry into Mental Health, the work of the Royal Commission into Victoria's Mental Health System, the Royal Commission into Aged Care Quality and Safety, and the work of National Suicide Prevention Advisor.

Within this context, the Commission is heartened to see that most Fifth Plan actions were either completed or progressing on schedule as at 30 June 2020. The continued progress of these reforms under difficult and changing circumstances demonstrates the commitment of all governments to improving the Australian mental health system.

Despite the collaborative efforts of all governments and the former AHMAC committees, we know from the Commission's 2020 Consumer and Carer Survey that many of Fifth Plan's intended outcomes for consumers and carers are yet to be realised. A National Mental Health and Suicide Prevention Agreement will be launched by National Cabinet in 2022, therefore the Fifth Plan reporting cycle will be completed with a 2021 final report. The status of any outstanding Fifth Plan actions will be reported in the 2021 final report as part of a review of the implementation of the Fifth Plan actions across the full life cycle of the Plan.

Appendix A

Status of Fifth Plan actions as at 30 June 2020

Appendix A Status of Fifth Plan actions as at 30 June 2020

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Governance					
Action i: Governments will establish a Mental Health Expert Advisory Group that will advise the Australian Health Ministers' Advisory Council (AHMAC), through the MHPC, on the implementation of the Fifth Plan and analyse progress.					
• MHPC will lead the joint development of Terms of Reference and membership for the Expert Advisory Group and establish a meeting schedule. • Governments will agree on cost-shared funding arrangements.	MHPC	December 2017, first meeting before June 2018		**Completed**	This action was reported as 'completed' in the Fifth Plan 2019 Progress Report.
Action ii: Governments will establish a Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment.					
• MHPC will lead the joint development of Terms of Reference and membership for the Suicide Prevention Subcommittee and establish a meeting schedule. • Governments will agree on cost-shared funding arrangements. • Refer to Action 3 for further information on implementation approach.	MHPC	First meeting mid-2018		**Completed**	This action was reported as 'completed' in the Fifth Plan 2019 Progress Report.
Action iii: Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment.					
• MHPC will lead the joint development of Terms of Reference and membership for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee and establish a meeting schedule. • Governments will agree on cost-shared funding arrangements. • The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will include representatives from existing Aboriginal and Torres Strait Islander AHMAC subcommittees, as appropriate. • Action 11 provides further information on the requirements for the Terms of Reference.	MHPC	First meeting mid-2018		**Completed**	This action was reported as 'completed' in the Fifth Plan 2019 Progress Report.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Action iv: Governments will renew the National Mental Health Policy. This review will begin in 2018 and be completed during the life of the Plan. It will be completed with sufficient time to inform development of any future National Mental Health and Suicide Prevention Plans under the Strategy.					
• MHPC will undertake a review of the Policy. • Secretariat support provided by the Commonwealth. • The Expert Advisory Group will provide advice to MHPC on renewal of the National Mental Health Policy.	AHMAC (progress reported by the MHPC)	Commence January 2018, completed December 2020	Early 2021	**Commenced – not on track**	The work to review the National Mental Health Policy was delayed during 2018–19 by the commencement of the Productivity Commission Inquiry into Mental Health. A working group was later convened. However, progress was hindered during 2020 because funding was not agreed due to the review of National Governance arrangements.
Measuring and reporting on change					
Action v: Governments will request the National Mental Health Commission delivers an annual report, for presentation to Health Ministers, on the implementation progress of the Fifth Plan and performance against identified indicators once the baselines have been established. These indicators will be disaggregated by Aboriginal and Torres Strait Islander status where possible.					
• The Commonwealth will negotiate this activity with NMHC. • The NMHC will consult with jurisdictions on agreed data and reporting processes. • The Commonwealth will contribute Commonwealth data and information to the NMHC to facilitate the NMHC monitoring and reporting role. • States and territories to participate in consultations with NMHC and agree to contribute data and information to the NMHC to fulfil the agreed monitoring and reporting role. • MHISSC to work with NMHC to identify data sources and indicator specifications for agreed indicators, and to advise on processes for coordinating data submissions to the agreed reporting authority (NMHC) where data are available.	MHPC	Negotiations commence January 2018 and implementation will be ongoing	2023	**Commenced – on track**	The MHISSC advised that 18 of 24 indicators have been specified. All specified indicators are included in the NMHC's annual progress report.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Action vi: Governments will evaluate the Fifth Plan, commencing in the final year of the Plan, to inform future directions in mental health policy. This evaluation will be principally informed by annual reporting on the Fifth Plan and targeted stakeholder consultation with governments, consumers and carers and the mental health sector.					
• The Commonwealth will commission an independent evaluation of the Fifth Plan, including development of an evaluation plan that will be cleared through MHISSC. • The Commonwealth contracted provider will be required to consult with MHISSC, Safety and Quality Partnership Standing Committee (SQPSC) and NMHC and other key stakeholders on the development of an evaluation plan. • Development of evaluation plan to precede commencement of evaluation in the final year of the Plan.	AHMAC (progress reported by the MHPC)	Evaluation plan agreed December 2018 Evaluation completed June 2022		**Commenced – not on track**	Progress of this action was delayed due to the COVID-19 pandemic and the review of the former COAG councils and ministerial forums. Some preliminary work (a draft project plan) has been undertaken by the Australian Government. However, further progress is on hold awaiting the outcome of the review.
Action vii: Governments will develop a longer-term strategy for information and indicator development. This strategy will be published as a Third Edition of the National Mental Health Information Development Priorities. It will include the identification of information development priorities and the development of additional national reform and system performance measures in consultation with consumers and carers and other key stakeholders.					
• Refer to Action 24 for implementation approach.	MHISSC	Published by December 2018	Mid-2020	**Completed (as per Action 24)**	The Third National Mental Health Information Priorities document was endorsed by the Mental Health Principal Committee in March 2020. The document has since been published on Australian Institute of Health and Welfare's (AIHW) Mental Health Services in Australia web report.

Appendix A Status of Fifth Plan actions as at 30 June 2020

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 1: Achieving integrated regional planning and service delivery					
1.1: Governments will support integrated planning and service delivery at the regional level by: • requiring development and public release of joint regional mental health and suicide prevention plans.					
• The Commonwealth will direct PHNs to jointly develop regional plans with LHNs and direct to publicly release draft plans for public comment. • States/territories will direct LHNs (or equivalent) to jointly develop regional plans with PHNs for public release. • The NMHC will include information on the status of joint plans as part of its annual reporting on the Fifth Plan.	MHPC	Progressively from December 2017		**Commenced – on track**	Final Regional Plans are expected in December 2020.
1.2: Providing guidance for the development of joint, single regional mental health and suicide prevention plans.					
Governments will jointly develop and release guidance material for a single regional plan that will cover scope, timeframes, governance arrangements, consultation processes, and requirements for government endorsement.	MHPC	Completed mid-2018		**Completed**	Regional Planning Guidance material was released in November 2018.
1.3: Developing a plan for ongoing development, refinement, and application of the National Mental Health Service Planning Framework (NMHSPF).					
• Governments will agree on the process for the ongoing refinement, application and resourcing of the NMHSPF. • The Commonwealth will manage contractual arrangements with an expert provider for ongoing development of the NMHSPF.	NMHSPF Steering Committee	December 2017	March 2021	**Commenced – not on track**	The NMHSPF Steering Committee was suspended during the first half of 2020 due to the COVID-19 mental health response. The NMHSPF Steering Committee has commenced discussions about future development, refinement and application of the NMHSPF following the expiry of the University of Queensland contract in June 2021.
1.4: Developing and releasing planning tools based on the NMHSPF and an evidence based stepped care model.					
• Governments will agree on licensing arrangements/ agreements. • The Commonwealth will issue licences to authorised users of the NMHSPF. • The Commonwealth will release the planning tools and support materials and lead the provision of training to be provided by the Commonwealth-contracted expert provider.	NMHSPF Steering Committee	Progressively to June 2018		**Commenced – on track**	The NMHSPF has been released as a Tableau interface, and key technical documentation has been made available to the public.

Appendix A Status of Fifth Plan actions as at 30 June 2020

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
1.5: Making available key national data to inform regional level understanding of service gaps, duplication, and areas of highest need.					
• Governments will contribute relevant data for the development of regional data. • The Commonwealth will use existing funding arrangements with the AIHW to facilitate this action. • Steering and coordination of the development of regional data reporting will occur through MHISSC.	MHISSC	Completed June 2018		**Completed**	AIHW is progressively publishing data at the sub-jurisdictional level on Mental Health Services in Australia. Under the MHISSC's governance, AIHW will build upon agreed tables to expand sub-jurisdictional reporting over time. As at June 2020, data is available at the Primary Health Network and Statistical Area Level 3 for residential, community, and admitted mental health care; mental health-related emergency department presentations; and mental health-related prescriptions. Data is also available by hospital for seclusion and restraint. Sub-jurisdictional reporting of Medicare data is expected to be available in 2021.
2.1: Governments will work with PHNs and LHNs to implement integrated planning and service delivery at the regional level. This will include: • utilising existing agreements between the Commonwealth and individual state and territory governments for regional governance and planning arrangements.					
• The Commonwealth will use existing agreements (such as bilateral agreements and other existing agreements, including National Partnership Agreements or MOUs) with state and territory governments to facilitate a coordinated approach to regional planning and service delivery.	AHMAC (progress reported by the MHPC)	Commencing early 2018		**Commenced – on track**	Progress of this action has been delayed due to COVID-19. Content relating to achieving a coordinated approach to regional planning and service delivery may be included in agreements that are delayed to December 2020.
2.2: Engaging with the local community, including consumers and carers, community managed organisations, Aboriginal Community Controlled Health Services (ACCHS), National Disability Insurance Scheme (NDIS) providers, the National Disability Insurance Agency, private providers and social service agencies.					
• PHNs and LHNs will work collaboratively to engage regional stakeholders in the regional planning and service delivery process. • Governments will strengthen existing partnerships with stakeholders to engage with the local community. • The Expert Advisory Group will provide advice to governments on strategies to maximise engagement.	AHMAC (progress reported by the MHPC)	Commencing early 2018		**Completed**	Advice on maximising engagement is included in the published Regional Planning Guidance (Action 1.2).

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Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
2.3: Undertaking joint regional mental health needs assessment to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability.					
• PHNs and LHNs will work towards data sharing to map regional service provision and identify areas of duplication, inefficiency and service gaps. • PHNs and LHNs will utilise the NHMSPF and other planning tools to facilitate regional needs assessment and planning.	MHPC	Progressively from June 2018		**Completed**	Relevant information included in the published Regional Planning Guidance (Action 1.2).
2.4: Examining innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support, to create the right incentives to focus on prevention, early intervention, and recovery.					
• PHNs and LHNs will explore opportunities for resource sharing and other innovative use of available funds to improve efficiencies, remove duplication and improve outcomes.	MHPC	Commencing mid-2020		**Completed**	Relevant information included in the published Regional Planning Guidance (Action 1.2).
2.5: Developing joint, single regional mental health and suicide prevention plans and commissioning services according to those plans.					
• PHNs and LHNs will jointly develop comprehensive regional mental health and suicide prevention plans. These plans should cover the lifespan from children through young adults to older people. • PHNs and LHNs will use these plans to progressively guide service development and commissioning.	MHPC	Commencing late 2017 Completed mid-2020		**Completed**	Relevant information included in the published Regional Planning Guidance (Action 1.2).
2.6: Identifying and harnessing opportunities for digital mental health to improve integration.					
• Regional plans developed by PHNs and LHNs will make best use of existing and emerging technology and digital mental health services within an integrated, stepped care approach. • Refer to Action 32 for information on implementation of a National Digital Mental Health Framework.	MHPC	Commencing 2017 Completed mid-2020		**Completed**	Relevant information included in the published Regional Planning Guidance (Action 1.2).

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
2.7: Developing region-wide multi-agency agreements, shared care pathways, triage protocols and information sharing protocols to improve integration and assist consumers and carers to navigate the system.					
• PHNs and LHNs will work towards integrating existing bilateral agreements (such as COAG agreements and new Health Reform Agreements) and broadening these to be regional in coverage. The new agreements will be developed to ensure engagement of all relevant service providers. • The Expert Advisory Group will provide advice to MHPC on mechanisms to improve integration, including best practice approaches to shared care, triage and information sharing.	MHPC	Mid-2021		**Completed**	Relevant information included in the published Regional Planning Guidance (Action 1.2).
2.8: Developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events.					
• PHNs and LHNs will jointly develop shared clinical governance mechanisms to ensure service pathways established and services commissioned across the system are clinically appropriate.	MHPC	Mid-2021		**Completed**	Relevant information included in the published Regional Planning Guidance (Action 1.2).

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Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 2: Suicide Prevention					
3: Governments will establish a new Suicide Prevention Subcommittee of MHPC, as identified in the Governance Section of this Plan, to set future directions for planning and investment.					
• MHPC will establish the Suicide Prevention Subcommittee to lead the joint development of Terms of Reference and membership, followed by the development of a Project Plan. • The Terms of Reference will include, but will not be limited to: defining scope, establishing timeframes, outlining governance arrangements and developing a consultation strategy.	MHPC	December 2017 First meeting early 2018		**Completed**	The Subcommittee was established as required (See Action ii, Governance section).
4: Governments will, through the Suicide Prevention Subcommittee of MHPC, develop a National Suicide Prevention Implementation Strategy that operationalises the 11 elements above considering existing strategies, plans and activities with a priority focus on: • the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system • timely follow up support available to people affected by suicide • improving cultural safety across all service settings • improving relationships between providers, including emergency services and • improved data collections and combined evaluation efforts to build the evidence-base on 'what works' in relation to preventing suicide and suicide attempts.					
• MHPC, through the Suicide Prevention Subcommittee, will lead the development of the National Suicide Prevention Implementation Strategy. The Strategy will include a focus on Aboriginal and Torres Strait Islander suicide prevention and will include releasing a version for public consultation to ensure stakeholder input.	MHPC	Commence 2018 Release of strategy for public consultation by mid-2019 Release of final strategy by 2020		**Commenced – on track**	The National Suicide Prevention Strategy (the Strategy) has been endorsed by the COAG Health Council and as at 30 June 2020 was awaiting publication. Publication is to be aligned with the release of the Interim Report of the National Suicide Prevention Adviser, which is awaiting endorsement by the Prime Ministers' office. An Implementation Plan will not be developed specifically for the Strategy (as agreed by the MHPC), as the Strategy can be implemented with other work under the auspices of the National Suicide Prevention Adviser.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
5: Governments will support PHNs and LHNs to develop integrated, whole-of-community approaches to suicide prevention. • This will include engaging with local communities to develop suicide prevention actions as part of a joint, single regional plan. • These regional plans will be consistent with the 11 elements above and informed by the National Suicide Prevention Implementation Strategy as it is developed • At a regional level, PHNs and LHNs will work together to map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them.					
• The Commonwealth will direct PHNs and states/territories will direct LHNs to jointly develop suicide prevention approaches as a discrete component of Action 1.1 and Action 10. • Governments will jointly develop and provide guidance to PHNs and LHNs on regional approaches to suicide prevention, informed by the systems-based approach outlined in the WHO's Preventing suicide: A global imperative.	MHPC	Commence 2019 and ongoing		**Yet to commence**	Commencement of this action was delayed while awaiting the National Suicide Prevention Strategy (Action 4). This action is linked to regional planning work and work to be completed under the auspices of the National Suicide Prevention Advisor. Engagement with Aboriginal Community Controlled Health Services (ACCHSs) has commenced across Western Australia. The ACCHSs will lead the community engagement and planning process as experts in Social and Emotional Wellbeing in their communities. The WA Mental Health Commission will support the ACCHSs to engage the WAPHA where relevant. Plans are anticipated to be developed by April 2021, and implementation will commence mid-2021.

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Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness					
6: Governments will negotiate agreements that prioritise coordinated treatment and supports for people with severe and complex mental illness. This will include planning for the community mental health support needs of people who do not qualify to receive supports under the NDIS, including fulfilment of agreed continuity of support provisions and ensuring any mainstream capacity is not lost for the broader population as a result of transition to the NDIS.					
• The Commonwealth negotiation of agreement/s with states and territories for psychosocial support services. • States and territories will negotiate agreement with Commonwealth for psychosocial support services.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the Commission has been advised that this work is being led by all jurisdictions via MHPC, the Commission requests the MHPC provides a status update on this action.	Commence in 2017 Finalised by the end of 2018	June 2021	**Commenced – on track**	This action has been delayed due to COVID-19. Jurisdictions are managing their own efforts in this area.
7: Governments will require PHNs and LHNs to prioritise coordinated treatment and supports for people with severe and complex mental illness at the regional level and reflect this in regional planning and service delivery.					
• The Commonwealth will direct PHNs to plan and commission services for people with severe and complex mental illness through PHN funding agreements. • Governments will use joint guidance material on regional plans (Refer to Action 1.2) to outline their expectations of PHNs and LHNs for coordinated treatment and supports for people with severe and complex mental illness. This will include specific consideration of the requirements of children and adolescents with or at risk of severe mental illnesses.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the lead on this action, as identified by the MHPC, the Commission requests that the Commonwealth provide a status update for this action on behalf of all relevant stakeholders.	Completed mid-2018		**Completed**	Nil update for the period of 1 July 2019 to 30 June 2020, as this action was completed in mid-2018.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
8: Governments will establish a time-limited Mental Health Expert Advisory Group, as identified in the Governance Section of this Plan, that will: • advise on the implementation of the Fifth Plan and analyse progress • where requested by AHMAC, provide advice on broader mental health policy issues, which may include cross-portfolio consideration of issues that may arise from the implementation of mental health reforms and the NDIS for people with severe and complex mental illness and opportunities to harmonise data collection strategies.					
• Refer to Action I in Governance section for implementation roles.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the lead on this action, as identified by the MHPC, the Commission requests that the Commonwealth provide a status update for this action on behalf of all relevant stakeholders.	2019		**Part 1 of this action is 'completed' as per Action i, Governance**	The committee was established as required.
9: Governments will develop, implement and monitor national guidelines to improve coordination of treatment and supports for people with severe and complex mental illness. These guidelines will: • clarify roles and responsibilities across the health and community support service sectors • be consistent with the COAG mainstream interface principles (which determine the responsibilities of the NDIS and other service providers) • specify criteria to guide targeting service delivery to consumers, including identifying pathways for culturally competent services • promote the roles of multi-agency care plans, care pathways and information sharing protocols • identify opportunities for the use of digital mental health and electronic health records in coordinating care; and • highlight the role of data in supporting these activities.					
• The Commonwealth will lead the joint development of national guidelines to be endorsed by AHMAC. This will include consultation with the social services sector. • The Commonwealth to undertake a targeted consultation process will be undertaken to inform the development of the guidelines.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the lead on this action, as identified in the Implementation Plan, the Commission requests that the Commonwealth provide a status update for this action.	Commence in 2018 Release in 2020		**Commenced – on track**	The Terms of Reference for an Action 9 Working Group were agreed to through the MHPC in December 2018. The first meeting of the Working Group was held in Melbourne on 4 October 2019. The Working Group identified the need for targeted consultations and a technical writer. The Australian Government Department of Health engaged a consultant to develop the guidelines and consult with stakeholders under the oversight of the Working Group. Draft guidelines have been developed and are undergoing consultation with various stakeholders. It is expected that the Working Group will deliver the guidelines by December 2020.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention					
10: Governments will work with PHNs and LHNs to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level. This will include: • Engaging Aboriginal and Torres Strait Islander communities in the co-design of all aspects of regional planning and service delivery • Collaborating with service providers regionally to improve referral pathways between General Practitioners (GPs), ACCHS, social and emotional wellbeing services, alcohol and other drug services, and mental health services, including improving opportunities for screening of mental and physical wellbeing at all points; connect culturally informed suicide prevention and postvention services locally and identify programs and services that support survivors of the Stolen Generation • developing mechanisms and agreements that enable shared patient information, with informed consent, as a key enabler of care coordination and service integration • clarifying roles and responsibilities across the health and community support service sectors • ensuring that there is strong presence of Aboriginal and Torres Strait Islander leadership on local mental health service and related area service governance structures.					
Guidance developed by governments for PHNs and LHNs on joint regional plans (Refer to Action 1.2) will outline expectations regarding integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples, including: • expectations for involvement of ACCHS and Aboriginal and Torres Strait Islander communities; • engagement of Aboriginal and Torres Strait Islander helpers and peer workers; • operationalising the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026* within regional mental health service systems; and • governance structures and mechanisms being inclusive of Aboriginal and Torres Strait Islander perspective.	MHPC	Commence mid-2018	Ongoing	**Commenced – not on track**	This action is linked to regional planning activities under Priority Area 1. This action has been delayed, in part, due to delays in finalising a work plan. Finalising the work plan was delayed by the impact of the COVID-19 pandemic on consultation.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
11: Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee of MHPC, as identified in the Governance Section of this Plan, that will set future directions for planning and investment and: • provide advice to support the development of a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander peoples for inclusion in the National Suicide Prevention Implementation Strategy • provide advice on models for co-located or flexible service arrangements that promote social and emotional wellbeing incorporating factors including a person's connection to country, spirituality, ancestry, kinship, and community • identify innovative strategies, such as the use of care navigators and single care plans, to improve service integration, support continuity of care across health service settings and connect Aboriginal and Torres Strait Islander peoples with community based social support (non-health) services • provide advice on suitable governance for services and the most appropriate distribution of roles and responsibilities, recognising that the right of Aboriginal and Torres Strait Islander communities to self-determination lies at the heart of community control in the provision of health services • overseeing the development, dissemination and promotion in community, hospital and custodial settings of resources that articulate a model of culturally competent Aboriginal and Torres Strait Islander mental health care across the healthcare continuum and brings together (a) the holistic concept of social and emotional wellbeing and (b) mainstream notions of stepped care, trauma-informed care and recovery-oriented practice • provide advice on workforce development initiatives that can grow and support an Aboriginal and Torres Strait Islander mental health workforce, incorporates Aboriginal and Torres Strait Islander staff into multidisciplinary teams, and improves access to cultural healers • provide advice on models of service delivery that embed cultural capability into all aspects of clinical care and implements the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026* in mental health services; and • provide advice on culturally appropriate digital service delivery, and strategies to assist Aboriginal and Torres Strait Islander peoples to register for 'My Health Record' and understand the benefits of shared data.					
• Refer to Action iii in Governance section for information on the implementation approach.	MHPC	First meeting mid-2018		**Completed (as per Action iii)**	This action was reported as 'completed' in the Fifth Plan 2019 Progress Report.
12.1: Governments will improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHS and other service providers by: • developing and distributing a compendium of resources that includes: (a) best practice examples of effective Aboriginal and Torres Strait Islander mental health care (b) culturally safe and appropriate education materials and resources to support self-management of mental illness and enhance mental health literacy and (c) culturally appropriate clinical tools and resources to facilitate effective assessment and to improve service experiences and outcomes.					
• The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will develop and distribute sector resources. The subcommittee will be required to consult widely on the development and distribution of this compendium to ensure strong sector engagement. • This role for the Subcommittee will be articulated in its Terms of Reference (Refer to Action iii).	MHPC	Commence 2018 Completed 2020		**Yet to commence**	This action has been delayed, in part, due to delays in finalising a work plan. Finalising the work plan was delayed by the impact of the COVID-19 pandemic on consultation.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
12.2: Increasing knowledge of social and emotional wellbeing concepts, improving the cultural competence and capability of mainstream providers, and promoting the use of culturally appropriate assessment and care planning tools and guidelines.					
• The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will develop joint guidance for mental health providers to increase knowledge and improve cultural competence. • This guidance will articulate government expectations for funded service providers and provide practical advice based on existing agreed policy documents, including the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023*, the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026* and the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and relevant state/territory strategies.	MHPC	Commence 2018 and ongoing		**Yet to commence**	This action has been delayed, in part, due to delays in finalising a work plan. Finalising the work plan was delayed by the impact of the COVID-19 pandemic on consultation.
12.3: Recognising and promoting the importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration.					
• The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will provide advice to MHPC on practical strategies to improve Aboriginal and Torres Strait Islander leadership. • This role for the Subcommittee will be articulated in its Terms of Reference (Refer to Action iii).	MHPC	Commence 2018 and ongoing	Ongoing	**Commenced – not on track**	This action has been delayed, in part, due to delays in finalising a work plan. Finalising the work plan was delayed by the impact of the COVID-19 pandemic on consultation.
12.4: Training all staff delivering mental health services to Aboriginal and Torres Strait Islander peoples, particularly those in forensic settings, in trauma-informed care that incorporates historical, cultural, and contemporary experiences of trauma.					
• Informed by advice from the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee, all governments will ensure training in trauma-informed care is provided to all staff in their mental health services. • All governments will put in place strategies for delivering training in trauma-informed care to providers of mental health services to Aboriginal and Torres Strait Islander peoples	MHPC	Commence 2018 and ongoing	Completion expected early 2021	**Commenced – not on track**	This action has been delayed, in part, due to delays in finalising a work plan. Finalising the work plan was delayed by the impact of the COVID-19 pandemic on consultation.

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Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
13.1: Governments will strengthen the evidence base needed to improve mental health services and outcomes for Aboriginal and Torres Strait Islander peoples through: • establishing a clearinghouse of resources, tools, and program evaluations for all settings to support the development of culturally safe models of service delivery, including the use of cultural healing and trauma-informed care.					
• Utilising AIHW's Close the Gap Clearinghouse, the Commonwealth will commission the establishment of a clearinghouse of resources, tools and program evaluations. • MHPC will request the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee to advise on implementation of this action. • This role for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will be articulated in its Terms of Reference (Refer to Action iii).	MHPC	Commence 2018 and ongoing		**Yet to commence**	This action has been delayed, in part, due to delays in finalising a work plan. Finalising the work plan was delayed by the impact of the COVID-19 pandemic on consultation.
13.2: Ensuring that all mental health services work to improve the quality of identification of Indigenous people in their information systems using appropriate standards and business processes.					
• MHISSC will develop strategies for ongoing testing and reporting on the accuracy of identification of Aboriginal and Torres Strait Islander peoples within key national mental health data collections.	MHISSC	Commence 2018 Completed 2021		**Completed**	The reference paper on the availability and quality of data on Aboriginal and Torres Strait Islander mental health in national data collections has been developed by the MHISSC and was provided to the Chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSIMHSPPRG) in August 2020.
13.3: Ensuring future investments are properly evaluated to inform what works.					
• All governments commit to embedding appropriate evaluation of their respective investments in mental health initiatives for Aboriginal and Torres Strait Islander peoples and report annually on achievement of this requirement through MHPC. • The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will provide advice on how to best embed evaluation of government investment into program design.	MHPC	From 2017 and ongoing		**Commenced – on track**	Although this work has commenced and is considered to be on track, it has been impacted (as all other actions in Items 12 and 13) by the delay in finalising work plans due to the impact of the COVID-19 pandemic on consultation.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
13.4: Reviewing existing datasets across all settings for improved data collection on the mental health and wellbeing of, and the prevalence of mental illness in, Aboriginal and Torres Strait Islander peoples.					
• MHISSC will work with stakeholders to ensure that the development and construction of mental health performance indicators include the capacity to disaggregate by Indigenous status where ever possible.	MHISSC	Commencing 2018 and ongoing		**Commenced – on track**	Performance indicators have been developed to use data sources specific to Indigenous people wherever available. The Fifth Plan indicator specifications have also been provided to the Chair of the ATSIMHSPPRG.
13.5: Utilising available health services data and enhancing those collections to improve services for Aboriginal and Torres Strait Islander peoples.					
• MHISSC will work with stakeholders to create opportunities for collating and reporting data on provision of mental health services to Aboriginal and Torres Strait Islander peoples. • The Commonwealth will facilitate this through existing funding arrangements with the AIHW and will ask AIHW and MHISSC to scope the development of mental health indicator/s in the Key Performance Indicators (KPIs) for Aboriginal and Torres Strait Islander primary healthcare.	MHISSC	Commence 2018 Completed 2021		**Yet to commence**	When the Implementation Plan was finalised, the ATSIMHSPPRG was not yet established. In its absence, the MHISSC was nominated as the Coordination Point for this action. However, the MHISSC has no specific expertise in Aboriginal and Torres Strait Islander mental health, or in Aboriginal and Torres Strait Islander primary healthcare, and no specific representation from the sector. The MHISSC believes that it would be more appropriate for this action to be allocated to the ATSIMHSPPRG work plan. The MHISSC would welcome the opportunity to provide technical advice and support to the ATSIMHSPPRG for this action. The MHPC to request the ATSIMHSPPRG to undertake work on Action 13.5 as part of its work plan.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality					
14: Governments commit to the elements of Equally Well – The National Consensus Statement for improving the physical health of people living with mental illness in Australia.					
• All governments and mental health commissions will embed the elements of Equally Well and take action in their areas of influence to make changes towards improving the physical health of people with mental illness.	All jurisdictions and mental health commissions	From 2017 following release of Equally Well			A national status rating is not possible, as states and territories are implementing this action independently. See status ratings and context for each jurisdiction below.
• The NMHC will monitor and report on implementation of the National Consensus Statement across jurisdictions.	National Mental Health Commission			**Commenced – on track**	The Commission monitors and reports on the implementation of the National Consensus Statement across jurisdictions through the annual Fifth Plan *Progress Report* (Action v). The Fifth Plan 2020 Progress Report reports on the progress of the National Consensus Statement between 1 July 2019 and 30 June 2020. In summary, with the emergence of COVID-19, Equally Well has approached the Commission for further project support funding. Equally Well has been funded by the Commission for an additional year for project support until 30 June 2021, on the basis that it is financially sustainable from 1 July 2021. Equally Well continues to drive initiatives such as: • an international collaborative network • monthly webinars (due to COVID-19, the annual symposium for Equally Well was cancelled) • collaboration with the Mitchell Institute for Education and Health Policy at Victoria University through 2019–2021 to develop evidence-based policy proposals and practice actions that will improve the physical health of people with mental health conditions. More than 70 organisations have pledged their support to the Equally Well National Consensus Statement for improving the physical health of people living with mental illness in Australia since it was launched in July 2017. This includes all state and territory government health departments and a number of Primary Health Networks and professional colleges and associations.

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Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
	Australian Government Department of Health			**Commenced – on track**	A priority for the Australian Government and state and territory governments is improving the physical health of people with mental illness. This is an area in which there is an opportunity and an imperative for effective planning and integration efforts to address an overwhelming inequity currently in the system for people with mental illness. Through the Fifth Plan, governments are committed to the principles of Equally Well – The National Consensus Statement on improving the physical health and wellbeing of people living with mental illness in Australia.
	New South Wales – NSW Health			**Commenced – on track**	The *Physical Health care for People Living with Mental Health Issues: A Guideline* is in the final stages of review and on track for publication by 31 December 2020. An implementation phase will follow publication, to support services to enact the guidelines.
	New South Wales – Mental Health Commission			**Commenced – on track**	NSW Mental Health Commission (NSW MHC) funded the development of an online consumer and carer resource 'Equally Well Healthtalk', to help improve the physical health of people living with mental health issues. Production of the resource commenced June 2020 and is due for completion in August 2022. The NSW MHC also provides in-kind support through expertise as requested by the project managers. The NSW MHC worked with Aboriginal communities to research and prepare the 'Journey of Wellbeing' a preliminary Aboriginal model of care based on documented examples of best practice across NSW. The model promotes the Aboriginal concept of a holistic approach to social and emotional wellbeing and health, including physical health care being integrated with, and vital to, mental health. The Living Well Mid Term Review, February 2019 to May 2020, identified and showcased several initiatives that promote better access to physical health by people with mental health issues, including a GP clinic in Summer Hill, Sydney and an integrated subspecialty clinic at Tahmoor Medical Centre, South Western Sydney.

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Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
	Victoria – Department of Health and Human Services			Commenced – not on track	Victoria prioritised its COVID-19 response from March 2020. COVID-19 specific support was directed from the Department of Health and Human Services (DHHS) to the sector in the context of physical health and safety within mental health services. Since the 2019 release of *Equally Well in Victoria – Physical health framework for specialist mental health services*, the team from the Office of the Chief Mental Health Nurse has worked with specialist mental health services to promote its implementation. In October 2019, an implementation workshop was held in Melbourne, with more than 100 participants. The workshop generated ideas about implementing the framework, and the roles of service providers and the DHHS. We learned that many Victorian mental health services are already working in this area and have established a range of initiatives to improve their response to the physical health needs of consumers. The workshop produced information about the current barriers and enablers such as capacity and expertise, time management, costs associated with equipment, pathology and specialist services. The workshop produced a summary of directions to guide implementation for consideration by the Chief Mental Health Nurse's team.
	Queensland – Department of Health			Commenced – on track	The Mental Health Alcohol and Other Drug services' Comprehensive Care Documentation suite provides a new range of physical health clinical documentation forms to strengthen the process of assessing, documenting and planning care relating to the physical health of consumers from mental health alcohol and other drugs services. The Mental Health Clinical Collaborative continues to lead mental health service engagement. This has resulted in significant increases in the uptake of metabolic monitoring in mental health services for consumers taking antipsychotic medications, and in screening and interventions for smoking cessation. An internal position paper promoting a focus on physical health has been developed to inform planning for the next Mental Health, Alcohol and Other Drugs Branch Services Plan, raising the importance of physical health as a priority area for the state.
	Queensland – Mental Health Commission			Commenced – on track	The results of Phase 1 of the research project 'Improving physical health for people with a lived experience of mental illness or problematic alcohol and other drug use' (completed in October 2019) have now been published. In this phase, the project combined desktop data and policy analysis with consultations with key service stakeholders to identify systemic reform opportunities for improving the physical health and wellbeing of people living with a mental illness, or problematic alcohol and other drug use in Queensland. Phase 2, to consult with people with a lived experience on the results of the research, is being planned and is due to be completed during 2020.
	South Australia – SA Health			Unknown	SA Health was unable to provide an update.

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	South Australia – Wellbeing SA				Due to a change in organisational scope and focus, Wellbeing SA no longer has responsibility for implementing this action.
	Western Australia – Department of Health and Mental Health Commission			**Commenced – on track**	The Western Australian Government has embedded the principles of Equally Well through a variety of activities. These include frameworks, policies, programs and tools. A formal research project centred on a smoke-free trial (using education and nicotine replacement therapy) at the Albany Health Campus showed significant reductions in exposure to environmental tobacco smoke for staff and patients. The WA Recovery College has been launched. It aims to create positive change and hope through bringing together individuals from various backgrounds and communities in a safe and welcoming learning environment to share experiences; promote personal recovery; and improve physical, social, emotional and spiritual wellbeing. Courses are currently being co-designed with consumers and carers.
	Tasmania – Department of Health			**Yet to commence**	A strategic response to *Equally Well – The National Consensus Statement* is part of the implementation of the Tasmanian Mental Health Reform Program (TMHRP). This will result in new operational service models for community mental health teams. However, some mental health teams have started taking action on their clients' physical health, including engaging exercise physiologists and dieticians to run group sessions on a monthly basis. It is expected that implementation of the TMHRP will address, on a systemic basis, the 4 leading causes of excess mortality for people with mental illness: cancer, cerebrovascular disease (stroke), cardiovascular disease (heart attack) and other circulatory or repository disease. The Tasmanian Department of Health is also leading, in partnership with Primary Health Tasmania, a mid-point update of the Rethink mental health plan. This update provides the opportunity to jointly consider the Tasmanian implementation of the Equally Well consensus statement during the first 12 months of the updated plan.
	Northern Territory – Department of Health			**Commenced – on track**	The implementation of Equally Well has commenced through a variety of activities. For example it was imbedded in the Department of Health Mental Health Strategic Plan, and the review of clinical policies, procedures and tools in both Top End health Service (TEHS) and the Central Australia Health Services (CAHS). Work has also commenced to review the primary health care response, including physical health indicators for people with mental illness accessing territory primary health care services. Both Top End Mental Health & Alcohol and Other Drugs Service (TEMHAODS) and Mental Health Central Australia Health Service (MHCAHS) have access to the 'Physical Health Monitoring – MetS Assessment' screening tool as an electronic document in the electronic patient information management system (CCIS). TEHS and CAHS both have specific policies and procedures guiding physical health screening and monitoring.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
	Australian Capital Territory – ACT Health and Office for Mental Health and Wellbeing			**Commenced – on track**	Activities relating to the improvement of physical health for people with mental illness are well established in the ACT. Examples include smoke free mental health units; metabolic screening programs for patients and on-going management for medications; the development of an updated Adult Community Model of Care which establishes closer referral links from mental health services to dieticians and exercise physiologists; and programs to support and improve the nutrition of people with mental illness and their participation in physical activity. The ACT Office for Mental Health and Wellbeing (OMHW) plays an ongoing role in integrating and coordinating mental health services in the ACT. The OMHW also has a focus on the wider social and economic determinants across the whole of government that can affect mental health, which includes the management of physical health conditions or inactivity. The work of the OMHW to increase the integration of mental health services will help to improve access to physical health care. Canberra Health Services (CHS) has established the Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) Physical Health Steering Committee which meets monthly to progress the Terms of Reference in line with the Equally Well consensus statement. A Project Officer has been engaged to progress work in line with the Fifth Plan (Priority 5) and the Equally Well consensus statement. The Project Officer completed a service mapping project on more than 25 groups (approximately 100 individuals) within ACT Health to identify opportunities and gaps in physical health care provision for MHJHADS consumers. The Project Officer presented to the ACT Health Chronic Disease Management meeting to discuss how to improve the physical health of people with mental illness. Physical health is included in the service principles of all MHJHADS Models of Care. Reporting of the needs of people with mental illness and psychological distress has been incorporated into the ACT Health Prevention Strategy and Chief Health Officer reports, to ensure there is a recognition of the connection between physical health and mental health needs. Physical Health KPIs have been set for program areas within the MHJHADS Business Plan aligned with the CHS strategic plan. The OMHW has promoted a whole of government focus on the social and economic determinants which have a flow-on effect for both physical and mental health. The OMHW has participated in the development of the ACT Wellbeing Framework, which has 12 domains defining the elements of wellbeing important to Canberrans. The framework will provide a basis for considering the wellbeing of people with mental illness in comparison to the broader community, including their physical wellbeing.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
15: Governments will develop or update guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental illness. Implementation of the guidelines and resources will be monitored and reported. These guidelines and resources will: • provide advice on how to ensure physical health checks are part of the routine care of individuals with mental illness • provide advice on screening, detection, treatment, and early medical intervention for people known to be at high risk of physical ill health; and • define the roles of GPs, other primary care providers and specialist health providers in supporting integrated physical and mental health care.					
• The Commonwealth and states and territories will review existing guidelines and resources and determine whether these require updating or whether additional guidelines and resources are required.	MHPC	Commence mid-2018 Completed late 2019 Annually from 2020		**Commenced – on track**	See responses to Action 14.
16.1: Governments will work with PHNs and LHNs to build into local treatment planning and clinical governance the treatment of physical illness in people living with mental illness by: • including it as part of joint service planning activity between PHNs and LHNs.					
• Governments will use joint guidance material on regional plans (Refer to Action 1.2) to outline their expectations of PHNs and LHNs for the inclusion of mechanisms to support the physical health of people living with mental illness in joint service planning activity. • PHNs and LHNs will jointly release regional plans that include mechanisms to support the physical health needs of people living with mental illness.	MHPC	June 2018 By mid-2020		**Completed**	Information is included in section 3.5 of the published Regional Planning Guide (Priority Area 1).
16.2: Including it as part of joint clinical governance activity.					
• Governments will use joint guidance material on regional plans to outline their expectation of PHNs and LHNs that joint clinical governance activity should include mechanisms for supporting the physical health of people with mental illness. • Refer to Action 1.2 for information on joint guidance.	MHPC	June 2018		**Completed**	Information is included in section 3.5 of the published Regional Planning Guide (Priority Area 1).

Appendix A Status of Fifth Plan actions as at 30 June 2020

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
16.3: Requiring roles and responsibilities to be documented as part of local service agreements.					
• The Commonwealth will direct PHNs to document roles and responsibilities for supporting the physical health of people living with mental illness in local service agreements. • States and territories will direct LHNs to document roles and responsibilities for supporting the physical health of people living with mental illness in local service agreements.	MHPC	From mid-2020		**Yet to commence**	This action is not due to commence until mid-2020. An options paper being developed by the MHISSC and the SQPSC (standing committees of the MHPC), which was due in June 2020, has been delayed due to the impact of COVID-19.
17: Governments will commence regular national reporting on the physical health of people living with mental illness. This will include: • building on existing datasets and reporting mechanisms • identifying and addressing data gaps; and • seeking opportunities to share data across traditional boundaries.					
MHISSC will: • identify mechanisms for reporting on the physical health of Australians with mental illness. • develop one or more nationally-consistent performance indicators on the physical health of Australians with mental illness. • identify strategies for ongoing analysis and reporting of the mortality gap for Australians with mental illness.	MHISSC	Commence October 2017 Completed 2022		**Commenced – not on track**	Development of indicator specifications for Fifth Plan physical health performance indicators with an identified data source (Rate of long-term health conditions in people with mental illness, and Rate of drug use in people with mental illness) is complete. The 2 remaining Fifth Plan physical health performance indicators (Avoidable hospitals for physical illness in people with mental illness, and Mortality gap for people with mental illness) require methodological development, and are being progressed by NSW Health. A draft options paper on physical health monitoring is being developed with the assistance of the SQPSC. However, drafting of the paper has been affected by COVID-19.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 6: Reducing stigma and discrimination					
18: Governments will take action to focus on the stigma and discrimination experienced by people with mental illness that is poorly understood in the community. This will: • involve consumers and carers, community groups and other key organisations • build on existing initiatives, including the evidence base of what works in relation to reducing stigma and discrimination; and • account for the specific experience of groups already at high risk of stigma including Aboriginal and Torres Strait Islander peoples and LGBTI.					
• The Commonwealth will engage an expert provider to undertake a review of existing initiatives and evidence to inform the approach to implementation of this action. • MHPC and the Commonwealth will lead targeted consultations on options for a nationally coordinated approach to stigma and discrimination reduction with a focus on that experienced by people with mental illness that is poorly understood in the community. • MHPC to propose direction to AHMAC for collaborative future government action.	MHPC	Completed mid-2018 Completed late 2018 Completed early 2019	September 2020	**Commenced – on track**	The Reducing Stigma and Discrimination Working Group continued to meet with the University of Melbourne and undertake its consultation work throughout the COVID-19 pandemic.
19.1: Governments will reduce stigma and discrimination in the health workforce by: • developing and implementing training programs that build awareness and knowledge about the impact of stigma and discrimination.					
• MHPC will seek advice from the Expert Advisory Group about an approach for developing and implementing training programs for the health workforce that build awareness and knowledge about the impact of stigma and discrimination. • MHPC will engage with consumers and carers, professional bodies, workforce accreditation bodies, mental health commissions, service providers and other key stakeholders on the development and implementation of training programs. • MHPC will engage with other AHMAC Principal Committees on the approach to implementing training programs for the health workforce.	AHMAC (progress reported by the MHPC)	Completed by mid-2021		**Yet to commence**	This action has been deferred until the work under Action 18 is completed.
19.2: Responding proactively and providing leadership when stigma or discrimination is seen.					
• MHPC will seek advice from the Expert Advisory Group about where national responses and leadership are needed to support stigma and discrimination reduction in the health workforce.	MHPC	Completed by mid-2018		**Yet to commence**	This action has been deferred until the work under Action 18 is completed.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
19.2: Empowering consumers and carers to speak about the impacts of stigma and discrimination.					
• MHPC will seek advice from the Expert Advisory Group about approaches for reducing stigma and discrimination in the health workforce by empowering consumers and carers to speak about the impacts of stigma and discrimination.	MHPC	Completed by mid-2018		**Yet to commence**	This action has been deferred until the work under Action 18 is completed.
20: Governments will ensure that the Peer Workforce Development Guidelines to be developed in Priority Area 8: • create role delineations for peer workers that provide opportunities for meaningful contact with consumers and carers and grassroots based advocacy; and • identify effective anti-stigma interventions with the health workforce.					
• Refer to Action 29 for implementation approach.	MHPC	Commence mid-2018 Completed 2021		**Commenced – on track (as per Action 29)**	RMIT University was engaged to conduct consultation on the project and significant progress was made in early 2020. Additional work has been affected by the COVID-19 pandemic. Also see responses to Actions 19.1 to 19.3 and Action 29.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 7: Making safety and quality central to mental health service delivery					
21.1: Governments will develop a National Mental Health Safety and Quality Framework to guide delivery of the full range of health and support services required by people living with mental illness. The Framework will describe the national agenda and work program for safety and quality over the next 5 years, and will include: • identifying new and emerging national safety and quality priorities, and updating the 2005 statement of National Safety Priorities in Mental Health.					
• SQPSC will work with the Australian Commission for Safety and Quality in Health Care (ACSQHC) to update the National Safety Priorities in Mental Health.	SQPSC	Commence 2018 Completed 2021		**Commenced – on track**	A steering committee was established in consultation with the Australian Commission on Safety and Quality in Health Care. New and emerging safety priorities have been identified through a review of grey and peer-reviewed literature and available safety data. These priorities have been revised and prioritised in consultation with more than 300 consumers, carers, and mental health and non-mental health workforces. A draft of the revised National Safety Priorities in Mental Health is on track for completion by the end of 2020, ahead of a national consultation scheduled for Phase 2 of this project. Phase 2 completion is dependent on approval of the 2020–21 AHMAC funding bid.
21.2: A revised national mental health performance framework to support reporting on performance and quality across all mental health service sectors.					
MHISSC will revise the National Mental Health Performance Framework in line with: • development of the National Mental Health Safety and Quality Framework. • amalgamation of the National Health Performance Framework and Performance and Accountability Framework being undertaken by AHMAC. • the updated National Standards for Mental Health Services (NSMHS) being developed by the Australian Commission on Safety and Quality in Health Care.	MHISSC	Commence 2019 Completed 2020		**Completed**	This action was reported as 'completed' in the Fifth Plan 2019 Progress Report.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
21.3: A guide for consumers and carers that outlines how they can participate in all aspects of what is undertaken within a mental health service so that their role in ongoing safety and quality initiatives is strengthened.					
• The NMHC will progress the development of a consumer and carer guide. • The NMHC will consult with the National Mental Health Consumer and Carer Forum and SQPSC on the development of the guide.	SQPSC	Commence 2018 Completed 2020		**Commenced – on track**	The written content for the Safety and Quality Engagement Guide is completed. The Commission project team is currently working with a graphic designer to progress the development of the final product. It will be released in 2020. Feedback on the draft from the Project Advisory Committee and the SQPSC has strengthened the document, ensuring that it is fit for purpose. It is now more practical, targeted and accessible for its intended audience. The team is focusing on promotion to ensure it is widely disseminated. AHMAC funding approval for 2020–21 will help ensure completion.
21.4: A process for revising the National Standards for Mental Health Services that accounts for interfaces with other relevant standards such as the National Disability Standards.					
• SQPSC will work with ACSQHC to develop a suitable process for revising the National Standards for Mental Health Services.	SQPSC	Commence 2019 Completed 2021		**Commenced – on track**	The process developed under Action 21.4 will be initiated after the finalisation of Action 22, to ensure that the mental health supplement to the National Safety and Quality Health Service (NSQHS) Standards is included in the standards mapping work and to inform stakeholder consultations.
21.5: Coverage of all relevant service delivery sectors.					
• SQPSC will develop an approach to ensuring all relevant service delivery sectors are covered by the Framework.	SQPSC	Commence 2018 Completed 2020		**Commenced – on track**	SQPSC membership covers all relevant service delivery sectors including: state and territory governments; Community Mental Health Australia; the Australian Government Department of Health; and the Australian Private Hospitals Association.
22: Governments will develop a mental health supplement to the NSQHS Standards (2nd ed.) which will align the NSQHS Standards and the NSMHS. • The NSQHS Standards (2nd ed.) and its mental health supplement will guide implementation of the Standards for all mental health services in public and private hospitals and community services provided by local health networks to ensure a single set of standards for these services. • The NSMHS will be maintained as the authoritative reference point on quality mental health care for continuing use by those organisations not subject to the NSQHS Standards.					
• SQPSC to work with the ACSQHC to develop a mental health supplement to the NSQHS Standards (2nd ed).	SQPSC	Commence 2019 Completed 2021		**Commenced – on track**	The ACSQHC has an endorsed project plan for implementation of this initiative. An advisory group of stakeholders and experts has been commissioned; its first meeting is expected to occur just after the end of the reporting period. Preliminary consultations have begun with key stakeholders and with ACSQHC advisory bodies. In the absence of AHMAC funding approval, the ACSQHC has decided to proceed with the action using its own resources.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
23: Governments will implement monitoring of consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary care mental health service sectors. Efforts should be made to ensure groups that are historically poorly represented in these surveys such as Aboriginal and Torres Strait Islander peoples are properly represented and that survey tools are appropriately adapted to allow for this.					
• MHISSC will lead work with the AIHW to pool consumer and carer experiences of care data nationally, to develop performance indicators of consumer and carer experience, and to report these indicators annually at the lowest level of geography possible. • MHISSC will lead the work required to develop a primary care version of the Your Experience of Service survey (YES) survey tool.	MHISSC	Commence 2018 Completed 2021		**Commenced – on track**	The national consumer experience of service performance indicator has been endorsed by the MHISSC and data is reported in the new Consumer perspectives section of the AIHW's Mental Health Services in Australia web report. Data is also provided to the National Mental Health Commission for inclusion in the Fifth Plan *Progress Report*. Development of the YES PHN survey is complete. The survey is available for use via the Australian Mental Health Outcomes and Classification Network website. Rollout of the Carer Experience of Service measure is underway in a number of jurisdictions. Once sufficient data is available to support analysis, the National Mental Health Performance Subcommittee will develop a formal performance indicator specification.
24: Governments will develop an updated statement on National Mental Health Information Priorities for information developments over the next 10 years.					
• MHISSC will develop a 3rd edition of the National Mental Health Information Priorities, in consultation with consumers and carers, service providers, the NMHC, relevant professional organisations, governments, PHN's and other relevant bodies.	MHISSC	Published by December 2018	June 2020	**Completed**	The Third National Mental Health Information Priorities document was endorsed by the MHPC in March 2020. The document has subsequently been published on AIHW's Mental Health Services in Australia web report.
25: Governments will ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publicly available.					
• Commonwealth-funded services will have safety and quality monitoring and public reporting mechanisms. • State and territory-funded services have safety and quality monitoring and public reporting.	MHISSC (formerly SQPSC)	Completed end 2021		**Commenced – on track**	The MHISSC, in consultation with the SQPSC, is developing a draft national policy on performance reporting for MHPC endorsement. This policy will provide a consistent nationally agreed approach to performance reporting and support improvements in reporting across state, territory and Commonwealth-funded mental health services. The draft policy is expected to be finalised by the MHISSC at its November 2020 meeting.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
26: Governments will improve consistency across jurisdictions in mental health legislation. This will be based on an understanding of their impacts on consumer and carers and consistent with the 1 July 2016 United Nations Human Rights Council Resolution on Mental Health and Human Rights and the 2006 Convention on the Rights of Persons with Disabilities.					
• All governments, through SQPSC, will continue to work together to develop effective working relations within existing legislative provisions.	MHPC	Commence 2017 and ongoing		**Commenced – on track**	On 4 February 2020, the COAG Health Council agreed to develop a national legislative scheme to address the issue of mutual recognition of mental health orders. The Queensland Department of Health is funded to develop the scheme and has established a dedicated project team to undertake this work. A project steering committee was established in March 2020. As at 30 June 2020, the project was on track to deliver the national legislative scheme to the COAG Health Council by 31 December 2021.
27: Governments will make accessible the WHO Quality Rights guidance and training tools to build awareness amongst consumers and carers, community managed organisations and other health services of consumer rights under the Convention on the Rights of People with Disabilities.					
• All governments will take steps to ensure the WHO Quality Rights guidance and training tools pertaining to mental health are accessible to promote awareness of consumer rights. • The Commonwealth and states/territories will request their funded organisations utilise the guidance and training tools.	All jurisdictions (formerly SQPSC)	Commence 2018 and ongoing			A national status rating is not possible, as states are implementing this action independently. See status ratings and context for each jurisdiction below.
	Australian Government Department of Health			**Completed**	In alignment with the recommendation of the MHPC at its July 2020 meeting and the previous assessment noted in the 2019 Progress Report that the action may not proceed due to prohibitive costs, this action has been marked as completed.
	New South Wales – NSW Health			**Commenced – on track**	The WHO Quality Rights guidance and training tools are included as a key resource in the NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022. All districts and networks advise that they have included training on culturally appropriate, recovery-oriented, trauma-informed care principles for all mental health staff. NSW Health ensures that the principles of trauma-informed care are incorporated in mental health policy and guidance when they are updated and reviewed.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
	New South Wales – Mental Health Commission			Commenced – on track	A key aspect of the NSW Mental Health Commission's (NSW MHC) role is to promote the voice of people with lived experience of mental health issues, and to listen and respond to people with lived experience of mental health issues, as well as those involved in caring, family and kin of people with lived experience. The NSW MHC Lived Experience Framework is supported by a grants program. The wide-ranging funded projects promote engagement with, and strengthening of, lived experience voices and participation in service and system improvement in diverse locations and among diverse target population groups. These projects reinforce messages regarding the rights of people with disability, including psychosocial disability. The NSW MHC has recently updated the Peer Workforce hub, which provides resources to promote and support the growing peer workforce. This workforce, in both public and community mental health services, assists each other and those they work with, in their recovery journeys. The NSW MHC has continued to advocate for mental health reform and has spent much of 2019–20 undertaking and reporting on the Living Well Mid Term Review. The plan for continued focused reform is expected to be made public soon following tabling in NSW Parliament. The NSW MHC continues to monitor the progress of the National Disability Insurance Scheme (NDIS) for people experiencing psychosocial disability and receiving NDIS services. It aims to keep NSW MHC staff abreast of changes and news in the field of the NDIS and psychosocial disability to inform the work of the NSW MHC.
	Victoria – Department of Health and Human Services			Yet to commence	COVID-19 has meant that most projects not related to the COVID-19 effort were postponed.

Appendix A Status of Fifth Plan actions as at 30 June 2020

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
	Queensland – Department of Health			Commenced – on track	The *Mental Health Act 2016* (Queensland) establishes provisions to strengthen patient rights. A range of resources on patient rights were developed by the Office of the Chief Psychiatrist in 2017 to guide and support least-restrictive, rights-focused care in Queensland mental health services. Patient rights resources are available at on the Mental Health Act website. The Office of the Chief Psychiatrist is working with the Independent Patient Rights Adviser network across all Queensland Hospital and Health Services, to incorporate the WHO Quality Rights guidance and training tools pertaining to mental health into existing patient rights platforms and resources.
	South Australia – SA Health			Unknown	SA Health was unable to provide an update.
	Western Australia – Department of Health and Mental Health Commission			Completed	Whilst the Western Australian Government is broadly supportive of the intention of the WHO Quality Rights guidance and training tools, there are concerns regarding the content of the materials and their alignment with aspects of the Mental Health Act 2014 (WA). Given this, the Western Australian Government will not be progressing this action further. Health service providers funded by the Australian and state or territory governments utilise training materials which align with the National Standards for Mental Health Services. Additionally, the Chief Psychiatrist of Western Australia provides training to Authorised Mental Health Practitioners who work in inpatient and community-managed mental health services, which aligns with the Chief Psychiatrist Standards for Clinical Care. Both sets of training materials include provisions that protect the rights of consumers, and appropriate safeguards.
	Tasmania – Department of Health			Yet to commence	Tasmania has had a very preliminary discussion with WHO representatives regarding implementation of this action in Tasmania. Any further consideration would be subject to negotiated costs and consideration of the outcomes of the 2020 Review Report regarding the operation of the *Mental Health Act 2013* (Tasmania). The Tasmanian Department of Health is also developing a commissioning framework for community sector mental health services. This framework will draw together the safety and quality frameworks that are applied to community sector services and govern the reporting of providers against relevant standards, so could complement the WHO Quality Rights guidance and training tools if they are adopted.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
	Northern Territory			Yet to commence	The NT Health draft policy on seclusion and restraint incorporates the WHO Quality Rights guidance and training tools as a resource for all NT Health staff to implement. As the Department of Health contracts in the community mental health sector are updated and reviewed, they will include a recommendation to promote and adhere to the WHO Quality Rights guidance and training tools for all staff. Future review processes (currently in the planning stage) provide further opportunity for incorporating the WHO guidance and training tools into supporting legislative material.
	Australian Capital Territory – ACT Health and Office for Mental Health and Wellbeing			Commenced – on track	Consumers are given access to the ACT Charter of Consumer Rights for People with mental illness through contact with clinical services.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
Priority 8: Ensuring that the enablers of effective system performance and system improvement are in place					
28: Governments will request the National Mental Health Commission to work in collaboration with the National Health and Medical Research Council, consumers and carers, states and territories, research funding bodies and prominent researchers to develop a research strategy to drive better treatment outcomes across the mental health sector.					
• The NMHC will lead the development of a research strategy in collaboration with the NHMRC, consumers and carers, states and territories, research funding bodies and prominent researchers.	MHPC	Commence mid-2018 Completed 2021		**Commenced – on track**	A workshop involving members of the National Mental Health Research Strategy Steering Committee was held in March 2020. Additional work has been affected by the COVID-19 pandemic.
29: Governments will develop Peer Workforce Development Guidelines consistent with the recommendation made by the National Mental Health Commission's 2014 National Review of Mental Health Programmes and Services, and the commitment made at Action 20.					
• The NMHC will lead the development of Peer Workforce Development Guidelines. • The NMHC will consult with all governments, mental health commissions, consumers and carers and the mental health sector on development of the guidelines.	MHPC	Commence mid-2018 Completed 2021		**Commenced – on track**	RMIT University was engaged to conduct consultation on the project and significant progress was made in early 2020. Additional work has been affected by the COVID-19 pandemic.
30: Governments will monitor the growth of the national peer workforce through the development of national mental health peer workforce data including data collection and public reporting.					
• MHISSC will continue development of data sources to monitor the growth of the national peer workforce in public sector mental health services. • MHISSC will also identify opportunities for reporting of employment of peer workers in the non-government sector, including PHNs.	MHISSC	Commence mid-2018 and ongoing		**Commenced – on track**	The MHPC endorsed the MHISSC's proposal for a peer workforce non-government organisation survey at its August 2019 meeting. Further work to implement the survey has been delayed by the COVID-19 pandemic and the need to identify a funding source.
31: Governments will use the outputs from the NMHSPF, and other relevant data, to develop a Workforce Development Program that will guide strategies to address future workforce supply requirements and drive recruitment and retention of skilled staff.					
• The Commonwealth will manage contractual arrangements with an expert provider to obtain outputs from the NMHSPF to inform the development of this activity. • MHPC will agree on the scope of the Workforce Development Program and will consult with relevant AHMAC committees on the approach to ensure alignment with broader health workforce policy arrangements.	AHMAC (progress reported by the MHPC)	Commence early-2018 Completed 2022		**Commenced – on track**	The Australian Government is developing a National Mental Health Workforce Strategy. A Taskforce to lead this work was established in March 2020 and met shortly thereafter. Progress has been affected by the COVID-19 pandemic.

Role	Coordination Point or nominated respondent	Milestone date in Implementation Plan	Amended completion date (if applicable)	Status	Context for ratings
32: Governments will develop a National Digital Mental Health Framework in collaboration with the National Digital Health Agency that will include: • an analysis of available research on new technology driven platforms that are already operational • an analysis of interoperability considerations relevant to future data developments • cohesive guidance on the structure of digital mental health help services • recommendations on the development of new digital service delivery platforms • actions for addressing access to new digital service delivery platforms for people from culturally and linguistically diverse communities and others who have limited engagement with these platforms • clinical governance mechanism for e-mental health services that builds appropriate safety and quality mechanisms into service delivery and provides for links into traditional face-to-face services; and • workforce development priorities to improve access to digital services.					
• MHPC will agree the approach to development of the Framework. • The Commonwealth, in collaboration with the National Digital Health Agency, will engage a suitably qualified provider to scope the requirements of a national digital mental health framework through a comprehensive consultation process, including with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee. • States and territories to contribute to Commonwealth consultation and development of the framework.	AHMAC (progress reported by the MHPC)	Commence mid-2018 Framework completed 2020		**Commenced – on track**	The Australian Government Department of Health is leading this action in consultation with the National Digital Health Agency. PricewaterhouseCoopers was engaged by the Australian Government Department of Health in August 2020 to develop the framework by June 2021. A broad consultation period will commence in November 2020 and is being widely promoted. This follows a period of project planning and preliminary discussions with key stakeholders. A Digital Mental Health Framework Advisory Group has been established to provide guidance and advice on the project. Membership was informed by the MHPC.

Glossary

Ambulatory mental health care

Ambulatory mental health care is mental health care provided to hospital patients who are not admitted to hospital, such as patients of emergency departments and outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

Community mental health care

Community mental health care refers to government-funded and government-operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.

Coordination Point

A Coordination Point is the stakeholder named in the *Fifth National Mental Health and Suicide Prevention Plan Implementation Plan* as having responsibility for coordinating the implementation of the action.

Developmentally vulnerable

Developmentally vulnerable is defined as an Australian Early Development Census (AEDC) domain score in the lowest 10% of scores, based on data from all children who participated in the AEDC, taking into account age variations in the population of children in their first year of schooling.

Illicit drugs

Illicit drugs are defined as illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes.

Long-term health condition

A long-term health condition is defined as any of the following conditions, which has lasted 6 months or more, or is expected to last 6 months or more:

- asthma
- arthritis
- cancer
- diseases of the circulatory system
- diabetes mellitus
- back problems
- chronic obstructive pulmonary disease (COPD; Bronchitis, emphysema).

Postvention

Postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers).

Psychological distress

Psychological distress is measured using the Kessler psychological distress scale. The scale consists of questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms a person may have experienced in the 4 weeks prior to interview.

Seclusion

Seclusion is defined as the confinement of a consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.

Separation

Separation is the term used to refer to an episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

Specialised mental health services

Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. This includes admitted patient mental health care services, ambulatory mental health care services and residential mental health care services.

Acronyms and abbreviations

2019 Progress Report	*Fifth National Mental Health and Suicide Prevention Plan, 2019: Progress Report 2*
ACCHS	Aboriginal Community Controlled Health Service
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ATSIMHSPPRG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group
CAHS	Central Australia Health Services
CHS	Canberra Health Service
COAG	Council of Australian Governments
DHHS	Department of Health and Human Services (Victoria)
Fifth Plan	*Fifth National Mental Health and Suicide Prevention Plan*
GP	General Practitioner
Implementation Plan	Fifth National Mental Health and Suicide Prevention Plan Implementation Plan
KPI	Key performance indicator
LHN	Local Health Networks
MHISSC	Mental Health Information Strategy Standing Committee
MHJHADS	Mental Health, Justice Health, Alcohol and Drug Services
MHPC	Mental Health Principal Committee
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NSMHS	National Standards for Mental Health Services
NSQHS Standards	National Safety and Quality Health Service Standards
NSW Health	New South Wales Ministry of Health
NSW MHC	New South Wales Mental Health Commission
OMHW	Office for Mental Health and Wellbeing
PHN	Primary Health Network
SA Health	South Australian Department for Health and Wellbeing
SQPSC	Safety and Quality Partnership Standing Committee
TEHS	Top End Health Service
TMHRP	Tasmanian Mental Health Reform Program
WHO	World Health Organization
YES survey	Your Experience of Service survey