nacmh
national advisory council on mental health

A Mentally Healthy Future for all Australians.

We don't just want to live in Australia, we want to live in a mentally healthy Australia

A DISCUSSION PAPER

NOVEMBER 2009

NATIONAL ADVISORY COUNCIL ON MENTAL HEALTH

The vision and architecture for an innovative response to Australia's continuing mental health crisis. Building a mentally healthy Australia by promoting resilience, preventing mental illness where possible, intervening early when a mental illness is first evident and providing integrated, ongoing care for those who experience a mental illness.

THE NATIONAL ADVISORY COUNCIL ON MENTAL HEALTH

The National Advisory Council on Mental Health (NACMH) was established as an election commitment of the Rudd Labor Government in June 2008. The NACMH provides a formal mechanism for the Australian Government to gain independent advice from a group of appointed experts to inform national mental health reform. The objective of the NACMH is to provide timely, expert, balanced and confidential advice to Government on mental health issues and respond to requests from the Minister for Health and Ageing.

The Secretariat for the NACMH is located in the Department of Health and Ageing in Canberra.

ACKNOWLEDGEMENTS

The NACMH wishes to acknowledge the work of Urbis Pty Ltd in the preparation of this discussion paper, particularly Duncan Rintoul and Tomas Lopata. We also acknowledge the sub-group involved in preparing this paper (Ms Dawn O'Neil, Adjunct Professor John Mendoza, Professor Lyn Littlefield and Professor Helen Milroy), as well as the NACMH Research Policy Officer, Dr Leanne Craze. Thanks are also due to the external reviewers who assisted in finalising the paper.

Members of the NACMH are:

- Adjunct Professor John Mendoza
- Mr Michael Burge
- Professor Lyn Littlefield
- Associate Professor Neil Cole
- Mr David Crosbie
- Professor Allan Fels
- Professor Ian Hickie
- Professor Helen Milroy
- Ms Dawn O'Neil
- Dr Robert Walters

CONTENTS

FOREWORD

We don't just want to live in Australia – we want to live in a mentally healthy Australia.

Australia was the first nation in the world to recognise the need for a national effort to improve mental health services for people with mental illness. In 1992, the then Keating Government, with the agreement of all States and Territories, committed to the development and implementation of the first National Mental Health Strategy, based on an agreed national policy and a five year plan.

In the seventeen years since, much has been achieved and much has changed about the way mental health services are delivered. Much has changed about the way Australians understand mental health and mental illness. However, the reporting of mental health issues, be it through the media, official reports or the professional literature, reflects the reality that the admirable intentions and genuine commitment of governments to reform services have left many vulnerable Australians without access to mental health care when they need it. Furthermore, it is clear that the greater vision of bringing people with mental illness successfully out of the 'asylum' and achieving integration with the broader community has not been realised.

The evidence of the shortfall in policy intention and outcomes is there for all of us to see and for many to experience on a daily basis. Mental health, Indigenous health and dental health have been identified as the areas for urgent action in the recent National Health and Hospital Reform Commission's final report *A Healthier Future for All Australians*. Each of these areas has the poorest health outcomes, the poorest resourcing and is the least functional in our national health system.

The National Advisory Council on Mental Health endorses this view and we believe that a fundamental and transformative change in policy and approach – in the very way we conceptualise mental health and illness – is necessary to address the reality confronting us as a nation.

A mentally healthy Australia is fundamental to our sustainability – economically, culturally and socially. Being mentally healthy means being in a state of complete mental, emotional and social wellbeing and this involves much more than merely 'the absence of a mental illness'. Being mentally healthy is more than having access to a first rate person-centred health care service where and when we need it.

Our governments' investment in mental health need to evolve significantly: beyond the dominant focus on acute and sub-acute health care to include a more balanced emphasis on community care, a clear focus on managing the risk factors that can give rise to mental illness and a strengthening of the protective factors that prevent mental illness and promote mental health.

To be successful, investment in a mentally healthy Australia needs to be embedded across a whole-of-government national policy framework. This means that we need to reflect a focus on mental health across the board – in our approach to education, social services, housing, employment, Indigenous affairs and so on – not just in our health or mental health services

Our vision is that all Australians can live a mentally healthy life and be able to access quality mental health services and support when and where they need it.

This discussion paper is about giving our mental health the priority it deserves and closing the mental health 'aspiration gap' – the distance between where we are now and where we know we should and can be.

John Mendoza

Chair
National Advisory Council on Mental Health

A VISION FOR A MENTALLY HEALTHY AUSTRALIA

Vision

That all Australians can live a mentally healthy life and be able to access mental health services and support.

Mission

Building a mentally healthy Australia by promoting resilience, preventing mental illness where possible, intervening early when a mental illness is first evident and by providing integrated, ongoing care for those who experience a mental illness.

Key Messages

Absence of mental illness does not mean the presence of mental health.
Mental illness is common and affects all Australian families.
The cost of poor mental health is high.
The problems are known, as is how to address them. Failure to act could have severe consequences.

Core Values

There is no health without mental health.
A mentally healthy Australia will have mental health services that are non exclusive, culturally inclusive, timely and flexible.
Valuing compassion, diversity and responsibility.

Impact Statement

Mentally healthy Australians will grow, develop and achieve personal goals, have healthy relationships and connections to community, have the ability to cope with life's stressors and be fruitful throughout life.

PROGRAM PRIORITIES

Mental health is everybody's business

- Whole of community involvement and engagement
- Leadership by all governments to make mental health the responsibility of all sectors
- All looking through a mental health lens, taking personal and collective responsibility
- Mental health literacy
- Stigma reduction
- Mentally healthy societal norms and values

Investing in our communities

- Engaging and resourcing communities to build solutions and to address locally the social determinants of mental health and illness
- Tackling equity and access issues that affect mental health
- Targeting the most disadvantaged as a priority
- A base level of community resources and supports for all
- A mental health focus in community building and social inclusion programs

Investing in our workplaces

- Increased employment of people with mental illness through:
  - Employment placement support and peer support
  - Employer incentives, supports and safety nets
- Focus on mental health in the workplace – improving workplace conditions and reforming OH&S legislation and practice
- Mentally healthy and family friendly workplace polices and practices

Investing in our children, youth and families

- Acting early and nurturing a healthy start in children and families
- Early childhood, family mental health and developmental services (0-25yrs)
- Schools as hubs for acting early and for supporting children and families
- Increased focus on promotion, prevention and early intervention
- A spectrum of services for high risk families
- Stable housing as a priority

Investing in our health system

- Higher benchmarks of mental health literacy and competency training for all health professionals
- Equitable access to care for people with mental illness
- Connecting care through integrated, multidisciplinary and holistic collaborative care
- Integration of priority and targeted health programs with mental health services and care
- A partnership with the community to address suicide and self-harm
- e-Mental Health Services to increase access and earlier detection

Investing in our mental health system

- Ensuring timely, safe and quality care and clinical leadership
- Access to affordable, flexible, person-centered and inclusive services
- Culturally appropriate services incorporating traditional methods
- Early psychoses programs national roll-out
- Integration of clinical and community-based support and recovery services
- Expanded community-based support and recovery services
- National roll-out of best practice for personality spectrum illnesses
- Improved rural and remote access

Investing in research and measuring progress

- An increased investment in research
- A Mental Health Reform Agency to improve quality, safety, performance and accountability
- A National Institute for Mental Health – a research clearing house to strengthen the evidence base
- National Service Standards, Benchmarks and an Accreditation Program
- Consumer and carer participation in measuring and reporting
- Uniform legislative provisions across all jurisdictions

nacmh national advisory council on mental health

PROGRAM PRIORITY AREAS	GAINING THE GREATEST IMPACT
A mentally healthy Australia is **everyone's business**	Establishing mental health as a national priority and the responsibility of all sectors
	Mental health literacy through expanded community education and stigma reduction initiatives
Investing in our **communities**	Priority Communities Initiative
	Mentally Healthy Communities Program
	Revision and implementation of the Social and Emotional Wellbeing Framework in Indigenous Communities Initiatives
Investing in our **workplaces**	A Mentally Healthy Workplace Study
	Employer Incentive and Safety Net Program
	Employment Support Program for people with mental illness
Investing in our **children, youth and families**	Early childhood and family mental health and developmental services
	Schools as hubs for acting early and nurturing children and families
	A spectrum of services for families at high risk
Investing in our **health system**	Services for the elderly
	Mental health practice and competency training for all health providers
	National roll-out of early psychosis intervention and treatment services
	National roll-out of early intervention services for high prevalence mental disorders
	Connecting Care Initiatives – person-centred, multidisciplinary, collaborative practice incentives that address the inequities in physical health of people with mental illness
	A partnership with the community to address suicide and self-harm
Investing in our **mental health system**	e-Mental Health Services
	Mental Health Service Reform Incentive Program – ensuring timely and quality services across life span, across disorders and across acuity
	Expansion of community-based support, recovery and stable housing models
	National Mental Health Workforce Strategy – a sustainable, supported and flexible workforce for the future
Investing in measuring our **progress**	Mental Health Reform Agency – strengthening accountability and quality
	Uniform legislative provisions
	National Institute for Mental Health – strengthening evidence and fostering learning

1 A MENTALLY HEALTHY AUSTRALIA

This is about a future we all want and deserve.

Being mentally healthy means being in a state of complete mental, emotional and social wellbeing. This involves much more than just 'not having a mental illness'. We need to be mentally healthy to get the most out of life: there is no health without mental health.

This discussion paper is about giving our mental health the priority it deserves and closing the mental health 'aspiration gap' – the distance between where we are now and where we know we should be.

In a mentally healthy Australia we will live in healthy communities with good social support.

We will grow up in safe and supportive family environments.

We will understand how to maintain good mental health, and be alert for warning signs that it might be deteriorating.

We will value our mental health, doing whatever it takes to protect and promote it.

We will do what we can to support or strengthen the mental health of our friends and neighbours.

We will have access to facilities, social supports and services that help us get the most out of life.

We will manage the normal stresses of life, be fruitful and participate in our communities.

We will understand and value diversity and respect difference.

We will oppose violence, racism, drug misuse and alcohol abuse in our families and communities.

We will be reconciled to the injustices of the past and committed to closing the many gaps between Indigenous and non-Indigenous Australians.

We will talk openly about our mental health with friends and work colleagues, confident that we will be understood, supported and included.

In a mentally healthy Australia we will all have access to a first-rate health system.

Our mental health problems will be identified early by people who are able to help us.

We will be comfortable talking with others, including health professionals, about our mental health.

We will be able to access the information, support and care we need, when and where we need it.

Health professionals from different disciplines will work cooperatively for our benefit.

We will be provided with a continuity of care and 'safe handover' within and beyond the health care system when it is needed.

This will be true for all of us, regardless of our origins, our income or our postcode.

In a mentally healthy Australia our mental health will be part of the big picture.

Our governments will think broadly about the factors that contribute to our mental health. This will shape the way they (and we) think about all manner of things – schooling, community services, housing, urban planning, workplace law and more.

Our governments will make serious investments in building resilience and in the prevention, early intervention and treatment of mental illness based on the best evidence available.

Our governments will protect the rights of all people, particularly recognising the important contribution of Aboriginal people and Torres Strait Islanders to the culture of our nation.

The approaches taken by our governments will be bipartisan and apolitical. They will demonstrate a sustained commitment to the vision that we don't just want to live in Australia – we want to live in a mentally healthy Australia.

2 WHERE ARE WE NOW?

Mental illnesses are common illnesses.

Almost one in two people aged 16-85 years can expect to experience a mental illness at some point in their lives – most commonly anxiety, depression and/or alcohol dependence.

Not surprisingly, most of us know someone who has had a mental illness – research shows that 17 in 20 people have a family member or friend who has had a diagnosis or suspected mental illness.

The annual cost of mental illness in Australia is estimated at $20 billion.

This estimate includes the direct cost of providing services to people affected by mental illness, as well as the cost of lost productivity, non-participation in the workforce and morbidity as a result of suicide. Mental illnesses are the largest cause of disability – accounting for almost a third of the total disability burden. Schizophrenia alone is responsible for more disability than any other single illness.

Billions of dollars are spent each year on providing mental illness-related services, and many advancements have been made in the treatment and prevention of mental illness. However, 65 per cent of all Australians with a mental illness do not access support services and, despite 10 years of investment, this has remained unchanged.

Much greater investment, and much smarter investment, is needed to ensure that our society is able to meet our current and emerging mental health needs over the coming decades.

Progress has been made.

Australia's mental health policy, program and service environment is remarkably better today than it was a few decades ago.

Governments have made a concerted effort to identify the many stakeholders and services involved in addressing mental illness – from anxiety disorders and depression through to conduct disorder and psychoses.

Similarly, there has been an increase in the promotion of mental health protective factors, and we are slowly beginning to take seriously the need to consider the bigger picture beyond the presenting symptoms.

We need to be ready for more.

The World Health Organisation predicts that developed nations will see an increase in the burden of disease and disability attributable to mental illness over the next decade.

Younger generations today are drinking alcohol and using drugs in ways which result in greater harm than previous generations. Equally, young people today are exposed to far greater family and relationship breakdown than any previous generation. The combined impact of these two factors on their mental health has already been significant, and will only escalate if effective action is not taken.

We need to learn to think differently about mental illness and mental health.

Increasing levels of community awareness about mental health should be celebrated: until very recently, mental illness has been something that people rarely spoke of. However, we are still far from achieving the goal of inclusive acceptance.

Some of us continue to resist confronting our own mental health problems and are reluctant to seek help. Some of us contribute to the ongoing stigma of people with diagnosed mental illness across our communities and workplaces.

The results of a 2008 community survey by beyondblue are telling: 78 per cent of respondents agreed they would 'feel embarrassed to talk to their doctor about depression', 32 per cent agreed that 'people with depression can't be trusted in positions of responsibility', and 15 per cent agreed that 'people with depression who work in high profile jobs (such as lawyers and doctors) should quit'. Attitudes to other mental illness, many less understood than depression, are not known.

Other community research has found that almost three in four Australians have negative associations with the term 'mental health'. Equally, talk of 'mental health services' tends to bring to mind services that deal with mental ill-health or illness.

The absence of mental illness does not mean the presence of mental health.

This is one of the most pervasive misunderstandings about mental health – and one of the most limiting in terms of how we think about our public policy and personal responses.

A person can be chronically angry and short-tempered without having a mental illness. In fact, only a small proportion of people who are free from mental illness are actually mentally healthy.

Mental health relates to the presence of positive attitudes, rather than the absence of something negative – a state of wellbeing in which we can manage the normal stresses of life, be fruitful and contribute in our communities and relationships. Evidence shows that people who are mentally healthy are more productive, more socially connected and more likely to achieve what they want from life.

Suicide is the worst outcome of mental distress in our society.

More Australians die each year as a result of self-inflicted harm than through motor vehicle accidents and homicide combined. Tens of thousands of Australians require hospital admission each year due to self-inflicted injury.

Suicide accounts for almost a quarter of all deaths among young Australian men aged 20-34 years. The rate of suicide among Indigenous Australians is around four times that of non-Indigenous Australians. People living in rural Australia (aged 15-24 years or 55+ years) are also 30-50 per cent more likely to end their life by suicide than their peers living in major cities. In the Kimberley region, the rate of suicide among Aboriginal people is seven times the rate of non-indigenous Australians.

International studies tell us that up to 83 per cent of individuals who take their lives have had contact with a primary care health professional within a year of their death, including 66 per cent within a month. The mental health needs of these people are not being sufficiently detected or met.

There are things we can do – things we must do – to respond to these tragic realities.

The most vulnerable are likely to miss out.

Research shows that people living in the most socio-economically disadvantaged areas of Australia experience a higher prevalence of mental or behavioural problems (12.3 per cent) compared with people who live in the least socio-economically disadvantaged areas. Social exclusion, with its barriers to everyday goods and services, can compound the impact of poor mental health. Some groups, including those with the most complex needs and those who are most vulnerable, are missing out and not getting the services they need.

More needs to be done to provide mental health care that meets the needs of specific groups such as Indigenous Australians, those who have experienced generational trauma and abuse, people who are homeless, children living in families with severe mental illness, people from culturally and linguistically diverse communities, offenders and their families, youth, the elderly and people with personality disorders; the latter often being excluded from even the most basic services and care.

More needs to be done, and much more quickly. Our mental health services are stretched beyond capacity, and their focus and distribution needs to change.

Change has been frustratingly slow and incremental, and we are clearly not where we need to be to provide the services that our citizens need and have the right to receive.

Our network of clinical and non-clinical services is poorly structured. The end result is that the identification, assessment, diagnosis and treatment of mental illness is too often ineffective.

Our systems are not organised to provide care at the earliest possible point. Too often, this leads to a 'reactive' approach that focuses on responding to crisis situations.

Mental illness continues to be treated in 'silos', with an over-emphasis on medical responses and a neglect of the countless triggers including financial hardship, trauma and personal loss, that are known to contribute to adverse mental health outcomes.

Our system is complex and disjointed and people continue to fall through the gaps. Even when referrals are made, effective follow-up is not the norm.

Access to timely and appropriate services in rural Australia continues to be particularly inadequate. Even though the mental health challenges faced by rural and remote communities are great and well-documented, our service system is still skewed towards higher-income urban areas.

For many people with mental illness, the first point of connection with the health system is primary health care. The enhancement of primary care as the front line of multidisciplinary health care is essential. It is vital for the role it can play in both mental health and public health initiatives and for enabling prevention, early detection, stabilisation and recovery. We need a connected system which is able to cope with the full range of challenges that emerge, including prevention, adequate care focused on individual need and the managing of complex needs in partnership with other health and community sectors.

We know what the problems are, and how to address them.

Although there are still some gaps in our knowledge about mental health and mental illness, we are not flying blind: there is ample evidence to guide more sophisticated individual and national responses than we currently implement.

We know what factors promote mental health, and equally what factors can trigger mental illness.

We also know what makes communities healthy – the factors that contribute to a positive child-rearing environment, the impact of alcohol, physical, emotional and sexual abuse on the future of young people and the counterproductive impact of stress in the workplace.

The question now is not one of what we ought to do, but whether we will do it, and when.

3 WHERE IS AUSTRALIA HEADING?

Australia has undergone fundamental social and environmental changes over the last 250 years, some of which have had an unavoidable impact on our mental health.

In order to make the best investment in Australia's future as a mentally healthy nation, we need to consider what this future is likely to hold.

The pace of technological change is tremendous and exciting – and challenging.

The way we relate to each other in Australia has changed dramatically in the last generation, and there is every indication of the pace accelerating.

The internet and email are revolutionising the way many of us communicate. Our expectations of instant response and access to information are only going to mount as national technological literacy expands and computer and internet access improves. Online communities and 'virtual worlds' are also allowing new and anonymous forms of identity-building and relationship development, without the need for personal contact.

Technology may be bringing some of us closer and making us more efficient, but it is also adding new dimensions of stress to our lives. We can sit in different continents and have face-to-face meetings as if we were in the same room, but unavoidably this will be in the middle of the night or during family time for someone. The internet in our homes gives us access to masses of information and entertainment, but it also gives our children easier access to pornography and other potential harms. Mobile technologies allow us to be in contact with our friends and colleagues wherever we go, but they also make it difficult for some of us to 'leave work at work' or avoid unwanted communications (like cyber-bullying).

Our family and household structures are changing.

The notion of the 'Australian family' extends far beyond traditional norms of married couples with their own biological children. The true picture of Australian families includes single parent families, blended families, same-sex couples with children, active grand-parenting, kinship care, assisted conceptions based on IVF or surrogacy, foster care arrangements and more.

At the same time, young people are staying in the family home into their 20s (and sometimes later), as they save for a home deposit and having children later in life.

We also have more single-person households and un-used bedrooms than ever before. This comes at a time when overcrowding is a significant issue in Indigenous communities and homelessness is an equally significant issue for many people with a mental illness. Both of these outcomes present major health risks and challenges for families, communities and governments.

Modern life can test our mental health.

Our fast-paced and consumer-oriented society has changed some fundamental things about our lives, including what we eat, how we produce our food, how we work and learn, how we socialise and interact and how much we exercise. All of these are factors that influence our mental health. Since it is possible to modify many of these influences, addressing growing mental health issues is within our grasp. Action is now needed to address the well-documented and understood social determinants of mental health: social inclusion, freedom from discrimination and violence and access to economic resources such as employment, income and housing.

Meanwhile, Indigenous Australians continue to live with significant and unacceptable inequalities in living standards, life expectancy and a wide range of education, health and employment outcomes.

We are also surrounded with cautionary information about the future of our health, our safety, our children, our economy, our environment and more. Media studies have shown that these messages can instil a culture of fear and fuel levels of collective and individual anxiety.

In Australia we are not immune from the impact of global financial trends and incidents. The current global financial crisis is placing many people in financial hardship, with increasing unemployment, reductions in working hours (leading to reduced income) and higher rates of loan and mortgage default. The consequences of financial hardship include emotional strain and distress as well as higher risk of some mental illnesses.

As we enjoy the benefits of living in the twenty-first century, we must also find ways of balancing the significant risks that our lifestyles pose to our health.

Whatever happens in the future, the human condition will stay the same.

Pan forward as far as you like, and we will still need the same basic things to function – things like food, water, shelter, healthy relationships, sleep and our health. A baby will still need care and nurturing to be healthy and develop to his or her full potential. We will still want to enjoy life and feel we are achieving something. We will still need care and support to get by as our independence is diminished by the ageing process.

Technology will be able to help us, but there will always be intrinsic and enduring qualities that make us human. It is these that we must strengthen, particularly in our children.

Our mental health is critical to our future.

We are living in exciting times. If we are to enjoy these times and thrive, we need to be mentally healthy.

Being mentally healthy does not happen by accident – we need to plan for our mental health: as individuals, families, communities and as a nation.

Australia needs a mental health lens.

It is time for all Australian governments to ensure that decision making does not occur without first assessing the mental health impacts of new strategic level policies, programs or changes. Social sustainability is as critical to our nation and it's peoples' success as economic and environmental sustainability. Decisions need to be viewed through a mental health 'prism' or lens of mandated questions:

- What is the evidence about the likely or possible impact of this proposal on people's mental health?
- Will this proposal enhance or inhibit the social and economic participation of those living with a mental illness?
- Will this proposal promote or detract from a mentally healthy community? A mentally healthy workplace? Mentally healthy families, homes and schools?

4 THERE IS NO HEALTH WITHOUT MENTAL HEALTH

"To prosper and flourish in a rapidly changing world, we must make the most of all our resources – both mental and material…"
(The mental wealth of nations; Nature/Vol 455/23 October 2008).

Because there is no health without mental health, failure to act could have severe consequences.

The elements of the human condition describe what it is to be human.

Our psychological, emotional, social and cognitive abilities help us construct meaning in our existence.

The health of our bodies and minds are interrelated: one can rarely be considered without the other.

The degree to which we feel connected to and supported in our families and social communities is also very important to our health.

Our spiritual and cultural understandings of ourselves also influence our self-perceptions, beliefs, choices and wellbeing. [1]

Holistic concepts of wellbeing have been a long-standing theme in Australian Indigenous culture. Definitions of Indigenous mental health have a holistic approach which explains the cultural importance of the connection between the mind and body, as well as the land, ancestors and other spiritual constructs.

An awareness of the individual aspects that make up the human condition and how they relate to a person's mental health is a key part of person-centred care approaches.

Life comes and goes in stages.

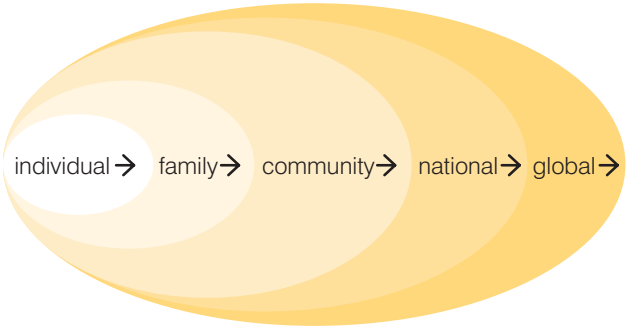
The experiences of childhood, adolescence, adulthood and old age present unavoidable points of change in our lives. These transitions can create vulnerability and stress, as can decisions about relationships, work and family, as well as 'crisis points' such as the death of a loved one. Equally, such changes and events can present great opportunities for learning and growth.

We are unavoidably affected by our natural and constructed environments.

Some of us are supported by our families and social networks. Some of us are able to access high-quality services which we can depend on. Some of us live in communities that are planned to keep people safe and make services accessible and responsive. In Australia we are fortunate to live in a democracy where all governments strive to build expectations of participation and inclusion of most people in society.

However, each of these spheres of possible support can also act in ways that undermine our mental health. Some of us belong to distressed families, are excluded from our communities, or feel threatened by global issues like climate change, racism or terrorism.

As a society and as individuals, we can and should choose to influence our environments in ways that benefit our mental health.



[1] The Flannel Flower shown in this diagram is used as a national symbol to promote awareness of mental health in Australia. To survive the harsh extremes of Australia's climate, the Flannel Flower has had to be adaptable. In the same way, all of us need to develop resilience and the ability to adapt to change in order to strengthen and maintain our mental health.

5 INVESTING IN A MENTALLY HEALTHY AUSTRALIA

5.1 A MENTALLY HEALTHY AUSTRALIA IS EVERYBODY'S BUSINESS

Our mental health needs to be a collective responsibility.

Our governments have a significant role to play in the provision of services and information that support our mental health and wellbeing. Their investments in mental health need to evolve significantly: beyond the dominant focus on reducing mortality and morbidity to also include a clear focus on managing the risk factors that can give rise to mental illness and strengthening the protective factors that prevent mental illness and promote mental health.

To be successful, investment in a mentally healthy Australia needs to be embedded across a whole-of-government national policy framework. This means that we need to reflect a focus on mental health across the board – in our approach to education, social services, housing, employment, Indigenous affairs and so on – not just in our health or mental health services.

Our mental health also needs to be a personal priority.

Lasting change will not come from simply ensuring that publicly available mental health services, facilities and information are adequate. As individuals, friends, family members and neighbours, we all need to take responsibility for taking better care of ourselves and each other to build and maintain good mental health and wellbeing. Broad change will only come from the individual actions of many.

Investing in our mental health is not all about medicine.

Each year there are billions of dollars invested around the world in medical research that allows us to live longer and healthier lives. The capacity of modern medicine to manage conditions and illnesses that were once fatal or greatly debilitating is surely one of the greatest achievements of our time.

There is more work to do here, and we must not forget the significant inequities in living conditions and access to medical technology across the nation. This is seen most obviously in the gap between the life expectancy of Indigenous and non-Indigenous Australians and for people with severe mental illness in Australia.

However, we also need to remember that medical developments only account for about 25 per cent of the increase in longevity over the last century. The bulk of our improved health can be attributed to the improved living conditions many of us enjoy today (through things such as sanitation, housing and environmental management) and reductions in preventable risk factors associated with what we eat, how much exercise we get, whether we smoke tobacco, how much alcohol we drink and so on.

Many of the factors that promote and protect our mental health are within our control (or at least influence) as communities, families and individuals.

As a nation, we intuitively have a sense of the mental health implications of our lifestyle, environment and life circumstances. For example, recent community research found that the top four factors considered to contribute to our mental health are 'having good friends to talk problems over with', having the 'opportunity to have control over one's life', 'keeping one's mind active' and 'physical activity'.

Although not all of us are always able to individually control or influence all of these lifestyle factors, there is no question that the way in which we treat ourselves and each other is an essential foundation for our mental health.

5.2 INVESTING IN OUR SOCIAL AND COMMUNITY INFRASTRUCTURE

A mentally healthy Australia needs strong communities.

For many years, policy makers have spoken of the need to invest in 'social capital', 'community development' and 'community capacity-building'. The message here is simple but powerful: communities have an inherent potential to achieve great things for themselves and for others, and they should be resourced to do so.

Strong communities are equipped.

In order to work together towards positive goals, communities need access to a range of resources, facilities and opportunities – these are broadly referred to as 'social and community infrastructure'.

In the same way as we need appropriate health and mental health services to help individuals living with a mental illness, we also need high quality social and community infrastructure to promote and maintain our mental wellbeing at a community level. This includes schools, parks, libraries, footpaths, theatres, youth facilities, shops, play groups, restaurants, places of worship, Indigenous cultural centres, community sporting clubs, public gathering places and more – the list is a very long one.

There are clear patterns of cause and effect.

Social problems have a habit of accumulating and building on each other. For example, unemployment, unstable housing arrangements and debt all lead to financial stress, which in turn erodes our self-esteem and can strain relationships in the home. Similarly, unsafe streets and limited access to parks discourage us from getting out of the house to exercise or socialise. The effects of social problems are compounded for many by the ongoing drought and reduced viability of rural towns and regional centres. All of these factors are dramatically increasing stress and anxiety levels and take a physical toll as well. The impact on emotional wellbeing and mental health is leading to debilitating mental health issues and resulting in significant costs both at a personal and social level.

As a consequence, we see clear geographic concentrations of social disadvantage across our cities and our nation, with particular suburbs and regional areas standing out as 'hot spots'.

Our disadvantaged communities deserve sustained and coordinated investment in their social and community infrastructure.

Some of the things that are taken for granted in the middle class suburbs of our capital cities are simply out of reach for people living in disadvantaged suburbs or more remote areas. Nowhere is this more clearly seen than in the health and education outcomes of Aboriginal and Torres Strait Islander peoples.

Disadvantaged communities that overcome adversity often take many years to do so. Investment in their citizens' capacity to work together towards a higher quality of life is very smart investment indeed.

5.3 INVESTING IN OUR WORKPLACES

Workforce participation can boost our mental health and wellbeing by contributing to our sense of worth, purpose and meaning.

Workplaces can support our mental health in a number of ways. They provide opportunities to be actively engaged in society, to build relationships, to get recognition for our efforts and to develop our sense of achievement, empowerment, satisfaction and identity.

Admittedly, workforce participation can also contribute to adverse mental health outcomes arising from stress, low job control or job insecurity. On average, 3.2 days per worker are lost each year as a result of workplace stress. Employers are becoming increasingly concerned about workplace stress. Figures from the Australian Safety and Compensation Council show that while compensation claims made by Australian employees fell significantly between 1996 and 2004, the number of stress related claims almost doubled over the same period.

However, workplace stress and its impacts can usually be managed or overcome if mental health and wellbeing in the workplace is actively promoted and mental illness risk factors are actively prevented.

For example, workplace programs that promote teamwork and achievement of group goals help foster a workplace culture of belonging and connectedness, both of which are mental health protective factors. Equally, workplace initiatives to tackle stress or bullying are targeting risk factors that have a known negative impact on mental health.

Investment in such workplace programs can yield more than benefits for the individual – it also has the potential to increase performance and productivity and reduce absenteeism nationally. This is no small matter: mental health problems cost Australian businesses an estimated $13 billion each year.

There is also an increasing trend for people with chronic health conditions to be in the workforce. As the relationship between mental health and physical health is clear, it makes good economic sense for employers to look after both the physical and mental health of their workforce. Chronic disease prevention programs in the workplace provide unique opportunities to focus on both. National preventative health initiatives could readily include mental health along with encouraging physical activity, healthy eating and changes in tobacco and alcohol use.

Most people with mental illness have the desire and capacity to work.

People with mental health problems in Australia have a low rate of workforce participation – lower than people with other forms of disability in Australia, and lower than people with mental health problems in most other developed countries.

While mental illnesses can limit some people's ability to work full time or under high stress, the right workplace conditions can allow many people with a mental illness to make just as legitimate and significant a contribution to their workplace as other employees.

An increase in workplace awareness, education and training will help overcome much of the stigma and discrimination associated with mental illness in the workforce, ensuring that workplaces are accessible and supportive.

A lack of employment options for people with mental illness creates a vicious cycle.

Unemployment is known to exacerbate the symptoms of mental illness and increase the likelihood of relapse. Investment in strategies that support workforce participation by people with mental illness will result in significant physical and mental health benefits for individuals, reduce dependency on government financial support and increase productivity for employers.

Equitable access to employment opportunities will require a workforce-wide culture shift that values the rightful place of people with mental illness in the Australian workforce. The success of such a significant culture change will rest on national leadership to develop policy and ensure coordination, consistency and development of programs in an evidence-based environment where cost effectiveness and best practice have, until now, been difficult to prove.

5.4 INVESTING IN OUR CHILDREN, YOUNG PEOPLE AND FAMILIES

We're already playing catch-up.

The mental health of Australia's children and young people compares poorly with those living in many other western countries. The evidence clearly points us towards a renewed focus on early intervention activities and the environments in which our children are born and develop.

Our children's environments contain natural elements (e.g. our families and communities) and constructed elements (e.g. infrastructure like schools and hospitals). Better understanding the impact of the environments in which children, young people and families live will help enable better targeting of effective early intervention activities.

Parents and carers need opportunities to learn about parenting and child development.

The early years of a child's life are critical for the development of solid foundations for being mentally healthy. We need to act early to nurture mentally healthy children and families.

The relationship between a child and his or her parents is crucial to the child's normal physical and psychological development. Similarly, abuse and neglect in childhood can significantly challenge a person's ability to maintain good mental health throughout their lives.

The relationship between parent and child is one that forms before the baby is born. How a pregnant mother lives her life, the food she eats and where she lives all impact on the growing baby. Her ability to bond with the baby and nourish its physical and emotional needs is a major predictor of the health of that child as it grows into adulthood.

Some mothers and fathers are able to provide what a child needs and some are not. We need to invest in programs that are targeted to support mothers and fathers who need help with parenting. This is a critical step in promoting mental health at the earliest possible stages of a child's life.

As one of the most accessible frontline services for new parents, our maternal and child health services in particular need to be resourced to assess the emotional needs of parents, as well as their coping and parenting skills.

An enhanced focus on more assertive outreach work (such as regular and ongoing home visits, especially to families that may be struggling) is another proactive way in which the existing system (including childcare centres, preschools and schools) can further ensure the mental health of new generations.

Families and family systems need to be empowered and supported.

Young people who grow up in safe and nurturing environments tend to have better health outcomes and are less likely to face mental health problems than those who experience abuse or neglect.

There are many things that can be done to promote mental health in children and provide the necessary support to their parents or carers to ensure their ongoing health as they grow older.

For example, caring family relationships have a lasting effect on our social and emotional wellbeing. Australian children report weaker family relationships than those of many other developed countries, spending less time eating a main meal with their parents or 'just talking' with them.

In addition, parents who are more socially connected and have better access to support services, stable housing and food are more likely to be able to prevent neglectful and harmful environments for their children.

Schools can have an important role in promoting mental health.

School environments also present a structured way for professionals to work with children and their parents or carers. Existing programs such as KidsMatter (a national mental health promotion, prevention and early intervention initiative for primary schools) have highlighted the important role of schools in contributing to mental health.

One additional benefit of investing in school-based early intervention is in school retention and completion rates. Assisting students with emerging or existing mental health problems is likely to result in their continued education, which is a strong predictor of future employment opportunities, community connection and overall quality of life.

Schools can also become a hub for strengthening formal and informal links and working relationships between local TAFE institutes, school staff (including school counsellors), youth services, employment services, family support services and local Child and Adolescent Mental Health Services. With training in the assessment and management of young peoples' mental health problems, this service hub centred on schools can work together to improve the understanding, recognition, management, support and prevention of mental health problems in young people. Services can come together to nurture and support children and families and promote a healthy start.

Early invention, treatment and follow-up for children and young people must be a priority.

Of all age groups, younger people carry the greatest burden of mental illness. For example:

- Suicide accounts for approximately 20 per cent of all deaths of Australians aged 15–24 years.
- More than 75 per cent of all severe mental health illnesses occur prior to the age of 25.
- One in seven young people aged 12-17 years (15 per cent) experience a mental health problem every year.
- One in four young people aged 16-26 years (26 per cent) have a mental disorder.

These are sad realities that should rightly jolt us into prioritising the mental health of young people.

Services have to be tailored to the specific needs of children and young people as a matter of priority. Services must be available to respond to immediate crises as well as long-term holistic support needs – both of these are integral components of successful mental illness prevention and intervention for young people.

This is not currently the case. Young people are less likely than adults to go from one appointment to another seeking help – often through a combined lack of confidence or transport compounded by confusion and anxiety. They are also less likely to successfully navigate the often-bureaucratic social support services available to them or have the financial resources to cover the fees required by various specialists.

Equally, investment in infant and child mental health would prevent many of the risk factors that result in mental illness from escalating. For example, we know that the best way to respond to emotional trauma in early life (e.g. bullying) is to intervene early, address the situation and then provide follow-up care and social support until it is no longer required.

The headspace Program is one example of a national program being developed to prevent young people from falling through the gaps.

5.5 INVESTING IN OUR HEALTH SYSTEM

Mental health services have to be part of a broader health care system that works.

Australia's health system is currently being examined from all angles as part of a national reform agenda launched by the Rudd Government in 2007/08. This encompasses all the health services that are provided in the community and in hospital settings and includes primary health care and preventative health care. The aims of the reform agenda are to produce a health system that tackles the major access and equity issues currently affecting health outcomes in Australia; is better positioned to respond to emerging health issues; and is truly agile, self-improving and sustainable.

There is broad acceptance that our health system can be improved, although the shape this improvement might take is still contested. As we debate how best to develop our health system, it is important that we consider how such investment aligns with a vision for a mentally healthy Australia. It is also important to acknowledge that governments cannot do this by themselves and need the support of all sectors – the community, workplaces, families and individuals.

The health system needs to prioritise the needs of consumers.

When we access support though our health care system, we should be treated like valued customers: actively consulted about our individual circumstances and needs, given options and informed about the evidence so we can make our choices wisely.

This 'consumer-centric' model is far from the current 'service-centric' reality, where the planning and implementation of our care is more often organised to suit the needs and preferences of health professionals, institutions and funders. The shift to a consumer-centric model will require services to reconsider how they provide their support and funders to reconsider how they fund.

The call for change is firmly grounded in the evidence about what works. For example, health interventions have been shown to be most effective when they are consistent with how a person already lives their life. Such interventions come about when a health professional's initial assessment considers all aspects of a person's life (not just their presenting symptoms); when services are aligned with the person's wishes, values, lifestyle and culture; and when health professionals and service users work together in partnership.

Health services need to be integrated, coordinated and connected.

Our journey through the health system (the 'consumer pathway') should be seamless, with all services working with each other for our benefit. As we enter the health system, we should find structures and mechanisms in place that help us understand and navigate the system, accessing what we need with a minimum of fuss.

This can only happen when services and disciplines work together, across jurisdictional and professional lines. This requires service providers to be trained in how the whole health system works, not just their part in it.

Service providers need to be given the responsibility for facilitating our journey in and out of the system as needed. Services need to be given incentives and mechanisms to work together, allowing for smooth transitions from one care setting to another. For example, the planned electronic health records system needs to allow for easier communication and transfer of information between professionals and social supports.

Importantly, we should not be left alone to 'work out what happens next'. Service providers in the health system should have the skills and the responsibility to be responsive and proactive – guiding our care during the time when we are accessing their service or support.

Our health services and other support structures need to be culturally appropriate.

Australia is a culturally diverse nation, and not all of our communities have the same family structures or age profiles.

For example, Australia's Indigenous population is younger and contains larger families than the non-Indigenous population. This makes it difficult for Indigenous communities to buffer children from adult roles, and the burden of care too often falls onto children.

Services and programs need to understand the different challenges in Indigenous and other communities if they are to provide culturally appropriate support and care.

Multi-disciplinary care approaches need to become the norm.

Professionals working at all levels of our health care system need to learn about the benefits of team-based work practices and multidisciplinary care approaches and how they can achieve this in their work. This approach also needs to be integrated into our social support systems.

Such workforce development and culture change is essential and will require a significant investment in training: from curriculum adjustment in tertiary courses through to continuing professional education for practising health professionals.

The health system also needs to have mechanisms and triggers that promote and encourage team-based care, especially where there are shortages and unequal distribution of health professionals.

We need to measure outcomes.

Outcomes and progress towards objectives need to be measured to demonstrate that our health interventions are effective. Investment in the development of measures that monitor the quality of care in our health care system is also critical.

5.6 INVESTING IN OUR MENTAL HEALTH SECTOR

We have come a long way.

Only one generation ago, many people with a mental illness in Australia lived in psychiatric hospitals, separated from the community, their friends and family. The idea that community integration could help people with a mental illness and promote mental health was socially unaccepted. A lot has changed since then, through a combination of considered planning and sustained effort.

The Australian Government's inaugural National Mental Health Strategy in 1992 was the first policy that coordinated the development of publicly funded mental health services in Australia. The Strategy outlined commitments to reform mental health services by supporting community-based initiatives, investing in mental health promotion and assuring the rights of people with mental illness.

Two other five-year plans followed, the most recent being the National Mental Health Plan 2003-2008, with another plan currently under development. The 2003-2008 Plan sets out four priority areas for the continued reform of the sector: mental health promotion; improving service responsiveness; strengthening quality; and fostering research, innovation and sustainability.

The current Council of Australian Governments National Action Plan on Mental Health 2006-2011 aims to progress areas that have not been sufficiently developed by the National Mental Health Plan. These include provision of non-clinical respite services; expansion of the mental health workforce; and development of community awareness and community-based social support programs.

But there is still much work to do.

We have a foundation to build on, but the job is far from done. Seventeen years after the first National Mental Health Plan, mental illness continues to be misunderstood, resources are still scarce and mental health prevention and early intervention has not been sufficiently embraced.

All too often, mental health experts and practitioners continue to reach the same bleak conclusions today as they did decades ago: Australia's mental health services are inadequate for meeting current and forecast demand and the quality of care still needs to improve.

The delivery of frontline services is what matters most.

The success of policy is assessed not in its potential for change, but in its effect: the way in which it engages and influences stakeholders and ensures the delivery of high-quality care.

Over the years, the process of developing mental health policy in Australia has clearly revealed the complexity of the sector. We now have a good understanding of just how multi-layered our provision of mental health services can be, with national and jurisdictional stakeholders across government, community and private sector providers, a range of clinical and non-clinical services available in various private practices and in institutional and community settings, and countless obstacles that inhibit the delivery of and access to services.

Australian mental health policy has also been successful in sparking debate and developing our understanding of mental health issues.

However, it has stopped short of effectively driving the delivery of the tangible changes that we need on the ground.

We need to act decisively and move quickly.

Investment in mental health needs to be a national priority. We need to use the bodies of evidence we have and make the serious investments required to meet current and future needs.

This means urgently refocusing our policies, increasing the tempo of change, supporting and training the professionals responsible for delivering mental health care and looking at how we can innovate and deliver services more cost effectively.

Our communities are the best place to start.

The value of community-based networks and facilities in supporting health promotion has been proven time and time again across a range of areas. We have seen, for example, that 'ageing in place' (i.e. in the family home rather than in a residential aged care facility) has significant positive health outcomes for older people and comes at a much lower cost to the health system. We also know that people with disabilities who are provided with opportunities to live and work in the community report a much higher quality of life than people in institutional facilities.

Equally, the promotion of mental health and prevention of mental illness is a whole-of-community matter. A person's experience with mental illness can be greatly influenced by their community and social

environment and the support and training available to them and their families. In some cases, social supports can be the difference between whether or not a condition remains manageable or becomes chronic and disabling. This is particularly important given the resistance to help-seeking and experiences of stigma that we know can pose such a barrier to accessing early treatment and support from professionals.

This means we need to continue to think more broadly than hospitals, crisis response mechanisms and traditional health approaches that focus on biological-medical treatment. Of course we still need these things, but we also need investment in efforts that maximise the preventative and treatment potential that exists in the community, our schools and our workplaces.

Demand for community-based mental health care is strong.

There is no stronger evidence to highlight the need for more community-based mental health services than consumer demand. One good example of this is the Better Access Program, which was launched in 2006 to increase access to mental health care provided in community settings by general practitioners, psychiatrists, psychologists and other qualified mental health practitioners like social workers and occupational therapists. Demand for this Program has been much higher than anticipated, resulting in significantly higher spending on the Program than originally estimated.

Only 12 per cent of total mental health expenditure in Australia is allocated to supporting people who live in the community. An increase in community-based investment would pay significant dividends for government, communities and individuals. The higher than anticipated demand for the Better Access Program demonstrates that people will take up mental health programs when they are provided in community settings.

The architecture of our system needs to provide a genuine framework for collaborative care along a continuum from social to medical interventions.

Our current system provides some incentives and opportunities for interdisciplinary and collaborative care, but for the most part we are still working in 'silos'. For example, a general practitioner or psychologist may be the first clinician to assess a person's mental illness, but they are not resourced to support that person through the system and ensure they get the help they need once they leave the clinic – whether it be to take medicine regularly or access a social support service.

The end result is that diagnoses and care plans can be too focused on the professional discipline of the person who makes the initial assessment and that referral services are not always accessed as intended.

The system sets up obstacles to accessing care, then assumes that people have the motivation and capacity to overcome them. The onus is on patients to reach out to the expert that can best help, and possibly to pay extra to receive the best care.

The reality is that our health and social services are often over-stretched and not user friendly, so the process of gaining access to them can add stress and frustration to an already difficult situation. For people who are vulnerable to mental health problems, the obstacles of access can be particularly difficult to navigate and can worsen perceptions of stigma and isolation.

Quick access to the right care is required for people at the onset of mental illness. Beyond this, people should be supported to enter and exit the system easily as needed: some people will require ongoing care for the rest of their lives, but others may only need to access services at crisis points.

Inherent in this care should be prompt assessment of people with moderate or severe mental health problems and provision of multi-faceted support when they need it. Our care pathways particularly need to help individuals with co-existing clinical and non-clinical conditions to navigate and access the range of different services they need to ensure positive mental health outcomes.

The effort involved in developing collaborative partnerships and clear linkages between specialist social services, specialist mental health services and general health services should not be underestimated. However, these partnerships are an essential part of closing the gaps that result in so many people with a mental illness going unnoticed, remaining untreated or relapsing unnecessarily. Partnerships will help to restore people to better mental health, to better physical health and to independent living.

Our services will only be as good as the people delivering them.

Our mental health sector suffers from overwhelming workforce shortages that must be addressed. To increase the mental health workforce more funding is required for education and training including pre-entry level training, continuing professional development and an expanded range of innovative clinical placements. Strategies and investments are needed to urgently address the intentions and morale of the existing

workforce and to support and provide incentives for the full range of mental health professionals to work in the areas of greatest need.

Investment also needs to be directed towards improving the focus, capacity, skills and knowledge of health and community sector workers to deliver the types of services we need. This will require a combination of education, modelling and structural reform to ensure that the current and new generation of workers are directed, supported and equipped for the roles we need them to play.

Supporting the workforce appropriately is also essential in retaining staff. Cultural security for Indigenous health professionals working in mainstream organisations is particularly important.

Incentives are needed to ensure service delivery targets those who need it most.

Our Medicare system is structured around individual health practitioners rather than the people who use the health system. This means that, regardless of what might improve access for people with a mental illness, each health professional is free to choose where to set up his or her practice and whether or not to co-locate with other specialists or health services.

For example, our system assumes that currently-available practice incentive payments will attract enough practitioners to service rural and remote areas, and that enough medical practices will choose to co-locate with youth services to provide an all-encompassing service for young people. These assumptions are not supported by the evidence: we still have a geographic mal-distribution of the mental health workforce (concentrating on cities) and the coming together of services is rare.

Instead of 'leaving it to the market', the structure of Medicare needs to be more intentional, requiring health and service providers to work in a collaborative manner across disciplines to target specific client groups (e.g. communities, regions or demographic groups).

Our investment should empower organisations to attract practitioners to service areas of need. Organisations in remote areas, for example, need adequate resources to develop viable holistic service systems that can competitively attract and retain practitioners across a range of clinical and social services. Rural health workforce shortages are a national problem, but are particularly profound in mental health.

Remuneration in these instances needs to move beyond a sliding scale based on the number of patients that walk through the door. Otherwise the commercial decision will always be a simple question of volume – more people in our major cities means more financial reward for practitioners.

We need to put the effort in early.

The benefits of early intervention have been demonstrated countless times, and our health system needs to give more attention to health promotion, primary prevention and other health interventions that take place 'up stream'.

For example, our initial assessments need to look beyond the reasons why a person has made an appointment and consider their broader needs in a way that is pre-emptive and protective.

In this way people are only provided with the services and support they need, thus reducing time spent later with multiple services or in hospital, when the risks and financial costs are greater and the prognosis less promising.

As previously discussed, early intervention with children and young people is a classic example of the health system being geared to give effective support when it can be most valuable.

We need to increase the pace and scale of investment in technological advances to achieve mental health outcomes.

When it comes to accessing information, we know that e-health is an effective way of engaging key target groups (such as young people) who would otherwise be reluctant or not interested to have their questions answered.

Static web pages, video and audio podcasts and downloads, online communities, chat rooms and email continue to present opportunities to effectively deliver complex information to technologically literate people in a format that is familiar and user friendly and puts them in the driver's seat of their own mental health. As technologies converge and evolve, we will no doubt see mental health communications adapt to suit them.

Advancements in web-counselling technologies and their supporting evidence base also continue to be made, establishing this tool as a permanent feature of Australia's mental health service sector.

There is an equally indisputable business case for continued investment in online dissemination and access of information and support, particularly given the 24-hour/7-day nature of the internet, workforce shortages across the mental health sector, the geographical challenges of our nation and the inherent cost barriers of our health system.

Quality assurance should remain an important area of

focus in this area, as technological advances move faster than our capacity to evaluate long-term impacts.

The onus is on all of us to lead cultural change.

The entrenched stigma faced by so many in our community is almost always based on misconceptions and misunderstandings of mental illness. This calls for considered investment in the promotion of acceptance and inclusion of people with mental illness through community awareness campaigns.

However, this realm of cultural change is one that needs leadership at all levels. As individuals, each of us needs to do more than talk about 'changing attitudes' in principle: we need to make changes in ourselves and call those around us to follow.

National coordination is essential.

There is consensus across public, political and practitioner realms that the health system, including mental health, needs to be better. A new structure for the funding, development and delivery of services is needed, to ensure that our services reflect good practice and reach those who need them.

Australia spends $94 billion annually on health services. As a recent report by the National Health and Hospitals Reform Commission noted, the $94 billion question is: who should be responsible for our health system?

Significant benefits would flow from our mental health system being better coordinated nationally. Responsibility for the system by one tier of government would increase accountability and transparency, and make it easier for strategies to be delivered consistently across the nation.

All options should be on the table.

In thinking about future options for our mental health system, key themes such as equity, access, consumer-centric planning and evidence-based practice should be at the forefront of our minds.

It is important to consider all options, including those that are a departure from our current practice. The concept of 'social insurance' is one such option. As it exists in many European countries, social insurance would transfer all funding, policy and regulation of health care to the Australian Government and establish a tax-funded community insurance scheme under which people choose from multiple health plans. This is only one option – others should be explored.

Investment in our mental health sector is a must.

Government policy and investment is intended to reflect the views and expectations of the public. The Australian people need to be informed of the significant gaps in our current mental health system, the contribution people with mental illness can make to their community and the many ways in which mental health can be promoted and mental illness prevented.

The benefits from investing in mental health promotion and mental illness prevention are robust and well-documented. Experts believe that a modest increase in mental health expenditure of around 30 per cent could produce significant health gains for around 90 per cent of people with mental illness.

Investment in clinical and applied research is also needed to continue the outstanding progress made in Australia to understand the causes of mental illness and how they might be prevented, cured and more fully treated.

It is also time to invest significantly in research including effective service delivery and to advocate for increased investment in leadership in our mental health system. We need expert leadership of specialist services by skilled clinicians, as is seen in other areas of health care. Clinical leadership in mental health remains underdeveloped and poorly resourced.

Mental health deserves to have one of the highest profiles in national health policy and investment.

6 INVESTING IN RESEARCH AND MEASURING PROGRESS

6.1 MINIMUM STANDARDS AND EQUITY

Some things should not be negotiable.

Mental illness can affect all of us, regardless of how much we earn, what school we went to, what we do for a job, or where we live. However, these social factors (along with others like them) currently play a big part in determining the quality of mental health care and support we can access.

All people in Australia should have access to the mental health care and social support services they need, as they need them. Our system needs to be accountable for this, and responsive if (when) inequity becomes apparent. This will require ongoing investment by our governments in health and social support services and the refocusing of existing resources.

There are particular barriers to overcome here, especially for Indigenous Australians and people living in remote and rural areas. This calls for an emphasis to be placed on investing in the communities most at risk of inequitable access to health services.

Responding to long-term inequity of access will require new ways of thinking. For example, the *Towards a National Primary Health Care Strategy* discussion paper (2008) reports innovative care models being trialled in Indigenous communities that focus on raising awareness of chronic disease through community development and community engagement activities. Resourcing of creative approaches such as these should be prioritised, as should the establishment of their evidence base.

The services we deliver need to reflect how we feel and what we believe.

A lasting difference to our mental health and wellbeing will not come from simply ensuring that services are adequately resourced. We need to focus on providing genuinely compassionate care that values people and understands their personal circumstances to ensure we deliver the best tailored services to achieve the most sustainable outcomes.

Support services should be within the reach of all Australians.

We should aspire to ensure that everyone has access to responsive health and mental health systems, social supports, workplaces and community infrastructure that meet nationally accepted minimum standards.

Minimum standards will help define what we can expect to access and in what timeframe. The presence of such standards will help ensure that we are working towards benchmarks for timely access to support when it is needed, irrespective of who we are and where we live.

It is particularly critical to ensure immediate help is available where life or safety is at risk.

6.2 EVIDENCE, ACCOUNTABILITY AND TRANSPARENCY

Research is essential for the accountability and transparency of the mental health sector.

There is a reasonable expectation that the delivery and development of mental health services in Australia will be firmly grounded in research evidence of good practice. This calls for ready access to robust data about the performance of the mental health sector as a whole, in all its complexity.

We need national consistency in service data.

Without consistent minimum standards in the recording of mental health service use, it is very difficult to accurately understand the national picture. A number of potentially very useful bodies of data are seriously lacking on this front, including in relation to the experience of people accessing mental health services, the quality of their experience and their suggestions for improvement.

We need to know about more than service-level outputs.

Output data are of limited use for broader mental health sector planning, as they only tell part of the story. For example, service-level data tell us about the needs of people who access services, but tell us nothing about those who have a mental illness and do *not* access services. Given that Australia's mental health system provides care for only 35 per cent of people in need, this is a significant gap. Additionally, there is an acute need for outcome measures that can enhance understanding of what works, for whom, when and why.

We also need to understand community attitudes to mental illness if we are to design effective mental health promotion and mental illness prevention programs. For example, if we are to reduce stigmatisation of people with known mental illness in Australia, we first need to understand what triggers these views in schools, workplaces and in the broader community.

People with a mental illness are entitled to good quality information.

People who receive services and support from the mental health sector are entitled to the same level and quality of information available in other health and community sectors. People with a mental illness, and their carers and families where relevant, should be supported in understanding the options available to them and encouraged to exercise control over decisions that affect them. This requires a free flow of information with clinicians and other experts.

Information about the performance of the mental health sector should also be available to consumers and practitioners. Transparency about the system's performance and consumer satisfaction with it will result in growing consumer confidence in the sector and, ultimately, increased access.

Good data isn't just for the bean counters.

For the government and the service sector, reliable data will allow the consideration of cost-benefit factors in the development of programs, provide a benchmark for good practice and foster the development of innovative responses to need.

For people with a mental illness, appropriate collection and use of data to enhance services will instil confidence in a system that is transparent, responsive and engaged in an ongoing process of quality improvement.

6.3 COMMUNITY INVOLVEMENT IN RATING PROGRESS

Just like the *Heart Foundation Tick* has been empowering families to challenge food companies to improve the nutrition of the foods, it is time for Australians to be supported to rate and measure progress toward a mentally health Australia.

7 NATIONAL LEADERSHIP

Australian Governments, starting with our Federal Government, need to reaffirm their commitment and declare investment in mental health to be a national priority. Whilst there have been National Mental Health Plans in place continually since 1992, the proportion of health care spending on mental health has remain stuck at or below 7.5 per cent. Mental health must become a national priority in words and funding commitment for there to be a mentally healthy Australia. A plan to increase funding to mental health, relative to all health expenditure, is required.

As recommended in 2006 by the all-party Senate Select Committee, mental health funding must be equal to 12 per cent of total health expenditure if the current gaps and failings in care are to be addressed.

More broadly, all Australian governments need to commit to a non-partisan and cross-jurisdictional approach to mental health, and to applying the mental health policy lens to all strategic-level decision making, policy development and change processes.

This will require equipping those policy makers responsible for strategic level policy development at Commonwealth, State/Territory and Local Government levels with the capacity to undertake mental health impact assessments. For example, at a local government level, this might mean requiring a Development Control Plan to be assessed in terms of its likely impact on the mental health and wellbeing of individuals, special populations and the community as a whole. It would not involve assessing individual development applications as such. At a state level it would involve an assessment of the State Transport and Infrastructure plans but not individual projects.

8 A PROGRAM OF INVESTMENT FOR A MENTALLY HEALTHY AUSTRALIA

Twenty-two programs across the seven Priority Areas are proposed. Investment in these programs will make significant contributions to achieving the vision of a mentally healthy Australia.

If we are to close the gap in social and health outcomes for Indigenous Australians, then with every initiative, their needs must be given priority. Importantly, each investment and its associated program initiatives should be developed within the context of the National Aboriginal and Torres Strait Islander Cultural Respect Framework incorporating principles of consultation, inclusion and cultural safety.

Each investment must also build in workforce needs and program evaluation from the outset.

PRIORITY AREA ONE: A MENTALLY HEALTHY AUSTRALIA IS EVERYONE'S BUSINESS

Program Investment 1: Mental health literacy through expanded community education initiatives

Description: Ongoing investment is required in mental health literacy through further community education and stigma reduction initiatives including an expanded role for beyondblue, Mental Health First Aid, school-based mental health education programs (eg Mind Matters and Kids Matters) and similar programs.

Indicators of success: Earlier recognition of mental disorders in the community and earlier seeking and accessing of appropriate intervention; decreased incidence of suicide and self harm; increased participation and inclusion for people experiencing mental illness; improvement in health and social outcomes and reduction of the overall health burden.

Program Investment 2: Mental health practice and competency training for all health and human service employees

Description: Mental health cannot be compartmentalised or ignored by the health and human services professions, given it impacts on all areas of physical, social and cultural health. There is a need to continue to support initiatives that improve mental health literacy and response to people with mental health issues among front line professionals across the board, but particularly in the health care, human service and emergency services workforce. This should include a review of mental health curricula within undergraduate, vocational and post vocational training with a view to identifying the mental health literacy, skills and practice training requirements necessary to ensure an appropriate level of mental health content given the prevalence and impact of these disorders. Training should include how to identify the early signs of mental illness and the knowledge and skills required to confidently and competently manage or respond to mental health problems and/or crises and to assist with referral or access to timely and effective assessment, treatment and care.

Indicators of success: Earlier identification and management of mental health problems has significant implications for reducing the longer term costs of mental illness, both in human and financial terms.

PRIORITY AREA TWO: INVESTING IN OUR COMMUNITIES

Program Investment 3: Priority Communities Initiative

Description: Using a range of relevant ABS indicators and indexes, the 100 most socially and economically disadvantaged communities experiencing high risk to wellbeing and to child social exclusion will be identified. A funding program to empower the priority communities to develop extensive supports and community-based initiatives to target inequities and to improve the emotional and social wellbeing and social participation of disadvantaged families is required.

Indicators of success: Improved health and wellbeing particularly among children and young people aged 0-25 years; increased early attendance at antenatal care and early childhood care; decreased rates of childhood injuries; increased levels of age appropriate social development; increased early identification of mental health care needs across all age groups of children; increased participation in under-school age activities; greater school retention rates; increased levels of housing stability; improved parental health and wellbeing; decreased rates of suicide and self harm; and increased employment and social participation.

Program Investment 4: Mentally Healthy Communities Program

Description: A funding program for communities to establish partnerships to enable communities to act early and to provide local solutions. The key emphasis is on targeted early intervention, prevention and promotion programs to address locally identified mental health needs. This program also seeks to establish service and support pathways for communities encountering significant barriers to accessing timely and appropriate services, treatment and care with a view to increasing their engagement and utilisation of mental health treatment and community support services. Addressing equity and access issues affecting mental health, independent living and social inclusion is a key aspect of this program.

Indicators of success: Greater recognition of mental health problems and mental illness; earlier seeking and accessing of help and assistance for mental health issues and problems; greater service responsiveness to the needs of people with mental health issues; greater recognition and responsiveness to co-occurring conditions and problems; and greater support for generalist services and access to specialist services when required; and greater workforce, educational and community participation for people with mental illness and mental disorders.

Program Investment 5: Revision and implementation of the Social and Emotional Wellbeing Framework

Description: In a mentally healthy Australia, the Australian Government's commitment to closing the gap between Indigenous and non-Indigenous communities must be accompanied by significant investments to address the link between chronic disease, mental health and chronic stress within Indigenous communities and to build on earlier achievements commenced with the development of the Social and Emotional Wellbeing Framework. The imperative for the development of the framework was the failure of mainstream mental health services to pick up the full spectrum of needs in Indigenous communities where the usual helping mechanisms that exist in a reasonably healthy society are absolutely overloaded due to the high levels of grief, and trauma. A project is recommended to revise and implement the Social and Emotional Wellbeing Framework. Implementation should include the development of processes for much greater accountability for what is achieved both through the National Mental Health Plan as well as the revised SEWB Framework. This project will compliment the work of the Healing Foundation and its emphasis on self-determination and Indigenous healing programs.

Indicators of success: Improved mental health, social and emotional wellbeing and physical health in Indigenous communities; decreased rates of suicide and self harm in Indigenous communities; self determination in Indigenous mental health; an expanded, supported and resourced Indigenous mental health workforce; expansion of trauma and grief prevention, support and counselling and healing programs; and the provision of specialised care and support through Indigenous Community Mental Health programs for families and children across all age groups.

PRIORITY AREA THREE: INVESTING IN OUR WORKPLACES

Program Investment 6: A mentally healthy workplace study

Description: Work can be a protective factor to good mental health. The level of control an employee feels over their work situation, the stress experienced and whether or not the employee feels valued in the workplace can affect work performance, absenteeism, workplace safety and staff turnover. Research is recommended to explore how mental health promotion can be embedded in workplace and occupational, health and safety legislation, policy, standards, codes and requirements. This study would make recommendations on changes, strategies, training and resources for promoting the mental health and wellbeing of employees, preventing the onset of mental health problems among employees and for assisting employers and managers to create mentally healthy workplaces.

Indicators of success: Decreased levels of workplace stress, absenteeism and staff turnover; reduction in days lost to stress and poor mental health and a reduction in associated costs; and increased levels of workplace safety.

Program Investment 7: Employer Incentive and Safety Net Program and Employment Support Program for people with mental illness

Description: A program to provide an employer incentive scheme and safety net options to support employers of people with mental illness which dovetail with transition and safety net arrangements for people on Disability Support Pension who seek to move into paid employment. Accompanying this program, expanded and specialised support is recommended for people with mental illness who are placed in jobs. Assistance and support after the job starts will vary depending on the employees, the severity of the impacts of their condition, the complexity of the job and the nature of the workplace.

Indicators of success: Increased workforce participation and employment rates of people with mental illness; higher rate of successful employment placements; and reduction in social costs due to decreased levels of unemployment among people with mental illness, the restoration to independent living for increased numbers of people and the prevention of chronic mental illness.

PRIORITY AREA FOUR: INVESTING IN OUR CHILDREN, YOUTH AND FAMILIES

Program Investment 8: Early childhood and family mental health and developmental services (0-25 years)

Description: Early childhood and family mental health and developmental services to provide integrated early intervention, early childhood and family clinical mental health services, health services, and family support services for families with children aged 0-25 years. Family-oriented services are envisaged which provide assessment, treatment, intervention, collaborative care and community-based responses within a framework of supporting social, emotional, personal and physical development.

Indicators of success: Improved health and wellbeing particularly among children, young people and emerging adults aged 0-25 years; increased early attendance at antenatal care and early childhood care; decreased rates of childhood injuries; increased levels of age appropriate social development; increased early identification of mental health care needs across all age groups of children; improved children's mental health and wellbeing; increased participation in under-school age activities; improved learning; greater school retention rates; increased levels of housing stability; improved parental health and wellbeing; and increased employment and social participation.

Program Investment 9: Schools as hubs for acting early and for nurturing children and families

Description: A program to facilitate the national roll-out of initiatives like Edlink and SchoolLink to assist in strengthening formal and informal links at local and area level between TAFE, all schools and school counsellors, youth services, family support services, local Child and Adolescent Mental Health Services and Headspace programs. The program will expand services for early childhood, the transition period to primary school and early adolescence and support for families during these developmental phases.

Indicators of success: Early identification of mental health and developmental issues; earlier access of mental health and psychological services; higher participation in pre-school aged education; higher school retention; increased labour force and community participation.

Program Investment 10: Services for families at high risk

Description: A program providing targeted services for families at high risk. The target audience includes families with multiple and complex problems such as long-term unemployment, poverty, economic and financial stress, high and persistent levels of stress, unstable housing or risk of homelessness, poor or persistent mental health difficulties or substance misuse, trans-generational trauma and abuse, risk of offending, school drop out or expulsion. Services provided will be multidisciplinary and partnership-based and would include a no 'wrong door' approach to access, wider systems of support, a family focus and family assessment, a dedicated key worker, intensive and structured support and a coordinated and integrated response.

Indicators of success: Reduced family dislocation and separation; improved social and emotional outcomes for children and young people; reduced child maltreatment and lower costs to child welfare system; reduced child accidents and injuries; lower costs for emergency room visits and other public health care costs; lower costs for public health care system.

PRIORITY AREA FIVE: INVESTING IN OUR HEALTH SYSTEM

Program Investment 11: Services for the elderly

Description: A program for the expanded provision of specialised mental health and dementia care services for older Australians, including those residing in age care facilities. Timely and skilled assessment of mental health problems and their differentiation from dementia must occur in unison with comprehensive physical health assessments. An appropriate range of treatment options proceeding through systems of connected and coordinated care for both mental health and physical health care needs must then be provided. A comprehensive range of support services for the elderly and their families is required to aid the return to independent or assisted living and participation in the community.

Indicators of success: Earlier detection and treatment of depression and anxiety leading to reduced suicides rates among the elderly; earlier detection of dementia and improved quality of life for the person affected and their families; reduced length of stay in long-term mental health and other health care facilities.

Program Investment 12: Connecting Care Initiatives – Person-centred collaborative practice incentives with a particular focus on addressing inequities in physical health and social circumstances of people with mental illness and their families

Description: A program to support the development of person-centred collaborative and multidisciplinary practice incentives to reduce risk factors, improve physical health and social wellbeing and improve quality of life and lifestyle. People with severe mental illness and their families experience increased morbidity and mortality associated with a range of physical conditions. Factors such as lifestyle, psychotropic medication, and inadequate physical health care contribute to the poor physical health of people with mental illness. Significant inequities are also experienced socially. Models for coordinating and integrating mental health care with a series of holistic health screen checks and healthy lifestyle programs will be developed. Also required will be family and social support, psychological intervention, dietary and exercise advice, and assistance with organising an active lifestyle. Restoring better health and independence are key outcomes in this program.

Indicators of success: Reduced morbidity and premature mortality among people with mental illness and their families; significantly better quality of life; improved mental health and prevention of relapse; reduced frequency and severity of episodes of mental illness and increased daily function through stabilization of symptoms and health.

Program Investment 13: A partnership with the community to address suicide and self-harm

Description: The development of a new national suicide prevention and post-vention strategy that enables real community engagement underpinned by significant levels of new funding commensurate with the scale of the problem. The new strategy will be supported by research, new institutions to support standards and training and education, community awareness and education and monitoring and reporting.

Indicators of success: Real and sustained reductions in suicide and self harm rates particularly in higher risk populations including men, rural populations, some occupational groups and Aboriginal and Torres Strait people.

PRIORITY AREA SIX: INVESTING IN OUR MENTAL HEALTH SYSTEM

Program Investment 14: The development of National e-Mental Health Services

Description: As an extension of the national e-health records program, the development of a National e-Mental Health Strategy including the creation of patient-centred electronic health records. This involves the development of a national e-Mental health portal providing one point of access to mental health services, and a national e-Mental health stepped care service to be used by consumers, schools, workplaces and health professionals, offering: e-Mental Health promotion; e-Mental Health prevention; e-Mental Health self-screening, assessment and early intervention; e-Mental Health treatment services; and e-Mental Health referral.

Indicators of success: Earlier identification; earlier and greater sustained engagement in treatment and care; lower cost therapies; quality use of medicines and more efficient information transfer between clinical teams and professionals.

Program Investment 15: A national early psychosis program

Description: A program to resource the national roll-out of partnership-based early psychosis intervention, treatment and recovery services is proposed. The services will target first or early psychoses irrespective of the age of onset.

Indicators of success: Early identification and treatment of primary symptoms of psychotic illness; improved access without delay to assessment and treatment; reduction in frequency and severity of relapse; reduced associated morbidity and impairment; reduced disruption to participation in education, employment and community for both the individual and their families.

Program Investment 16: A national early intervention program for high prevalence mental disorders

Description: A program to resource the design and roll-out nationally of partnership-based early intervention, treatment and recovery services for high prevalence mental disorders including depression, anxiety disorders, conduct disorders, drug use disorders and alcohol use disorders.

Indicators of success: Early identification and treatment of disorders affecting many people often with highly debilitating and far-reaching consequences for individuals, families and society; improved

access without delay to assessment and treatment; reduction in frequency and severity of relapse; reduced associated morbidity and impairment; reduced disruption to participation in education, employment and community for both the individual and their families.

Program Investment 17: Mental Health Service Reform Program – ensuring timely and quality services across life span, across disorders and across acuity

Description: Service reform incentive program to ensure that appropriate mental health services are provided across life span, across disorders whether high or low prevalence and across acuity. For example, mental health services should be specifically tailored to the needs of infants, children, adolescents, youth, emerging adults, adults and older Australians. Mental health services should also comprise early psychoses prevention and intervention, crisis assessment and treatment service, acute and sub-acute services, stepped/phased prevention, treatment and recovery services, and longer term treatment and follow-up services for people with severe mental disorders including older Australians. Services should be inclusive of all mental disorders whether low prevalence conditions, high prevalence conditions, personality disorder spectrum or co-existing with other conditions.

Indicators of success: Improved access without delay to assessment and appropriate treatment and recovery support services irrespective of age, diagnosis and acuity of disorder.

Program Investment 18: Expansion of community-based support and recovery models

Description: An expanded national community mental health program is proposed to provide an increased range of psychiatric disability and recovery services and social support models including key worker programs, stable housing programs and programs targeting the supported recovery of those with complex needs including comorbidity with drug and/or alcohol problems.

Indicators of success: Reduction in frequency and severity of relapse; reduced associated morbidity and impairment; reduced disruption to participation in education, employment and community for both the individual and their families; and reduced homelessness and risk of homelessness among people with severe mental illness.

Program Investment 19: Mental health workforce strategy

Description: The development and implementation of a national mental health workforce strategy must be at the core of transforming the mental health services in Australia. The strategy and targeted resources are necessary to ensure that there are sufficient numbers and an appropriate mix and spread of mental health staff delivering services with the appropriate expertise, who are well supported and led, and who are delivering services that meet the needs and preferences of people experiencing mental illness and their family and friends. The strategy must address the issues of morale, retention, re-skilling and re-deployment as well as recruitment, learning and training including pre-entry level training, continuing professional development and an expanded range of innovative clinical placements. Targeted and increased support and incentives are required for clinicians across all mental health professions to encourage them to work in the areas of greatest need.

The expansion of some roles such as peer support workers and consumer advocates and the development of new roles for supporting people living in the community is required, similar to the development of the Support, Time and Recovery (STAR) workers in the UK. The strategy must also address organisational leadership, clinical leadership and changes to work practices to build a more skilled, flexible and responsive workforce.

Indicators of success: Improved morale, higher intentions to stay in mental health services, increased recruitment and retention of mental health staff particularly in rural and remote and other under-serviced and resourced areas; greater utilisation of mental heath services; improved consumer and family satisfaction with mental health services.

PRIORITY AREA SEVEN: INVESTING IN RESEARCH, EVALUATION AND MEASURING OUR PROGRESS

Program Investment 20: Mental Health Reform Agency to strengthen quality and accountability

Description: The establishment of an independent, national mental health reform agency. This national agency would report independently from and to the government and would monitor service safety, effectiveness and quality across all service settings and identify gaps in service provision, leadership, training, work force and research. The agency would be informed by consumer, carer and service provider

knowledge, experience, and by evidence-based research. It would also advise on improving community awareness, decreasing stigma and discrimination and improving the expertise and sustainability of the mental health workforce. The agency will work with other national agencies in Canada, New Zealand and elsewhere to develop and implement international benchmarking. A critical inclusion in the Mental Health Reform Agency must be processes for strengthening quality and accountability in mental health and social and emotional wellbeing reform agendas in Aboriginal and Torres Strait Islander communities.

Indicators of success: National and international benchmarks for mental health services; nationally agreed outcomes-based monitoring framework; greater consumer and carer participation in outcome and performance measurement and reporting; and more integrated service delivery approaches that respond to mental illness nationally.

Program Investment 21: Uniform legislative provisions

Description: A reference to the Australian Law Reform Commission to recommend on the development and implementation of uniform legislative provisions for the treatment and care of people with mental illness and related disorders that take into account their expressed preferences and wishes.

Indicators of success: Uniform legal provisions irrespective of where a person lives in Australia; and cross-jurisdictional recognition of orders.

Program Investment 22: National Institute for Mental Health to strengthen research and evidence and to promote learning

Description: A National Institute for Mental Health to work collaboratively with the government, non-government, business and community sectors to promote evidence-based, socially just, approaches to preventing, treating and supporting the recovery from mental illness and related disorders and to reducing their personal, health, economic and social impacts. The Institute would provide national leadership in continuing to transform the understanding and treatment of mental illnesses through research and dissemination of information and, by so doing, assist to pave the way for prevention, recovery and cure.

Indicators of success: Increase of evidence-based research in Australia; increased dissemination of best practice in prevention, treatment and recovery services; increased information sharing between government, non-government, business and community sectors.

9 CONCLUSION

We don't just want to live in Australia – we want to live in a mentally healthy Australia.

Our vision is that all Australians can live a mentally healthy life and be able to access mental health services and support.

This is a clear, aspirational statement of what can be, based on our current knowledge of brain and mind development. This document proposes a pathway and a service architecture for creating a mentally health Australia.

It envisages an Australia where collective and personal responsibility for building good mental health and wellbeing in our communities is assumed. It clearly positions mental health as central to our wealth creation and wellbeing as a nation.

It envisages that all governments and service sectors will apply a mental health policy prism to proposed changes and strategic decisions.

The vision emphasises the need for immediate action to tackle equity and access issues. Support for communities to act early to nurture mentally healthy children and families is central. Connected, timely and safe services and care are envisaged for all irrespective of age, gender, condition and location.

Underpinning service reforms must be significant investments in creating a sustainable and supported mental health workforce for the future. A national e-Mental health system and the fostering of continuous learning in our mental health system are also priorities.

Improved mental health, restoration of physical, social and emotional wellbeing and improved independence and social inclusion must be attained.

For the vision to become a reality, robust and independent systems of governance and accountability are required. These new systems must take on board the views and experiences of those living with mental illness and their families.

Being mentally healthy does not happen by chance or through a well-worded policy statement. We need to plan for our mental health: as individuals, families, communities and, as a nation, follow through on the commitments, monitor and openly report our successes, learning and progress.

FURTHER READING AND SOURCE DOCUMENTS

Below is a list of the key sources for this document.

AUSTRALIAN GOVERNMENT PUBLICATIONS

Achieving Balance: A review of systemic issues within Queensland Mental Health Services 2002-2003. Report of the Queensland Review of Fatal Mental Health Sentinel Events. Queensland Health (2005)

A healthier future for all Australians. Final report of the National Health and Hospitals Reform Commission, 2009.

Australia's Health 2008. Australian Institute of Health and Welfare (AIHW), Canberra, 2008.

Australia's Health Workforce: Productivity Commission Position Paper. Productivity Commission, Australian Government, Canberra 2005.

Australia: The healthiest country by 2020: National Preventative Health Strategy – the road map for action. Report prepared by the National Preventative Health Taskforce, 2009.

A national approach to mental health – from crisis to community. The Senate Select Committee on Mental Health, 2006.

Apology to Australia's Indigenous Peoples. House of Representatives, Parliament House, Canberra, 13 February 2008.

Because Mental Health Matters: Victorian Mental Health Strategy 2009-2019. Department of Human Services, Melbourne, 2009.

Causes of Death Australia 2007. Australian Bureau of Statistics, Cat. no. 3303.0, Canberra (Included Technical Note 1: Coding of Suicide Deaths).

Compendium of Workers' Compensation Statistics Australia 2004-05, Australian Safety and Compensation Council, 2007

Human capital reform: report by the COAG national reform initiative working group. Council of Australian Governments, February 2006.

National Action Plan on Mental Health 2006-2011. Council of Australian Governments, July 2006.

National Action Plan on Mental Health 2006-11. **Attachment A: COAG Response to the Productivity Commission Report on Australia's Health Workforce.** Council of Australian Governments (COAG) (2006).

National Mental Health Information Priorities (2nd Ed) National Mental Health Strategy, Department of Health and Ageing, Commonwealth of Australia, Canberra 2005.

National Mental Health Plan 2003-2008. Australian Health Ministers, July 2003.

National Mental Health Policy 2008. Department of Health and Ageing, Commonwealth of Australia, Canberra 2009.

National Mental Health Plan 2009-2013. (Draft). Approved by Australian Health Ministers Sept 2009.

National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005. Department of Health and Ageing Commonwealth of Australia, Canberra 2008.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, 2004-09. National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group, 2004.

National Survey of Mental Health and Wellbeing: Summary of Results. Australian Bureau of Statistics (ABS) Canberra, Oct 2008.

Primary Health Care Reform in Australia. Report to Support Australian's First National Primary Health Care Strategy, Australian Government Department of Health and Ageing, 2009.

Promotion, prevention and early intervention for mental health – a monograph. Commonwealth Department of Health and Aged Care, 2000.

Queensland Plan for Mental Health 2007-2017 – Improving Mental Health for Queenslanders. Queensland Health. Queensland Government, Brisbane 2008.

Review of Government Mental Health Initiatives Across Australian Jurisdictions. National Advisory Council on Mental Health, Oct 2008.

The Mental Health of Australians: Report on the 2007 National Survey of Mental Health and Wellbeing. National Mental Health Strategy, Department of Health and Ageing, Commonwealth of Australia, Canberra, 2009.

Towards a National Primary Health Care Strategy – a discussion paper from the Australian Government. Australian Government Department of Health and Ageing, 2008.

What's new in mental health: a brief summary of recent reports, publications and issues around mental health programs. National Advisory Council on Mental Health, March 2009.

Which Way Home: a new approach to homelessness. Australian Government, May 2008.

OTHER PUBLICATIONS

A Mentally Healthy Workforce – It's good for business. Partnership for Workplace Mental health. American Psychiatric Foundation, 2006.

A national approach to mental health – from crisis to community. Senate Select Committee on Mental Health, Commonwealth of Australia, Canberra 2006.

A new vision for mental health. Discussion Paper. The Future Vision Coalition. Sainsbury Centre for Mental Health, UK, 2008.

Australian Social Trends 2009 – Mental Health. Australian Bureau of Statistics, Cat. no. 4102.0, 13-18, Canberra.

Because mental health matters – Victorian mental health reform strategy 2009-2019. Mental Health and Drugs Division, Victorian Department of Human Services, February 2009.

Bipolar disorder: costs. An analysis of the burden of bipolar disorder and related suicide in Australia. Access Economics for SANE Australia, 2003.

Capabilities for Inclusive Practice. National Social Inclusion Programme, CSIP Department of Health (UK), London 2007.

Capable Teams Approach: Best practice guidance to support the implementation of New Ways of Working and New Roles. Department of Health (UK), London April 2007

Destination: Recovery. Te Unga ki Uta: Te Oranga. Mental Health Foundation of New Zealand Auckland 2009.

Evaluation of Best Practice Employment Assistance to People with Mental Illness. Urbis, Sydney, August 2007.

Improving Mental health Outcomes for Victoria: the next wave of reform. Boston Consulting Group, July 2006.

In the face of fear – how fear and anxiety affect our health and society, and what we can do about it. Mental Health Foundation (UK), 2009.

Investing in Australia's Future: the personal, social and economic benefits of good mental health. Mental Health Council of Australia. Deakin West, ACT, Dec 2004.

Let's Get Real: Real skills for people working in mental health and addiction. Ministry of Health, New Zealand, Wellington, 2008.

Let's Get to Work: a national mental health employment strategy for Australia. Mental Health Council of Australia. Deakin West, ACT, Nov 2007.

Mental Health: Britain's Biggest Social Problem. Richard Layard, Social Inclusion Unit Dept of Prime Minister, London, 2004.

Mental health: future challenges. Foresight Mental Capital and Wellbeing Project, 2008, The Government Office for Science, London.

Mental Health Policy, Planning and Service Development: Human resources and training for mental health. The WHO MIND Project: mental Improvement for Nations Development. WHO, Geneva, Sept 2007

Mental Health and Work: Impact, issues and good practice. Harnios, G and Gabriel, P World Health Organisation and International Labour Organisation, Geneva 2000.

Never better – or getting worse? The health and wellbeing of young Australians. Australia21, 2008.

New Ways of Working for Everyone: a best practice implementation guide. National Institute for Mental Health in England. York, 2007.

Restraint and Seclusion: the model for eliminating their use in healthcare. Murphy T and Bennington-Davis M. HCPro, Marblehead, MA, 2005.

Smart Services: Innovative models of mental health care in Australia and overseas. Mental Health Council of Australia. Deakin West, ACT, 2006.

Social Inclusion: Its importance to mental health. Mental Health Coordinating Council. Sydney, 2007.

Time for Service: Solving Australia's Mental Health Crisis. Mental Health Council of Australia. Deakin West, ACT, 2006.

Towards a National Mental Health Report Card for Australia – transforming mental health in Australia through a national accountability framework. A Report prepared by Mental Health Council of Australia (2009) for the National Advisory Council on Mental Health.

Not for service – experiences of injustice and despair in mental health care in Australia. Mental Health Council of Australia, 2005.

Promoting Mental Health: concepts, emerging evidence and practice. A Report of the World Health Organisation and the Victorian Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and Melbourne University, 2005.

Report card – the wellbeing of young Australians. Australian Research Alliance for Children and Youth, 2008.

Schizophrenia: costs. An analysis of the burden of schizophrenia and related suicide in Australia. Access Economics for SANE Australia, 2002.

Thematic Review of Peer Supports: Literature review and leader interviews. Mental Health Commission, Wellington, New Zealand 2008.

Understanding the stigma of mental illness: theory and interventions. Arboleda-Florez J, Sartorius N (eds), Oxford: John Wiley and Sons, 2008

Weaving the Net: Promoting Mental Health and Wellness Through Resilient Communities. Mental Health Council of Australia. Deakin West, ACT, 2006.

Why people die by suicide. Thomas Joiner, published by Harvard University Press, 2005.

JOURNAL ARTICLES

Beaulieu, MS and Flanders, T (2000) *Uncovering the Elements of Success: working with co-occuring disorders in residential support programs.* **International Journal of Psychosocial Rehabilitation, 4, 11-17.**

Beddington J, Cooper C, Field J, Goswami U, Huppert F, Jenkins R, Jones H, Kirkwood T, Sahakian B and Thomas S (2008) *The Mental Wealth of Nations*. **Nature** 2008; Vol 455, p1057-1060.

Crosbie D (2009) *Mental health policy – stumbling in the dark?* **Medical Journal of Australia** 2009; 190(4):S43-S45.

De Leo D (2007) *Suicide mortality data need revision.* **Medical Journal of Australia** 2007; (letter to the editor); 186(3):157-158.

De Leo D, Dudley M, Aebersold C, Mendoza J, Barnes M, Harrison J, and Ranson D. *Achieving standardised reporting of suicide in Australia: rationale and program for change* (in press)

Donovan R, Henley N, Jalleh G, Silburn S, Zubrick S and Williams A (2007) *People's beliefs about factors contributing to mental health: implications for mental health promotion.* **Health Promotion Journal of Australia** 2007:18(1).

Hickie I, Groom G et al, *Australian Mental Health Reform: Time for Real Outcomes*, **Medical Journal of Australia**, 2005; 182 (8): 401-406

Goldney R. *Suicide in Australia: some good news.* **Medical Journal of Australia** 2006; 185 (6): 304.

Keyes C (2007) *Promoting and protecting mental health as flourishing – a complementary strategy for improving national mental health.* **American Psychologist** 2007: Vol 62(2):95-108.

Patel, V, Fisher, AJ, Hetrick, S and McGorry, P (2007) *Mental health of young people: a global public health challenge.* **Lancet**, 369, 1302-1313.

Rosen, A, Gurr, R and Fanning, P (2009) *The Future of Community Health Services in Australia* (in press).

Rosenberg S, Hickie I and Mendoza J (2008) *National mental health reform: less talk, more action.* **Medical Journal of Australia** 2009; 190(4):193-195.

Media articles

Greenfield S (2009) *Screen culture may be changing our brains* **ABC 7.30 Report**, 19 March 2009.

Hall N (2009) *A mental-health plan for the next 30 years.* **The Vancouver Sun** February 6, 2009.