3.1 Introduction

As noted in Part 1, the current *National Mental Health Report* can be distinguished from its predecessors by the inclusion of new outcome oriented indicators agreed for monitoring progress of the *Fourth National Mental Health Plan*. Part 3 presents the most current quantitative data on the *Fourth Plan* indicators, and draws on qualitative information about the progress of the actions agreed under the *Plan*. Part 3 is organised around the five priority areas of the *Fourth Plan*, namely:

- social inclusion and recovery;

- prevention and early intervention;

- service access, coordination and continuity of care;

- quality improvement and innovation; and

- accountability – measuring and reporting progress.

Quantitative indicators

The development of indicators under the *Fourth National Mental Health Plan* was underpinned by a number of principles. The 25 indicators were selected to be inclusive of all components of the mental health sector, including public, private and non-government agencies in both the primary care and the specialist mental health sector. They were also designed to go beyond this, and consider key intersections in cross-sectoral reform. There was a commitment to using existing national data wherever possible, and to specify the indicators in a manner consistent with currently recognised quality frameworks. Eleven of the 25 indicators were taken directly from the 12 indicators specified by the COAG *National Action Plan on Mental Health*, to ensure their continued publication given that reporting on the *National Action Plan* has now been completed. The need for extensive work to develop suitable data sources to populate some indicators was recognised, along with the fact that proxy indicators might need to be used in the interim where preferred data were not available.

As a preliminary exercise to reporting the *Fourth Plan* indicators in future *National Mental Health Reports*, work was undertaken to develop detailed specifications and identification of data sources through the then National Mental Health Information Strategy Subcommittee (now Standing Committee), which acts as an inter-governmental group and operates under the auspices of the Australian Health Ministers Standing Council on Health. The resulting

document, *The Fourth National Mental Health Plan Measurement Strategy 2011*,[32] has guided the presentation of all indicators in the current report.

Table 8 provides an overview of the indicators. Three indicators (1, 2 and 20) are split because they require data from two different sources. This effectively means that the total number of indicators is 28, rather than 25. Data sources and specifications (including proxy measures) have been developed for 19 of these (1a, 2a, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 19, 20a, 21, 22 and 23, highlighted by a green traffic light symbol in the table). No current data sources are available for the nine remaining indicators, but work is in progress for seven of these (1b, 2b, 5, 17, 18, 24 and 25, highlighted by an amber traffic light symbol), and there is no foreseeable data source for two indicators (10 and 20b, highlighted by a red traffic light symbol). The first 19 are reported in Part 3 and will continue to be reported for the rest of the *Fourth National Mental Health Plan*. No further detail is provided on the remainder in the current report.

Data sources and explanatory notes for quantitative data presented in Part 3 are provided in Appendix 2.

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Table 8
Overview of indicator status

Priority Area	Indicator		Indicator status
Priority area 1: Social inclusion and recovery	1a	Participation rates by people with mental illness of working age in employment: General population	🟢
	1b	Participation rates by people with mental illness of working age in employment: Public mental health service consumers	🟠
	2a	Participation rates by young people aged 16–30 with mental illness in education and employment: General population	🟢
	2b	Participation rates by young people aged 16–30 with mental illness in education and employment: Public mental health service consumers	🟠
	3	Rates of stigmatising attitudes within the community	🟢
	4	Percentage of mental health consumers living in stable housing	🟢
	5	Rates of community participation by people with mental illness	🟠
Priority area 2: Prevention and early intervention	6	Proportion of primary and secondary schools with mental health literacy component included in curriculum	🟢
	7	Rates of contact with primary mental health care by children and young people	🟢
	8	Rates of use of licit and illicit drugs that contribute to mental illness in young people	🟢
	9	Rates of suicide in the community	🟢
	10	Proportion of front line workers within given sectors who have been exposed to relevant education and training	🔴
	11	Rates of understanding of mental health problems and mental illness in the community	🟢
	12	Prevalence of mental illness	🟢
Priority area 3: Service access, coordination and continuity of care	13	Percentage of population receiving mental health care	🟢
	14	Readmission to hospital within 28 days of discharge	🟢
	15	Rates of pre-admission community care	🟢
	16	Rates of post-discharge community care	🟢
	17	Proportion of specialist mental health sector consumers with nominated GP	🟠
	18	Average waiting times for consumers with mental health problems presenting to emergency departments	🟠
	19	Prevalence of mental illness among homeless populations	🟢
	20a	Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities	🟢
	20b	Prevalence of mental illness among people who are remanded or newly sentenced to juvenile correctional facilities	🔴
Priority area 4: Quality improvement and innovation	21	Proportion of total mental health workforce accounted for by consumer and carer workers	🟢
	22	Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	🟢
	23	Mental health outcomes for people who receive treatment from state and territory services and the private hospital system	🟢
	24	Proportion of consumers and carers with positive experiences of service delivery	🟠
Priority area 5: Accountability: Measuring and reporting progress	25	Proportion of services publicly reporting performance data	🟠

Key to indicator status: 🟢 – Data sources and specifications developed; 🟠 – No current data sources available (including proxy measures) but work is in progress; 🔴 – No foreseeable data source

Qualitative data sources

The *Fourth National Mental Health Plan* committed governments to collaborative action in 34 areas designed to achieve reform at a national level in each of the five priority areas. Twenty three of these actions are examined in the current *National Mental Health Report*, on the grounds that they are being pursued independently of broader national reforms (see 1.3). Each action is being led by a lead agency (generally a jurisdiction, or a working group established under the auspices of the Australian Health Ministers' Standing Council

on Health). Each priority area has an overall lead which is required to report on the *Fourth Plan's* implementation process, and these reports are collated in the *Fourth Plan's Second Progress Report of Implementation Activity.* For the purposes of the current report, the most recent progress report to 2010-11, as endorsed by the Mental Health Drug and Alcohol Principal Committee, has been used as the primary source of information on progress of the specific actions of the *Fourth Plan*.

3.2 Priority area 1: Social inclusion and recovery

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists seven actions that relate to social inclusion and recovery. Progress has been made on five of these (see Appendix 3). By way of example, considerable activity has occurred in relation to Action Area 4, which involves adopting a recovery oriented culture within mental health services that is underpinned by appropriate values and service models. A National Mental Health Recovery Framework that is designed to support implementation of a recovery oriented culture in all mental health services is being finalised. In addition, a National Recovery Forum was held in June 2012 at which three international experts gave keynote addresses. This enabled exchange about the implementation of a recovery oriented culture, and provided an opportunity to promote the development of the National Mental Health Recovery Framework.

Indicator 1a: Participation rates by people with mental illness of working age in employment: General population

KEY MESSAGES:

- In 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness.

- Employment participation rates for this group ranged from 52% in Tasmania to 73% in the Australian Capital Territory.

- Nationally, employment rates for this group decreased slightly from 64% in 2007-08 to 62% in 2011-12.

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Mental illness can reduce participation in the workforce in two broad ways. For those in employment, untreated mental illness can diminish engagement and activity in the workplace. Annual losses to national productivity caused by untreated mental illness in the Australian workforce have been estimated at $5.9 billion.[33]

For those not in the workforce, mental illness can act as a barrier to gaining or holding a job. Additionally, the absence of meaningful vocational roles can compromise recovery from mental illness through the associated impacts of social exclusion, welfare dependency, unstable housing and long term poverty.

An increasing body of evidence is accumulating that suggests that vocational outcomes for people affected by mental illness can be improved substantially, leading to better health outcomes.

Using data from the 2011-2012 National Health Survey (NHS) component of the Australian Health Survey (AHS),[34] Figure 44 shows that the 2011-12 employment rate for Australians aged 16-64 years with a self-reported mental illness[D] was 62%, only three quarters of the rate for people without a mental illness (80%). Employment rates for people with mental illness varied across states and territories, ranging from 52% in Tasmania to 73% in the Australian Capital Territory.

Lower employment rates should not be taken as an indicator that people with a mental illness cannot or do not wish to work. Additional 2011-13 AHS data indicate that 6% of people with a self-reported mental illness are unemployed (that is, they are not currently working but actively searching for work). This is double the percentage of people without a mental illness who are unemployed (3%).

D The approach to identifying mental illness used in the National Health Survey is based on the respondent self-reporting that he or she has a mental or behavioural problem that has lasted, or is likely to last, for six months or more. This approach yields lower prevalence estimates of mental illness than methods that rely on independent assessment against objective criteria (14% in 2011 compared with 20% found in the National Survey of Mental Health and Wellbeing of the adult population), because it does not include people who experience milder forms of mental illness that resolve within a six month period. See Appendix 2 for further details.

Figure 44
Percentage of people aged 16-64 years who are employed, nationally and in each state and territory, by mental illness status, 2011-12
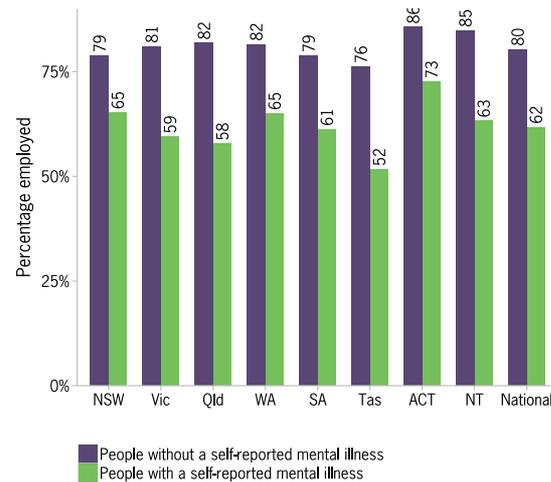

Figure 45
Percentage of people with a mental illness aged 16-64 years who are employed, nationally and in each state and territory, 2007-08 and 2011-12

The data also show that many working age Australians with a self-reported mental illness (32%) are not participating in the labour force (that is, they are neither employed nor looking for work), compared to 17% without a mental illness. Reasons for this are many, but include impaired capacity to work arising from the mental illness. In 2011, people with a mental illness comprised the largest proportion (30%) of the 820,000 Australians receiving a Disability Support Pension (DSP).[35] This equates to 16 in every 1,000 adults of working age being on a DSP due to mental illness. Rates vary across the states and territories.

Comparison of data from the 2007-08 NHS[36] and 2011-12 NHS in Figure 45 shows that, nationally, employment rates for working age people with a mental illness decreased slightly from 64% in 2007-08 to 62% in 2011-12. However, the amount and direction of change varied across states and territories, with employment rates increasing in New South Wales, South Australia and the Northern Territory.

A major driver of employment participation rates among people with a mental illness is severity of disorder. A report by the Organisation for Economic Cooperation and Development (OECD) showed that 49% of people with a severe disorder were employed, compared to 72% with a moderate disorder, and 81% with a mild or no mental disorder.[37]

Mental disorders make the largest contribution of all the major health conditions (cancer, cardiovascular, major injury, mental disorder, diabetes, arthritis) to health-related labour force non-participation rates. Averting the impact of mental illness has the greatest potential to lift labour force participation rates.[38] A body of evidence is now available to show that vocational outcomes for people with mental illness can be improved through the introduction of models of supported employment.[39] The optimal model of such interventions is an evolving science currently being debated by employment specialists.

Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population

KEY MESSAGES:

- In 2011-12, 79% of Australians aged 16–30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, compared to 90% of their same age peers.

- Employment and education participation rates for this group for most states and territories were within 10% of the national average.

- Nationally, employment and education participation rates for this group remained stable between 2007-08 and 2011-12.

Participation in employment and formal education provide important opportunities for social inclusion. Mental illnesses are particularly prevalent during early adulthood. Many disorders emerge during the late adolescent and early adult years, a period coinciding with important developmental milestones such as the completion of education or training and the commencement of employment. The onset of mental illness, particularly severe mental illness, often involves a decline in functioning leading to compromised academic performance, premature drop out from school or training, and failed or delayed transition between education and employment. These disruptions in education can negatively affect a person's career prospects, increase the risk of long term unemployment or reliance of welfare as their primary income source, and limit opportunities for social inclusion in the broader community.[40] Evidence from Australian studies shows that, among people with a mental illness, previous educational attainment is associated with current employment regardless of type of diagnosis.[41]

Using data from the 2011-12 National Health Survey (NHS),[34] Figure 46 indicates that, in 2011-12, 79% of people aged 16-30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, one eighth lower than for people without a mental illness (90%). Employment and education participation rates for people with a mental illness varied across states and territories, being highest for South Australia and lowest for Western Australia, but all were within 10% of the national average. Data for the Northern Territory should be interpreted with caution due to small numbers in the 'self-reported mental illness' category.

Comparison of data from the 2011-12 NHS with the 2007-08 NHS[36] in Figure 47 shows that, nationally, the rate of participation in employment and education for people aged 16-30 years with a mental illness remained stable between 2007-08 (80%) to 2011-12 (79%). However, the amount and direction of change varied across states and territories. There were relatively large increases in South Australia and Tasmania, compared to a relatively large decrease in Western Australia. Again, small numbers in the Northern Territory mean that 2011-12 data should be interpreted with caution and 2007-08 data are unavailable.

Work and education play an important role in recovery from mental illness. There is increasing evidence that supported employment and education programs can improve employment outcomes and reduce welfare reliance among young people with mental illness.[42]

Figure 46
Percentage of people aged 16-30 years who are employed and/or enrolled for study, nationally and in each state and territory, by mental illness status, 2011-2012
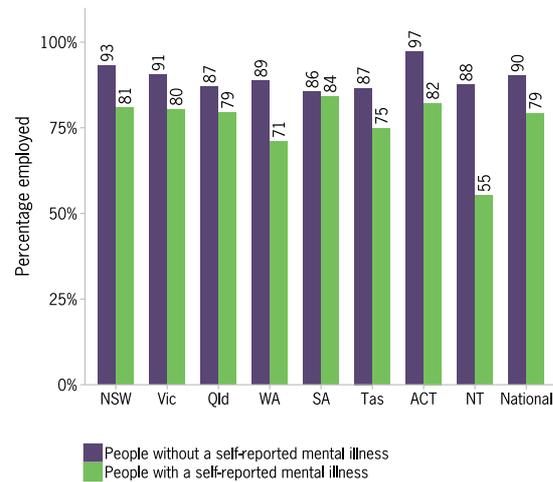

Figure 47
Percentage of people with a mental illness aged 16-30 years who are employed and/or enrolled for study, nationally and in each state and territory, 2007-08 and 2011-12

Indicator 3: Rates of stigmatising attitudes within the community

KEY MESSAGES:

- Social distance is a term used to indicate the willingness of people to interact with people experiencing mental illness. In 2011, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to interact socially with people with a mental illness. Stigmatising attitudes varied across the different types of mental illness, with the average desire for social distance being highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.

- Comparing the 2011 results with equivalent data from 2003-04, Australians' desire for social distance from people with depression with suicidal thoughts had decreased. However, their desire for social distance from people with depression without suicidal thoughts, early schizophrenia and chronic schizophrenia remained relatively unchanged.

- There is evidence that the efforts of organisations like *beyondblue* may have contributed to this improvement, at least in the case of depression.

Stigma is often nominated as the issue of most concern by people who live with a mental illness. Stigmatising attitudes have the potential to inhibit help seeking, increase the experience of psychological distress and adversely impact upon the recovery process and achievement of educational and vocational goals.[43 44]

Data for this indicator are taken from the *National Surveys of Mental Health Literacy and Stigma*, conducted in 1995, 2003-04 and 2011.[45] These surveys assessed rates of stigmatising attitudes in Australia using measures of social distance, which are indicators of the willingness of Australians to interact with people suffering from a range of mental illnesses, in a variety of situations. Figure 48 provides data on social distance from the 2003-04 and 2011 surveys.

Data from the 2011 survey suggest that, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to socially interact with people with a mental illness. In 2011, the average desire for social distance was highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.[45 46]

Comparing these results with those from the 2003-04 survey, there is evidence that the Australian public has become more willing to interact with people showing symptoms of depression (with suicidal thoughts). People's willingness to interact with people with depression (without suicidal thoughts) and early schizophrenia also showed improvement in the right direction, but this did not reach statistical significance. Their willingness to interact with people with chronic schizophrenia remained the same across the two years.[45 46]

Figure 48
Average desire for social distance from the person described in the vignette, 2003-04 and 2011

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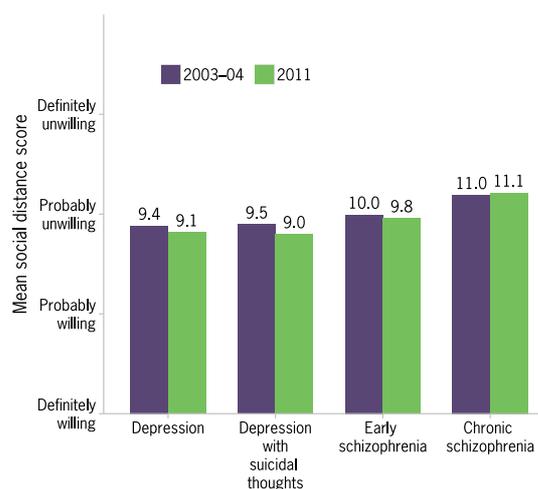
There may be a range of reasons for the improvements observed above. Over the last decade Australia has invested considerable resources in reducing stigmatising attitudes in the community. For example, beyondblue: the national d*epression initiative* has been funded by the Australian Government and state and territory governments since 2000 with the goal of improving the Australian community's awareness of and response to depression and related disorders. Similarly, initiatives such as the federally funded MindMatters and Kidsmatter (described in more detail under Indicator 6) have promoted mental health literacy in schools. States and territories have also invested in their own anti-stigma campaigns.

Indicator 4: Percentage of mental health consumers living in stable housing

KEY MESSAGES:

- Nationally, the percentage of adult consumers of state and territory mental health services (aged 15-64) with no significant problems with their living conditions has been stable from 2007-08 to 2010-11 (sitting at around 78%). Consumers in the Australian Capital Territory were the least likely to report problems and those in the Northern Territory were the most likely to do so.

- The percentage of older adult consumers (aged 65+) with no significant problems with their living conditions has shown a slight improvement over time, rising from 79% in 2007-08 to 83% in 2010-11. Older consumers in New South Wales were the least likely to report problems, and those in Tasmania were the most likely to do so.

- Safe, secure and affordable accommodation is critical to recovery for people with living with a mental illness.

Mental illness can act as a risk factor for homelessness, and, in turn, unstable housing can exacerbate symptoms of mental illness. Good collaboration between mental health services, housing providers and accommodation support services can improve the housing prospects of people with mental illness and contribute to their overall wellbeing.

Proxy information on this indicator is available for consumers of state and territory mental health services. For adult consumers (aged 15-64) it is derived from the Health of the Nation Outcome Scales (HoNOS) and for older adult consumers (aged 65+) it is taken from the HoNOS65+. These measures are administered routinely at selected points during episodes of care in state and territory mental health services. Item 11 on the HoNOS and the HoNOS65+ requires the treating clinician to rate the consumer's problems with living conditions and is scored from 0 (no problem) to 4 (severe to very severe problem). These data provide an indicator of the housing status of consumers but should be interpreted with caution for several reasons. Item 11 on the HoNOS and HoNOS65+ relies on the clinician knowing the living circumstances of the consumer and is not optimally completed.

Figure 49 provides national and jurisdiction-level data on the percentage of adult consumers who, on admission to care, had no significant problems with their living conditions. Nationally, the percentage has been stable from 2007-08 to 2010-11 at around 78%. Of all states and territories, the Australian Capital Territory performs the best, with figures close to 90% in the latter years of the period. Consumers in the Northern Territory are most likely to have difficulties in this area, with only 69% having no

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significant problems with their living conditions in 2010-11, down from 81% in 2007-08.

Figure 50 provides equivalent data for older adult consumers. The total includes data from all states and territories, but individual figures for the Australian Capital Territory and the Northern Territory are not presented because of small numbers. Nationally, the percentage of older adult consumers with no significant problems with their living conditions has shown a slight increase over time, rising from 79% in 2007-08 to 83% in 2009-10 and 82% in 2010-11. Consumers in New South Wales appear to be the most likely to be rated as having no problems, peaking at 89% in 2009-10.

Governments have acknowledged the crucial role played by stable housing in promoting recovery from mental illness. The *Fourth National Mental Health Plan* emphasised the importance of developing integrated programs between mental health support services and housing agencies to provide tailored assistance to people living with a mental illness. The Council of Australian Governments (COAG) reinforced this in its recent endorsement of the *Roadmap for National Mental Health Reform*, 2012–2022.[1]

Figure 49
Percentage of state and territory mental health services consumers aged 15-64 years who are recorded at admission as having no significant problems with their living conditions
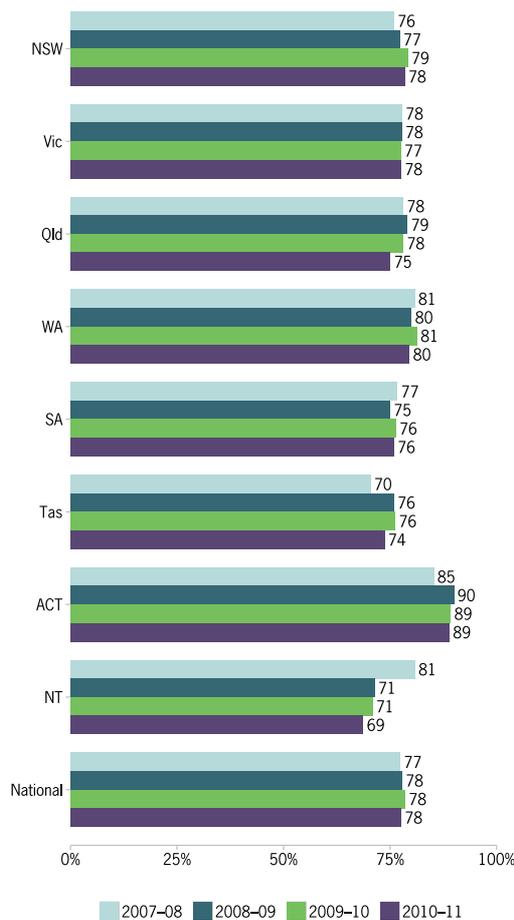

Figure 50
Percentage of state and territory mental health services consumers aged 65+ years who are recorded at admission as having no significant problems with their living conditions

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