AUSTRALIAN CAPITAL TERRITORY MENTAL HEALTH AND SUICIDE PREVENTION PLAN 2019-2024

PART B: IMPLEMENTATION PLAN

PART C: PERFORMANCE & MONITORING PLAN

This activity is supported by funding from the ACT PHN through the Australian Government's PHN Program

BACKGROUND

The joint regional ACT Mental Health and Suicide Prevention Plan (ACT Plan) is a five-year plan that identifies local mental health and suicide prevention program and service planning priorities and actions. The ACT Plan is informed by the priorities of the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) and speaks to the local context and needs of the ACT region.
The ACT Plan outlines the challenges facing us as a community and what we will do to address these challenges, working in partnership over the next five years to improve mental health outcomes for people in the ACT.

The ACT Plan consists of three parts:

PART A

The Framework consists of information about the strategic drivers, context and direction for the ACT Plan and provides a strategic framework for the Territory as well guidance for practical implementation by stakeholders in the region.

PART B

The Implementation Plan consists of short, medium and long-term activities mapped against each of the strategic priorities.

PART C

The Performance and Monitoring Plan provides a framework for measuring how well the ACT Plan is achieving its objectives including indicators of successful reform and key evaluation activities.

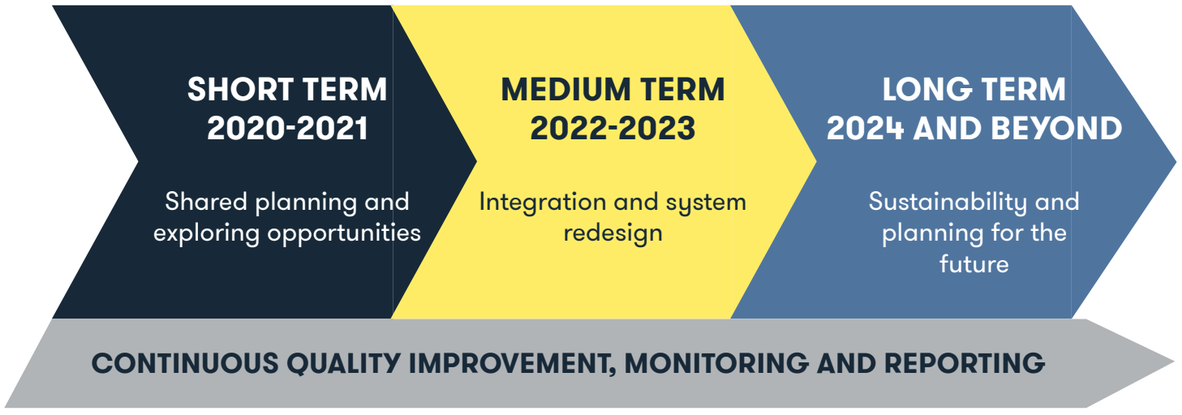
INTRODUCTION

The Implementation Plan covers a range of shared initiatives over a five-year period.

It is structured as a five-year road map across three key phases:

- Planning activities that will largely focus on ensuring a strong foundation for future activities. This will be done by identifying opportunities for, and co-designing solutions to improve services and integration, improve data collection, and establish shared planning and governance frameworks.
- Integration and system redesign activities, where the bulk of the change will happen. This includes implementation of new initiatives, codesign of new approaches and services, integrated models of service delivery and innovative solutions.
- Sustainability activities that will take place throughout the life of the plan with a focus on sustainable results and outcomes.

While these are described as discrete phases, most activities will continue in some form throughout the lifespan of the ACT Plan. The phases are highlighted to describe the key focus and themes for activities in that period with each building on the learnings from the previous years. The Implementation Plan is underpinned by continuous quality improvement and evaluation activities which will make up Part C: The Performance and Monitoring Plan. The activities are monitored by a set of signs of success for each focus area, which were identified through consultations with consumers, carers and members the mental health workforce.



IMPLEMENTATION PLAN

The identified activities within the Implementation Plan have been informed by community consultations carried out specifically to inform the ACT Plan, as well as separate consultations held by Working Group member organisations. The activities will be delivered in partnership, with shared responsibility by:

Organisations	Lead roles
Capital Health Network (ACT PHN)	Commissioning, integration and service improvement
ACT Health	Commissioning, integration and service improvement
Canberra Health Services	Service improvement and integration
Office of Mental Health and Wellbeing	Multisector and multiagency engagement
Mental Health Carers Voice- Carers ACT	Carer engagement and co-design
Mental Health Community Coalition of the ACT	Community sector engagement and co-design
ACT Mental Health Consumer Network	Consumer engagement and co-design

Partner stakeholders will review and update the plan regularly throughout its five-year lifespan to ensure it stays relevant and continues to address the needs of the community. Each year, partners will also develop individual and joint work plans that align with the priorities and outline key activities that will assist with progressing shared actions and achieving outcomes within the Implementation Plan.

Focus area 1: Improved mental health outcomes for everyone

What needs to be done:

Deliver services and programs that reduce barriers to access.

Provide culturally inclusive and responsive programs and services for:

- Aboriginal and Torres Strait Islander people;
- multicultural communities;
- families and carers;
- LGBTIQ+ communities;
- people with disabilities; and
- people in the justice system.

Use standard outcome measures.

Provide feedback on engagement and experience of target groups.

Collect consumer and carer feedback.

To do this, we will:

1.1 Planning

1.1.1 Identify specific needs of target groups and the barriers and enablers for access to services and programs.

1.1.2 Establish a set of shared outcome and experience measures across primary, secondary and tertiary care.

1.1.3 Establish a local approach to data sharing to inform planning and implementation.

1.2 Integration and system redesign

1.2.1 Co-design service improvements that address barriers to access and are tailored to meet the needs of target groups.

1.2.2 Commission and co-commission programs and services that are safe and responsive, trauma-informed, culturally sensitive and recovery focused.

1.2.3 Collect and share data to inform reporting, monitor performance and inform further improvement.

1.3 Sustainability

1.3.1 Use outcome and experience data and research for informing ongoing service improvements, identifying emerging needs, and planning system development.

1.3.2 Invest in effective services and programs that decrease barriers to access and promote equitable outcomes for identified target groups.

Signs of Success

Consumers and carers:

- experience culturally appropriate and sensitive services;
- have access to services that are safe and responsive;
- experience fewer barriers and a responsive service system; and
- feel included, involved and informed.

Health care and other providers:

- feel adequately informed and skilled to do their work well.

Focus area 2: Services that are responsive and integrated

What needs to be done:

Collaborate and partner in the planning, funding and delivery of services.

Hold regular forums for cross-sectoral engagement.

Share accountability for achieving outcomes.

Redesign services to address gaps and barriers.

Explore opportunities for co-location and interdisciplinary ways of working.

Explore the use of technology and digital solutions.

Establish clear pathways between programs and services.

To do this, we will:

2.1 Planning

2.1.1 Co-design integrated models of service delivery that include clear referral pathways and coordination across a range of services.

2.1.2 Explore opportunities to integrate treatment and support; for example, shared intake and triage for funded community mental health programs, team-based care, co-location, and digital health tools across providers.

2.1.3 Identify the processes, agreements, resources and contractual arrangements needed to implement changes.

2.2 Integration and system redesign

2.2.1 Establish and implement an integrated intake, assessment and treatment model of service delivery for funded community services.

2.2.2 Implement effective partnerships, referral pathways and digital health tools that support communication and collaboration across a range of service providers.

2.2.3 Evaluate the impact of service redesign to ensure gaps and barriers are addressed and services are meeting the needs of consumers, carers and the workforce while providing value for investment.

2.3 Sustainability

2.3.1 Continue to build effective partnerships and referral pathways between health and social services through cross-sector and multi-agency forums, interdisciplinary training and use of technology.

2.3.2 Continue monitoring and evaluation to ensure investment in effective, evidence-informed services, tools and strategies.

Signs of Success

People:

- report knowing where to go for help and feeling confident and able to do so;
- hear back from services in a timely manner with information that meets their needs;
- get the right referral and are supported to connect to the right service;
- feel informed and involved in referral processes; and
- experience a ‘no wrong door’ approach to accessing services.

Health care and other providers:

- are aware of other services; and
- are confident in referring people to the right service at the right time

Focus area 3: A highly skilled and sustainable mental health workforce

What needs to be done:

Engage staff on workplace initiatives and improvements.

Develop and maintain a skilled and experienced workforce.

Implement initiatives that:

- promote safety of the workforce;
- are evidence based; and
- are informed by the needs of the sector.

Partner with education and training organisations to develop programs and pathways into mental health work.

Explore innovative approaches to address workforce gaps.

Develop career pathways for Aboriginal and Torres Strait Islander workers and peer workers.

Support the workforce to deliver sensitive and culturally safe services.

To do this, we will:

3.1 Planning

3.1.1 Identify needs, strategies and shared principles across primary, secondary and tertiary care to inform the co-design of workforce initiatives.

3.1.2 Undertake joint planning and co-design of workforce initiatives that focus on:

- Expectations around collaboration, workforce partnerships and networking arrangements
- Joint strategies to address supply shortages, recruitment and retention across common workforce streams and workplace culture
- Capacity building and interdisciplinary training including in culturally appropriate care and trauma informed care

3.2 Integration and system redesign

3.2.1 Develop and implement career pathways and flexible workforce models.

3.2.2 Develop formal partnerships with education providers, programs and workforce support initiatives at all levels and across all disciplines that promote pathways into mental health work, including:

- Specific training, support and pathways for peer workers and Aboriginal and Torres Strait Islander health workers
- Strategies for attracting and maintaining a multidisciplinary mental health workforce
- Trialling new ideas and workforce strategies including partnerships with universities and other training and education organisations

3.3 Sustainability

3.3.1 Continue to develop and plan for the future through workforce modelling and needs analysis.

3.3.2 Evaluate the impact of changes and initiatives implemented.

3.3.3 Continue to explore and develop evidence-informed responses to:

- Shortages in workforce capacity
- Training and education needs
- Workforce safety
- The use of technology to support the workforce
- Opportunities to enhance capacity of other healthcare workers to care for people with mental health issues

Signs of Success

People:

- have a positive perception of the mental health workforce;
- have confidence in their service provider's competence; and
- participate and feel valued in codesign and consultations on the mental health workforce initiatives.

Health care and other providers:

- feel safe, supported and valued in their work;
- have opportunities and pathways to grow their careers;
- are satisfied with consultation and codesign opportunities that are undertaken to inform workforce initiatives and service design; and
- access regular, up-to-date and relevant training.

Focus area 4: Early intervention in life, illness, and episode

What needs to be done:

Develop programs and services that promote wellbeing and prevent mental illness.

Establish the right mix of mental health programs and services across the lifespan and for different levels of need.

Develop and deliver mental health promotion in schools, workplaces and other community environments.

Deliver programs and services that focus on building resilience and coping skills.

Respond early to onset or relapse of illness.

Increase awareness of mental health programs and services in primary care and community services.

Improve the identification of mental health concerns early in life, illness or episode and ensure easy.

To do this, we will:

4.1 Planning

4.1.1 Explore opportunities to enhance mental health promotion, prevention and early intervention services.

4.1.2 Explore opportunities for mental health promotion, prevention and early intervention for children (aged 0-11 years) and young people (aged 12-25 years) including school-based intervention, early childhood education and community initiatives.

4.1.3 Undertake mapping to understand the current mental health services, including access and referral pathways, and to identify gaps and opportunities to invest in the right mix of services across the lifespan and levels of need, with increased focus on intervening early in life, episode and illness.

4.2 Integration and system redesign

4.2.1 Invest in mental health promotion, prevention and early intervention services across the lifespan for children and young people, including specific opportunities for Aboriginal and Torres Strait Islander children and young people.

4.2.2 Promote access to care pathways and services provided by primary care and in the community.

4.2.3 Coordinate service provision across the journey of care, with focus on intervening as early as possible to address signs of deteriorating mental health.

4.2.4 Commission programs and services that incorporate prevention and early intervention in their approach to treatment and support.

4.3 Sustainability

4.3.1 Provide training to staff across the care continuum that will support them to safely identify early signs of declining mental health and to respond and refer effectively.

4.3.2 Equip the mental health and primary care sector to provide high quality mental health assessment and intervention.

4.3.3 Promote and distribute available resources, including online resources, that improve mental health literacy, resilience and capacity for self-management.

Signs of Success

People:

- know when, where and how to access support in the places where they live, work and learn;
- can access mental health information and resources that meet their needs easily;
- can access a range of services for young people experiencing mental health issues and mental illness;
- are better able to identify mental health issues in themselves and others; and
- have access to services and supports that help them to build resilience, develop skills to self-manage and seek help early

Health care and other providers:

- can identify early signs of mental health issues or mental illness; and
- are confident in their ability to provide evidence-based information, referral, support or intervention relevant to the person's level of need.

Focus area 5: Whole of person care

What needs to be done:

Develop co-ordinated approaches that are responsive to the whole person, including their medical, psychological, functional and social needs, and that address co-occurring issues such as disability and alcohol and other drug use.

Explore opportunities to engage with agencies that influence the broader determinants of health.

Deliver programs and services to address the physical health of people with mental illness.

Promote healthy living and access to both physical and mental healthcare.

Develop innovative approaches to integrating primary care, community and hospital services.

Undertake joint planning, service design and delivery in collaboration with consumers and carers.

To do this, we will:

5.1 Planning

5.1.1 Partner with stakeholders to undertake a needs analysis and scoping study exploring co-occurring health needs including chronic disease, alcohol and other drug related harm, and disability.

5.1.2 Partner with consumers, carers and health professionals to design a shared care plan that takes a holistic approach, addressing the mental, physical, and social needs of people and supports a person-centred approach to care.

5.2 Integration and system redesign

5.2.1 Commission a mix of services that meet the holistic needs of consumers and carers.

5.2.2 Pilot and evaluate innovative approaches to integrating primary care, community and hospital services including co-location, in-reach/outreach models, and e-health tools.

5.2.3 Pilot and evaluate a shared care plan that is holistic and facilitates a person-centred planning approach that can be adopted across the sector.

5.2.4 Monitor activity against the ACT's commitment to "Equally Well" and deliver activities that support the physical health of people with mental illness.

5.3 Sustainability

5.3.1 Support health and community services to collaborate on planning and service delivery.

5.3.2 Explore innovative solutions, including new technologies, that support person-centred collaborative planning and integrated treatment and support.

5.3.3 Incorporate physical and mental health promotion outcomes in procurement criteria and funding agreements.

Signs of Success

People:

- receive holistic planning and care that addresses the physical, social and mental factors influencing their wellbeing;
- can easily access a range of services to address their health needs in one place; and
- set their own recovery goals and work together with services in support of these goals.

Health care and other providers:

- feel confident addressing the physical, social and mental health needs of consumers;
- know how to refer and support consumers to access other services; and
- communicate and collaborate with other services as part of a team approach.

Focus area 6: Reduced self-harm and increased suicide prevention

What needs to be done:

Establish a co-ordinated system approach to self-harm and suicide prevention.

Deliver programs that raise awareness, build resilience, and promote help-seeking.

Engage across communities and sectors to develop a sustainable approach that is evaluated.

Deliver suicide awareness and response training for frontline staff.

Establish support programs for people following a suicide attempt or crisis.

Develop targeted approaches for people that may be at higher risk, such as Aboriginal and Torres Strait Islander people and people who identify as LGBTIQ.

Establish aftercare support services for families and communities following a death by suicide.

To do this, we will:

6.1 Planning

6.1.1 Use available evidence, including data and learnings from existing programs and consultations, to plan and inform further delivery of self-harm and suicide prevention activities.

6.1.2 Identify specific training needs and plan targeted and culturally appropriate suicide awareness and prevention training for groups within the ACT community, including general practitioners, police, mental health workers, and the broader community.

6.1.3 Jointly monitor, evaluate and undertake service improvement planning for existing services and programs aimed at self-harm and suicide prevention.

6.2 Integration and system redesign

6.2.1 Through implementation of LifeSpan, deliver coordinated, integrated, evidence-based suicide prevention activities, including options for lived experience peer workers. This includes follow-up support after a suicide attempt.

6.2.2 Collaborate with cross-sector partners to deliver system-wide suicide prevention activities where people live, work and learn, with targeted approaches for vulnerable groups.

6.2.3 Provide adequate support for people, families and communities following a suicide attempt or a death by suicide.

6.3 Sustainability

6.3.1 Monitor evidence and data and develop a sustainability plan for integrated suicide prevention activities.

6.3.2 Continue to deliver programs that promote resilience building and help seeking.

6.3.3 Engage stakeholders across communities and sectors to evaluate activities in suicide prevention and inform further investment in successful, evidence-based strategies and programs.

6.3.4 Continue to provide frontline worker suicide prevention training that is evidence-based and culturally appropriate.

Signs of Success

People:

- feel confident and willing to seek help;
- are informed about what the early signs of declining mental health look like, and know where to access more information and support;
- have timely access to follow-up care after a suicide attempt;
- have timely access to aftercare after the death of a loved one by suicide; and
- have access to information and supports that are culturally appropriate and tailored to meet their needs.

Health care and other providers:

- know how to identify and support people that may be at risk of self-harm or suicide;
- are confident in asking about suicide and self-harm;
- are confident in delivering evidence-based support to prevent self-harm and suicide; and
- can provide early intervention support for people who are experiencing suicidal thoughts but have not exhibited suicidal behaviour.

Focus area 7: Improving the social and economic conditions of people's lives

What needs to be done:

Ensure mental health and wellbeing is addressed in all policy and action.

Explore flexible models of funding and services.

Establish forums that facilitate collaboration across sectors.

Ensure programs and services are available where people live, work and learn.

Provide support for people within and exiting the justice system.

Promote 'housing first' approaches.

Reduce the impact of social and economic disadvantage.

To do this, we will:

7.1 Planning

7.1.1 Explore opportunities to integrate funding and service delivery to address the broader economic and social influences on health and wellbeing.

7.1.2 Draw on evidence and available data to inform development of flexible models of funding and service delivery that can respond to the breadth of unmet need for individuals.

7.1.3 Codesign collaborative programs and services in partnership with relevant agencies across sectors.

7.2 Integration and system redesign

7.2.1 Drive cross-sector and multiagency collaboration through establishing mechanisms such as forums, communities of practice, and training and co-design processes.

7.2.2 Invest in programs and services respond to mental illness and trauma by addressing the social and economic conditions that influence mental health; including:

- 'housing first' options;
- support for people within and exiting the justice system; and
- specific solutions for at-risk populations.

7.3 Sustainability

7.3.1 Advocate for and drive inclusion of mental health and wellbeing as part of all policies.

7.3.2 Strengthen relationships and build awareness of the importance of mental health and wellbeing across government and community sectors, including housing, education, policing and corrections, and environment and economic policy.

7.3.3 Monitor and evaluate the impact of the social and economic circumstances within which people live, work and learn to continue to address disadvantage and to improve mental health and wellbeing.

Signs of Success

People:

- receive integrated, co-ordinated care that addresses the social, economic and environmental factors that influence their mental health and wellbeing;
- know when and where to go to receive help within their communities; and
- experience reduced stigma and discrimination and greater community understanding of their mental health needs in the areas where they live, work and learn.

Health care and other providers:

- recognise the influence of people's social and economic circumstances on their mental health and wellbeing;
- seek to improve integration and coordination of social and economic services with mental health supports;
- engage in mental health and wellbeing initiatives from all government and community sectors; and
- advocate and take action to improve the mental health and wellbeing through addressing social and economic circumstances including homelessness, recidivism, low income and unemployment.

PART C: ACT REGIONAL MENTAL HEALTH AND SUICIDE PREVENTION PERFORMANCE AND MONITORING PLAN

BACKGROUND

The ACT Mental Health and Suicide Prevention Plan (ACT Plan) is comprised of 3 parts:

PART A

The Framework consists of information about the strategic drivers, context and direction for the ACT Plan and provides a strategic framework for the Territory as well guidance for practical implementation by stakeholders in the region.

PART B

The Implementation Plan consists of short, medium and long-term activities mapped against each of the strategic priorities.

PART C

The Performance and Monitoring Plan provides a framework for measuring how well the ACT Plan is achieving its objectives including indicators of successful reform and key evaluation activities.

INTRODUCTION

This Performance and Monitoring Plan will provide a structure to guide monitoring the outcomes of the ACT Plan. It will also outline how progress will be reported on and shared back to the wider ACT community.

The Performance and Monitoring Plan is comprised of indicators that will be used to monitor progress against the ACT Plan. These measures aim to provide a framework for assessing whether system-level change is contributing to wider changes in outcomes for people experiencing mental health issues. These indicators have been informed both by the Fifth National Mental Health and Suicide Prevention Plan and by local priorities that were identified in community consultations.

Governance

The ACT Plan implementation will be overseen by a Steering Committee to monitor performance and outcomes. The Steering Committee will provide an annual progress report on activities, achievements and progress toward meeting the ACT Plan's outcomes. Progress reports will include an analysis of performance against the identified indictors and measures. The ACT Plan's Steering Committee will also undertake interviews and consultations with the community to ensure that the consumer experience is reflected.

The ACT Plan Steering Committee will also act as a forum for partner organisations to:

- discuss activities implemented under the ACT Plan;
- ensure the alignment of work across key priorities and activities outlined in the ACT Plan;
- ensure consultation with stakeholders continues to inform the implementation, performance monitoring and evaluation of the ACT Plan;
- identify, monitor and manage potential risks;
- communicate and address any issues that may have implications for the success of the ACT Plan;
- share individual organisational action plans and develop joint action plans where appropriate; and
- monitor progress, report on performance and promote the achievements of the ACT Plan.

INDICATORS

The following indicators are informed by the Fifth National Mental Health Plan and speak to the locally identified priorities for the ACT Plan as identified in stakeholder consultations.

Outcome indicators

- Self-rated mental health
- Prevalence of mental illness
- Rate of people with high to very high levels of psychological distress
- Rates of suicide

Individual Indicators

- Proportion of children developmentally vulnerable in the Australian Early Development Index
- Experience of discrimination of people with mental illness
- Self-rated overall health of people with mental illness
- Proportion of people with mental illness in employment*
- Proportion of people with mental illness in suitable housing*
- Rate of social, community and family participation amongst people with mental illness*

System Indicators

- Proportion of consumers and carers with positive experience of care (YES and CES surveys)*
- Population access to mental health care
- Change in mental health consumers' clinical outcomes
- Readmission to hospital
- Presentations to hospitals and emergency departments for mental health concerns
- Population access to clinical mental health care*

Workforce Indicators

- Proportion of total mental health workforce accounted for by the mental health peer workforce
- Proportion of specialised mental health professionals
- Workforce retention*

*Measures require further development over the period of the ACT Plan.

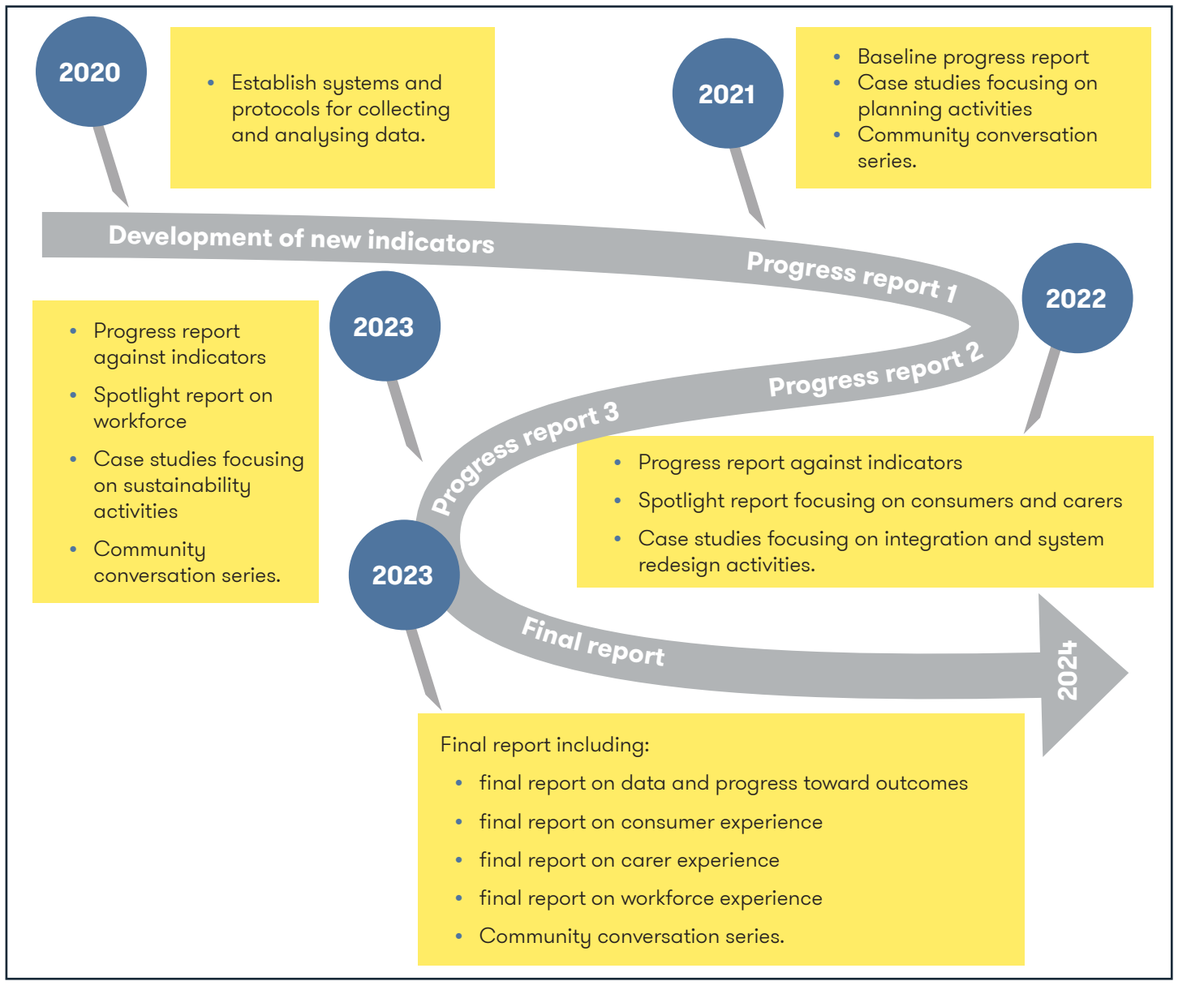
REPORTING

Each year, the Steering Committee will develop a progress report to demonstrate both the successes and challenges of implementing the ACT Plan. The progress reports will include:

- Updated data against the indicators where available;
- Spotlight series that focus on the experience of consumers, carers, and workforce based on community consultation, focus groups and interviews; and
- Case studies to demonstrate progress, successes and challenges against activities.

Community conversations will continue to act as a mechanism to share results with the community and provide a forum for ongoing conversations and feedback.

Acknowledging that some indicators will need further development and the release of publicly held data sets will likely be staggered throughout the life the plan, the following road map sets out a clear timeframe for reporting.

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