Mental Health Australia

Advice to Governments on the Proposed National Mental Health and Suicide Prevention Agreement

A view from the mental health sector

August 2021

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Executive Summary

This document provides a comprehensive view from the mental health sector on the reform opportunities presented by the development of a National Mental Health and Suicide Prevention Agreement (the National Agreement). It has been developed through a comprehensive consultation with consumers and carers, Mental Health Australia members and other key stakeholders. It contains structures, priorities and initiatives to improve outcomes for people with a lived experience of mental ill health and those who love and care for them.

Mental Health Australia highlights the following key points for governments to consider. These are:

1. The foundational principle that there must be involvement of people with a lived experience of mental ill health in the development, implementation, oversight and evaluation of the agreement.

2. The need for clear accountability, coordination of activity, and transparency of action; and the need for First Ministers to take responsibility for the outcomes of the agreement.

3. There must be a commitment to long-term funding enhancements based on an objective reference point; and that investment is incrementally added to the system against a set of transparent priorities with transparent governance and oversight.
4. Governance and implementation mechanisms must include representation from the sector, drawing on its expertise and to recognise the foundational principle of the involvement of individuals with a lived experience of mental ill health.

5. Endeavour must focus on activity beyond the health system and include responses that address the social determinants and root causes of mental ill health and suicide including poverty, trauma and incarceration.

6. The evaluation and measurement of outcomes built into the National Agreement must include whole-of-government measures that deal with long-term improved mental health and wellbeing for the whole community.

The National Agreement must be constructed as a document that enables continued reform and system evolution over time, a living document that first establishes clearly defined roles and responsibilities for governments and an agreed funding architecture.

Mental Health Australia strongly encourages governments to engage with people with a lived experience of mental ill health to develop and deliver a National Agreement that will truly improve the lives of every Australian.

The measures contained within this document will assist to begin this collaborative journey.

This Advice to Governments has been developed through a comprehensive consultation with consumers and carers, Mental Health Australia members and other key stakeholders.

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Introduction

In all the multitude of inquiries into the mental health system in Australia, the problems caused by fragmentation have been consistently identified by consumers and carers as creating an ad hoc patchwork of services that are difficult to navigate and access. This issue featured again in many submissions and the recommendations of the Productivity Commission Inquiry into Mental Health when it released its findings in November 2020. The lack of clear roles and responsibilities between the Commonwealth and state and territory governments was identified as a major factor in this fragmentation.

As part of the Australian Government response to the Productivity Commission's findings, the Prime Minister announced the development of a National Agreement on Mental Health and Suicide Prevention (the National Agreement) to be agreed with the states and territories by November 2021, providing twelve months in total for its development. Implementing such a National Agreement is one of the key actions identified in Mental Health Australia's Charter on Mental Health that was signed by over 110 organisations in the mental health sector. The Prime Minister indicated that the National Cabinet had established a Health Reform Committee and this group would take accountability for delivering the National Agreement.

In announcing the National Agreement in October 2021, the Prime Minister Scott Morrison stated:

"The agreement matters because it will clarify that grey… between the states and federal in the most important areas of where mental services have been found to be ambiguous or missing… We need the Health Reform Committee to be supported also by a small strategic advisory group which brings together the views of experts, and importantly, Australians with lived experience of mental health, ill-health and the business sector.'

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Our consultation

It has been more than eight months since the announcement of the National Agreement and there is little publicly available material about its development and no clear national consultation process. Membership of the 'small strategic advisory group' has not been widely promulgated, its advice to date not public, and it is not evident that this group has sought views from the sector on the development of the National Agreement. The mechanism for seeking the views of 'Australians with lived experience of mental ill health' in particular, is not known.

Mental Health Australia is not represented on the expert advisory committee overseeing the development of the National Agreement nor have we been asked to undertake a consultation with the sector in relation to its content. In the absence of alternatives, Mental Health Australia undertook its own consultation to provide a voice for our members to inform the development of the National Agreement and to galvanise the sector in relation to key reform priorities and how they will be included.

Many of the issues that ought to be covered in this National Agreement relate to the activities of the individuals and groups that Mental Health Australia represent, and the policy outcomes are potentially significant for the whole sector.

Mental Health Australia has undertaken consultation with the breadth of its membership and beyond, preparing a consultation paper, convening forums, and accepting submissions from across the sector. Specific, targeted consultation occurred with individuals with a lived experience of mental ill health. The views contained in this paper reflect the concerns, needs and hopes of those involved in mental health care in our communities.

This 'Advice to Governments' directly reflects member views on how the current ambiguities should be resolved going forward. It is also guided by existing documents that reflect the principles and priorities of the sector, key reform initiatives proposed by the Productivity Commission Inquiry into Mental Health, outcomes from the Royal Commission into Victoria's Mental Health System as well as the work of the Select Committee for Mental Health and Suicide Prevention. This submission will be distributed to state, territory and federal governments and to our members with the intent that it informs the National Agreement.

The Productivity Commission Inquiry into Mental Health

The Productivity Commission was asked to inquire into the role of improving mental health to support economic participation and enhancing productivity and economic growth.[1] This followed concern within the governments that an increasing number of Australians were experiencing mental health conditions that affect not only the individual and their families' social engagement and connectedness, but can also reduce economic participation, incomes and living standards.

The Productivity Commission's Inquiry into Mental Health Terms of Reference outline the underlying rationale for the inquiry as follows:

> *"Mental ill-health affects all Australians either directly or indirectly. Almost one in five Australians has experienced mental illness in a given year. Many do not receive the treatment and support they need. As a result, too many people experience preventable physical and mental distress, disruptions in education and employment, relationship breakdown, stigma, and loss of life satisfaction and opportunities".*[2]

The inquiry examined the effect of mental health on participation in the community, and the effects it has more generally on the economy and productivity. It also examined how governments across Australia, employers, social services, housing and justice can contribute to improving mental health for all Australians.

It stated that in order to achieve its recommendations for reform it "*would require the agreement of both levels of government, as would the broader recasting of the NMHC as an interjurisdictional statutory authority (recommendation 22), and the need to clarify government roles and responsibilities for; mental healthcare; psychosocial supports; mental health carer supports and suicide prevention services (chapters 9 and 18; appendix G).*

There would also be a need for additional Australian Government financial transfers to State and Territory Governments to support the transfer of responsibility for psychosocial supports to State and Territory Governments and to assist with filling the sizeable gaps in State and Territory Government provision of clinical mental healthcare and psychosocial supports (chapters 12, 13 and 17). Administering these reforms and funding flows via a single intergovernmental agreement is preferable to a patchwork approach of making modifications to existing agreements or negotiating a range of smaller new agreements".[3]

Refer to Appendix A for further excerpts.

[1] Productivity Commission, Mental Health, Inquiry Report, Terms of Reference, Volume 1, p.3.
[2] Productivity Commission, Mental Health, Inquiry Report, Volume 1, No.95, 30 June 2020, p.2.
[3] Productivity Commission, Mental Health, Inquiry Report, Volume 1, No.95, 30 June 2020, p.1145.

Advice to Governments on the National Agreement

Foundational principle

The foundational principle that must apply to the National Agreement is that individuals with a lived experience of mental ill health[4] must be involved in the development, implementation, oversight and evaluation of the agreement.

The National Mental Health Policy 2008 remains the central policy document in Australia relevant to the mental health field. It states '[*People with mental health problems and mental illness] also have the right to contribute to the formulation of mental health legislation and policy, and to the design, implementation and evaluation of mental health services at national, state/territory and local levels to ensure that services comprehensively meet their needs, including from a cultural perspective.*'[5]

This is a clear statement. Its intention is to ensure that the process of designing, implementing and measuring the system is driven by those for whom it is designed. The Productivity Commission Inquiry recognised the importance of this in the body of its recommendation on the National Agreement. There is limited evidence however in the development of the National Agreement to date to indicate this prescribed policy position has been followed.

Consistency with this policy intention requires genuine engagement with those with a lived experience of mental ill health, and inclusion of people with lived experience in governance arrangements in the design, negotiation, implementation and ongoing monitoring of the National Agreement. People with lived experience need to be partners with government and to be part of senior governance groups. The system must be genuinely consumer-centred, with consumers needs at the forefront, and the process of drafting the National Agreement should reflect this. For example, asking consumers about their experience, in comparison to capturing activity data.[6]

The National Agreement should include an embedded outcomes framework developed using a co-design approach with people with lived experience. It must include the outcomes that matter most to consumers and carers.

[4] The term 'a lived experience of mental ill health' is generally used in this document to refer to someone with experience of a mental health problem. Where direct quotes are used the terms consumer and carer may appear and can be used interchangeably with the term 'a lived experience of mental ill health'.
[5] Commonwealth of Australia. National Mental Health Policy 2008. First published 2009, p.12.
[6] Submission from Beyond Blue to this consultation.

Beyond the National Agreement itself, the governance principles it establishes must necessitate ongoing co-design of programs within jurisdictions, driven by a consumer-centred approach to mental health care. The National Agreement should establish advisory structures and mandated processes that bring individuals with a lived experience of mental ill health into policy decision making.

> *As proposed by a mental health carers representative body, the Australian Government should "develop a national co-design framework to be applied across all service settings, where the development of any new mental health-related services and products is undertaken in conjunction with consumers and carers, as appropriate.*

Such a framework should include information about the continuum of consultation, guiding principles on how to establish governance mechanisms, how to identify and engage key stakeholders and provide funding to ensure effective engagement. There needs to be more attention to the involvement of families and friends caring for persons with mental ill health in all aspects of mental health system development and implementation."[7] Finally, this national co-design framework should define and establish co-funding mechanisms for consumer and carer bodies.[8]

What should the objective and principles of the National Agreement be?

Mental Health Australia's Charter 2020 states in its description of a proposed National Agreement:

> *'An agreement that delivers integration and coordination of mental health services, including agreed objectives, indicators, monitoring arrangements and funding between all levels of government. Critical to this agreement is improved accountability, coordination and transparency through clarity of governance and funding responsibilities across Commonwealth and state and territory governments.'*[9]

The Productivity Commission Inquiry recommended the National Agreement would '*agree to and clarify responsibilities for mental health service delivery, funding, monitoring, reporting and evaluation.'* The stated intention of the Prime Minister in announcing the agreement concurred with this.

There is a clear consistency of view that the National Agreement needs to clarify and reform the architecture of the system to address the waste, confusion and lack of accountability that has plagued mental health approaches in Australia.

However, identifying responsibilities for the operation of the system requires at its heart an agreement on the objective of that system. It is not possible to form the type of agreement envisaged by the Productivity Commission without agreeing firstly on the objectives to be achieved. Further, the principles that underpin the National Agreement will drive the priority activity to be progressed.

[7] Mental Health Families and Friends Tasmania submission to the Productivity Commission 2020, p.4.
[8] Submission from Beyond Blue to this consultation.
[9] Mental Health Australia 2019. '*Charter 2020: Time to Fix Mental Health'*.

Objectives

The Mental Health Australia Charter 2020 document contains clear examples of objectives to drive the reform of mental health in Australia.

Following consultation with the sector the following are offered as objectives for the National Agreement:

- That all Australians achieve the best possible mental health and wellbeing
- Address the root causes of mental ill health and suicide including poverty, trauma and incarceration.
- Address Indigenous mental health, wellbeing and suicide prevention.
- Build a mental health and suicide prevention system that is truly person-led.
- Create incentives and funding arrangements that are aligned across funding bodies and across sectors of service delivery and that prioritise community-based approaches to mental health.
- Build a system based on evidence and outcome focussed measures of performance.
- Articulate a clear point of accountability for every element that comprises the mental health system.

Principles

The National Agreement should, by definition, be a high-level document that provides the architecture for reform without prescribing every element of how that should be achieved.

It is expected that the National Agreement would be the genesis of targeted strategies and plans that focus on areas that require combined effort, without needing to spell out in the National Agreement specifically what that effort will be. Recommendations for specific strategies and plans to be developed and progressed are included in this document.

The National Agreement should be structured such that the Australian Government is responsible for providing funding to states and territories according to a set of broad and nationally agreed principles, while actions in each state and territory are tailored to local needs. Examples of such nationally agreed principles regarding the health system could be:[10]

- Programs must be evidence-based and improve access to care and outcomes.
- Each state and territory should have alternatives to Emergency Departments for mental health care.
- Each state and territory should ensure that everyone in a mental health hospital setting has the option of non-clinical approaches.
- Mental health investment in each state and territory should progress toward an optimal mix of mental health services according to local need and based on current modelling. Investment should align with contemporary approaches to mental health, including a focus on prevention and community supports. There should be staged and sustainable growth in investment.
- Transformative programs need to be at a scalable level to have impact.

[10] Submission by WAAMH to this consultation.

Culture and cultural identity

A commitment to respecting culture and cultural identity is an important principle to include in the National Agreement both in relation to First Australians and in relation to culturally and linguistically diverse communities.

In broad terms social and emotional wellbeing is the foundation for physical and mental health for Aboriginal and Torres Strait Islander Australians. It is a holistic concept which results from a network of relationships between individuals, family, kinship, and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual.[11]

Social and emotional wellbeing

Social and emotional wellbeing is affected by the social determinants of health. Addressing the social determinants will require a collaborative approach that includes services outside the health sector.

Addressing social determinants will require First Ministers of each jurisdiction to be a party to the National Agreement to ensure it is implemented across the different portfolios in cabinet.

Roles and responsibilities

The National Agreement must provide a model that holds all governments to account, without allowing the current abrogation of accountability via ambiguity of authority***.***

The Productivity Commission posited a number of propositions that it indicated should be included in the National Agreement. Many of these are dealt with in other sections of this document but three must be singled out in a discussion on roles and responsibilities. These are drawn from the body of the Productivity Commission's recommendation which states that a National Agreement should be developed that:

- 'governs the transfer of psychosocial support responsibility outside of the NDIS and associated Australian Government funding to State and Territory Governments
- 'clarifies the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services
- 'commits all governments to establishing Regional Commissioning Authorities if cooperation between Primary Health Networks and Local Hospital Networks does not drive sufficiently improved outcomes'.[12]

[11] Submission by Gayaa Dhuwi to this consultation.
[12] Productivity Commission, Mental Health, Inquiry Report, Volume 3, No.95, 30 June 2020, p.1149.

Funding

In response to these guiding parameters, we must begin by stating clearly that any proposition regarding a transfer of roles and responsibilities that sees any government decrease its investment in mental health responses would be utterly unacceptable.

- The transfer of responsibility for the provision of services between governments does not abrogate the responsibility to fund those services, and any responsibility transfer should see a concomitant transfer of funding and a continuing accountability to fund necessary growth in that stream of services.

- The funding of the mental health system must continue to grow over time in alignment with the National Agreement to address the shortfalls identified by the Productivity Commission.

Regulatory frameworks

The sector is agnostic about the transfer of responsibility for psychosocial support provision outside the NDIS to the state and territory governments. The sector supports the need for these services to remain outside the constraints imposed by the NDIS legislation whatever the reform opportunity. Irrespective of which level of government manages the funding for these services, regulatory and oversight arrangements must align with NDIS services. It has proven difficult for one level of government to establish a single regulatory framework for psychosocial support services, and it seems unlikely that another level of government would be better placed to do so, however this need for simplification of regulation is the pressing concern for the sector.

The National Agreement should establish clearly who is responsible for aligning the regulatory frameworks and what mechanisms will be established to allow the alignment to occur.

Commissioning services

As a general rule in identifying system responsibilities, the sector believes that the Australian Government is responsible for providing funding to states and territories according to a set of broad principles, while actions in each state and territory are tailored to local needs. In general, commissioning services, and delegating responsibility for the service provision itself is better managed at the state and territory level where local circumstances can be better aligned to commissioning approaches. The sector however does not foresee any substantive argument for changing the existing arrangements for regulation and funding of private mental health care.

Regional Commissioning

The sector is ambivalent about the creation of regional commissioning authorities per se, although the commitment to a regional based program of integrated service development and delivery across the continuum of care from hospital acute to community based and psychosocial services and to primary care, and across the age ranges is very well supported. The challenge is how to do this efficiently and effectively so that layers of administration don't effectively take away funding from the provision direct mental health services. It is clear that where there is a risk of substantial administrative and transition costs, any benefit in better use of funds for mental health outcomes would need to exceed these costs. However, if these entities deliver better aligned services with integrated objectives, and all governments voluntarily choose to contribute to establish these arrangements as shared models, and the benefit outweighs the costs then this would be supported.

Regional commissioning authorities still carry the risk of expanding the accountability ambiguity if the responsible government minister accountable for their performance is not clear. In our system of representative government, the sector wishes to ensure that these commissioning bodies do not mislead on who the ultimate individuals with accountability are. Ministerial accountability for delivery, funding and reporting should be explicit.

What governance and oversight should the National Agreement have?

Our foundational principle applies in this context. Individuals with a lived experience of mental ill health should be fundamentally involved in the governance of the agreement.

Addressing mental ill health is everyone's responsibility

National Cabinet has tasked Health Ministers to develop the National Agreement. This reflects the traditional allocation of responsibility to address mental ill health, largely through treatment-oriented programmatic responses.

It is now well understood however that in order to get widespread improvement in the experience of mental health, and effective responses to mental ill health, the involvement of many government portfolios is necessary.

Improved approaches to prevention and addressing the social determinants of mental ill health requires the involvement of ministers responsible for law and justice, education, disability services, housing, employment and social services. Mitigating the impact of social inequality, trauma and discrimination can only be achieved through co-ordinated government action.

Role of First Ministers

First Ministers generally oversee issues of national significance and this often brings their own departments into the oversight and implementation process. The 2006 COAG Agreement on Mental Health was overseen by First Ministers, and arguably this is what made it successful.

Notwithstanding the allocation of responsibility for developing the National Agreement to Health Ministers, First Ministers must retain the primary role in governance for the National Agreement. Assuming that Health Ministers are also given primary implementation accountability for the National Agreement then at a minimum this requires:

- A report every six months from Health Ministers on progress against the National Agreement and reports from other ministerial portfolios on progress against any allocated actions every twelve months.
- A mechanism through First Ministers for Health Ministers to request allocation of activity to other ministerial portfolios, documentation of the action allocated to other ministers in the National Cabinet communique and notification of the allocated activity to the oversight body for the agreement (see later section).
- An implementation group in each state and territory that is chaired by a relevant cabinet minister and includes representation from all relevant portfolios and inclusive of people with lived experience, carers and key sector stakeholders particularly (where they exist) Mental Health Commissioners. It would be expected that the depending on the jurisdiction the Deputy Chief Medical Officer for Mental Health, or the jurisdictional Chief Psychiatrist where applicable would participate. These groups would provide progress reports on implementation through to the Health Reform Council for inclusion in the six-monthly progress report to First Ministers.
- Recognition of National Indigenous Governance consistent with the Gayaa Dhuwi Declaration and enhance outcomes for Aboriginal and Torres Strait Islander peoples by ensuring their full involvement in its development and implementation. Advance Aboriginal and Torres Strait Islander peoples involvement, engagement and autonomy through equitable participation, shared authority and decision-making in relation to the National Agreement.

Oversight of the National Agreement

The monitoring of mental health reform in Australia requires a truly national entity.

The National Mental Health Commission as currently constructed is fundamentally an Australian Government agency with primary reporting accountability to Australian Government Ministers. This impacts on its capacity to effectively compare and measure activity across levels of government.

There exist already within the health portfolio a number of statutorily created agencies under the *National Health Reform Act 2011*. These include, amongst others, the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the Independent Hospital Pricing Authority (IHPA). The legislation prescribes board membership, governance processes, powers, reporting obligations and consultation mechanisms and is inclusive of the involvement of all Australian jurisdictions in covering these issues.

Similarly, the *Australian Institute of Health and Welfare Act 1987* establishes that institution and prescribes its governance processes, powers and reporting obligations. Again, it accommodates the need to incorporate state and territory, and federal government views in the statutory provisions.

A Redesigned National Mental Health Commission

In order to effectively monitor both the National Agreement and the operation of the various systems that apply to mental ill health in Australia, it is time for a statutorily created, truly national mental health agency, or as recommended by the Productivity Commission, redesign of the National Mental Health Commission to undertake this set of functions.

- Such an agency's legislation must contain provisions for governance, powers, reporting obligations and consultation that reflect the need to accommodate input from authorities in all jurisdictions. Without prescribing these provisions in detail, the *National Health Reform Act* provides useful direction. Embedding the involvement of people with a lived experience of mental ill health should also feature.

- This national mental health agency should be established as the oversight and monitoring agency for the National Agreement and monitor and report both on progress against the Agreement and on the key national performance indicators that are agreed to be measured.

Involving expert knowledge and experience

Effective implementation of the National Agreement requires the input of those with expertise in mental health and mental ill health. The involvement of people from outside of government provides a helpful check and balance on the implementation of the National Agreement and can assist to prevent government becoming captured by its own administration issues. It also allows identification of the key skills necessary to implement the National Agreement very early on and provides a mechanism for drawing those skills into implementation.

- A new entity, such as a Mental Health Reform Committee, should be established with an explicit focus on leadership, oversight, and implementation of reforms. Subject matter experts need to be embedded within the highest levels of the governance structures (at governmental and local levels). Experts include clinical leaders, service providers, academics and those with lived experience leadership expertise.

The Mental Health Reform Committee could be auspiced by the national mental health agency and provide advice to the leadership of that agency on the progress of implementation, and on continuing progress with mental health reform. The Mental Health Reform Committee ought to also be available to provide advice to Health Ministers on relevant mental health issues and to comment on implementation of the National Agreement.

What are the priority actions that should be progressed through the National Agreement?

The National Agreement needs to incorporate clear actions that will drive genuine reform. This requires changes to the mechanisms of decision making, the basis of authority and accountability and the transparency of the systems processes.

The issues below are drawn from the consultation process undertaken by Mental Health Australia. The list below should not be considered exhaustive. The sector believes that the National Agreement should be a genuine vehicle for reform drawing on the breadth of possible expertise to drive its actions, including expertise held inside of government. The implementation of these actions should be undertaken with reference to our foundational principle.

A transparent objective reference point for funding need

The Productivity Commission recognised the need for a clear objective, evidence-based reference point for determining the need for system resources. It relied heavily on the National Mental Health Services Planning Framework (NMHSPF) for its calculations on current service enhancement priorities and on the gaps in the system, including the gaps identified in the provision of psychosocial disability supports.

The NMHSPF is an attempt at a consensus-based, evidence-driven, objective reference point for required system resourcing. It is currently the best tool of this type available. It is however a restricted access tool, and not widely available in the public domain, making it a less than transparent mechanism for initiating discussion and action on system enhancement.

The NMHSPF was developed in 2011 via a modified Delphi (consensus based) method. It was limited by the knowledge and data available at that time. It has subsequently been subject to further review.

In order for the NMHSPF to provide the necessary transparent objective reference point the following is required:

- It must be made available in the public domain.
- It should be subject to ongoing review and maintenance, including a review of the Delphi process at regular intervals, approximating five years apart.
- The data and knowledge gaps should be made known to the sector to encourage targeted research that may improve the assumptions of the model.
- Its governance and stewardship should be transferred to the national mental health agency to oversight its review and maintenance, in collaboration with key academic partners.
- In particular its modelling of psychosocial disability support should be honed and subject to expert input from service providers and individuals with a lived experience of mental ill health.
- It should provide clear modelling of the role and resources needed for private sector mental health care.
- Future iterations should model the role of digital interventions.
- It should indicate the volume of care to be provided inside and outside the NDIS.

Planning and investment to meet resource need

The availability of a transparent and objective measure of resource need provides the opportunity for governments to undertake systematic planning and commit to a long-term investment plan to address identified resource gaps from the NMHSPF. Use can be made of the established governance and advisory structures articulated earlier in this paper to work through the necessary steps to allow commitment to investment.

Upon transfer of the NMHSPF to the national mental health agency, an audit of existing system resourcing should occur against the estimates of need produced by the NMHSPF. An assessment of any resultant gaps should be made. The national mental health agency should then be accountable for providing advice on the prioritisation of those gaps to responsible ministers and for providing targets to governments for investment.

Long term investment

Governments must commit to a long-term incremental investment to address the gaps.

It is the view of the sector that the likely resource gaps will be substantive. The sector recognises that addressing this takes long term planning for workforce, assets and systems to get the best value from additional government investment. Time is also required for appropriate service co-design. As such, cumulative annual additional investment of between 1 and 2% of the identified gap[13] would allow incremental change and would eventually address the anticipated resource need.

Focus on providing mental health services in the community

It is the view of the sector that the most pressing gap that will be identified is in the provision of mental health care in the community.

The sector strongly supports preferential investment in community-based care, in all the forms indicated in Appendix B to this paper.

This includes recognition of specialist community mental health teams, the importance of office-based psychiatry and psychology services, and the full range of interventions provided by community managed organisations. Further, connections and pathways between these services must be built into planning and funding models.

[13] That is, if the identified gap between available resources deployed and resources required is a 25% deficit, then that gap should be addressed in intervals of 1 to 2% per annum cumulatively, over and above the additional investment required simply for population growth, requiring around 15 years to address the resource deficit.

Addressing the Gap in Psychosocial Service Funding

Notwithstanding the need for a systematic objective process for investment planning, numerous studies have already concluded that the gap in psychosocial disability support service provision in Australia is profound, with nearly 154,000 people by Productivity Commission estimates, not receiving the service they need[14].

Numerous stakeholders have indicated that the level of underfunding in this area is acute. Immediate attention must be paid to this need as this support is fundamental to getting the best long-term value out of investment in all other service streams and preventing readmission and recurrent co-morbidity.

Workforce Planning

A national workforce plan for mental health is required as a matter of urgency. The future anticipated gaps in the psychiatric workforce are estimated to be higher than for any other specialty. The success of any system will depend on having highly trained clinical staff to manage assessments and triaging. There is a requirement to have adequate community mental health services to provide quality clinical assessment and care. A recognition that a significant expansion in community-based care is necessary, requires a concomitant investment in that community-based workforce. Without buttressing the National Agreement with a sufficient workforce, it risks fragmenting under-resourced services even further.

- The mental health workforce actions must ensure a redesigned mental health system provides mental health care to people from all cultural backgrounds, and of all ages and stages of mental ill health. Addressing the current workforce challenges is a multi-generational commitment and will need considerable coordinated investment from the Australian Government and state and territory governments.[15]

- The National Agreement should use the outputs from an improved NMHSPF that is inclusive of community mental health service provision to identify future workforce needs and set quantifiable targets for the creation of that workforce at dedicated milestones across jurisdictions. These targets should be monitored and modified as new service models become available. Targets should be set for peer workers along with clinical staff.

- The National Agreement should establish a national peer worker agency with responsibility for developing and implementing national peer workforce framework, which provides for training and certification, professional development, supporting infrastructure and a dedicated agreed national wage structure.

- Workforce planning must include undertakings to provide the necessary skills to work with the diversity of the Australian population including building a sufficient cohort of interpreters who understand the language of mental ill health and mental health promotion, appropriately skilled community-based service providers who can operate across the diversity of communities and supported, skilled peer workers. Similarly, the workforce must be appropriately skilled to work with the needs of the LGBTQI+ community and foster the development of additional peer workers in this community.

[14] Productivity Commission, Mental Health, Inquiry Report, Volume 1, No.95, 30 June 2020, p.861.
[15] Submission from RANZCP to this consultation.

- The National Agreement should facilitate the establishment of curriculums for suicide prevention training that traverse health, first responders, drug treatment services, social service providers and corrective services agencies, building on common language and cultural approaches.

Improved systems

The National Agreement, in addition to achieving structural reform, should also focus on achieving better overall system responses to key problems.

There is widespread duplication of effort in the sector driven by inconsistency of approach by funding bodies, particularly for community managed organisations. This relates to regulatory compliance, contracting compliance and administrative obligations. This duplication reduces value from government investment in service provision.

- The National Agreement should include in-principle commitment from all governments to a single national contracting framework for services. This framework should include consistent contracting provisions, consistent KPI's, agreed pricing structures and a commitment to minimum funding terms of at least five years. The contracting framework should be utilised by Departments or Ministries of Health, Primary Health Networks and Local Health Networks in implementing their funding streams. If regional commissioning bodies are operational they should also use this framework.

- A single accreditation framework should be operational for service providers using a consistent set of accreditation standards. Agencies are subject to multiple sets of standards from different funding bodies requiring multiple accreditation processes. A national mutual recognition framework recognised by all funding agencies, including the NDIS, should be established.

- A national data framework should be incorporated into the National Agreement allowing for nationally consistent data collections and mechanisms for growing those data collections. This data framework should prioritise the creation of clinical registries. The establishment of clinical registries would institute nationally consistent data systems on mental health and suicides. Clinical registries enable the collection of wider demographic information and key risk factors for suicide including mental ill health and addiction comorbidities. This provides the potential to improve understanding of the factors that contribute to quality care and improving patient outcomes.[16]

[16] Submission from RANZCP to this consultation.

Balance the endeavour

The need for accessible and appropriate treatments for people with a lived experience of mental ill health is recognised. Responses to mental ill health in Australia have for too long however, relied almost entirely on this approach without addressing the root causes of mental ill health.

While the NMHSPF, acknowledging its current gaps, will identify the necessary investment gaps in the treatment sphere, this should not be at the expense of renewed endeavour to address the root causes of mental ill health and to establish appropriate prevention-based responses.

The National Agreement should commit to policy frameworks, planning and investment in the following priorities:

- Concerted long term action to address stigma.
- Co-ordinated action by Housing Ministers to ensure a commitment to investment in supported accommodation programs and better access to safe long-term housing.
- Co-ordinated action by governments to drive return to employment opportunities, provide necessary supports to allow individuals with a lived experience of mental ill health to retain employment and endeavour to build overall resilience in the workplace.
- Regular mental health screening of children at prescribed intervals beginning in the pre-school years, accompanied by widespread training for educators in the identification of mental health problems.
- Ensure that approaches to prevention and early intervention reflect the cultural diversity of the Australian community.
- Addressing the needs of veterans and their families.
- A commitment to a National Mental Health Carer Strategy.
- A commitment to engage with the cultural diversity that is representative of the entire Australian population.

Investment in Aboriginal and Torres Strait Islander peoples mental health

Our foundational principle and the principles of indigenous governance apply to these actions.

All government funding needs to be based on the principle of equity of need, rather than equity of population. Suicide rates among Aboriginal and Torres Strait Islander people are more than twice the rate for non-Indigenous Australians. In some key demographics, such as those aged between 10-17, the rate is more than six times higher than non-Indigenous Australians.[17]

There is overrepresentation of Aboriginal and Torres Strait Islander people affected by the upstream factors of suicide, such as unemployment, lack of adequate housing, low education, family violence, out of home care, racism, and addiction. The Australian Institute of Health and Welfare quantified that more than half of the health gap between Indigenous and non-Indigenous working-age adults can be accounted for by a set of 5 selected social determinants: employment and hours worked, highest non-school qualification, level of schooling completed, housing adequacy and household income.[18]

Failing to address the upstream factors of mental health and suicide results in a higher number of Aboriginal and Torres Strait Islander people experiencing psychological distress.

The interim advice of the National Suicide Prevention Advisor recommends an equity approach is adopted to suicide prevention planning, acknowledging the disproportionate impact experienced by some population groups, making them vulnerable to suicidal behaviour and requiring targeted approaches, including Aboriginal and Torres Strait Islander Peoples (Recommendation 10).[19]

This requires funding well in advance of the population share of Aboriginal and Torres Strait Islander people.

- Where budget allocations are made to the benefit of “all Australians”, clear statements are needed on how each initiative responds to Aboriginal and Torres Strait Islander peoples’ needs for mental health and suicide prevention and this commitment is reflected in contracts and agreements with the service provider.[20]

- We also support the Productivity Commission Inquiry recommendation that the National Agreement should include arrangements for Aboriginal Community Controlled Health Organisations (ACCHOs) to be the preferred providers of mental health services for Aboriginal and Torres Strait Islander people.[21]

[17] Submission from Gayaa Dhuwi to this consultation
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Productivity Commission, Mental Health, Inquiry Report, Volume 1, No.95, 30 June 2020, p.57.

Improved health system design

Notwithstanding the need to deal with the root causes of mental ill health and acknowledging the need for additional investment in service delivery expected to be demonstrated by an improved NMHSPF, significant improvements in health system service design are needed. The following actions should be captured in the agreement:

- Recognition that community-based care is the default option for treatment and thus a long-term commitment to expanding investment in services in the community in preference to inpatient care.
- Acknowledgement of the use of restrictive practices as a breach of our international human rights treaty obligations with targets of zero use of restrictive practices such as seclusion and restraint.
- Incentives[22] to facilitate transitions of care from primary care to hospital care to community care and back. The measurement of effective care transitions should form a key KPI for all service providers with payment structures attached.
- Incentives to facilitate treatment of co-occurring conditions including addictions to drugs and/or alcohol, intellectual disabilities and co-occurring physical health issues.
- Incentives and health system KPIs should facilitate the integration of psychosocial support into the care pathway.

Health system design needs to provide a greater emphasis on cultural competency and the orientation of health services needs to reflect the diversity of the Australian population.

Funding and performance models must incorporate best practice service provision across the diversity of the Australian community including embedding the use of interpreters, using appropriate consultation mechanisms and supporting individuals from diverse backgrounds to contribute to service governance and co-design.

Even with the best health system design, navigation and access to the correct service for someone's needs is not guaranteed.

The National Agreement should provide the oversight and monitoring necessary to ensure that triage and referral however configured locally provides a reputable and reliable contact point for individuals with a lived experience of mental ill health.

This service should be able to provide a brief assessment for a person, a referral point for care and a set of finalised actions that ensures connection of the person to that service.

[22] The term 'incentives' is used here to refer to financial and performance mechanisms to drive changes in policies, procedures and workforce behaviour in health service providers.

How should the initiatives in the National Agreement be implemented?

Mental ill health interfaces with almost every government portfolio, although traditional responsibility for policy responses has been with the health portfolio. This is appropriate for a treatment-oriented policy response but not for addressing the social determinants as then portfolios addressing housing, education and employment become increasingly important.

This has been a traditional difficulty in getting coordinated action on the drivers of mental health as Health Ministers, and the public servants who report to them, have no authority over these portfolios of housing, the law, social services, education, police and employment. Getting action from those portfolios when they are not directly accountable for implementing the outcomes of an agreement can be hard as those portfolios have their own agreements to progress and these are generally prioritised.

Cooperation across whole of government

In order to address portfolios across government it is important to bring those agencies into the implementation process. The implementation approach must also allow for accountability and co-operation between levels of government.

This will require action nationally but will also require both levels of government to ensure that local arms of their responsibility work together such as Primary Health Networks (who are contracted by the Australian Government) and Local Health Networks (who are run by the states and territories).

The eight state and territory implementation groups discussed in the governance section address this requirement, involving all relevant portfolios such as housing, education and the law. These state and territory committees advised local state and territory ministers on progress.

These eight local implementation groups should develop and publish annual action plans that detail how relevant initiatives will be progressed, what new activity is foreseen and when action will be required by stakeholders to assist to bring actions into reality.

These groups should engage their own local consultation structures to ensure that actions have local knowledge guiding their implementation.

Duplication created by commitments to other national agreements should be avoided. In particular activity driven by the NDIS agreement should be consistent with the activity arising from the National Agreement. However, other important agreements must be considered including the Closing the Gap agreement, the National Housing and Homelessness Agreement and the National Health Reform Agreement.

How should the performance of the National Agreement be measured and reported on?

Performance monitoring, public reporting and evaluation are key to ensuring continuing and ongoing engagement with the National Agreement.

It is important to have clear measures that relate to better outcomes and experiences for people involved with the mental health system.

Publishing those measures in the public domain and bringing scrutiny to how they change over time are necessary to maintain the responsiveness to the action required in an agreement.

There can often be a focus on system measures in intergovernmental agreements because they are easier to count, such as resource inputs or service counts. Measures that focus on better outcomes are harder to measure.

Development of measures

The sector recommend government pursue measures that indicate improvements for individuals who receive a service over time, population prevalence of mental ill health and changes to the social determinants. These measures have more overall meaning in relation to the objective the National Agreement should seek to achieve.

The National Mental Health Commission has completed work on a selection of measures that has great utility and is a sensible reference point.[23] The sector would encourage governments to develop a dashboard of quantitative measures that measure amongst other things:

- Improvements in mental and physical health in those who have come into contact with the treatment system.
- Community connection, social wellbeing, and the social determinants of health.
- The connectedness of the various elements of the system architecture and the movement between those elements.
- Long-term clinical outcomes and personal recovery measures.
- Global measures of the mental health of the Australian community
- Reference to relevant ‘closing the gap’ targets.

Improved data collection

A mechanism must be included in the agreement that establishes the capacity to continually improve data collections through data collaboration, data sharing, data linking and data development. This is particularly important for improving data collections for the community mental health sector, culturally diverse communities, for veterans and for the LGBTIQ+ population.

[23] National Mental Health Commission 2012. Mental Health Report Card.

Public reporting of outcomes

Public reporting of outcomes is an important part of the accountability process. Reporting is important for the sector to be able to understand how things are changing, what is working and what is not. It also allows for the sector to contribute to the implementation process.

An annual report from the Australian Government and each state and territory government on progress should be built into the commitments in the National Agreement.

Evaluation

It is important to have evaluations conducted prior to the expiry of the National Agreement. Looking at the impact of an agreement as a whole via an evaluation toward the end of its life also ensures that its benefits can be captured for future decision making and to inform determinations on the continuation of the funding arrangements that are captured in the agreement or whether some redistribution may be warranted. The task of progressing an evaluation should fall to the National Mental Health Agency once established.

The evaluation should be completed prior to the completion of the lifetime of the National Agreement in order to assist decision making on the appropriate steps at its conclusion. Six to twelve months in advance of the agreement's expiry provides enough time to assess whether there is merit in continuing the arrangements**.**

The evaluation should consider as its primary reference point whether the experience of the system of those with mental ill health in our community has improved in the lifetime of the National Agreement. It should also consider improvements in the global mental health of the community.

A final issue for consideration…

Terminology is powerful and words can have important impacts on people subject to the agreement. The sector strongly encourages government to engage with individuals with a lived experience of mental ill health in refining the language of the National Agreement prior to its promulgation to the community. The language used should be rights based, encourage a recovery focus, and empower those with a lived experience to achieve the best outcomes for their circumstances.

Conclusion

The mental health sector has been heartened by the body of evidence collected and the recommendations made by the Productivity Commission Inquiry and the Royal Commission into Victoria's Mental Health System that were followed by major investment by the Australian and Victorian governments.

The announcement by the Prime Minister to develop a National Mental Health and Suicide Prevention Agreement was also hailed as key step forward to address the decade's long fragmentation of the mental health system.

Whilst acknowledging the tight timelines to develop the National Agreement it would be a huge loss if the National Agreement was developed without input from the people who use and provide these services.

Mental Health Australia hopes that the key people who are overseeing the development of the National Agreement take this advice and give it full consideration in the drafting process. Mental Health Australia and our members stand by, ready to provide additional information as required to make the National Agreement a platform to deliver on much-needed mental health reforms.

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Appendix A: Productivity Commission Inquiry recommendations for national agreement

The following excerpts from the PC Inquiry report provide context on the national agreement *'Action 23.3: Governments should agree to and clarify responsibilities for mental health service delivery, funding, monitoring, reporting and evaluation.*

The Australian, State and Territory Governments should develop a National Mental Health and Suicide Prevention Agreement that:

- *sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians*
- *governs the transfer of psychosocial support responsibility outside of the NDIS and associated Australian Government funding to State and Territory Governments*
- *clarifies the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services*
- *specifies minimum funding commitments by both levels of government and governs the transfer of Australian Government funding to State and Territory Governments to support expansion of mental healthcare and psychosocial supports*
- *declares the role of the National Mental Health Commission as an interjurisdictional evaluation body and its role in monitoring Primary Health Network–Local Hospital Network cooperation*
- *commits all governments to establishing Regional Commissioning Authorities if cooperation between Primary Health Networks and Local Hospital Networks does not drive sufficiently improved outcomes*
- *sets out clear and transparent performance reporting requirements.*

The Australian, State and Territory Government health ministers should be responsible for developing and implementing the National Mental Health and Suicide Prevention Agreement. Governments consult thoroughly with consumers and carers to inform the development of the agreement.

Arrangements for additional funding to State and Territory Governments provided under the NMHSPA should be carefully designed to ensure that it is used as intended. The NMHSPA should … ensure that any Australian Government funding is additional and does not replace existing State and Territory Government contributions. Moreover, safeguards would likely be needed to ensure that this funding is funnelled toward the areas of greatest need as identified in the regional gap analyses.

The NMHSPA should also outline the role of the AIHW in facilitating and performing gap analyses using the NMHSPF (chapter 24).

The Australian, State and Territory Government health ministers should be responsible for developing the NMHSPA. They should ensure that consumers and carers are key partners in its development. The agreement would constitute a major shift in government policy that aims to improve the lives of people with mental ill-health, and their carers, families and community groups. Accordingly, governments should ensure early consultation with people with lived experience to determine the most effective approach to co-design the NMHSPA. Further, they should ensure that the co-design process is properly resourced and managed to effect real change.[24]

[24] Productivity Commission, Mental Health, Inquiry Report, Volume 3, No.95, 30 June 2020, pp.1045-1048.

Appendix B: What are the elements of the mental health system?

There is no nationally approved taxonomy of mental health services and only limited clarity on which levels of government have constitutional responsibility for the various elements. Descriptors for the various parts of the mental health system can change by location and over time.

Broadly speaking however, there are hospital-based inpatient services providing overnight admitted care and a range of community based mental health services comprising specialist community (ambulatory) based mental health services providing treatment in community settings, community residential care, psychosocial disability support services, privatised MBS services provided by psychiatrists, general practitioners, psychologists, mental health social workers and mental health occupational therapists, and the adult mental health centres currently under development. [25] This list however is a gross over-simplification as there many other services across other areas such as housing, social security, employment and education to name but a few that support people with mental ill health. Hospital inpatient services can be emergency based, acute or non-acute inpatient, or consultation services to non-mental health wards.

Specialist community-based services can be provided as office-based services, day programs or outreach programs, and can be structured to provide intensive treatment, case management or assessment and screening. Office-based services can be Medicare funded provided through private psychology, social work, occupational therapy and psychiatry, or provided by similar professionals including nurses in Local Health Network community teams.

Community residential programs can be acute, non-acute or extended stay. They can be run by government or by non-government organisations and funded by either level of government.

Psychosocial disability support programs can focus on support for day-to-day living, employment support, facilitating relationships building or educational support and can be funded through the NDIS or through separate government programs at both the state and federal level. They are provided by both the community managed and private sectors.

All of these service approaches can be overlaid by programs for specific age groups (such as children, youth and older people), for specific life experiences (such as perinatal mental health, veteran's mental health or forensic mental health), for specific diagnoses (such as for eating disorders) or for particular demographics (such as women's mental health, Aboriginal and Torres Strait Islander mental health or LGBTQI specific services). The mental health system is complex.

There is also a growing suite of digital and online services funded by governments, the private sector and universities.

Finally, there is collective responsibility for the provision of prevention services designed to reduce the prevalence and impact of mental ill health. Prevention initiatives focus on reducing risk factors for mental ill health and enhancing protective factors.

Primary prevention initiatives target the whole community or high-risk groups and are aimed at preventing the onset and development of mental ill health. Resilience training in schools is a primary prevention activity. Secondary prevention strategies lower the severity and duration of mental ill health experiences for instance through early intervention programs. Tertiary prevention activity aims to reduce the impact of mental ill health through activity rehabilitation and relapse prevention programs and the provision of psychosocial supports. No one government has responsibility for prevention activity.

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25 https://www.ihpa.gov.au/sites/default/files/publications/uq_stage_a_final_report.pdf?acsf_files_redirect

About Mental Health Australia

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, professional bodies, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Mental Health Australia aims to promote mentally healthy communities, educate Australians on mental health issues, influence mental health reform so that government policies address all contemporary mental health issues, conduct research on mental health issues, and carry out regular consultation to represent the best interests of our members, partners and the community. These endeavours in education and policy reform are matched by our commitment to researching more innovative approaches to the provision of mental health care. In addition, Mental Health Australia continues to focus on the human rights of people with a mental illness.

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Mental Health Australia Charter

In 2019 Mental Health Australia undertook to identify the key policy priorities in the mental health field. An extensive consultation process was undertaken prior to releasing Mental Health Australia's Charter 2020. Over 140 organisations in the mental health field signed onto the charter that articulated key principles for resolving the problems within the mental health system.

The Charter sought to provide a clear and simple reference point for governments on the key issues that require resolution, listing nine (9) key objectives:

- Strike a new national agreement for mental health
- Build a mental health system that is truly person led
- Address the root causes of mental health issues
- Invest in early intervention and prevention
- Fund indigenous mental health, wellbeing and suicide prevention according to need
- Provide integrated, comprehensive support services and programs
- Expand community based mental health care
- Support workforce development
- Build an evidence based, accountable and responsive system

For each of these nine points a descriptor provides government with a clear roadmap on the priority areas for action.

With regard to the National Agreement the Charter states:[26]

> 'An agreement that delivers integration and coordination of mental health services, including agreed objectives, indicators, monitoring arrangements and funding between all levels of government. Critical to this agreement is improved accountability, coordination and transparency through clarity of governance and funding responsibilities across Commonwealth and state and territory governments.'

The Charter can be found at **https://mhaustralia.org/time-fix-mental-health**

[26] Mental Health Australia 2019. '*Charter 2020: Time to Fix Mental Health*'.