Mental Health Australia comments on the National Mental Health and Suicide Prevention Agreement

The National Mental Health and Suicide Prevention Agreement was recently posted onto the Federation Financial Agreements website.

The Agreement has not been signed by all jurisdictional governments with Victoria, Western Australia and the ACT yet to sign as they are still negotiating bi-lateral agreements. The agreed bi-lateral agreements are not provided on the website with media releases being the basis of any additional information.

Mental Health Australia's *Advice to Governments on the Proposed National Mental Health and Suicide Prevention Agreement* sought the following key points for governments to address in the National Agreement. These are provided below along with an initial assessment as to whether they have been addressed.

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.

This has not been achieved. People with lived experience remain as participants in potential consultations rather than leaders influencing outcomes.

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.

This has not been achieved as the Agreement will be the responsibility of Health Ministers.

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.

This has not been achieved as there are no long term funding commitments.

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.

This has not been achieved with the proposed re-establishment of the previous Mental Health Principal Committee as it does not include external representation.

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.

This has been partially achieved but with little accountability as how issues outside of health will be progressed at National Cabinet

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.

This has been partially achieved but without whole of government measures and little clarity on how it will be undertaken.

The National Agreement does provides a set of high level principles that will be supported by the mental health sector however the Agreement itself does not provide the necessary detail and structures to deliver on them.

Reporting is largely voluntary and accountability is internal to government without any external oversight and transparency. The Agreement is in some respects a step backwards from the previous 5th National Mental Health Plan that included a higher degree of external involvement and consultation in its design and implementation.

National Agreement Overview

The Agreement sets out the national objectives, outcomes and outputs for mental health and suicide prevention.

Principles

The Principles it outlines, while high level, reflect issues raised by the mental health sector over a long period. They commit governments to:

- Working together to improve mental health and suicide prevention services with people with lived experience of mental ill health and/or suicide of consumers and their families and carers embedded in the design, planning, delivery and evaluation of services;
- Facilitate an effective investment, policy and service mix that reduces gaps
- Reduce system fragmentation, gaps and duplication across prevention, primary and secondary care specialist settings
- Support and enhance the capability of the mental health, suicide prevention and broader health and related workforce
- Evaluate new models of care to drive improvement
- Establish clear roles, responsibilities and accountabilities for the funding and delivery of mental health and suicide prevention services
- Consider system design changes that are person-centred and evidence based to drive meaningful improvement in outcomes
- Enable effective regional and national cooperation between providers, systems and governments
- Improve transparency and accountability of mental health and suicide prevention outcomes

- Recognise the role of social determinants of health on people's mental health and wellbeing
- Work together to close the gap, improve mental health and wellbeing outcomes and reduce suicide for vulnerable cohorts, including Aboriginal and Torres Strait Islander peoples, CALD communities, LGBTQIA+ communities, people impacted by problematic substance use and people with a co-occurring disability, and deliver services to these cohorts in a culturally and locally appropriate manner.

Objectives

The objectives are more operational about how governments will work together but they do identify priorities for immediate reform as informed by the Productivity Commission's Inquiry Report on Mental Health (PC Report), the National Suicide Prevention Adviser's Final Advice (NSPA Final Advice) and other relevant inquires including to:

(a) reduce system fragmentation through improved integration between Commonwealth and State-funded services;

(b) address gaps in the system by ensuring community-based mental health and suicide prevention services, and in particular ambulatory services, are effective, accessible and affordable; and

(c) prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions.

Outcomes

The outcomes as expected are high level and aspirational aiming to:

- improve the mental health and wellbeing of the Australian population, with a focus on improving outcomes for priority populations
- reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports;
- provide a balanced and integrated mental health and suicide prevention system for all communities and groups;
- improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress; and
- improve quality, safety and capacity in the Australian mental health and suicide prevention system.

Outputs

The outputs of the Agreement are disappointing being largely administrative with commitments to undertake analysis, provide reports, collect data, evaluate, develop strategies and frameworks. The only actions focussed on service improvements are the consideration of delivery stigma reduction strategies and workforce priorities.

Commonwealth, State and Territory responsibilities

There are no major changes to the exiting roles and responsibilities of the Commonwealth which remains responsible for system management, funding and policy direction for primary mental healthcare, as well as physical and mental health services subsidised by the Medicare Benefits Scheme (MBS) and commissioned through the Primary Health Networks.

The Commonwealth also provides some clinical and non-clinical community based mental healthcare and subsidises private specialist mental healthcare via the MBS and the Pharmaceutical Benefits Scheme (PBS) and has a national leadership role in suicide prevention.

Under the Agreement the States and territories continue to be responsible for providing health and emergency services through the public hospital system. This includes public hospital mental health services for people with severe and persistent mental illness, as well as specialist community-based mental health services and responding to people in suicidal distress. This also includes the system management of public hospitals, taking a lead role in managing public health activities; and providing legislative and governance arrangements for Local Hospital Networks. A list of more detailed responsibilities are included in the Agreement (p15).

Shared responsibilities

The Agreement commits governments to shared responsibility to:

- address existing gaps over time in the funding and delivery of new and additional community-based mental health services to support equitable access to treatment, care and support for people experiencing mental illness and psychological distress
- Psychosocial support services for people who are not supported through the NDIS including working together to develop and agree future psychosocial support arrangements (including roles and responsibilities).
- Co-designing place-based approaches at a local level with affected communities.

Governance

The Agreement will be the responsibility of Health/Mental Health Ministers in National Cabinet not First Ministers as recommended by the mental health sector. This is disappointing as it will reduce the capacity of the Agreement to influence broader improvements across the social determinants of health.

Government senior public servants across the Commonwealth, state and territory governments will report to Health Chief Executives and Mental Health CEOs on the Agreement which has no external representation unlike the previous Mental Health Principal Committee. While this group may establish time limited Working Groups and consult with relevant organisations and experts to progress key priority areas it does not address the mental sectors recommendation that people with lived experience be embedded at all levels of the Agreement and its implementation. Nor does external representation form part of the governance structure as advised.

While the Agreement does commit governments to ensure that people with a lived experience are consulted throughout its implementation it does not do so in way that provides them with any legitimate authority or identified systemic engagement. Instead it offers opportunities to influence matters of service design, planning, implementation, evaluation, data and governance.

Reporting

Annual Jurisdiction Progress Reports will be consolidated into a National Progress Report, which will be finalised and endorsed by Health Chief Executives, and Mental Health CEOs where relevant, and provided to Health Ministers and Mental Health Ministers by 30 November each year, commencing 30 November 2023. The detail contained in these reports is not stipulated nor whether they will be made public.

Data and evaluation

The commitments made to share data are positive in that they commit to share public sector data as a default position where it can be done securely, safely, lawfully and ethically. They have also agreed to monitor and evaluate the mental health and suicide prevention system, including activities in the Agreement and associated Schedules.

Priority Groups

Priority Groups are identified and listed on page 25 of the Agreement however aside from acknowledgment, consideration and working in partnership with them there is little detail on actions to be undertaken across jurisdictions to address known gaps in the mental health and broader eco-system.

Psychosocial Supports

The Agreement commits governments to working together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS.

This will occur via further analysis of psychosocial supports outside of the NDIS, to commence within the first twelve months from the commencement of this Agreement and be completed as soon as possible within the first two years of this Agreement.

While there is commitment to continued funding of existing programs for people with a psychosocial disability outside of the NDIS it is a lengthy delay to a known funding gap already identified and quantified by the Productivity Commission

Workforce

The Agreement commits to the National Mental Health Workforce Strategy as a ten-year plan however this has yet to be released and has been seen to exclude a range of workforce alternatives outside the National Mental Health Services Planning Framework (NMHSPF).

This section does include one of the few specific deliverables in the Agreement to increase the number of full-time equivalent (FTE) mental health professionals per 100,000 population (FTE rate) over the life of this Agreement for professional groups of psychiatry; psychology, mental health nursing; Aboriginal and Torres Strait Islander mental health and suicide prevention workers (e) Lived experience (peer) workforce; Other relevant allied health professions and any other professions agreed upon by the Mental Health Workforce Senior's Officials group. These workforces exclude the community based organisations workforce and other workforces not currently covered by the NMHSPF.

Summary

Considering the emphasis that Mental Health Australia has placed on the National Agreement as being the platform for transformational mental health reform it is a disappointing document that has failed to address almost all of the advice provided by the mental health sector in the *Advice to Governments on the Proposed National Mental Health Agreement* paper.

The lack of external engagement and consultation in the Agreements development is reflected in its insular structures and processes that shield governments from much needed commitments and accountability.

The missed opportunity to embed lived experience across it reflects lack of government commitment to consumer and carer leadership in the mental health sector.

The lack of detail on deliverables during the course of the Agreement, the absence of any implementation framework such as Vision 2030 or a 6th National Mental Health Plan and no external oversight will potentially translate into continued tick the box service enhancements rather than the mental health reform that Mental Health Australia has been strongly advocating over the past three years.