National Mental Health Commission
May 2023

Submission for the Mid-term Review of the National Health Reform Agreement Addendum 2020-25

Australian Government
National Mental Health Commission

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The National Mental Health Commission supports the underlying principles and objectives of the NHRA 2020-25 Addendum and welcomes the long-term health reform commitments identified. The Commission recommends a shift from monitoring levels of activity to monitoring the value derived by consumers and the community, exploration of value-based payment models and initiatives to facilitate greater flexibility to address local needs.

About the National Mental Health Commission

The National Mental Health Commission (the Commission) provides cross-sectoral leadership on policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia. There are three main strands to the Commission's work: monitoring and reporting on Australia's mental health and suicide prevention system; providing independent advice to government and the community; and acting as a catalyst for change.

The Commission welcomes the opportunity to participate in the Mid-term Review of the National Health Reform Agreement Addendum 2020-25 (NHRA 2020-25 Addendum). As part of its monitoring and reporting role, the Commission has been tasked with monitoring and annual reporting on progress against the National Mental Health and Suicide Prevention Agreement[i] (the National Agreement). The National Agreement is intended to complement the NHRA 2020-25 Addendum and build upon its agreed principles to improve the mental health of all Australians and enhance the mental health and suicide prevention systems.

Prior to the commencement of the National Agreement, the Commission was responsible for monitoring and reporting on the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan)[ii] and the performance of the mental health system against the identified performance indicators. Key learnings from monitoring the Fifth Plan's progress in fulfilling its vision have informed this submission. The submission also draws on data, information and insights from its annual reports to the Australian Government and the community on the mental health and suicide prevention system in Australia.

Our response is structured around key focus areas the Commission considers critical in addressing through future reforms and agreements to support the mental health and wellbeing of Australians. If you would like to discuss this submission in further detail, please contact Michael Copland, Executive Director at Michael.Copland@mentalhealthcommission.gov.au

Response

Principles and Objectives

The Commission supports the underlying principles and objectives of the NHRA 2020-25 Addendum. The Commission recognises the importance of ensuring equitable access, prevention, better coordination and achieving better outcomes to support the mental health and wellbeing of Australians. These priorities are appropriately captured within the Addendum and align with findings and recommendations from key reviews of the mental health system, including the Productivity Commission's Inquiry Report on Mental Health[iii] and the Final Advice of the National Suicide Prevention Taskforce[iv].

It is well established that people with mental ill-health, and particularly those with severe mental illness, are more likely to develop long-term physical health conditions, more likely to be hospitalised for potentially preventable reasons and more likely to die earlier than the rest of population[v]. Research also suggests that

people with mental ill health commonly experience unfair treatment by health professionals when seeking help for physical health problems[vi]. The Commission therefore welcomes the NHRA 2020-25 Addendum's specific commitments to promoting mental health and wellbeing, assuring the rights of people with mental ill health and reducing the effects of stigma (Clause 1j). The disparities in health outcomes for people living with mental ill health are unacceptable and require urgent attention across all levels of government.

The Commission has been tasked with the development of a National Stigma and Discrimination Reduction Strategy to be finalised in 2023. This national strategy outlines a vision for an Australian community where people with lived experience are treated with equal dignity and respect and where mental health related stigma is not a barrier to living a life of meaning and purpose. The Commission recommends that future health agreements and reform efforts seek to align with the focus and objectives of this Strategy and actions to eliminate structural stigma and discrimination within the health system.

Achievement of Objectives

The NHRA 2020-25 Addendum commits to improving outcomes that matter most to people, facilitating equitable access to care and supporting innovation. Assessing the extent to which these objectives are being achieved in the mental health system is challenging due to the lack of in-depth quantitative and qualitative data collected from consumers, carers and system participants, as well as the absence of a suite of metrics to measure innovation across the system. Despite these gaps, several broad indicators of the mental health status of the population and the performance of the system can provide a partial picture of progress and enable some insights into the extent to which change is occurring in line with objectives.

Some national data indicates that certain aspects of the performance of the mental health system are improving on a national level, including progress towards a safer, more responsive and streamlined system. For example, available data shows that:

- the national seclusion rate has halved since the first year of data collection for all states and territories, from 14 per 1,000 bed days during 2009–10 to 7 per 1,000 bed days during 2021–22[vii].
- the rate of community mental health care following hospital discharge has increased from 53.6% in 2010–11 to 76.0% in 2020–21[viii]. Encouragingly, remote and very remote areas now have rates of post-discharge community mental health care that are comparable to that in major cities, inner regional and outer regional locations.
- the rate of full-time equivalent (FTE) lived experience (consumer) workers employed in specialised mental health care facilities managed or funded by state or territory health authorities has increased from 44.3 per 10,000 mental health care provider FTE staff in 2015–16 to 70.4 in 2019–20.

However, data also shows that despite the significant resources devoted to promoting mental health, the system continues to struggle to meet demand and rates of mental ill health in Australia are not decreasing. Recent data from the National Study of Mental Health and Wellbeing 2020-21[ix] indicates that in 2020-21:

- over 2 in 5 (44%) Australians aged 16–85 had experienced a mental disorder during their lifetime and 1 in 5 (21%) had a 12-month mental disorder
- 15.4% of Australians experienced high or very high levels of psychological distress.
- 2.2 million Australians with a 12-month mental disorder did not have any consultations with health professionals for their mental health and, of these people, 20.3% reported that their need for counselling was not met, suggesting barriers to accessing appropriate care.

Long-term physical health conditions also continue to disproportionately impact people with mental ill health, with 50.6% of people with mental illness having a long-term physical health condition in 2020–21 compared with 33.6% of people without mental illness[x].

Available data also suggests a lack of progress in the system's ability to prevent the incidence and recurrence of severe mental ill health. Of note, the rate of mental health presentations at hospital emergency departments (EDs) continues to rise[xi]. In 2020-21, the national rate of mental health-related ED presentations was 120.6 per 10,000 population, with an average annual increase of 1.5% between 2016–17 and 2020–21. Meanwhile, the proportion of mental health-related hospitalisations followed by readmission within 28 days of discharge was relatively consistent from 2016–17 (15.1%) to 2020–21 (14.7%)[xii]. The percentage of consumers showing improvement in clinical mental health outcomes following inpatient care has also remained relatively stagnant over the 5 years to 2020–21.

Taken together, while progress appears to be being made in some select areas of system performance over recent years, available data is not showing improvements in the system's ability to meet demand, prevent distress or support recovery for mental health. Further, data suggests that the quality of mental health care delivered by acute services – in terms of reducing clinical symptoms and preventing the onset of future deterioration of mental health – is not improving despite decades of reforms and investments.

Barriers Preventing Change and Recommendations

Measuring Change and Impact

Within the mental health and suicide prevention systems, significant data and information limitations restrict the type and level of analysis that can be done to understand the true impact of health reform efforts. These challenges include:

- data collection and reporting processes being largely activity-focused
- an absence of metrics to measure key reform priorities, including:
    - the extent to which coordination and integration of care is occurring
    - the broader determinants of mental health outcomes (e.g., education, employment and social supports)
    - innovation in the health system
- a lack of specific targets and timeframes to promote accountability and assess progress
- a focus on summative evaluations that assess funding and activities produced, as opposed to achievement of outcomes
- a lack of national coordination to drive research and innovation, contributing to misalignment of research priorities, inconsistency in measures, gaps, duplication and knowledge silos.

The Commission notes that the NHRA 2020-25 Addendum commits to "delivering improvement in outcomes that matter most to people and communities" (Clause 5a) and improving performance reporting on the health system through the Australian Health Performance Framework. However, the Australian Health Performance Framework currently lacks indicators which measure people's experiences of the system, instead focusing on administrative measures such as waiting times, unplanned hospital readmissions and adverse events treated in hospitals. Only basic demographic information accompanies this data. This significantly limits conclusions that can be drawn about whether the NHRA 2020-25 Addendum is achieving its stated objectives.

In light of these barriers, the Commission recommends a shift from monitoring the level of activity and service delivery to a more comprehensive approach that includes monitoring the value derived by the consumer and the community. This should include measurement of service user experiences that matter to people, which may include factors such as respect, dignity, participation (including in treatment and care decisions), quality of life and the achievement of personal recovery goals. Measures should be agreed in collaboration with people with lived experience of ill health and reflect the outcomes being sought through reform. Noting the NHRA 2020-25 Addendum also focuses on incentivising innovation and encouraging collaboration across care settings, appropriate measures of these outcomes at the system and meso level should also be developed as a priority to understand the extent to which this happening across the system and to learn from innovative and successful collaborative practices.

The Commission notes that the NHRA 2020-25 Addendum does not define a specific set of targets and timeframes for key outcomes. It is well-established that setting explicit and realistic targets is an important accountability tool to send clear signals about priorities and to motivate system participants to drive change. The Commission recommends gaining agreement on a set of ambitious but achievable targets that specify key outcomes over a defined period for future reform efforts. To ensure targets are relevant and fit for purpose, they should be co-designed with consumers and carers, as well as the portfolios that play a role in determining outcomes (such as housing and justice). Following this co-design process, targets should be published with clear information on how they were set, how they will be monitored and reported on, and who will be responsible for achieving them. In line with the Productivity Commission Inquiry's Mental Health Final Report, Governments should commit to an explicit target to reduce the gap in life expectancy between people with severe mental illness and the general population.

In addition to target setting, the Commission cannot overstate the importance of evaluation planning for future reform efforts. This should be guided by agreed principles that align with best practice for the planning, management and conduct of evaluations. Critically, evaluation should not be limited to summative evaluations that assess funding and activities produced. Instead, there should be a move towards multiple forms of evaluation, including formative, outcomes-based, developmental and process evaluations, which occur in planned ways and are aligned to the purpose of system reform. Findings from evaluations should be published to support learning, evidence-based decision-making, practical improvements to policies and programs across the system, and future funding decisions.

The Commission acknowledges that steps towards addressing data gaps and strengthening evaluation culture are being initiated under both the NHRA 2020-25 Addendum and the National Agreement, including commitments to develop evaluation frameworks to improve transparency and accountability. Moving forward, it will be essential that these commitments are translated into action, supported by sufficient investment in time, resources and capacity to implement.

To enhance treatment and intervention approaches, the Commission recommends that future reforms seek to create opportunities for collaboration, data sharing and embedding research into practice. Under the Fifth Plan, the Commission has released the National Mental Health Research Strategy[xiii]. The Strategy is intended to be used by academics and practitioners to stimulate partnerships and collaboration in mental health research and to guide future policy from Australian governments. The Commission recommends that future health agreements and reform efforts seek to align with the principles of this Strategy and, particularly, supporting actions to improve connection between the research sector and health system and to increase translation of research into practice.

Funding and Commissioning Arrangements

Current funding arrangements under the NHRA do not provide the necessary flexibility to provide best practice care and support early intervention for mental ill health. The disconnect in funding and focus on acute health care contributes to persistent gaps in community-based care, while discouraging the very actions that have been identified as critical to achieving reform. These include but are not limited to:

- facilitating service integration between inpatient and community care
- ensuring the best balance between inpatient and community care
- reducing hospitalisations and avoiding repeated admissions
- expanding non-acute and low intensity care options within the community
- trialling innovative models of care

Existing funding models also disincentivise multidisciplinary care for those with complex needs or those with physical comorbidity. For example, while the benefits of Consultation-Liaison Psychiatry Services in

managing mental health conditions in hospital inpatients and preventing readmissions are well established, funding has remained stagnant despite major growth in acute health services. This has major impacts on consumers and providers and jeopardises the sustainability of the multidisciplinary workforce. As identified in the Productivity Commission Inquiry Mental Health Report, there are also practical difficulties with activity-based funding for mental healthcare due to casemix classification. While many medical procedures have predictable average costs, this is often not the case for mental ill health, due the unpredictability and high individual variability of mental health and the range of interventions often required.

Current funding models do not adequately support or incentivise improvements in mental health and wellbeing outcomes. The Commission therefore welcomes the NHRA 2020-25 Addendum's commitments to exploring funding and payment mechanisms to create stronger incentives for providers to focus on outcomes (Clause C19) and the development of new and innovative trials of funding and payment reforms at both a program and system level (Clause C21). The Commission recommends that value-based payment models should be explored as they have the potential to enable providers to deliver better integrated and person-centred care. Importantly, trials should be supported by adequate resource allocation for high-quality evaluation and planning. Evaluations should measure the attributable impact of payment models, as well as systems level impacts within and beyond mental health.

The Commission acknowledges that currently there are substantial data gaps on mental health outcomes and costs to providers that impede the ability to conduct rigorous evaluation and to make assessments of value for money. This is further complicated by the fact that there is not clear consensus on what constitutes "effective outcomes" across consumers. The recommended reforms detailed under 'Measuring Change and Impact' will therefore be an essential enabler in evaluating new funding and payment mechanisms.

Beyond the hospital system, current funding mechanisms and polices for community-based mental health care also prevent continuity and innovation. The system offers standardised approaches to contracting, limited flexibility for design, and short funding windows that hamper efforts to deal with long-term issues and attract and retain staff. Services and programs are specified in government contracts and sent to local areas for implementation. Fixed activity reporting pushes service providers to deliver services that do not match local needs. Short-term contracts (1–3 years) for services and programs contribute to a lack of employee retention and service continuity in rural and regional areas, driving local providers away from their communities and perpetuating workforce maldistribution. Communities lose trust in local services if they must establish relationships with new clinicians and repeat their stories. This repetition also reduces service throughput and so, ultimately, funding renewal.

Greater flexibility is needed to address local needs and ensure greater focus on the outcomes that matter to consumers and their families. To achieve this, the Commission recommends a move beyond high-level, commitment-based and time-limited coordination agreements towards shared needs assessments and resource planning at a local level. This should include:

- funding decisions and allocation being made at the regional level, guided by local assessment of needs and resource availability
- joint commissioning of Primary Health Network (PHN) and Local Hospital Network (LHN) funding for mental health services
- a greater focus on community engagement at all stages of commissioning including planning, identification of needs, context-appropriate co-design/co-production and commissioning of services
- flexibility in the design of programs, including workforce recruitment based on local context

System Integration

Coordination and integration of care across services is critical to developing care pathways that support person-centred care, and enabling ease of referral, information sharing and connection to other needed services. However, the current mental health system in Australia is overly complex and highly fragmented,

resulting in a lack of coordinated care, difficulties navigating the system and slowed recovery. There is a lack of integration between different levels of health care (e.g., primary, secondary and tertiary), but also across different systems, including mental and physical health services. This often contributes to poor communication between service providers, role ambiguity and a disinclination to take on additional roles.

A key driver of this fragmentation is disjointed approaches to planning and funding service delivery and unclear responsibilities of different levels of government. The Commission therefore welcomes the NHRA 2020-25 Addendum's joint commitment across all agencies and governments to ensure better planning and co-ordination of health services at the local level. In particular, the Commission supports the Addendum's broad commitment to encourage PHNs and LHNs to collaborate when planning health services and making investment decisions (Clause C26a). The Commission also welcomes the commitment to the development of a reform plan for *Joint Planning and Funding at a Local Level* that will include:

- nationally agreed principles for local-level commissioning
- identification and support for the removal of barriers to joint governance, needs assessment, service integration, evaluation and funding, at a national and State and Territory level
- commitments to progressively trial and evaluate joint planning and funding arrangements

To promote accountability and drive change, the Commission recommends that actions detailed under this proposed reform plan are specific, measurable, time-bound and closely monitored. Expectations and roles of stakeholders should also be clearly defined.

The Commission acknowledges that even with the appropriate direction, guidance and tools, there are gaps in existing data collections which hamper the extent to which reliable local planning and modelling can be carried out. Addressing current data gaps is therefore an essential enabler of more effective planning and coordination at a local level. Developing appropriate predictive planning frameworks will also be critical in ensuring capacity to guide informed decisions around local investments and ensuring combined resources are put to best use. Decision support tools and frameworks should be developed through a collaborative process including academics, policy makers, clinicians, economists and people with lived experience.

Within the mental health system, there have been developments to address service fragmentation, and to plan and provide better targeted and integrated care at a regional level. This includes the development of joint regional mental health and suicide prevention plans to drive effective cooperation between PHNs and LHNs (Action 1.1 under the Fifth Plan). However, as identified by the Productivity Commission's Inquiry Report on Mental Health, existing guidelines for these plans are not sufficiently stringent to effectively clarify roles and responsibilities or to enable accountability for commissioning and service delivery.

The Commission notes that the National Agreement includes commitments to enhance direction in this space by developing national guidelines on regional planning and commissioning (Clause 133) and strengthening Joint Regional Plans with an agreed terms of reference to improve cooperation between PHNs, LHNs and other commissioning bodies (Clause 134). Concerted action and monitoring must be undertaken to ensure these commitments are honoured and implemented to produce tangible changes in the level of coordination between different funding bodies.

As identified by the Productivity Commission's Inquiry Report on Mental Health, objective measures of PHN-LHN cooperation should be measured and monitored as part of this. There should also be an assessment of how PHN-LHN groupings are engaging with consumers and carers, allocating their funds and integrating their services. Publication of learning and of progress in implementing these reforms will be critical to build the evidence base and inform an expansion of integrated and coordinated care.

Future planning for reform should also look to integrate health and non-health portfolios to guide the efficient allocation of resources over the long term and to ensure the wider determinants of health are appropriately

addressed. Within the health system, greater recognition and action on influencing the social determinants of mental health at the individual level is required, through better coordination of care and collaboration with non-health sectors. Appropriate indicators to measure the extent to which this is occurring should be identified and developed as a priority.

Rather than the current approach, which largely attributes improved outcomes to the impact of clinical treatments, an approach that recognises that mental health is determined by a complex interplay between social determinants and treatment is recommended. In particular, the Commission recommends that multiple portfolios beyond health play a role in measuring collective impact or outcomes to understand how and which combinations of treatment services and other interventions can better support improved health and wellbeing outcomes. This information would help inform long-term priorities, resource allocation and the budgeting process through a wellbeing lens.

The establishment of the NHRA Addendum 2020-25 and the National Agreements are important steps forward in achieving these reforms, by providing platforms to ensure different portfolios and jurisdictions work together. It will be essential that this commitment to collaboration is translated into structural change, supported by stronger governance structures, clear roles and responsibilities and stronger monitoring and reporting on action across all portfolios.

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