Strengthening the National Mental Health Commission and National Suicide Prevention Office

Discussion Paper – Comments

Associate Professor Sebastian Rosenberg, Mental Health Policy Unit, Health Research Institute, University of Canberra and Senior Lecturer, Brain and Mind Centre, University of Sydney

Professor Alan Rosen, AO, Clinical Associate Professor, Brain and Mind Centre, University of Sydney, Professorial Fellow, Graduate School of Medicine, University of Wollongong.

Professor Luis Salvador-Carulla, Head, Mental Health Policy Unit, Health Research Institute, University of Canberra

Professor Ian Hickie, AO, Co-Lead, Brain and Mind Centre, University of Sydney

THE UNIVERSITY OF SYDNEY

UNIVERSITY OF CANBERRA

Background

We have long been proponents of the potential of mental health commissions to function as effective agents for systemic mental health reform. All authors have either been members of Commissions, helped establish them or advised them. This covers both Australian and international mental health commissions.

We have continued to reflect on the role Commissions have played over the past decade, both in formal journals and informal, setting out ideas about how to strengthen current approaches.

The multi-dimensional nature of mental health, along with the Federal/State split in responsibilities, makes this area surely one of the most challenging in which to drive policy and service reform. Nevertheless, it remains our strong contention that:

- well organised, properly resourced, mission-focused Mental Health Commissions can play central roles in effectively monitoring, protecting and enhancing mental health service systems, and sustaining the dedication of their budgets and acquittals to these services; and
- Australia's investment in both national & jurisdictional Mental Health Commissions is internationally unique and potentially endows mental health services with a great national asset if they are consistently focussed, effectively articulated and networked, with commonalities of purpose and negotiated divisions of labour and portfolios.

The following comments are provided under each question posed by the Discussion Paper. The recurring theme in these comments is that for the Commission to demonstrably add value to the mental health system, it needs to refocus around the core skills and tasks associated with their responsibility to promote systemic improvement in mental health care for all Australians, which entails establishing and driving accountability for systemic improvement in mental health and mental health care.

Consultation Questions and Responses

1. *Do you think the proposed objectives and functions create an effective framework for the NMHC to deliver on its original intent of promoting transparency and accountability in the performance of the mental health and suicide prevention systems?*

No. Too much of the existing statement about objectives and functions is implicit, rather than explicit. For example, reforms are designed to ensure "that the NMHC and NSPO are positioned for success". What does success actually look like? And success for whom?

What are the desired outcomes or changes we hope to see in the way Australia responds to mental illness and what is the role the Commission is supposed to execute to reach these outcomes? Another example is that the NMHC is supposed to report "on federal and state s system performance against service expectations". What are these expectations and how were they set?

The existing proposed objectives and functions are not well enough described and lack detail. Fuller explanation of what accountability is, the specific role of the Commission and how it is supposed to drive systemic quality improvement are missing, for example, in relation to candidate mechanisms and subsets of accountability.

2. *Are there any elements of the NMHC's objectives or functions that you would change, add or remove?*

NMHC needs to consider implementation science as key role – how does it actually effect change? What theory or theories of change are to be deployed? This means the Commission needs to understand not just what it seeks to change, but how.

This entails deploying Mental Health-care Ecosystem and multi-dimensional Complexity Science approaches encompassing big data, epidemiological, social determinants, service mapping and modelling, clinical observations, and other demographic and sociocultural contexts. This work necessarily draws on research, clinician, cultural and lived experience expertise.

Central to this discussion must be consideration of the human resource capability it needs to fulfil this accountability mandate. The box below is from Page 85 of the Picone Review and reflects the key skills the Commission must have:

The primary purpose of the Commission is to produce the National Report. To produce this report, a diverse set of skills are required:

• **Data analysis:** this involves understanding statistics and probability and various data analysis techniques like regression and factor analysis.

• **Data visualization:** it is essential to know how to present data understandably. This will involve using graphs, charts, and tables.

• **Data management:** this includes understanding how databases work and how to extract data from them, as well as skills in using data analysis tools, such as SQL, Excel, or more specialised software like Tableau, Power BI, or SAS.

• **Understanding of KPIs:** these metrics measure the effectiveness of various aspects of a business. To create a National Report, it is imperative to know what KPIs are essential for the business or project being assessed.

• **Critical thinking:** this includes being able to interpret the data and understand what it means in the context of the business or project. This involves making connections between different pieces of data and making conclusions.

• **Communication skills:** this involves communicating findings clearly and effectively in writing and verbally. This might also include presentation skills.

• **Technical skills:** familiarity with business intelligence and analytics software is often required. Tools like Tableau, Power BI, or data science languages like Python or R can be essential.

• **Problem-solving skills:** this involves being able to figure out the best ways to present and analyse data, and this usually involves solving complex problems.

A key step in the Commission fulfilling its remit is therefore judicious recruitment of requisite skilled staff.

In addition to the technical and other skills listed above, the Commission also needs interdisciplinary clinical staff possessing contemporary evidence informed knowledge and skills, as well as bi-cultural /transcultural and lived experience and family expertise. Researcher skills should include epidemiological, big data, cohort, qualitative, lived experience service user and family expertise.

Lacking these skills, past national report cards have often focused on amorphous or unhelpful 'case studies', rather than publishing actionable, comparable, benchmarked data. There is little if any evidence these report cards permitted useful comparisons or resulted in organisational learning.

It should be noted that the Commission's inception coincided with the Federal Government ceasing to publish the National Mental Health Report Series. This Series was a specifically tailored publication, provided with dedicated resources to enable timely reporting on jurisdictional progress towards agreed goals under the National Mental Health Strategy. It is arguable that failure to replace the Series, in favouring of relying on AIHW and ROGS data, has weakened national accountability for mental health.

The Commission has noted the historical power imbalance in mental health care, leaving lived experience service-users and families often victims of poor care, neglect or human rights abuse. The Commission has been very concerned to demonstrate its support for service users and carers in response.

It now needs to rebalance its activities and attitudes away from (any) partisan concerns, no matter how laudable, and towards its core business of driving accountability. The new lived experience service-user and carer peak national bodies are more appropriately placed to take on this advocacy. A delicate balance of interdisciplinary, clinical and support provider, and lived experience viewpoints need to be developed, and sustained. This includes the clear transmission of the voices of all stakeholder viewpoints to Governments.

3. *Should the NMHC's coverage of mental health systems include a focus on the broader concept of wellbeing?*

This is not a matter to be dealt with in isolation, but instead fits into a broader discussion regarding conceptualisation of mental health reform, from wellbeing through to forensic or long-term mental health care. In turn, this raises questions regarding the role to be played by the Commission in setting national mental health strategy. If national strategy does refer to wellbeing, then this should be part of the accountability framework adopted and deployed by the Commission.

An holistic and people-centred perspective should of course consider both mental health and mental illness components. This requires different, separate and additional data analysis and investment in collection. This is the case now in both cancer and in cardiovascular diseases.

4. *Is it necessary to formalise the role of the NMHC in working with Mental Health Commissions across jurisdictions, and if so, do you have any views on how this role should be described?*

Noting the differences between jurisdictions and their commissions, our view is that some transparent coordination of roles and functions is desirable. With limited resources in the face of considerable reporting challenges, splitting and sharing some reporting functions would be seem an appropriate and practical response from the Commissions.

However, the overall monitoring and reporting function is predicated on a level of independence. For some commissions, like WA, this isn't really practical given their role as government purchaser of mental health services. They rely on an Auditor General to conduct independent reviews of progress. Other commissions, like NSW and Victoria, theoretically have all the legislative 'teeth' they require, enabling them to conduct their own inquiries and audits, yet have very rarely chosen to use these powers, or are constrained from doing so by being obliged to go through the Minister or Director of Health for delegations to do so.

An agreement to share reporting responsibilities across commissions from different jurisdictions would require transparent alignment of such powers and processes.

Key to this role is formulating a common language and developing standard procedures for mapping care and support in the different jurisdictions as well as the mapping of financing flows. This common language creates a platform for fair and transparent benchmarking.

5. *In what ways should the NMHC hold the Government accountable for the performance of the mental health and suicide prevention systems?*

Consideration should be given to the establishment of a short, practical list of data items that best reflects the systemic changes the community wishes to see. Ideas about what this should look have been developed already, such as here. We understand that Mental Health Australia also undertook a broad stakeholder consultation about reporting priorities some years ago though we cannot locate the report which they provided to the Federal Government subsequently.

An update to reflect current community views about reporting priorities would be advisable. Such an update may well reinforce the community's concern that reporting about progress in mental health extend beyond the health sector and should necessarily reflect those matters of most interest to consumers and their families, like employment, education completion, housing, social connectedness and so on.

The Commission should have a key focus on the development of systems of evaluation and impact analysis, including through assessment in open, forums. Mental health has proceeded for too long without good systems for this evaluation, not implementing sound programs while permitting continuation or expansion of others of lower value.

6. *To what extent should the NMHC engage in advocacy and what does this look like?*

Rather than 'advocacy' a key role formerly played by the NZ Mental Health Commission was the preparation and presentation of data to enable regional benchmarking and comparison. Aimed principally at service providers, both clinical and psychosocial, the aim of this work to permit local leadership to consider their results compared to others and how they could be improved.

This kind of process would enable the Commission to identify opportunities for local systemic improvement. This is not advocacy.

7. *Do you have any views on the future functions of the NSPO – and whether its current functions should be maintained, amended, or aligned with the NMHC?*

A mental health commission refocused around the core function of accountability would be concerned to properly assess and report on trending of suicidality in the community and on ameliorative initiatives, but would not be engaged in promotion and prevention activities per se. It may be able to draw on local information to illuminate more or less successful strategies or approaches, but this would again be part of the benchmarking and accountability function.

Note we favour Option 1 with NMHC as statutory authority but located centrally in Prime Minister and Cabinet (PM & C), not Health. NSPO should be separate and could sit in DHAC or Dept of PM & C as a non-statutory office relating to all of government.

8. *Do you have any views on whether the NMHC should retain its coverage of suicide prevention, or if this should be led solely by the NSPO?*

See 7 above.

9. *What parameters or governance arrangements could be put in place to ensure 'other reports as requested or approved by Government' remains within the scope of the NMHC's objectives and functions?*

One key element of independence needs to be the Commission's capacity to conduct inquiries and self-initiated reports. The capacity to report directly to Parliament is an important part of this independence, with powers of discovery, as is perhaps an annual requirement to do so. This elevates the reporting function to a broader, national and hopefully bipartisan level.

This should include the reporting function related to financial accountability, including an annual national audit / survey of national and jurisdictional mental health service budgets, expenditure and reconciling of purported budgets with mental health service acquittals to the LHD and PHN levels. The aim here is to ensure that the money allocated to mental health stays in mental health.

10. *Do you have any views on how the involvement of lived experience should be captured in the purpose and functions? What measures can the NMHC and NSPO take to effectively empower the voices of lived experience?*

The main function of the Commission should be driving accountability, both quantitatively and qualitatively. Lived experience is just one of the essential key resources to be tapped in this mission. The Commission could usefully consider real time reporting, as a mechanism to support accountability, and as a way of adding to its understanding about the impact of care on the ground without adding to the burden of data collection currently faced by providers. At the same time, it is essential that qualitatively, the NMHC functions as a clear conduit and amplifier of the voices and viewpoints of all key stakeholders of mental health services to Australian governments and the Australian public.

11. *Which option would most adequately empower the NMHC to monitor and provide robust, expert advice on the state of Australia's mental health and suicide prevention systems?*

The Commission will need excellent and detailed relationships with data providers, such as PHNs and the States and Territories, and with data collectors like the AIHW, the ABS and the Productivity Commission. The Commission should be funded to explore independent, new data collections where necessary, to support their accountability mission. This could include real time consumer and carer feedback systems, not currently collected elsewhere.

12. *Which option would most adequately support the NSPO to deliver on its whole-of-government policy responsibilities?*

See other answers.

13. *Which of these options do you see as providing the most overall benefits to the community including to consumers and their families, carers and loved ones?*

Expected benefits to the community, to consumers, families etc are poorly specified now which makes advice difficult.

Moreover, the main task for an effective commission should be to drive accountability leading to systemic reform across the regions. This could help identify community benefits.

14. Which option would most adequately shape and support the strategic direction of the NMHC and NSPO?

Placement of any commission under a Department of Health makes establishing a broader, social determinants role much less likely. As with the mental health system generally, this situation makes it much more likely that commissions will undesirably focus on hospitals, beds and other health administrative data (such as Medicare statistics), rather than keep a broader focus.

In relation to statutory authorities, there are advantages to this administrative model. However, as has been proven by several existing commissions, there is quite a difference between having the necessary teeth to demand data, run inquiries, report independently to parliaments, and choosing to use these powers. A statutory authority, holding its own delegations, reporting publicly but administratively linked to Dept of PM&C may well be the optimal arrangement.

15. What skills, experience and expertise do you see as critical to each Advisory Body's core membership?

See 2. above

16. What advisory structures would best empower the voices of lived experience?

Especially now with a peak body established, empowering consumers should not be the focus of the Commission. Rather, they should consider how best to enable lived experience to feed into new accountability. For example, this could usefully focus on establishing systems of real time, validated feedback from consumers and carers. Consumers and carers could be trained to lead, manage and report on a federated system of real time reporting, providing invaluable, direct insight into the changing health and welfare of people with a mental illness, including their experiences of care.

But even armed with this data, actually changing the nature of service provision will need the Commission to have strong and trusted relationships with service providers and professionals. A model or theory of change is necessary to provide the anticipated method and process by which the Commission intends to lead change in mental health.

17. What training, support or arrangements does the Advisory Body need to set it up for success, including to support the full engagement of a diverse membership?

The Advisory Body needs to fully understand the model of change and the data developed to support it. It could lead change processes locally, making the Commission much more useful to local planners, funders and others who are interested in make change happen where they live.

18. If the Advisory Bodies were to include designated positions for peak bodies, do you have any views on which organisations across the mental health and suicide prevention sectors should be represented?

The Commission's focus should not be about representation or advocacy, but about accountability and change management.

Conclusion

We hope this feedback is helpful. It draws on more than a decade's experience developing and working with commissions. For your additional information, at Appendix 1 is a brief proposal (prepared by authors Rosenberg and Rosen) focusing on options for evaluating the effectiveness and potential synergies between Australia's mental health commissions. Several of these components of inquiry could contribute considerably to the robustness, complementarity, coherence and integrity of these important organisations. It is understood that this paper has been submitted to a meeting of all commissioners where it is receiving some consideration.

We would be happy to discuss the feedback provided here at your convenience.

About the Authors

Alan Rosen and Sebastian Rosenberg have long been proponents of the potential of mental health commissions to function as effective agents for systemic mental health reform. This was derived initially from several review articles published in international journals, concluding with our view of the way nascent and established reform oriented mental health commissions were operating in other countries. This academic editorial provided an international comparison and typology between Type I narrow MH administrative or medico legal commissions, often tied to the operation of mental health acts, and Type II reform-oriented commissions of much wider scope.

We were then part of the panel which established the legislation to stand up the NSW Mental Health Commission in 2011. This process was heavily influenced by visits to both WA and to New Zealand. We authored peer reviewed papers that first described the process of evolution of the commissions, and then set out some criteria by which their contributions could be assessed.

We have prepared reports for Commissions focusing on international benchmarking, and published similar work in peer reviewed journals. We have also assessed Australia's approach to community mental health viz other nations, here.

Prof Rosen led the Royal North Shore Hospital & Community Mental Health Services in Sydney, an epicentre of national mental health reform nearly 30 years and was an inaugural Deputy Commissioner of the NSW Mental Health Commission. Assoc Prof Rosenberg was the key consultant responsible for drafting the 2017 report establishing the ACT Office of Mental Health and Wellbeing. We have from time to time also consulted with other Commissions, both in Australian and internationally.

We have continued to reflect on the role Commissions are playing over the past decade, both in formal journals and informal, setting out ideas about how to strengthen current approaches. The multi-dimensional nature of mental health, along with the Federal/State split in responsibilities, makes this area surely one of the most challenging in which to drive policy and service reform. It remains our strong contention that:

- well organised, properly resourced, mission-focused Mental Health Commissions can play central roles in effectively monitoring, protecting and enhancing mental health service systems, and sustaining the dedication of their budgets and acquittals to these services.
- having established both national & jurisdictional Mental Health Commissions is internationally unique and potentially endows Australian mental health services with a great national asset if consistently focussed, effectively articulated and networked, with commonalities of purpose and negotiated divisions of labour and portfolios.

Ian Hickie was a member of the National Mental Health Commission from 2012 to 2018. He was part of the Commission at the time of the Review into Mental Health Services and Programs, published in 2015.

Luis Salvador Carulla led the paper which produced the first international classification system and instruments for international MH services at local and regional levels (DESDE). He has conducted analysis of local and regional service provision in more than 15 countries and been a consultant to several governments, as well as the Royal Commission into Mental Health in Victoria.

Appendix 1

Mental Health Commissions Evaluation Project

Assoc Prof Sebastian Rosenberg and Professor Alan Rosen, AO.

Aim

To propose a project to create a new common approach to evaluating the impact of Australia's mental health commissions. This project would have five components:

1. a brief updated international review of the current status, characteristics, practical achievements and longevity of all Type II / reform-oriented Mental Health Commissions.
2. consideration of the viability of developing a nationally consistent framework and suite of optimal evaluative indicators, quantitative, qualitative and cultural variables and metrics by which to assess the impact of all Australian Mental Health Commissions.
3. to work with all Australian Commissions to establish a new, common platform for reporting and accountability.
4. a comparative analysis of the respective government's enabling functions, delegations and powers of independent data discovery, inquiry and reporting assigned to each Commission.
5. mapping of a pathway to develop a capacity for the Commissions to learn from each other, to more formally collaborate, coordinate and synergize their activities to become more effective in their separate and combined roles, in the service of affected individuals, families and communities.

Background

The idea for this proposal arose following a recent conversation between Ivan Frkovic and Sebastian Rosenberg.

Over the past 15 years or so, Australia has made a globally unique and significant commitment to the concept of mental health commissions, as a way of making further progress on mental health reform. 7 out of 9 jurisidictions have adopted some version of a commission, with the specific arrangements and powers of each body varying.

Most of these organisations have already been subject to some kind of evaluation, either internal (such as here, here and here) or external, such as here. The role of the Victorian Mental Health Complaints Commission underwent considerable expansion of its reform promoting role as result of recommendations made by the Royal Commission there, based on numerous invited witness statements and open submissions.

The National Mental Health Commission was reviewed in 2023. While this review focused on some cultural issues, it also described serious workforce deficiencies preventing the Commission from fulfilling its role. In particular (at Recommendation 6.5, p85), it identified the need for increased analytical capability, including data analysis and visualization, technical skills in data and financial management and communication. There may well be parallel needs for up-to-date clinical, cultural and workforce development skills, as well as in implementation research, lived experience and family expertise.

30 years of national and jurisdictional planning in mental health has not led to uniform approaches to service development, monitoring or reporting. Significant variation and gaps remain. In a country as vast as Australia, some of this variation may well be desirable – there is no "one size fits all."

However, what does this variation mean for systemic quality improvement and prevention of discontinuities of care and serial system failures (e.g., Bondi Junction Shopping Mall disaster of April 2024)? How do mental health systems learn from each other and incrementally improve the experience of care for service users, family carers and their clinicians and support providers working in those systems?

What would this Project do?

Working in conjunction with each Commission, this project would have five key deliverables:

1. A brief international review of the current status, practical achievements and longevity of all Type II / reform-oriented Mental Health Commissions.

2. Consideration of the viability of developing a nationally consistent framework and suite of optimal evaluative indicators, quantitative, qualitative and cultural variables and metrics by which to assess the impact of all Australian Mental Health Commissions. This would include the benefits and limitations of, as well as the opportunities for and obstacles to devising such a framework, which could contribute to improved jurisdictional and national accountability for systemic mental health reform.

3. The third key deliverable would be to work with all the Commissions to establish a new, common platform for reporting and accountability. Different approaches and report cards have been established. Some focus much more on the health system than others, which attempt to address other issues of community interest such as housing, education and employment. Some have well-developed sets of indicators, often with a focus and priority set on mental illness, while others have charters requiring them to be mindful of and to prioritize broader individual and communal mental health and wellbeing frameworks. These variations between districts prevent comparison and make the consistent identification and application of opportunities for systemic improvements more difficult. The key product here would be the coproduction of an initial agreed short-list of candidate common indicators which could guide the shared evolution of a national approach to monitoring and impact reporting by the mental health commissions on the quantity, quality, workforce development and outcomes of Australian mental health services, as well as the allocation, dedication and sustaining of resources for them.

4. The fourth key deliverable would be a comparative analysis of the constructs, delegations and powers assigned to each Commission. The aim would be to understand the extent to which these affect the capability of each organisation to fulfil its mandate. For example, do statutory powers help Commissions deliver change or do they make little difference? These arrangements could include unfettered independent delegations, enabling powers of compulsory data access and discovery, and to initiate independent inquiries and report on their findings publicly or to parliament. Other examples could be budget-holding and the power to commission services at arm's length.

   Understanding the comparative strengths of different models of Commission could enable refinement of individual jurisdictional models, to give them the best chance of success.

5. Acknowledging that this already happens to some extent, the fifth deliverable could be the mapping of a pathway to develop a more systematized capacity for the Commissions to learn consistently from each other, to more formally collaborate, coordinate and synergize their activities, to become more effective in their separate and combined roles, in the service of affected individuals, families, our communities and our nation.

Conclusion

Australia's audacious experiment and globally pioneering initiative with mental health commissions, both national and jurisdictional, as a mechanism to encourage, incentivize and guide the next stage of mental health reform is at an important juncture. This evaluation would focus on options for evaluating the effectiveness and potential synergies between Australia's mental health commissions. Several of these components and levels of inquiry could contribute to the robustness, complementarity, coherence and integrity of these important organisations.

As long-time proponents of the commission model, we would welcome the chance to work with the Commissions as they develop a clearer way of synergizing and demonstrating the impact they can have on stimulating and sustaining systemic mental health reform throughout Australia.

We would welcome the opportunity to develop this proposal further in conjunction with the Commissions.