SYNERGIA

ACT Office for Mental Health

Design Options and Recommendations

February 2018

CONTENTS

1. EXECUTIVE SUMMARY

This report sets out the findings of a review to determine options to improve the mental health of people living in the Australian Capital Territory (ACT) through the establishment of a dedicated Office for Mental Health. Alternative approaches are considered in the body of the report along with analysis explaining the preferred approach.

The summary below sets out the recommended mission and functions for a new Office, suggested to be titled the ***ACT Office for Mental Health and Wellbeing.***

1.1 Mission

Operating as a change agent for mental health reform the ACT Office for Mental Health and Wellbeing:

- *identifies opportunities for quality improvement across the entire continuum of mental health care;*
- *supports responsible agencies and people to address these opportunities; and*
- *reports on progress.*

1.2 Key Functions

For the new Office to fulfil its mission, it needs to perform five key functions, as shown below:

1. Vision
2. Community engagement
3. Integration
4. Systemic quality improvement
5. Intelligence and monitoring

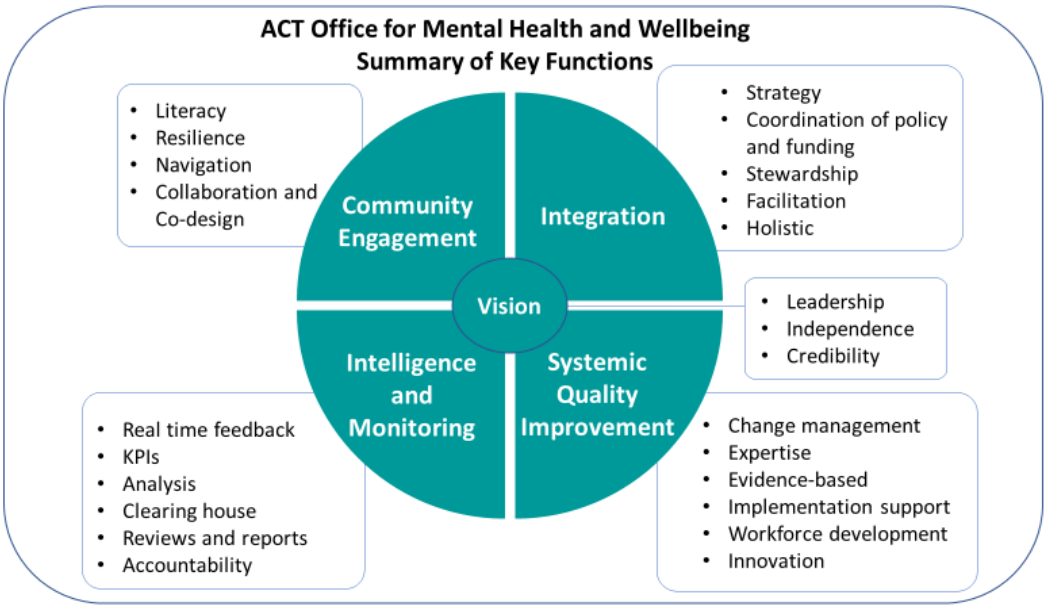

Figure 1: Functions of ACT Office for Mental Health and Wellbeing

To deliver these functions a set of recommendations are presented below.

1. **Vision: To lead a process of co-design to develop a new Territory-wide vision for mental health in the ACT. This new vision needs to reflect how the ACT wishes to foster the mental health and wellbeing of its people into the 21st century.**

Rec 1 That the Office develop a new Territory-wide vision for mental health and wellbeing in the ACT working with the community, the Agency Stewardship Group and the Community Advisory Council.

2. **Integration: To develop a better coordinated approach to policy, strategy and funding**

Rec 2 That the Office be established as an independent agency, within Government but outside the Health Directorate.

Rec 3 Based on the work of a new Agency Stewardship Group to the Office, ACT Government Directors General make regular reports to Cabinet about their progress against a mental health reform workplan (see Rec 10 below) led by the Office.

Rec 4 The Office works with other agencies outside of government, to identify suitable projects to include on this workplan – e.g. Capital Health Network and the non-government sector. The workplan also needs to reflect the ACT's geography within a broader region catchment.

Rec 5 The Office does not hold the budget for mental health and is not a commissioner of everyday services.

Rec 6 The Office holds funding to sponsor innovation and change across services.

Rec 7 The Office must be consulted about Government decisions in relation to all mental health funding, particularly growth funding. This is to ensure that over time, funding aligns and drives the strategy underpinning the workplan, to shift the balance across the continuum of care towards building resilience and earlier intervention.

3. **Systemic Quality Improvement: To focus on systemic reform and improvement right across the continuum of mental health care, including physical health, drug and alcohol and the social determinants of health.**

Rec 8 That the focus of the Office be on change management and systemic quality improvement, including all aspects of the experience of mental health and mental illness, including health services, drug and alcohol, primary care, housing, employment, community services, justice, the police, education, social inclusion and so on.

Rec 9 That the Office be led by a Coordinator General, leading a team expert in change management. Core capabilities of the Office will be analytics, quality improvement, systems design, the identification and application of evidence and community consultation and engagement. A key focus is on turning research and evidence into *sustainable* practice. The work of the Office would benefit from the capacity to draw on the practical experiences of service providers and service users.

Rec 10 Working with the Agency Stewardship Group, the Office prepare a practical mental health reform workplan within 100 days of commencing and agreed to by Cabinet as soon as possible subsequently. This workplan would then be further developed through community co-design.

Rec 11 That the Office work with existing agencies to ensure the Territory capitalises on opportunities for systemic quality improvement arising from individual complaints and trended data from agencies.

4. Intelligence and Monitoring: To understand the system and whether improvements are making a positive difference to the experience of care.

Rec 12 That the Office has the authority to request and receive any information and to undertake service reviews and site visits for the purposes of quality improvement. Government agencies have an obligation to assist the Office compile the data necessary to drive reform.

Rec 13 That the Office have the authority to conduct its own independent reviews, inquiries and reports. The Office has discretion to make these reports public.

Rec 14 That the Office provide an annual report to Government and the community about progress towards mental health reform, referring to the workplan and data in relation to agreed key performance indicators.

Rec 15 That the Office provide Cabinet and the ACT community with regular reports on progress against this workplan and against the identified KPIs.

Rec 16 That in order to lead improvements in consumer-centred care, the Office gives priority to working with consumers and carers and ground level providers to establish an effective system of real time feedback reflective of the entire continuum of care. This feedback will permit transparent real time tracking of consumer and carer and on the ground providers of experiences of mental health services, at the point of care.

Rec 17 That the Office develop a 'clearing house' of best practice information and current translational evidence, accessible by the ACT community.

5. Community Engagement: To work with all parts of the Canberra community to co-design better responses to mental illness and better promote mental health and wellbeing.

Rec 18 That the existing Ministerial Mental Health Advisory Council Terms of Reference be modified, using the template from the Queensland Mental Health Commission, to become as the Community Advisory Body to the new Office, bringing the voice of consumers, carers, health professionals, service providers and others into the work of the Office and conveying these voices to Government.

Rec 19 The Office supports and sustains standing networks of consumers, carers, health professsionals, service providers and others to ensure it understands the everyday situation of mental health care in the ACT.

These five functions and the associated recommendations and alternatives will be described more fully later in this report.

1.3 Evaluation of the Contribution of the Office

Rec 20 That the Office is subject to a review in relation to its own effectiveness and contribution to reform, five years after its commencement (July 2023).

1.4 Where to Start

The Office is scheduled to begin on 1 July 2018. It is advisable to begin recruitment for the Office as soon as possible, so there is the best chance for staff to be available at commencement. However, there is no need to wait to start work.

Indeed, there is some momentum now around the Office that should be exploited. On this basis, consideration should be given to setting up an Establishment Team, tasked with the following duties:

a) Beginning the process of co-design around a new vision for mental health in the ACT. This could be achieved through structured public meetings led by consumers, carers, professionals, providers and other stakeholders.

b) This same process of co-design could drive development of the approach to be taken to development of a set of key performance indicators by the Office. This report sets out a draft outcome framework for consideration. It is by these key performance indicators, some aspirational and some practical, that the level of ambition for mental health reform can be determined and reported. The process to refine this approach could start immediately.

c) Work could also commence with ACT Government officers from the various agencies to set up the Stewardship Group and begin to identify and prioritise possible reform projects to include on the Office workplan. This would give the Office an opportunity to hit the ground running, making it more likely the Office would meet the planning timeframes outlined at Recommendation 10.

d) More broadly, the Establishment Team could start the process of communication with the ACT community in relation to the Office, to manage expectations and build understanding about its role and purpose.

The establishment of the new Office for Mental Health and Wellbeing represents a unique opportunity to drive real reform in this complex area and develop a world class response aimed at keeping people well and supporting recovery. Perhaps more important, it provides an opportunity to create an inclusive Canberra community, which values people with mental illness and provides opportunities for them to live decent and fulfilling lives.

2. INTRODUCTION

The ACT's mental health system is already one of the best in Australia based on some key markers of performance [1]. A more intelligent and coordinated effort could see the ACT lead Australia, and even the world, in the delivery of a more effective response to mental illness.

All mental health services across Australia, including those in the ACT, face pressures. The workforce is ageing and there are unfilled vacancies. Pressure on hospital-based mental health services keeps rising. There is a lack of mental health services integration between primary, secondary and tertiary, between government and non-government, and between public and private. The system remains largely focused on responding to acute care and crisis. It has not shifted towards promotion, prevention and early intervention, even though evidence to support this is stronger than ever. Furthermore, the system does not consistently address the wider range of health and social services required to support individuals with high and complex mental health problems to live well in the community.

This pressure manifests in the everyday experience of many mental health consumers and carers who struggle to find the care they need in a timely way. While our system helps many, too often still people feel let down, that opportunities for earlier recovery are missed. This is a sentiment shared not only by consumers and their families, but indeed by many professionals working in the mental health system, or in housing or community services, or education or the non-government sector, primary care or elsewhere.

The challenge we face is to re-focus and re-organise around an agreed vision for mental health in the ACT and to make the most of our resources, our people and our community.

Several Australian jurisdictions have responded to this challenge by establishing mental health commissions, typically set up to lead and drive change. Here in the ACT, the potential role to be played by an Office was initially described in the *Conversation Starter* document published by the Minister for Mental Health. The Minister for Mental Health, Shane Rattenbury, outlined four objectives in developing an Office:

1. to lessen the impact of mental illness on the ACT community,
2. to provide system-wide oversight and drive quality improvement,
3. to create a more person-centred approach to mental health and
4. to drive better coordination and integration across services.

This report describes how a mission-focused mental health reform agency could operate and lead a process of positive mental health reform the ACT.

[1] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/specialised-mental-health-care/community-mental-health-care-services

3. BACKGROUND

The ACT Government agreed to establish an Office for Mental Health during the 2016 election.

Synergia was engaged in November 2017 *to provide options for the design and development of an ACT Office for Mental Health, informed by public consultation and scoping of appropriate models for the ACT context*. The Synergia team consisted of Dr Sebastian Rosenberg, Dr Lynne Lane, Prof Alan Rosen and David Todd (Managing Director, Synergia).

3.1 Process

A process of data gathering occurred between 1 November 2017 and 14 February 2018. A variety of approaches were used to inform the process.

First, Synergia gained access to the feedback provided by seven organisations to the Conversation Starter paper [2] and summarised the issues raised. Key common issues provided as feedback included:

- That the current ACT mental health system was fragmented and would benefit from greater funding and role clarity, as well as making it easier for people to navigate the system to find the help they need.
- There was a need to improve the ACT's approach to monitoring and accountability.
- There were urgent service and workforce gaps.
- That the role of an Office should be beyond just health services, to consider the whole of person's life, including the social determinants of health, across the whole lifecourse.
- There was a need for new strategic leadership and advocacy.
- More could be done to promote effective research and the promulgation of best practice.
- There was a gap in mental health promotion/community mental health literacy.

A series of structured interviews with key stakeholders was then undertaken. Data was gathered from every Australian mental health commission, as well as several former commissioners, plus several similar bodies overseas. The template we used for the structured interviews is at Appendix 1. The full list of people interviewed is at Appendix 2.

[2] https://www.health.act.gov.au/sites/default/files//Conversation%20Starter.pdf

A Project Steering Committee was also formed, chaired by ACT Health. This group met three times over two months to provide input to the project, note progress and give direction. The membership and terms of reference for this group are at Appendix 3.

Several community, sector and public forums were also held, as follows:

Date	Meeting
20 Nov 17	MH Service Directors
24 Nov 17	MH Service Directors
29 Nov 17	Project Steering Committee
7 Dec 17	Consumer Consultation
7 Dec 17	MHCC Stakeholder Consultation
13 Dec 17	Ministerial Advisory Council
18 Dec 17	Carer Public Forum
20 Dec 17	Project Steering Committee
6 Feb 18	Ministerial Advisory Council
8 Feb 18	Consumer Consultation
9 Feb 18	Carer Public Forum
13 Feb 18	MHCC Stakeholder Consultation
14 Feb 18	Project Steering Committee

Meetings also occurred involving the Aboriginal and Torres Strait Islander Elected Body in the ACT, the Public Advocate, the ACT Human Rights Commission, the ACT Branch of the Royal Australian and New Zealand College of Psychiatry, the Commissioner for Family Safety, the Director-General of ACT Health, the Mental Health Policy Unit of ACT Health, the Education Directorate, Capital Health Network and the ACT Chamber of Commerce.

A desktop literature search was also undertaken to compile evidence from other Mental Health Commissions about their outputs and contribution to reform. This was not simple. Most of these organisations are new. Most are yet to publish or report widely. Concrete evidence to demonstrate their impact in their jurisdictions is hard to find.

This project also saw the construction of an online submission process, permitting the ACT community to provide their written views on the Office. The online portal was open between 7 December 2017 and 8 February 2018. The portal was advertised by ACT Health and by the Mental Health Community Coalition and Carers ACT. Overall there were 67 submissions made online, split by role as follows:

Role	Number	Percentage
Carer	22	33%
Consumer	15	22%
Health professional	14	21%
Other	15	22%
Service provider	1	1%
Total	**67**	**100%**

A thematic analysis of all the online submissions is presented at Appendix 4 and been incorporated in the advice presented here.

People who submitted their views online were also invited to leave their contact details if they wished to be kept informed of progress regarding the new Office. 32 individuals (48%) chose to leave their contact details. This group forms an early 'community of interest' for a new Office to cultivate as it begins work in 2018.

To this mixed methods approach to data capture, the consulting team brought its own expertise. Dr Lane is a public health specialist and was formerly a mental health commissioner in NZ. Prof Rosen was inaugural Deputy Commissioner in NSW, practices with and researches evidence-based outcomes and characteristics of mental health service delivery systems, and has been a consultant to ACT Health, the National Mental Health Commission and to the WA Mental Health Commission. Dr Rosenberg led the taskforce which set up the NSW Mental Health Commission and has also worked for the National Mental Health Commission as a consultant.

4. CONTEXT

The new Office will not emerge on a greenfield. Like every jurisdiction in Australia, the ACT's mental health system has been and remains subject to considerable scrutiny. While there is consensus about the need to improve system integration, people differ in their assessment of where this need is greatest and where to start.

The ACT's mental health system also faces some systemic problems in relation to staffing pressures and skill shortages. The demographic profile of nurses in the ACT is ageing and this is most acute in mental health.

There are workforce shortages in some key areas, including public psychiatry. It is also clear that the advent of the National Disability Insurance Scheme is affecting the shape of the community psychosocial mental health service sector.

It is also clear that a key risk associated with a new Office is unrealistic expectations. Any new Office will need to carefully manage community expectations about realistic change in mental health.

It is also important to note that it is not envisaged that the advent of the Office in any way supplants existing mental health policy expertise in ACT government agencies. The Office will need this expertise going forward. One option in the future would be a kind of 'in-posting' from Directorates to the Office, providing additional project-specific expertise.

Clear advice from other jurisdictions is that critical to the Office's success is role clarity and good governance. The following options have been presented with this in mind.

5. KEY FUNCTIONS FOR THE OFFICE

Figure 2: Functions of ACT Office for Mental Health and Wellbeing

As stated earlier, the evidence gathered suggests there are five key functions for the new ACT Office for Mental Health and Wellbeing. These are described below.

5.1 Vision

Vision function summary - to lead a process of co-design to develop a new Territory-wide vision for mental health in the ACT. This new vision needs to reflect how Canberra wishes to foster the mental health and wellbeing of its people into the 21st century.

Recommendation 1 - That the Office develop a new Territory-wide vision for mental health and wellbeing in the ACT working with the community, the Agency Stewardship Group and the Community Advisory Council.

Characteristic of most similar mission-focused mental health agencies is a role in the leadership and articulation of a vision to address mental health and mental illness. This is something the new Office could undertake early in its inception. A process of co-design would enable partners to be identified and given licence to own the direction of the new Office. This is especially important to consumers and carers who, despite best efforts, often feel estranged from the process of policy and decision-making. It should be remembered that more than 30 people have already left their contact details as part of online survey, the start of a community of interest with which the Office can engage.

This vision could be minimal, focusing on considering how best to organise existing services and programs and promote quality care. Alternatively, this new vision could more fundamentally seek to address and guide the views of the community in relation to mental health and wellbeing: how does the community perceive and value their own mental health and how do they want Canberra to respond to mental illness? What does this mean for the way we design and deliver care? How can the ACT make the promise of deinstitutionalisation a reality, offering people with a mental illness equality of opportunity and the chance to live in the community with dignity?

While the development of a vision would be an important part of the work of the new Agency, it need not delay starting other projects. Indeed, the trust and credibility associated with the new Office would benefit from simultaneous engagement in a variety of practical improvement projects, as well as co-design of a new vision.

5.2 Integration

Integration function summary - to develop a better coordinated approach to policy, strategy and funding

Integration was one of the clearest themes arising from the consultations. By some measures the ACT outperforms other Australian jurisdictions – in relation to community follow up within 7 days of discharge for example. The ACT also spends more than other jurisdictions on the range of clinical and psycho-social services provided by the non-government sector. This is important, providing evidence-based alternatives to care provided in the public system, often hospital-based care. Mental health reforms in New Zealand, led by their mental health commission, saw the NGO sector become a large and viable partner to public mental health services, receiving nearly 30% of the total mental health budget. The ACT is around half that now.

Ironically, this local strength also poses real challenges – to ensure that NGO services are properly understood and established alongside primary and tertiary mental health services as part of an organised response to mental illness. This is not the case now, as identified by Capital Health Network in its Needs Analysis document [3].

There is an urgent need to ensure valuable resources are allocated as effectively as possible, meaning a key role for the new Office would be to bring together primary, secondary and tertiary mental health service providers, as well as others (housing, employment, education etc) to drive better, holistic integration. Advice received during consultations suggests that the new Office would find a willing partner, for example, in the ACT Chamber of Commerce.

[3] (https://www.chnact.org.au/sites/default/files/ACT-PHN-Core-and-Mental-Health-Needs-Assessment-reporting-template.pdf).

They would be interested in discussing practical improvements that could enhance employment opportunities for people with a disability, including mental illness. Capital Health Network expressed similar interest, particularly as it aligns with their current work to develop a regional plan for mental health.

Integration also means facilitating a platform for more joined up action by ACT government agencies. Here the Office would support the work of a 'stewardship group' of key interagency officials at the right level, working to identify and priorities agreed mental health reform activities on a shared workplan. The Office would support these agencies identify the best way to achieve their part of the workplan. Each agency and each Director General would have genuine 'skin in the game' to help the Office drive the Government's mental health reform agenda.

Rec 2 That the Office be established as an independent agency, within Government but outside the Health Directorate.

While it is an option to establish a new Office completely separate from government, none of the existing commissions operate in this fashion. While their independence varies, they are all more or less part of government, not non-government organisations. This is partly because a key shared role is to influence public mental health services and this is more easily achieved from within government than without.

Messages from ACT stakeholders, public servants and commissions elsewhere all strongly favoured positioning the new Office in government but outside of Health. The Health Directorate is a key player in mental health reform but its focus is services, particularly hospital-based and emergency services. The remit of the new Office is broader than this, looking engage around issues in relation to the social determinants of health and shift mental health care along the continuum of care towards promotion, prevention and early intervention. It has different priorities to Health and these are best pursued by establishing the new body outside of Health. An independent structure within government also encourages the Office to provide a new and reliable source of frank and fearless advice about mental health to the Minister, Cabinet and the Canberra community.

Rec 3 Based on the work of a new Agency Stewardship Group to the Office, ACT Government Directors General make regular reports to Cabinet about their progress against a mental health reform workplan (see Rec 10 below) led by the Office.

Key to success for the new Office will be knitting its work into the work of other agencies, especially ACT Government agencies. In NSW the work of the Mental Health Commission became the subject of the Social Policy Committee of Cabinet. In WA, the Commission was its own entity represented directly in Cabinet. The NZ experience was that the Commission drove change through individual District Health Boards – not an approach we can replicate here.

The ACT's situation is different. We are a smaller jurisdiction, mixing both local and state responsibilities. We are not looking to replicate the WA model of direct commissioning (see Rec 5 below).

Considering the different approaches and the advice provided by local decision-makers, it is recommended that an Agency Stewardship Group be established. The intention here is to ensure each agency commits to new, real action in relation to mental health reform. It is tempting to suggest the Stewardship Group be comprised of Directors-General. However, not only is this of dubious practicality, frankly the right people to drive mental health reform, who really know how the system works and where it could be improved work commonly work at lower levels. For this reason, the Stewardship Group needs be the right group of managers, reporting directly to the Directors-General.

Supporting effective and sustainable reform requires more than good governance and leadership. It requires people and organisations to come together, across boundaries, often with differing pressures and challenges to work together towards common goals and objectives over a sustained period. In complex systems such as mental health a traditional command and control leadership approach will not work. What is needed are more effective mechanisms guide and supervise reform. What we need are people and organisations who act as stewards, caring for the change process, guiding and supervising reform.

Stewardship helps establish the conditions for diverse stakeholders to work together across traditional boundaries to more successfully and creatively lead health system redesign, implement high impact system improvements and innovations, and avoid sticking points along the way. It helps create the conditions for successful systems change [4].

Working to the Office, the Stewardship Group would prepare an initial mental health reform workplan for consideration by the broader community as part of a process of co-design. Progress against this set of practical projects would be the subject of regular reports by the Directors-General to Cabinet (see Rec 10 below). The essential terms of reference for this Group would include:

- assisting the Office develop a Territory-wide vision for mental health in the ACT
- developing a draft mental health reform workplan, engaging all ACT government agencies and Capital Health Network
- committing to the execution of a set of practical projects aimed at systemic quality improvement in mental health in the ACT
- participating with the Office in a process of co-design with the community in relation to refining and prioritising the workplan
- enabling Directors-General to report to Ministers and Cabinet on progress
- drawing on co-design to add new projects over time to drive process of continuous improvement

[4] Stewarding Regional Health Transformation: A Guide for Changemakers. ReThink Health, NJ, USA. 2015.

Rec 4 **The Office works with other agencies outside of government, to identify suitable projects to include on this workplan – e.g. Capital Health Network and the non-government sector. The workplan also needs to reflect the ACT's geography within a broader regional catchment.**

Rec 5 **The Office does not hold the budget for mental health and is not a commissioner of everyday services.**

Rec 6 **The Office holds funding to sponsor innovation and change across services.**

Change costs money. Based on evidence from other jurisdictions, the capacity for bodies such as the new Office to sponsor innovation is critical in encouraging agencies and professionals to choose to try new approaches. Too often in the past, professionals and leaders willing to experiment or change the way things work have not been supported. This has helped create a culture of caution and risk aversion that must be addressed by the Office. Funds to support innovation and change will be important to permit this to occur.

Rec 7 **The Office must be consulted about Government decisions in relation to all mental health funding, particularly growth funding. This is to ensure that over time, funding aligns and drives the strategy underpinning the workplan, to shift the balance across the continuum of care towards building resilience and earlier intervention.**

The ACT could choose to replicate the WA model of fundholding, by which the WA Commission really took on the role previously played by the WA Health Department in purchasing and arranging mental health services. This has merit, permitting direct control of spending by the Commission. We gathered evidence to indicate that WA's Commission was driving some significant changes in the shape and nature of mental health services and spending in that jurisdiction. For example, the WA Commission had presided over a considerable expansion of NGO services in recent years.

However, the ACT is a different jurisdiction, with different issues. A key role for a strategic, influencing Office is independence and this is not possible if the Office is also the funder. There was little local enthusiasm for direct budget control for the ACT's new Office, particularly given there are already several other 'commissioners' of services.

However, if the Office is not the budget holder, then it needs the power of oversight across all ACT mental health-related spending, to ensure that over time there is greater and more transparent alignment of funding with strategy. The Office needs the capacity to track all mental health funding and review the acquittal of mental health spending.

Directors-General may find this difficult, particularly as they struggle to meet increasing demand for existing services in some areas. This process of alignment does not need to happen immediately or all at once. The Office needs sufficient powers and support to see this alignment occur over time, shifting mental health services along the continuum of care, away from expensive and often traumatic hospital-based care and towards earlier intervention in the community. This shift will need the support of the community, politicians and the media particularly given the unhelpful current focus on reporting hospital performance, waiting lists and so on.

This model was used in NZ. The Commission in that jurisdiction did have some oversight across all mental health spending, having set out a clear Blueprint to guide commissioning [5].

However, the funding oversight function for the Office is perhaps one of the most sensitive and difficult to get right, relying on excellent relationships and communication with Director-Generals who face daily pressure in relation to services, targets and budgets. A place to start would be to ensure reciprocal consultation between the Office and agencies in relation to any proposal to withdraw or enhance funding to any local or regional mental health service or agency. This reciprocity would foster systemic coherence, transparency and avoid surprises.

5.3 Systemic Quality Improvement

> *Systemic Quality Improvement function summary* - To focus on systemic reform and improvement right across the continuum of mental health care, including physical health, drug and alcohol and the social determinants of health.

Rec 8 That the focus of the Office be on change management and systemic quality improvement, including all aspects of the experience of mental health and mental illness, including health services, drug and alcohol, primary care, housing, employment, community services, disability services, justice, the police, education, social inclusion and so on.

All existing mental health commission-type bodies bar one focus on systemic reform. The exception is Victoria which has purposely built a tailored mental health complaints commission into their latest Mental Health Act. This was an option for the ACT but had little support, given the range of existing complaints mechanisms already operating. There is a role for the Office to ensure these mechanisms are operating well and that trended complaints data is properly exploited for systemic reform (see Rec 11 below).

The overwhelming consensus from the consultations was that the new ACT Office should focus on mental health holistically and systemically, taking into account the breadth of the experience of mental health and mental illness.

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5 http://www.hdc.org.nz/media/200649/blueprint%20for%20mental%20health%20services%20in%20new%20zealand,%20how%20things%20need%20to%20be%20dec%2098.pdf

A Model of Change

One reason why mental health has struggled to sustain reform is failure to clearly articulate a model of change. The Office needs a model of change strategy that is informed by evidence from literature and research on change, feedback from consumers and families, knowledge of clinical leaders and providers and learning from current innovations and exemplar services. The UK's NHS Change model uses eight interconnected components and promotes a strong mix of quantitative (KPIs, measures, data) and qualitative (story-telling, vignettes) elements as required to drive successful change efforts (see below).

Figure 3: NHS Model of Change [6]

[6] https://www.england.nhs.uk/sustainableimprovement/change-model/

This model is further informed by the work of the UK's 'Delivery Unit' [7], which offers something of a template for the new ACT Office. The Unit's role was to focus on assessing whether a reform strategy was being delivered or not, where it wasn't, why and what help agencies or others might need to make it happen. There were several critical elements to the Unit's approach, including:

1. Making sure agencies understood the reform strategy and their role in achieving it – these could be achieved through agency-specific reform implementation plans;

2. Making sure the reforms were really delivering positive, transformational change. This means access to the right data to make such assessments as well as excellent relationships with providers and service users;

3. A strong understanding of the process of change – what are the practical ingredients, workforce, resources, delegations etc. needed to make change happen at the local level. Without this understanding it will be impossible for the Office to clearly assess whether change is happening, where it is working well and where it is foundering. The Office needs to become expert in these 'chains of delivery' so as to appreciate the practicalities of making change happen at the local level and how it can help when problems arise;

4. A clear set of estimated changes or goals. Even if these are based on partial data, the Office must work with agencies across the workplan to set a series of expected targets to be achieved by agreed deadlines. For example, to lift the rate of access to care to a certain level by a given year. Even constructed on a best guess basis, these targets set a trajectory for reform and change that can be measured. If some areas or services get closer to meeting the target than others, this can elicit further consideration about why some seem more successful than others;

5. Regular stocktakes of progress with agencies against reform objectives – developing agreed data to describe progress for discussion with senior staff and Ministers;

6. Ensuring Government gets a clear picture of which elements of its mental health reform workplan are on track and which are not. This could be expressed in terms of a rating of how likely each strategy is to be achieved according to schedule. Where problems are identified, the Unit and the relevant agency would also report corrective actions.

As stated earlier, the Office needs to work in close cooperation with agencies and a high level of trust will be required. Under the powers outlined here, the Office would also have the capacity for public reporting of progress (see Rec 15 below).

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[7] Barber M, *Instruction to Deliver*, Methuen, London, 2012

Across the Lifecourse

Systemic quality improvement in the ACT is currently very difficult to achieve because the 'system' currently consists of largely separate siloes. Separations have occurred based on who funds, which illness, what age group or other criteria.

An alternative approach is described as Mental Capital [8] and calls for a more organised response by all agencies to meet the needs of people at typically critical moments or junctures in their lives. Starting with creating a community that values mental health, wellbeing and resilience, Mental Capital identifies several other key 'journeys'. For example, the system can usefully be organised to respond in a more coherent fashion around the needs of youth in transition to adulthood, or to people facing comorbid conditions, or older people with a mental illness. Better addressing these 'journeys' can alter people's trajectory towards health and away from illness. The new ACT Office could bring some of this thinking into quality improvement. More about the Lifecourse approach is provided at Appendix 5.

Rec 9 **That the Office be led by a Coordinator General, leading a team expert in change management. Core capabilities of the Office will be analytics, quality improvement, systems design, the identification and application of evidence and community consultation and engagement. A key focus is on turning research and evidence into *sustainable* practice. The work of the Office would benefit from the capacity to draw on the practical experiences of service providers and service users.**

The Coordinator General role has been established recently across different aspects of ACT Government, including in relation to family safety and the environment. These roles focus on bringing often siloed agencies together in a new coordinated effort to address agreed goals. This model would suit mental health well and reflects the ACT's unique characteristics. Other jurisdictions have commissioners operating as de-facto directors-general. Some have ministerial appointees more akin to advisors. These roles would not fit well in the ACT and create potentially confusing governance. A draft position description for a new Coordinator General is at Appendix 6.

The Office as Change Agent

To realise change the Office the new Coordinator General must support a network of change agents right across mental health. To do this requires a range of skills and functions that the Office will need to be embed in how it works. These include:

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8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292453/mental-capital-wellbeing-summary.pdf

- Being a partner in reform
- Acting as a broker across people and ideas
- Supporting reformers with evidence
- Active listening
- Creating an environment of accountability for results

Being a partner in reform

The Office is not the owner of the reform but a partner in its realisation. To be a partner in reform the Office will have an active role in the reform delivery and stewardship structures established to support reform. Being a partner also means that the Office will take responsibly, aligned with its legislative functions to lead key aspects of the reform. These areas will be agreed in partnership across the range of whole-of-government partners.

Acting as a broker

The independence of the Office enables it to operate across a wide range of stakeholders. To be able to broker new and different conversations about reform and to support the forming of new relationships between stakeholders is critical. This brokerage role applies to relationship, knowledge and data where the Office can act as the independent bridge between stakeholders.

Supporting reformers with evidence

Many past reform efforts have failed due a lack of expertise about 'how' to realise reform not because of a lack of ideas about 'what' to do. Reformers need support with approaches, frameworks and evidence about how to realise reform. There is a wealth of evidence relating to how to realise reform. The Office will take an active, lead role to source this evidence, to tailor it to required needs and established processes to share these resources. The Office will also develop approaches to assisting reformers to structure programmes of reform using the evidence of what works.

Active listening

The Office has a role to listen to the sector. Listening to consumers, families and professionals experience of care and reform. This will require the establishment of processes that enable the sector to communication 'into' the Office in ways that match their requirements. Stakeholders can be the 'eyes' and 'ears' of the Office, seeing real reform as it happens and support the Office with information and knowledge to continue to support the reform process.

Creating an environment of accountability for results

A key role for the Office is to establish an environment where stakeholders feel able to share results of reform – successful or otherwise. It is critical that this role enables stakeholders a safe place to share, learn and improve. Evidence of effective accountability shows that a trusted environment of support is required to enable people to share bad or indifferent performance and trust that support will be offered to improve at the same time as accepting the accountability for any results.

Evidence indicates that without this environment bad performance is often hidden or misreported causing unintended consequences and unstable reform results.

Rec 10 Working with the Agency Stewardship Group, the Office prepare a practical mental health reform workplan within 100 days of commencing and agreed to by Cabinet. This workplan would then be further developed through community co-design.

Agencies and stakeholders already have views and ideas about how the ACT's mental health system can be improved. It is therefore recommended that the Office work with the proposed Stewardship Group and other organisations (such as the Capital Primary Health Network) on a process to develop a practical workplan (see Rec 3 above). The focus of this workplan are projects designed to *reduce the impact of mental health problems* to be undertaken across all ACT government agencies. A list of suggested areas for reform may need further refinement and prioritisation, which the Office can help agencies achieve. This workplan would need to be further refined through a process of community co-design to ensure it is robust and reflects agreed, practical priorities.

A strong focus for the Office is then to assist agencies articulate and realise the goals and projects they commit to in the workplan. The Coordinator General would have regular meeting with Directors-General and others about workplan progress.
This workplan will require Government support to ensure it has the resources needed to drive progress. It will also need strong input from people working in the sector to ensure projects are practical and contribute to workforce development.

The workplan must include a set of indicators and measures of progress, to be signed off by Cabinet and subject to regular reporting (see Section 6 of this report below).

Rec 11 That the Office work with existing agencies to ensure the Territory capitalises on opportunities for systemic quality improvement arising from individual complaints.

The Victorian Mental Health Commission is the only such body that focuses on the management of individual complaints. There are already several bodies performing this function in the ACT. There was little support for duplicating or replacing this function. However, some carers in particular felt that existing avenues for complaint were failing to drive positive resolutions or systemic change. Part of community engagement for the Office must be to ensure it has close relationships with carers to identify where opportunities for systemic learning from individual complaints are missed. The Office can also work with existing complaints agencies to improve processes of recording complaints and using information to drive systemic reform where this is possible.

5.4 Intelligence and Monitoring

Intelligence and Monitoring function summary - to understand the system and whether improvements are making a positive difference to the experience of care.

Rec 12 That the Office has the authority to request and receive any information and to undertake service reviews and site visits for the purposes of quality improvement. Government agencies have an obligation to assist the Office to compile the data necessary to drive reform.

Rec 13 That the Office have the authority to conduct its own independent reviews, inquiries and reports. The Office has discretion to make these reports public.

Rec 14 That the Office provide an annual report to Government and the community about progress towards mental health reform, referring to the workplan and data in relation to agreed key performance indicators.

Rec 15 That the Office provide Cabinet and the ACT community with regular reports on progress against this workplan and against the identified KPIs.

A frequent comment during consultations was that any new Office in the ACT would need 'powers', some ability to 'compel' compliance in other organisations. Feedback from other jurisdictions is that this is simplistic. These kinds of offices, attempting to strategically influence the direction of mental health reform, in fact rely on productive partnerships and collaborations to make progress. Threats and powers to compel or punish are either not useful or have been shown in a number of cases to be counterproductive to reform. This is particularly the case when considering that the ACT Office will need to be working in close partnership with organisations outside of government, for example the Capital Health Network. As a Federally-funded organisation, the PHN is beyond compulsion by an ACT Government agency. The only way to build the collaborations necessary to drive reform is through agreement and cooperation.

While specific 'powers' are not a major focus of this report, the unfettered capacity to undertake reviews and provide reports, to Government and to the community more broadly is fundamental to maintaining independence and promoting influence.

The Office also needs the capacity to access any necessary government data with the same authority as any other government agency. Government agencies have an obligation to assist the Office in the compilation of the data necessary to drive reform. The Office also needs to authority to visit service providers, to learn from them and to provide them with feedback about performance.

The aim of the Office is not to embarrass service providers, agencies or Government. These powers need to be used judiciously.

Like the 'Closing the Gap' report, an annual statement will provide the Office with some focus and broad community attention around the issue of mental health reform. This will involve the Office working with agencies to develop a new approach to shared accountability for mental health reform.

While there is a lot of data about mental illness collected in the ACT, much of it seems directed towards discharging state or national reporting obligations. Little seems available for the specific purpose of driving quality improvement. There is also evidence of new and potentially helpful data sources which are currently underutilised – the ACT School Climate Survey [9] being one such example. And while the ACT has invested in NGO services, their capacity to provide useful data and reports on their services and outcomes is currently mixed at best. The Office needs access to and the skills to interrogate the data necessary to build an intimate understanding of mental health in the ACT and ACT government agencies need to help the Office build this understanding.

Pre-dating the WA Mental Health Commission was the WA Data Linkage Study which permitted a more joined up approach to health data normally kept separately by both federal and state agencies. The ACT Office should consider this kind of data linkage approach as a priority.

The Office should engage a process of co-design around the development of a set of agreed indicators by which to assess progress towards reform in mental health. Co-design means the people responsible for the services and actions on which the results depend have a chance to shape the outcomes for which they are held accountable. This process needs to be fair and positive, avoiding perpetuating a culture of blame. Some of these goals might be aspirational (zero suicide) and some practical or realistic (a percentage reduction in suicides year on year). More about this process is described in Section 6 of this report below.

Rec 16 That in order to lead improvements consumer-centred care, the Office gives priority to working with consumers and carers to establish an effective system of real time feedback reflective of the entire continuum of care. This feedback will permit real time tracking of consumer and carer experiences of mental health services, at the point of care.

NZ built a system of real time feedback for consumers and carers (http://hdcrtf.co.nz/). Victoria has developed the MH ECO suite of tools (http://www.mheco.org.au/). Two ACT universities already have consumer mental health research units. There is every opportunity to build and deploy this critical element of quality improvement feedback. Data collected here would primarily be for services to better understand the impact of the care they have provided. Data would also be compiled for the Office to develop a broader picture of the mental health and welfare of people using services across the ACT.

[9] http://psychology.anu.edu.au/node/805/edit/australian-school-climate-and-school-identification-measurement-tool

A Note about Accountability

A sharper approach to accountability for mental health is a common function of mental health commissions and implicit in the functions outlined here for the new ACT Office. Access to data, independent reporting, the capacity to properly track and acquit mental health funding are all enablers of a responsible approach to accountability by the new Office. But the task also sits squarely with the proposed Stewardship Group and the Directors-General to whom they report, and, in turn, with their Ministers. Accountability also rests with consumers, carers, providers and professionals who really know what is working in the system and where improvements are necessary. They need the skills, tools (like real time feedback) and willingness to contribute their knowledge.

Accountability is an active function and critical to systemic quality improvement. It will need to cover several domains or areas of interest, including health, social and system domains. This is explained more in Section 6 below.

Implementation of sustained reform has proven elusive across all Australian jurisdictions. With proper systems backed with enduring authority and attention, the ACT can use a more powerful model of shared accountability to drive reform and become a world leader in the promotion of mental health and the response to mental illness.

Rec 17 That the Office develop a 'clearing house' of best practice information and current translational evidence, accessible by the ACT community.

Canada's mental health commission maintains a clearing house function, making it easier for mental health reformers to find the evidence about what works. This would be important new infrastructure available to support better decision-making in the ACT.

5.5 Community Engagement

Community Engagement function summary - to work with all parts of the Canberra community to co-design better responses to mental illness and better promote mental health and wellbeing.

Rec 18 That the existing Ministerial Mental Health Advisory Council legislation and terms of reference be amended, using the template from the Queensland Mental Health Commission, to become as the Community Advisory Body to the new Office, bringing the voice of consumers, carers, health professionals, service providers and others into the work of the Office and conveying these voices to Government.

The ACT already has a Ministerial Mental Health Community Advisory Council, reporting to the Minister for Mental Health. It is set up under legislation. It would seem like duplication to set up another body.

Having excellent working relationships with consumers, carers, professionals, providers, researchers and others is critical to permitting the new Office to understand what is really happening or changing on the ground. The Office will need to establish a Community Advisory Council-type function to fulfil this role.

While every jurisdiction recognises the merit of such a body, the experience working with this kind of community council varies considerably between the jurisdictions. Some have been assessed as lacking influence while others have considered themselves in fact in charge of the Commission to which they report. There is clearly a need to carefully balance clear governance with genuine representation.

It is suggested that the Queensland Mental Health Commission offers a useful template. Some of the key features of the Queensland approach include:

- Ministerial appointment based on ensuring diversity, skills and representation
- Council provides advice to the Commission on its own initiative or at the request of the Commission
- Council makes recommendations to the Commission
- The Commission supports the Council
- The Commission must respond to the Council's recommendations and where it decides not to take action on a Council recommendation must explain why.

An extract from the Qld legislation is provided at Appendix 7 of this report.

Rec 19 The Office supports and sustains standing networks of consumers, carers, health professsionals, service providers and others to ensure it understands the everyday situation of mental health care in the ACT.

The success of the Office will depend on close partnerships – with consumers, carers, professionals, providers, researchers and others. Deploying co-design seems a natural fit with this imperative, creating a new level of understanding and ownership of the process of reform by all key parties. This goes beyond 'consultation'. It means these key stakeholders working collaboratively to identify and prioritise reform. It means the Office needs structures to support and sustain a level of co-design engagement sufficient to build confidence and increase the robustness of the reforms undertaken.

Community engagement could also involve the Office in making it easier for people to know where to go for help. This kind of navigation support is important, given the complexity of the current system. There are several existing repositories of relevant information, held by ACT Health, Capital Health Network and the NGO sector. The Office could facilitate bringing this information together, mindful of existing initiative such as Head to Health.

Community engagement at the highest level would concern the Office with boosting the mental health literacy of the ACT community, increasing understanding about the actions people can take to look after their own mental health.

5.6 Evaluation of the Contribution of the Office

Rec 20 That the Office is subject to a review in relation to its own effectiveness and contribution to reform, five years after its commencement (July 2023).

A mixed methods approach to an evaluation after around five years would be good practice. This project would seek the views of people within government and without regarding qualitative perceptions of the effectiveness of the Office. It could also look for quantitative data in relation to services, quality of care, funding etc, with a view to gauging the impact of the Office on mental health reform in the ACT.

In addition to this formal evaluation, the Office should consider some form of ongoing, independent evaluation from the start. Some kind of external sounding board or coaching could provide the Office with independent feedback on the extent to which it was functioning properly and meeting its goals.

6. TOWARDS AN OUTCOME FRAMEWORK

At the highest level, there is a paucity of information regarding the impact Australia's mental health commissions have had on reform. Indeed, the criteria by which to assess this impact is unclear. It has been suggested that for a Commission-type body to be deemed successful, it should be possible to see change in four key areas [10]:

1. Better resources – have commissions been successful in attracting new funding into mental health?
2. Better services – is there evidence to indicate that commissions drive improvements in service quality?
3. Better accountability – do commissions make it easier to decide which services really work and if the mental health of the community is improving?
4. Better stakeholder engagement – are commissions seen by consumers, carers, service providers and others as being effective advocates for mental health reform?

So far, no Commission has been assessed against these criteria. It is also not possible to see the Commissions themselves applying this sort of explicit criteria to report progress.

As stated earlier and at the next level down from the criteria listed above, a key task for the Office is to manage a process of co-design around a set of local performance indicators. Mixing aspirational and practical goals, a set of indicators creates a framework for leadership and action, sending a new clear message about the way the ACT wants to manage the issue of mental health going forward.

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[10] Rosenberg S, Rosen A, Can Mental Health Commissions Really Drive Reform? Towards better Resourcing, Services, Accountability and Stakeholder Engagement, Australas Psychiatry, June 2012; vol. 20, 3: pp. 193-198.

During the consultations, a list like the one below was used for illustrative purposes. A critical message from the consultations was to ensure the level of ambition was high enough to impel meaningful reform. Tinkering with services was not seen as adequate by most stakeholders.

Key Performance Indicators for Mental Health Reform in the ACT	
1	100% of all discharges from acute care have a recovery plan in place
2	100% of all discharges from acute care have community follow-up with 7 days
3	Building community capacity to support a shift to promotion, prevention and early intervention: what proportion of total mental health spending in the ACT is hospital-based care?
4	Equity in mortality – lifting the life expectancy of people with a mental illness. There are high rates of co-morbidity in the ACT currently. This marker would reflect better management of co-occurring chronic and metabolic disorders.
5	Zero suicides; a percentage reduction in suicides and attempts year on year
6	Zero unnecessary involuntary treatment
7	Zero seclusion and restraint – the ACT is already the lowest in Australia
8	Zero homelessness – the ACT has the second highest rate in Australia. This marker could also include a reference to mental health services in public housing and stable housing.
9	Equity in employment – people with mental illness are three times more likely to be unemployed than the general community.
10	Equity in educational outcomes – the capacity of young people to surmount mental illness and complete their education is critical to their long-term life trajectory.

The markers above are some suggested places to start. The co-design process recommended earlier would refine these, towards development of a more complete outcomes framework.

What is an outcomes/performance framework?

An outcomes/performance framework describes a series of layers of outcomes; a hierarchy from high level, general, societal outcomes though increasing levels of specificity, health system to sub-system or component parts (organisations, services etc).

A powerful outcomes hierarchy provides a cohering frame or logic that enables actions across a wide range of parts to build to the desired results for the whole. An outcomes framework both provides focus (answering 'why are we doing this' questions through higher level outcomes). It can also guide actions ('how should we do' questions through lower level, intermediate outcomes) without being prescriptive, enabling both creativity and discipline within a system.

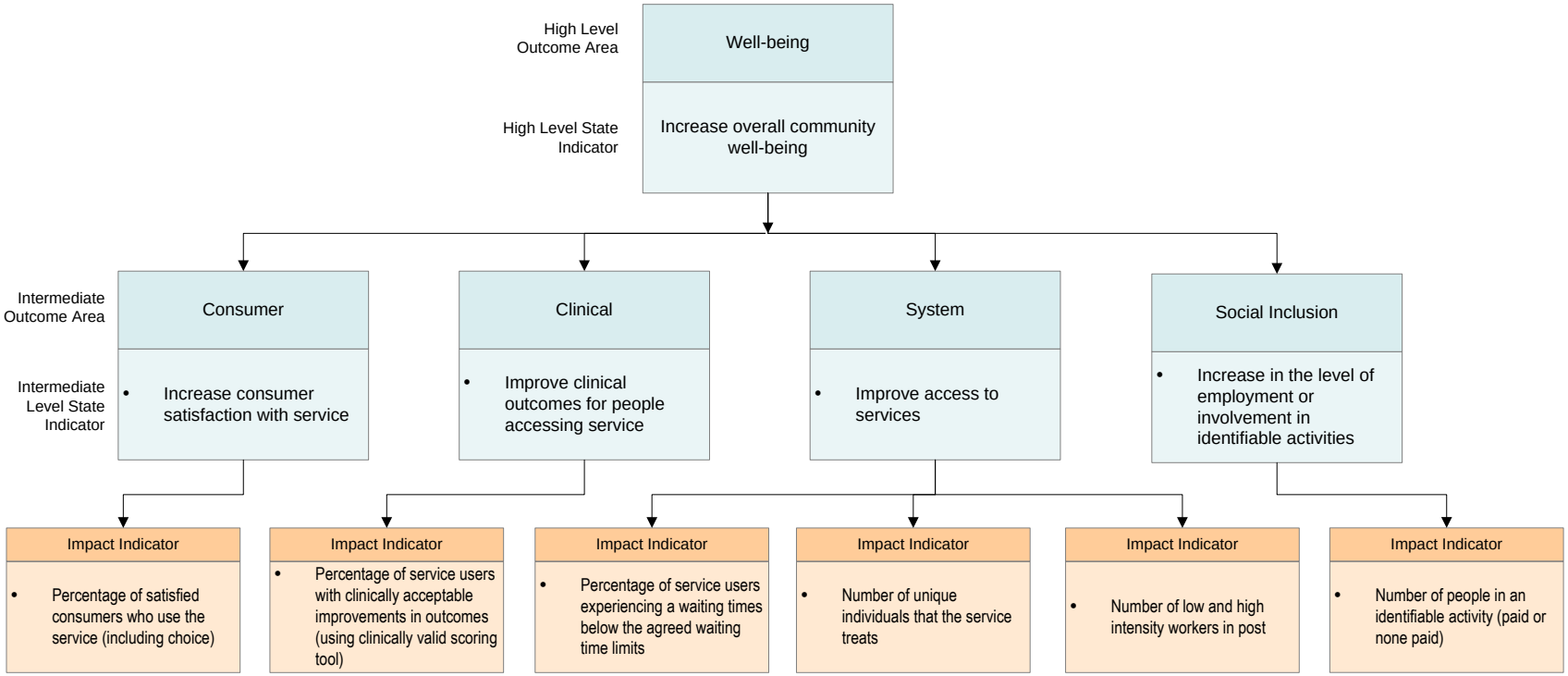
By associating outcomes with 'state' indicators (for high level outcomes) or impact indicators (for lower level indicators of the effectiveness of our actions) an outcome hierarchy can provide a frame for continuous learning and improvement.

The example below outlines some initial thinking on a possible outcomes/performance framework. The framework not only reflects different levels of indicator but also different domains of interest, from consumer, clinical, system and social perspectives. These can be further refined in the course of co-design.

There will also be markers of success and progress associated with the projects identified on the mental health reform workplan (see Rec 10 above).

Beyond individual markers or indicators, success in the ACT might also be reflected in new or innovative ways of funding. For example, in a small jurisdiction such as the ACT, it is possible to imagine a new pooled funding arrangement, in which the main funders of mental health services combine their funds in a more coordinated fashion, against the strategy identified and led by the Office. The Commonwealth already signalled its in-principle support for Primary Health Networks to pool funding currently allocated to the Better Access Program. There are pools of mental health funding spread across ACT government agencies that could be usefully brought together under this concept, including funding directed towards non-government services.

An Example of an Outcomes Framework



7. APPENDICES

7.1 Appendix 1 – Key Stakeholder Inteview Template

ACT Office for Mental Health

Interview Questions on Existing Mental Health Commissions

The ACT Government has engaged Synergia Consulting to provide advice regarding the establishment of a new Office for Mental Health in ACT. Our aim in this interview is to seek your views about the impact such specific offices or commissions can have on mental health.

These questions are suggested to guide the interview process. Some interviews may not ask all these questions.

- Over the period of its operation in [Jurisdiction], what difference do you think the Commission has made? How have things changed a) in Mental Health Services in the MHC's jurisdiction b) for the MHC? What influence has the MHC had on these changes?
- Is there any evidence to demonstrate this impact?
- How has the Commission in [Jurisdiction] evolved over time? Is this for better or worse?
- In setting up the Commission in [Jurisdiction] were there particular strengths or weaknesses in its establishment that made success more or less likely?
- Which of the Commissions powers were most important in making a difference, and what other powers not available to the Commission might have been most useful?
- Benchmarking – QI
- Did the advent of the Commission lead to changes in the role or structure of other government (or non-government) agencies?
- What is critical for these bodies to establish effective working relationships with government, specialist public & private health & mental health professionals, support agencies, consumers, carers or other key groups? Which relationships are important to get right, e.g. with Health/Chief Psychiatrist etc? Do you have any advice on how this could be done well or what not to do?
- How valuable is the role played by "Community Advisory Council" type bodies to Commissions? What factors will affect their contribution?
- How should the success of these kinds of bodies be evaluated? Are there specific measures you could suggest? What are achievable & acceptable outcomes for your MHC?
- How can these bodies develop & sustain more functional 'whole of government' facets and connections to the policy development & delivery of more effective mental health services?
- If you could go back in time, what 3 things would you change about the MHC?
- Going forward in time, what 3 main things should the MHC try to change about a) the MHC b) the MH services in its jurisdiction.
- How easily accessible is the MHC to the public, consumers and families & providers?
- Does the MHC develop, sustain, nurture and regularly access a live consultation network of all stakeholder groups made up of members who are interested in MHS reform?

7.2 Appendix 2 – List of Key Stakeholder Interviews

Name	Role
Chris Burns	SA Mental Health Commissioner
Eddie Bartnik	Former WA Mental Health Commissioner
Peggy Brown	CEO, National Mental Health Commission
Lesley Van Schoubroeck	Former Qld Mental Health Commissioner
Tim Marney	WA Mental Health Commissioner
Peter McGeorge	Former Mental Health Commissioner of New Zealand
Catherine Lourey	NSW Mental Health Commissioner
John Feneley	Former NSW Mental Health Commissioner
Ivan Frkovic	Qld Mental Health Commissioner
Lynn Coulson-Barr	Victorian Mental Health Commissioner
Barbara Disley	Former Mental Health Commissioner of New Zealand
Kevin Allan	Mental Health Commissioner of New Zealand
Louise Bradley	Canadian Mental Health Commissioner
Geraldine Strathdee	Previous Mental Health Director of the NHS (UK)

Several other interviews were undertaken with ACT Government office holders.

7.3 Appendix 3 - Office for Mental Health Project Steering Committee

Membership and Terms of Reference

This committee is to be established to provide input and strategic oversight to the project, which aims to provide advice about the design and operation of the new ACT Office for Mental Health. The committee will be comprised of:

- ACT Health Mental Health Policy Unit – Director and Senior Policy Officer
- ACT Health Mental Health Justice Health Alcohol & Drug Services (MHJHADS) – delegates of Executive Director and Chief Psychiatrist
- ACT Mental Health Consumer Network (ACTMHCN)
- Mental Health Consumer representative
- Carers ACT
- Mental Health Carer representative
- Mental Health Community Coalition of the ACT (MHCCACT)
- Capital Health Network (CHN)
- Mental Health Ministerial Advisory Council – Chair or delegate

The committee will be chaired by ACT Health and facilitated by Synergia Consulting.

The terms of reference for the committee are to:

1. Provide strategic direction and leadership to ensure the successful development of a proposed model for the Office of Mental Health.
2. To link the project to key stakeholders, groups and insights across the ACT, including facilitation of community involvement in the project consultation process
3. Provide guidance and practical support for the Consultant Project Team including contributing to relevant material and commenting on drafts
4. Share relevant information back to represented constituencies, as determined in each meeting.

The aim of the committee is to provide recommendations. The intention is to operate by consensus. Final decisions about the Office are the responsibility of government. The committee will operate without a set quorum. Members are welcome to send a delegate or email their contribution out of session if unable to attend, to ensure the work of the committee reflects all members' interests while meeting tight timelines.

This project is due to be completed by February 2018. It is expected the committee will meet three times:

- 29th November 2017 - Meeting Room 4.05 Level 4 2-6 Bowes Street Woden
- 20th December 2017 - Meeting Room 4.05 Level 4 2-6 Bowes Street Woden
- 14th February 2018 - Meeting Room 4.05 Level 4 2-6 Bowes Street Woden

All meetings will be 10am-12pm.

7.4 Appendix 4 – Online Survey Findings

To support broad consultation with stakeholders an online survey was undertaken. The survey was open between 7 December 2017 and 8 February 2018. The submissions were analysed and the open text responses analysed thematically. The key themes and findings are summarised below.

The survey asked the following questions:

#	Question	Response Type
1	What are the key challenges facing mental health in the ACT?	Free text
2	How can a new Office address these challenges?	Free text
3	Are there specific powers, tasks or roles a new Office should undertake? Any that should be avoided?	Free text
4	How could a new Office drive better Territory-wide integration of our mental health system?	Free text
5	If the new Office was to be judged as successful, what would have changed in the ACT in five years' time?	Free text
6	What relationship should the new Office have with Government itself (part of, separate, arm's length etc) as well as with consumers, carers, health professionals, individual government agencies, researchers, others?	Free text
7	Please select the role that best reflects the perspective from which you have completed this survey. Options were: Consumer, Carer, Health professional, Service provider, Other	Select one
8	This survey is designed to be anonymous. However, if you are interested in registering your interest in receiving further information on the development of the ACT Office for Mental Health please enter your email below.	Free text

Overall

Overall there were 67 submissions, split by role as follows.

Role	Number	Percentage
Carer	22	33%
Consumer	15	22%
Health professional	14	21%
Other	15	22%
Service provider	1	1%
Total	**67**	**100%**

For the final question 32 people (48%) provided their contact details.

Question 1: What are the key challenges facing mental health in the ACT?

The key themes for this question were:

- Lack of funding
- Poor co-ordination of care
- Stigma around mental illness
- Inadequate inpatient mental health facilities
- Poor management (of resources and staff)

Lack of funding was commonly acknowledged as one of the biggest issues facing mental health in the ACT. Funding was mentioned in some capacity in 23 of the survey responses. Funding in terms of staffing was most common – retention of staff is difficult due to low financial resources, which negatively impacts on continuity of care for mental health patients. This issue was raised by a number of health professionals in their survey responses.

Poor coordination of care was addressed 17 times across the survey responses. With the primary concern being around transition from inpatient facilities to community care. Further, connection and coordination with NDIS was found to be inadequate – this was mentioned by both health professionals and consumers.

Lack of care coordination was also considered in the capacity of integration between general health and mental health services. The separation between these two arms of 'health' are considered to be problematic and challenging by a number of the survey respondents.

Stigma around mental health was noted as a key challenge facing mental health by 14 of the survey respondents. Stigma and lack of education were considered significant challenges, among both the general public in speaking out and seeking help, and some consumers noted stigma from health professionals.

Inadequate inpatient mental health facilities were considered a key challenge seven times. Six of these were referring to child/adolescent facilities specifically.

A smaller number of responses considered the current management of mental health to be the biggest challenge. Management refers to the management and distribution of resources, as well as the current management system in place.

Question 2: How can a new office address these challenges?

The key themes for this question were:

- Developing a client-focused system
- Improving distribution of fiscal resources/increase funding
- Be a liaison across services to improve service integration/coordination
- Provide accountability
- Be a source of research for evidence-based action
- Prevention and early intervention

Also of note: 4 responses answered this question doubting the ability of an Office for Mental Health to address the challenges at all.

The role of the office in developing a client-focused system occurred seven times in the survey responses. It should be a source of stakeholder engagement and have the capacity to act in response to client needs.

Six survey respondents identified the role of the office in managing resources more effectively, which would help to address some funding challenges the sector was experiencing.

Eight respondents also noted the importance of the role the Office would play in liaising with services across the health sector to improve integration of 'general' and 'mental' health services.

It was noted in six survey responses that a new office for mental health should provide accountability for services under the mental health umbrella. It should have systems for monitoring, evaluation, feedback and follow up.

It was also mentioned by seven respondents that the Office would operate as a source of new research and provide a hub for generation of knowledge, to inform evidence-based action. In this vein, the office would work closely with the government to inform appropriate action.

Four responses noted the lack of prevention/early intervention for mental illness and noted that a new office for mental illness could be a source of encouragement for this type of care to be delivered to the population. Suicide prevention was named specifically a number of times.

Question 3: Are there specific powers, tasks or roles a new Office should undertake? Any that should be avoided?

The key themes for this question were:

- Suicide prevention
- Evaluation, research and monitoring
- Foster culture change to reduce stigma
- Increase access to mental health services

Suicide prevention was noted by a significant proportion of survey respondents as something that should be a priority for a new Office. It was suggested that a target should be set by the Office to reduce rates, as well as the Office working in conjunction with other areas of the health sector and government to ensure suicide prevention is a priority.

The Office should be a centre for evaluation, research, feedback and monitoring and should inform evidence-based actions in the wider health and other social sectors. It was acknowledged by six survey respondents that an overarching Office should be responsible for evaluating and monitoring organisations within the sector.

The Office should be able to advocate on behalf of clients and liaise with organizations within the health/mental health sector to reduce barriers and improve access to care. This could be done by reducing stigma and fostering a culture change around the attitudes towards mental illness, which was suggested by three survey respondents.

Question 4: How could a new Office drive better Territory-wide integration of our mental health system?

The key themes for this question were:

- Acting as a liaison across services
- Integrating mental health with mainstream health services
- Fostering a client-focused system

Eight responses identified the need for a new Office to liaise across varying services to ensure they are working collaboratively for better outcomes, in the most efficient way. Within this, monitoring these services and encouraging coordination and collaborative working environments were identified as key functions of the new Office. Monitoring and evaluation also came under this theme, as coordination and direction coming from the Office's research capacity will be able to inform the direction taken by services across the system.

The integration of mental health with mainstream health services was noted by six responses as being critical to a fully integrated system, as well as integration within the mental health system.

Fostering a client-focused system was considered important by several survey responses for the integration of the mental health system. It was noted that by improving the focus on clients within the system, integration may naturally follow. A coordinated, integrated system is within the client's best interests.

Question 5: If the new Office was to be judged as successful, what would have changed in the ACT in five years' time?

The key themes for this question were:

- Adequate supply of mental health professionals
- Improved cohesion of services
- Decreased stigma around mental health
- Improved access to and efficiency of mental health services
- Reduction in suicide rates

Question 6: What relationship should the new Office have with Government itself (part of, separate, arms length etc.) as well as with consumers, cares and health professionals?

The key themes for this question were:

- The Office should be separate but work closely with the Government
- The Office would work as a regulator for agencies and practitioners providing Mental Health care
- Work as bridge between government and consumers

A clear majority of the respondents identified that the Office should be connected and work closely with, but not be a part of government. It would have the capacity to make recommendations to the government, while remaining separate. The relationship would be two-way, where the government would respect the Office and listen/act on the advice and directions it gives. Achieving this level of balanced independence and influence is critical.

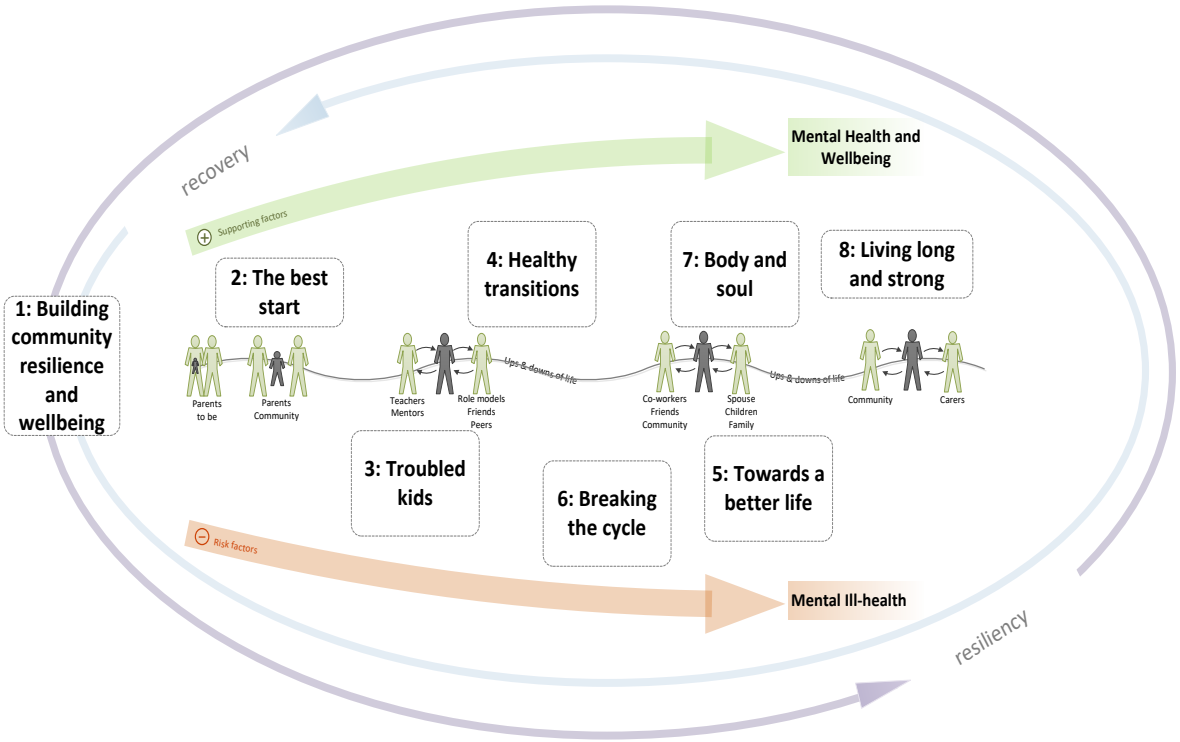
The Office was thought to be a regulator for ensuring that all agencies and practitioners are working together effectively. It should be an umbrella organization, that encompasses public health and NGO services, as well the authoritative oversight to cohesively improve accessibility and suitability of service provision for mental health consumers. Strong links with consumers are essential. Five responses noted that the Office should be accountable to the public, through regular reporting.

Several responses alluded to the Office acting as a bridge between management and government and the consumers of mental health services.

7.5 Appendix 5 - Mental Health Across the Lifecourse

There is strong evidence to show that responding earlier and more effectively can improve people's lives, avoid negative impacts on society and reduce the level and intensity of demand for services arising later (REFS)

It is also clear that mental health issues can impact people in different ways at different times throughout their lives.



Mental Health Across the Lifecourse

Taking a 'life course' approach highlights the fact that mental health needs, and the responses we can deploy, change over the course of peoples' lives. It allows us to look at the critical points in the development of mental health issues and where we can intervene earlier and more effectively to create positive, reinforcing trajectories. It covers the whole life course, from before birth through to older people. It focuses on the eight most common points in the lives of people with mental health, addiction and behavioural issues where there is an opportunity to identify issues and to make a real difference.

How we support people to be mentally well and healthy throughout their lives changes. There is also strong evidence that events that occur at certain times in people's lives can put them on a trajectory towards health or illness. For example, issues in early childhood development are more likely to cause learning and behavioural issues later in life. Hence understanding these key transitions and journeys and how they are connected throughout people's life is critical to making a long-lasting difference.

To be successful, the life course approach requires integrated responses from the whole health sector, the broader social, education and justice sectors, as well as the mental health and broader health sector.

The life course approach can also focus our thinking about the opportunities we have at different ages and stages to support people, families and communities to be resilient and to weather adversity. The UK Mental Capital and Wellbeing project https://www.gov.uk/government/publications/mental-capital-and-wellbeing-making-the-most-of-ourselves-in-the-21st-century) used a life course approach to explore how to build mental capital and resilience throughout people's lives and that to do this changes over time. Having mental capital means more resilience against adverse events when they happen, often at transitions points in life such as leaving school, becoming a parent and getting a job.

For example, for older people, effective health promotion and self-care would include physical exercise programmes, social support and activities, home visits, volunteering and attention to spiritual needs. Health promotion and self-care is not an area where the mental health sector can take sole responsibility. It needs a broader support base including people, their families, communities, and employers alongside the health and wider social sector.

7.6 Appendix 6 – Draft Position Description for Coodinator General, ACT Office of Mental Health and Wellbeing

The ACT Office for Mental Health and Wellbeing is modelled partially on the UK's 'Delivery Unit' in that its focus is on implementation science and quality improvement. It also takes into account the most effective features of reforming Mental Health Commissions both internationally and in Australia. The Office works with partners both within government and without, to identify the direction of mental health reform in the ACT, to drive change, implement reform and measure progress.

There is already mental health policy and provider expertise in the ACT, spread across government and non-government agencies. There is also a deep wellspring of service-user, family carer and provider expertise, grounded in their experience of local services and systems. There is a need to better harness all this expertise and provide a more integrated system to address mental illness and promote mental health across the Territory.

The Coordinator-General (CG) of the Office for Mental Health and Wellbeing will report directly to the ACT Minister for Mental Health (or equivalent) and to other Ministers as necessary, in relation to different aspects of mental health reform. The CG will also provide regular reports to Cabinet, the Assembly and the ACT community.

For the Office to be successful, its CG needs:

1) High level change management skills and the ability to lead a change management team engaging staff from both the Office and other agencies
2) Skills in leadership to articulate and build support for a new vision for mental health in the ACT
3) Demonstrated ability to apply these skills in health, particularly mental health
4) Demonstrated capacity to build and sustain partnerships across government and non-government agencies, including mental health commissions elsewhere.
5) The ability to use and interpret data, financial and service, to ensure funds allocated for mental health are spent in mental health in accordance with agreed strategy, and to identify opportunities for improvement and drive change
6) The ability to develop and sustain excellent relationships with networks of key stakeholders, including service-users, family carers, health professionals, service providers and other agencies who are involved with mental health services.
7) The capacity to initiate, prepare and deliver routine or other reports aimed at demonstrating progress and identifying systemic problems and areas for systemic quality improvement

The C-G and the Office will have the statutory authority necessary to execute the role.

7.7 Appendix 7 - Extract of Queensland Mental Health Commission Act 2013 in relation to the Queensland Mental Health and Drug Advisory Council

Division 1 Establishment and functions

37 Establishment of Queensland Mental Health and Drug Advisory Council

The Queensland Mental Health and Drug Advisory Council is established.

38 Functions of council

The functions of the council are—(a) to provide advice to the commission on mental health or substance misuse issues—(i) on its own initiative; or (ii) at the request of the commission; and (b) to make recommendations to the commission in relation to the commission's functions.

Division 2 Membership

39 Membership

(1) The council consists of the number of persons appointed by the Minister that the Minister considers appropriate.

(2) In making an appointment the Minister must ensure—(a) the membership of the council reflects he diversity of the Queensland community; and (b) that members have appropriate skills, knowledge or experience, for example, skills, knowledge or experience of mental health and substance misuse issues in relation to the following—(i) service users and their families, carers, and support persons;(ii) service providers;(iii) people living in remote and regional communities;(iv) members of culturally and linguistically diverse communities;(v) Aboriginal and Torres Strait Islander persons.
(3) members are to—(a) hold office for the term, not longer than 3 years, stated in the member's instrument of appointment; and(b) be paid the fees and allowances decided by the Governor in Council.

40 Chair and deputy chair of council

(1) The Minister may appoint—(a) a member of the council to be chair of the council; and (b) another member to be deputy chair of the council.

(2) Member may be appointed as the chair or deputy chair at the same time as the person is appointed as a member.

(3) A vacancy arises in the office of chair or deputy chair if the person holding the office—(a) resigns office by signed notice of resignation given to the Minister; or (b) ceases to be a member; or (c) is suspended by the Minister under section 41(3).
(4) A person resigning the office of chair or deputy chair may continue to be a member.

(5) The Deputy chair is to act as chair during vacancy in the office of the chair; and (b) during all periods when the chair is absent from duty or for another reason cannot perform the duties of the office.

41 Vacancy in office of member

(1) The office of a member of the council becomes vacant if the member—(a) completes a term of office; or (b) resigns office by signed notice to the Minister giving at least 1 months' notice; or (c) is removed from office by the Minister under subsection (2); or (d) is suspended by the Minister under subsection (3).

(2) The Minister may remove a member from office if the Minister is satisfied the member—(a) has been guilty of misconduct; or (b) is incapable of performing the member's duties; or (c) has neglected his or her duties or performed them incompetently; or (d) has been absent without permission of the chair from 3 consecutive meetings of which due notice was given.

(3) The Minister may suspend a member for up to 60 days by signed notice to the member if—(a) there is an allegation of misconduct against the member; or (b) the Minister is satisfied a matter has arisen in relation to the member that may be rounds for removal under this section.

Division 3 Conduct of business by council

42 Conduct of business by Council

(1) The council may conduct its business, including its meetings, in the way the chair of the council considers appropriate.

(2) However, the chair must consult with the commissioner before deciding the way the council is to conduct its meetings.

(3) The Minister may direct the council about the conduct of its business, including its meetings.

(4) The Commissioner is to attend all meetings of the council, unless excused by the chair.

43 Quorum

A quorum for a meeting of the council is one-half the number of its members, or if one-half is not a whole number, the next highest whole number.

44 Presiding at meetings

(1) The chair is to preside at all meetings of the council at which the chair is present.

(2) If the chair is not present at a meeting, the deputy chair is to preside.

(3) If neither he hair nor deputy chair is present at a meeting, a member of the council chosen by the members is to preside.

45 Conduct of meetings

(1) A question at a meeting of the council is decided by a majority of the votes of the members present.

(2) Each member present at the meeting has a vote on each question to be decided and, if the votes are equal, the member presiding also has a casting vote.

(3) A member present at the meeting who abstains from voting is taken to have voted for the negative.

(4) The council may hold meetings, or permit members to take part in meetings, by using any technology that reasonably allows members to hear and take part in discussions as they happen, e.g. Teleconferencing.

(5) A member who takes part in a meeting of the council under subsection (4) is taken to be present at the meeting.

(6) A resolution is validly made by the council, even if it is not passed at a meeting of the council, if—(a) a majority of the council members gives written agreement to the resolution; and (b) notice of the resolution is given under procedures approved by the council.

46 Minutes

(1) The council must keep—(a) minutes of its meetings; and(b) a record of any resolutions made under section 45(6).

(2) Subsection (3) applies if a resolution is passed at a meeting of the council by a majority of the members present.

(3) If sked by a member who voted against the passing of the resolution, the council must record in the minutes of the meeting that the member voted against the resolution.

47 Committees

(1) The council may establish committees of the council for effectively and efficiently performing its functions.

(2) The term of a committee is decided by the council.

(3) A committee may include a person who is not a member of the council.

(4) The council is to decide the terms of reference of a committee in consultation with the commissioner.

(5) The function of a committee is to consider and advise on matters referred to the committee by the council.

Part 6 Cooperation between commission and council

48 Commission must support Council

The commission must support the council in performing its functions by providing information to the council about the performance by the commission of its functions — (a) at regular intervals; or (b) when requested by the council.

49 Consultation on reports and whole-of-government strategic plan

The commission must consult with the council on the following before they are given to the Minister—(a) any special or ordinary reports;(b) the whole-of-government strategic plan.

50 Commission must respond to council's recommendation

(1) This section applies if the council makes a recommendation about matters relating to a function of the commission.

(2) The commission must respond to the council in writing within a reasonable period (a) detailing the steps it has taken, or plans to take, in relation to the recommendation; or (b) advising that it has decided not to take any action in relation to the recommendation.

(3) If subsection (2)(b) applies, the commission must provide the council with the reasons for its decision.

51 Details of recommendations to be included in annual report

The commission must include in its annual report details of—(a) each recommendation by the council to the commission during the financial year; and(b) action taken by the commission in response to the recommendation; and(c) any statement about the conduct of the council's business provided to the commission by the council for inclusion in the commission's annual report.