Mental Health
Community Coalition ACT

Towards an ACT Mental Health Outcomes Framework: a discussion paper

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Acknowledgements

Acknowledgement of country

Mental Health Community Coalition ACT is located on Ngunnawal Country. We acknowledge the Traditional Custodians of the land. We pay our respects to their Elders, past and present. We further acknowledge all Aboriginal and Torres Strait Islander Traditional Custodians and Country and recognise their continuing connection to land, sea, culture and community.

Acknowledgement of mental health lived experience

We also acknowledge the individual and collective expertise of those with a living or lived experience of mental health. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

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Knowing is not enough, we must apply.

Willing is not enough; we must do.

—Goethe

Introduction

A process to develop a Mental Health Outcomes Framework has begun in the ACT. This paper has been prepared to help this process.

An effective outcomes framework can drive a process of accountability systemic

quality improvement in mental health to identify opportunities for improvement.

The need for effective accountability for mental health was identified back in 1992, as part of the very first National Mental Health Strategy:

> There needs to be greater accountability and visibility in reporting progress in implementing the new national approach to mental health services. Currently mental health data collection is inconsistent and would not be adequate to enable an assessment to be made of the relative stage of development of the Commonwealth and each State/Territory Government in achieving the objectives outlined in the National mental health policy.
>
> It is essential that such a consistent system of monitoring and accountability be created. In developing such a system, it needs to be recognised that each State and Territory will be at a different stage as a result of the historical development of its mental health system. The central approach should be to measure progress in each State and Territory.

This Strategy prioritised the reporting of consumer outcomes, given the primacy of organising mental health care to help people with mental illness with their recovery, to achieve their goals. It acknowledged the need to link data beyond the health system, to include issues such as housing, employment, justice, education and community services, to develop a necessary, fuller picture of the mental health and welfare of people with a mental illness.

Despite these commitments it is reasonable to suggest that the task of developing effective accountability for mental health in Australia remains largely unfulfilled. Despite a lot of mental health data being collected by professionals and service providers, it is difficult to discern organised approaches to systemic or service quality improvement in mental health and overall, we remain largely outcome blind to mental health and wellbeing in the community.

Outcomes as a platform for action, not blame

It is important to note that an outcomes framework could be useful to a range of actors. It can reveal data to the broader community about the mental health and wellbeing of its citizens.

It can demonstrate the impact of services or treatments provided to consumers and carers. It can provide some indication of efficiency to funders, keen to ensure that precious resources in mental

health are not wasted. It can also provide data to planners to help them respond to the community's changing mental health needs.

Outcomes data can also identify opportunities for quality improvement for service providers, helping them to track the impact of the care they provide.

At all these levels however, it is important to disassociate outcomes from blame. Mental health care in Australia has been subject to repeated inquiries from governments and related bodies, often in response to shootings, deaths, human rights abuses or poor treatment. People working in the system may feel unsupported and at risk of blame in a system they cannot control or improve. It is vital that this process of mental health outcome development become clearly associated with a culture of quality improvement rather than blame. From a workforce point of view, it is of course easier in health care to attract people to positions where they can clearly see the positive impact they are having on people's lives.

This association might be boosted by application of an approach to outcomes taken by the US Department of Veterans Affairs, which focuses on three key concepts in outcome measurement: collect, share, act. At the practice level, an organization can collect and aggregate data, share the information back with the team, and act by collaboratively developing improvement initiatives that support organizational goals. This kind of approach might cement joint improvement activities between, for example, Canberra Health Services and the Capital Health Network, in relation to identification of shared responsibility for a particular group or cohort of clients.

Building on the ACT Wellbeing Framework

An outcomes framework can also reflect the mental health and welfare of the broader community, not just people who have used mental health services. In this respect, there is an opportunity to align a new ACT mental health outcomes framework with the considerable work already undertaken to establish the ACT Wellbeing Framework and its 12 key domains (see Figure 1 below).

Figure 1

Given the interrelationship between mental health and people's perception of their wellbeing, the Wellbeing Framework already includes an undertaking to conduct a self-rated survey of the Canberra community, designed to measure the proportion of persons who rate their mental health as either very good or excellent. This indicator will also report on levels of psychological distress in the community.

There is an important opportunity now to develop the ACT Mental Health Outcomes Framework as a more detailed 'lens' that focuses the Wellbeing Framework on the issue of mental health specifically. This kind of lens has already been developed by the

ACT Community Services Directorate for the Wellbeing Framework, in relation young people. The first release of the Children and Young People Lens has 49 measures using data from ACT and national sources, across 11 of the 12 domains of wellbeing show in Figure 1.

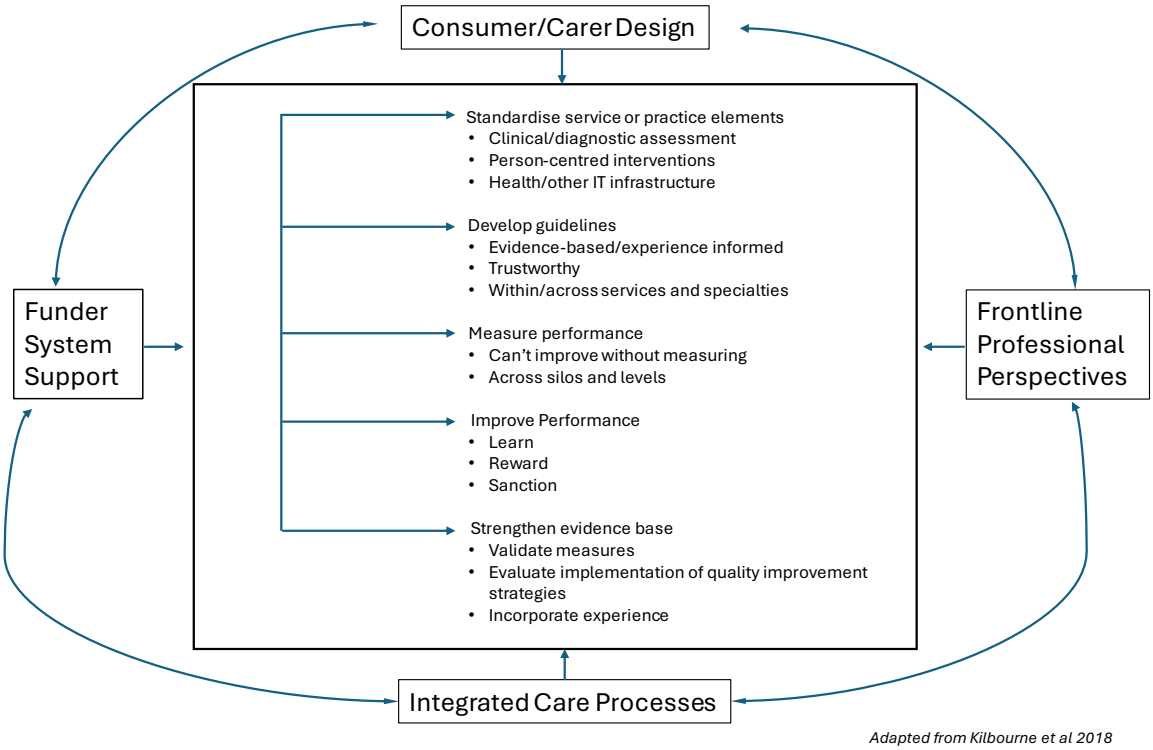
This mental health 'lens' could then underpin the outcomes described as part of the forthcoming Territory-wide Mental Health Strategic Plan, bringing together mental health services provided by the ACT Government, as well as other key players, such as the Capital Health Network, the community sector and others.

Improving the quality of mental health care is a team sport[a]

Figure 2 below shows how key players in mental health care need to work together and the key tasks to build and maintain an effective system of outcomes and quality improvement. While people's mental health journeys may be individual, there are still good reasons to establish standards in practice to deliver person-centred care, supported by good IT infrastructure to enable reporting and monitoring.

Standards and guidelines can also help demystify mental health care, making it clearer what people should expect, from whom and with what expected outcome.

Figure 2



Adapted from Kilbourne et al 2018

[a] Kilbourne et al 2018

Measuring and reporting is vital to drive improvement. Data arising from this process can stimulate learning, change, reward or, potentially, sanction. The application of activity-based funding to mental health care offers an opportunity to consider how best to link rewards and sanctions to mental health outcomes.

Towards a portfolio of validated measures

The ACT already collects a lot of data about mental health but there are few links between this data and identifiable processes of quality improvement. There is no need to finalise a complete approach to the outcomes framework immediately. A staged approach is practical, building up a portfolio of validated measures over time, increasing the utility of reporting. This will require resources – reporting and IT systems are not free. There are some parts of our mental health system that do not currently enjoy good reporting systems, particularly in the community sector. We can prioritise investment here to build the necessary reporting capacity.

A list of possible outcome measures is provided here, at Appendix A, split into the 12 domains of the Wellbeing Framework. This list is a mixture of data collected already in the ACT or elsewhere. Some measures require further development of indicators and collection processes.

Consumer and carer reported outcomes

Several of the measures listed at Appendix A lend themselves to consumer and carer reporting. This is an emerging field, supported by new technologies, enabling the gathering of real time data on the experience of care and broader wellbeing of people with a mental illness and their loved ones.

It is possible to imagine a new reporting hub, with consumer and carers, supported by appropriate IT, trained in data collection, analysis and reporting. This places them at the centre of the quality improvement process, while at the same time avoiding placing additional reporting burdens on already overloaded staff.

A start here would be for consumers and carers to review the Your Experience of Service (YES) survey to assess its suitability.

Next steps

We need to understand what data is already available and the extent to which it fits our needs. A stocktake of existing mental health data collection and reporting would address this and identify gaps. Gaps in data collection from community mental health services are likely to be significant.

We need to more clearly understand what the Canberra community needs to know

in order to have confidence in its mental health system.

We also need to understand what consumers and carers want to know about the system they use and the effectiveness of the care provided.

Many of the measures listed in Appendix A relate to different aspects of professional care. There is an urgent requirement to make sure that the measures chosen are identified and agreed by providers as being of genuine use to them, revealing important aspects of the nature of their work. We cannot

afford to collect data that is not useful. Providers need to be engaged in this selection process if an outcomes framework has a chance of influencing change.

Finally, key funders in the ACT mental health system need to ensure or promote a level of consistency between emerging reporting required under any new outcomes framework and their existing reporting obligations, to central agencies, under existing reporting agreements etc.

Conclusion

Developing an outcomes framework for mental health that meets the needs of different stakeholders is challenging. The good news is that many of these measures are already collected or available in some manner. Others can be developed over time.

The development of a Territory-wide Strategic Plan for mental health, engaging all the key players, represents a major opportunity to make progress now. Nesting this work as a 'lens' over the existing ACT Wellbeing Framework would embed accountability for mental health as part of the routine reporting obligations of governments and agencies going forward.

More than 30 years have passed since Australia's first commitments to accountability for mental health were made. Nobody is expecting a perfect performance enhancement system to emerge swiftly. But that doesn't mean we can't start.

Appendix A: Example measures by wellbeing domain

Health domain

- Suicide
- High psychological distress in adults and secondary students
- Medicare expenditure on mental health-specific services per person
- Mental health-related expenditure as a proportion of Government health expenditure
- Death rates (and causes of death) at 3 months and 12 months after discharge from a mental health facility
- Use of tobacco, alcohol and other drugs
- Health professionals listened and showed respect
- Hospital avoidance
- Full-time equivalent staff employed in specialised mental health services by service setting (including the community sector)
- Use of Medicare-funded mental health services
- Use of mental health medications
- Mental health-related emergency department presentations
- Access to treating doctor or psychiatrist
- People diverted from custody into community-based treatment
- Waited longer than acceptable for an appointment with a health professional
- Delayed or forgone health care due to cost
- Use of community mental health care services
- Residential mental health service beds
- Community Treatment Orders
- Mental health readmission
- Seclusion
- Restraint
- Expenditure on community-based specialised mental health services
- Expenditure on specialised mental health services
- Expenditure on specialised mental health services per person
- Change in a person's clinical outcomes
- Safety and fairness of service
- Overall experience of service
- Service made a difference
- Emergency department presentations seen on time
- People experience coordinated and integrated service responses
- Post-discharge community mental health care
- Coordination of care by health professionals
- Proportion of people with psychosis seen by a community-based mental health professional within 7 days after discharge from a mental health facility
- Service provided advice about physical health care
- GP visits
- Intentional self-harm hospitalisation

- Long-term health conditions for people with a mental illness
- Accredited General Practitioner Mental Health Treatment Plan
- People with a mental health diagnosis who are overweight or obese
- Family and carer involvement in treatment and care
- Mental health consumer and carer peer workers
- Children developmentally on track
- Children in out of home care
- Parental mental health
- Parental substance misuse
- Supporting children in statutory protection
- An increase in carers' personal wellbeing scores over time, with a score closer to that of non-carers
- A 10% decrease in carers reporting uncertainty about how to best support the person/people they care for
- Respectfulness of service
- A 5% increase in the number of carers who report feeling confident in having a say and being heard
- A 20% increase in the number of carers reporting inclusion, respect, and communication with mental health services.

Safety domain

- PACER team callouts
- Experiences of violence
- People feeling safe
- Number of apprehensions by apprehending professional
- Involuntary detentions authorised for up to 3 days
- Revocation of ED3 without further orders being made
- Extensions of involuntary detention (ED11) granted by ACAT
- Psychiatric Treatment Orders (PTOs) made by ACAT 6
- PTOs revoked by ACAT after a hearing
- Contravention of PTO
- Restriction orders made by ACAT together with a PTO
- Electro convulsive therapy
- Interstate transfers

Living standards domain

- Average life satisfaction
- Disability support payment recipients with psychological/psychiatric primary medical condition by earnings
- People with mental illness experiencing poverty
- People returning to work following an episode of mental illness

Housing and home domain

- Marginal housing
- Access to emergency housing

- Having a safe and secure place to live - homelessness
- Housing stress
- Use of specialist homelessness services

Environment and climate domain

- Access to green spaces by people with a mental illness
- Mental health included in government policies about climate change.

Social connection domain

- Loneliness
- Feeling part of the local community
- Full participation and inclusion as a citizen
- Social contact with friends and family
- Social and community group participation
- Access to peer support.

Education and lifelong learning domain

- Children enrolled in more than 600 hours of pre-school education
- Students who report having a positive sense of belonging
- Students who report positive peer relationships
- High school completion
- Students engaged in school sport or extra-curricular activities
- Students experiencing bullying at school
- Secondary students with high, medium or low levels of optimism.

Time domain

- Waiting time for access to mental health care – hospital-based services
- A 7% increase in mental health carers reporting high quality use of personal time, bridging the gap between carers and non-carers.
- Waiting time for admission to a supported mental health place in the community
- Waiting time for admission to a supported drug and alcohol place in the community
- Waiting time for mental health emergency community support.

Identity and belonging domain

- Aboriginal and Torres Strait Islander students who report positive responses to Aboriginal culture
- Kinship identification in Aboriginal and Torres Strait Islander people
- Family, carers and kinship groups are included and supported
- Strong and supportive communities
- General trust in others
- Living free from stigma and discrimination
- Disability-based discrimination due to psychosocial disability
- Support person's (carers) experiences of stigma and discrimination

- Unfair treatment by type of mental health issue
- Unfair treatment in public life domains
- Anticipated experience of stigma

Governance and institutions domain

- Embedded lived experience
- Formal consumer participation arrangements
- Carers taken into consideration & involved with decisions affecting consumers

Access and connectivity domain

- People with a mental illness with poor internet access.

Economy domain

- Labour force participation
- Young adults engaged in/disengaged from employment, education or training.

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