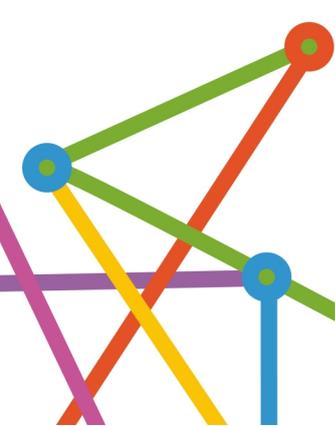


Mental Health Inquiry Submission

WA Primary Health Alliance submission to the Productivity Commission
Inquiry into The Social and Economic Benefits of Improving Mental Health



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22 January 2020



WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH,
COUNTRY WA
An Australian Government Initiative

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1. Executive Summary

The WA Primary Health Alliance (WAPHA) welcomes the Productivity Commission's thorough analysis and rationale for significant structural reform of Australia's mental health system. The fragmented nature of funding and service provision has been highlighted in numerous reports at both a State and National level, consistently putting a spotlight on the difficulties consumers and carers experience when trying to access care. While WAPHA is encouraged that the Productivity Commission is promoting the continuation of a stepped care model within its call for reform, we believe there are caveats to the Commission's options for transformation – ie, the *Renovate* and *Rebuild* models.

In general, we believe it is unfair to expect PHNs to assume collective responsibility for program-level efficiency and effectiveness when this is not built into either the program structure or guidance materials provided by the Department of Health. To optimise value we know, individually and collectively, that we need to reduce unwarranted variation (ie, variation not explained by need or patient preference). However, current operational arrangements and delegations do not enable us to address this in any meaningful sense. The absence of a formal accountability framework that permits PHN organisations to share and compare information on value - performance and outcomes - is a weakness of the current program structure and should be addressed irrespective of whichever reform model is favoured.

WAPHA is proposing a third option for the Productivity Commission to consider. This option has similarities with the proposed *Renovate* model but differs in that it leverages the unique commissioning structures that exist in Western Australia. The proposed option is intended to facilitate strategic leadership in addressing the many problems people with lived experience of mental illness or suicidal behaviour, and their carers and families, currently face. These include fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision.

We call this option the **Repurpose** model, which comprises:

- A State/Territory PHN commissioning body that oversees the operational activities and strategic commissioning functions of all regional PHNs within the State/Territory (WAPHA)
- A State/Territory Mental Health Commission that is responsible for planning, strategy and purchasing of state-based mental health services (WA Mental Health Commission)
- Development of an overarching COAG agreement between the States/Territories and Commonwealth that clearly defines the roles, responsibilities, and funding models for the two bodies, including the parameters of integrated regional planning and co-commissioning (*National Mental Health and Suicide Prevention Agreement*).

Adoption of the **Repurpose** model would enable regional needs and alliances to be developed and attended to across the stepped care continuum, by ensuring that primary care and those experiencing mild-moderate mental health issues are not overshadowed by the focus of State-funded agencies toward individuals with severe and acute presentations. The **Repurpose** model would provide the architecture, authority and levers to enable joint regional planning for integrated mental health and suicide prevention services, as required under a key priority of the Fifth National Mental Health and Suicide Prevention Plan and would extend to authorising pooled funding arrangements between the two commissioning bodies. The **Repurpose** model would also incorporate key performance indicators (KPIs) for both parties to ensure they work in partnership with shared accountability for outcomes. The **Repurpose** model has alignment to the long-term system wide reforms required under the 2020 -2025 National Health Agreement.

We thank the Productivity Commission for the various submission opportunities they have afforded us and appreciate their consideration of this material.

2. About WAPHA

In Western Australia, a unique arrangement exists whereby a single organisation, WA Primary Health Alliance (WAPHA) oversees the commissioning activities of the three Primary Health Networks (PHNs). WAPHA was formed in 2015 to undertake the strategic commissioning and operate the three Western Australian PHNs – Perth North, Perth South and Country WA.

The boundaries of the Western Australian PHNs are generally aligned geographically with Local Hospital Network (LHNs) in Western Australia, referred to in WA as Health Service Providers (HSPs).



Table 1: PHNs alignment with LHNs in Western Australia

PHN	LHN / HSPs
<ul style="list-style-type: none"> Perth South PHN 	<ul style="list-style-type: none"> South Metropolitan HSP East Metropolitan HSP (part) Child and Adolescent Health Service
<ul style="list-style-type: none"> Perth North PHN 	<ul style="list-style-type: none"> North Metropolitan HSP East Metropolitan HSP (part) Child and Adolescent Health Service
<ul style="list-style-type: none"> Country WA PHN 	<ul style="list-style-type: none"> WA Country Health Service Child and Adolescent Health Service

WAPHA is committed to building the capacity of the primary care sector to contribute to the health and well-being of Western Australians, and to working in partnership across the spectrum of community, primary and acute services. From the outset, WAPHA has been clear that its vision is to achieve improved health equity in the Western Australian community.

Equity can be measured in several ways, but recognising the role of PHNs, it is taken to refer to a conscious effort to allocate resources to those communities and individuals:

- With demonstrably poorer health outcomes compared to the experience of Western Australians as a whole; and
- Who experience disadvantage as a result of poor access to health and social care services

compared to the rest of the community.

Through its needs assessment, and work to identify where there are unnecessary hospitalisations for diseases and conditions that can be effectively managed in primary care, WAPHA is building its capacity to target resources to where they can have the biggest impact on improving equity of access to care.

WAPHA's expenditure on services and programs has grown from \$40 million in 2015/16 to more than \$100 million in 2018/19. Approximately 50% of our program expenditure is on mental health services, with a further 13% targeting alcohol and other drug treatment.¹

3. WAPHA Presentation to the Inquiry, November 2019

On 21 November 2019, Ms Learne Durrington, WAPHA Chief Executive Officer, provided a verbal presentation to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health (Inquiry).² This followed the release of the Draft Report of the Inquiry, in October 2019.³ During the presentation, Ms Durrington indicated WAPHA's agreement with many of the findings of the Draft Report, including the need for:

- structural reform of the mental health system;
- a balanced service mix across the continuum of care;
- well-coordinated and transparent regional commissioning;
- more equitable arrangements regarding the Better Access program;
- increased service access and workforce enablers in rural and remote regions; and
- greater sector wide emphasis on co-occurring physical and mental health issues.

4. Submission Overview

WAPHA acknowledges the Productivity Commission's focus on restructuring the Australian mental health system, as outlined in the Draft Report. WAPHA broadly supports the major reform initiatives recommended, aimed at bringing together state and federal funding across services within a stepped care model.

This submission provides additional information in response to the Draft Report, with specific focus on *Information Request 23.1 – Architecture of the Future Mental Health System* (p. 952).³

The Productivity Commission also requested further information from WAPHA during the Perth Public Hearing into Mental Health, offering three questions on notice:²

- More detail on the development of robust intake and assessment processes through GPs in particular, and the ability to link up with Medicare Benefit Schedule (MBS) and non-government organisation (NGO) services.
- Accessibility of the PORTS service – with reference to issues of poverty and limited phone access, particularly in regional and remote areas; and
- Filling the gaps in the rural and regional workforce.

These three items on notice are addressed in the annexure.

¹ WA Primary Health Alliance. *Commissioning for Better Health*. April 2019.

² Productivity Commission. Public Hearing Into Mental Health – Transcript of Proceedings, 21 November 2019, Perth.

³ Productivity Commission 2019, Mental Health, Draft Report, Canberra.

5. Western Australian Context

In Western Australia, people experiencing mental health issues have access to services provided by health care professionals in several care settings. Both the Australian and State Governments have developed mental health programs and services to address the mental health needs of Western Australians. Commonwealth funded mental health services are primarily delivered through Medicare-subsidised services (including the Better Access Initiative), the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme for subsidised mental health prescriptions, veterans' mental health services, Primary Health Networks (PHNs), and social welfare payments (eg, Disability Support Pension).⁴

State-funded services

The Western Australian State government funds approximately 60% of the State's mental health services, with the bulk of this expenditure spent on the operation of public hospitals (47%) and community mental health services (43%),⁵ while private health insurance funds contribute a further 5% to the service mix.⁴

Recent changes to the governance of the WA public health sector was initiated by the enactment of the *Health Services Act 2016*, with the intention of *providing a modern legal framework for clear roles, responsibilities and accountabilities at all levels of the system and a devolved model of governance that will enable decision-making closer to service delivery and patient care*.⁶ The WA Department of Health, led by the Director General, has been established as the System Manager responsible for the overall management, performance and strategic direction of WA Health, while HSPs have been established as health service providers that are separate, board-governed statutory authorities, legally responsible and accountable for the delivery of health services for their local areas and communities. The five HSPs comprise – the Child & Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, and the WA Country Health Service. The *Health Services Act 2016* provides a framework for the purchasing of mental health, alcohol and other drug (AOD) services by the state Mental Health Commission from the WA public health system.

The WA Mental Health Commission (WA MHC) purchases all state-funded public health mental services in WA. The WA MHC has articulated its overall intentions concerning service, transformation and expansion of state-funded mental health and AOD services in *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (the Plan).⁷ The outline of the optimal service mix and level of services in the Plan relates only to the small proportion of Western Australian population estimated to experience severe mental illness and or AOD services in hospital, other bed-based, and specialised community/ambulatory services. In 2018-19, 78% of the WA MHC's \$917.8 million expenditure across the Plan's five identified service streams – Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services and Hospital-Based Services – was provided through bilateral funding contracts to HSPs for the delivery of specialised mental health services in the public health system.⁸

⁴ Department of Parliamentary Services (2019). Mental health in Australia: a quick guide. RESEARCH PAPER SERIES, 2018–19. Commonwealth of Australia, Canberra.

⁵ Office of the Auditor General Western Australia (2019). Access to State-Managed Adult Mental Health Services. Perth.

⁶ Government of Western Australia (2016). Health Reform Fact Sheet: *The Health Services Act 2016: A Snapshot*. Department of Health, Perth.

⁷ Mental Health Commission WA (2015). Better Choices, Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025. Perth.

⁸ Government of Western Australia (2019). Mental Health Commission: Annual Report 2018-19. Perth.

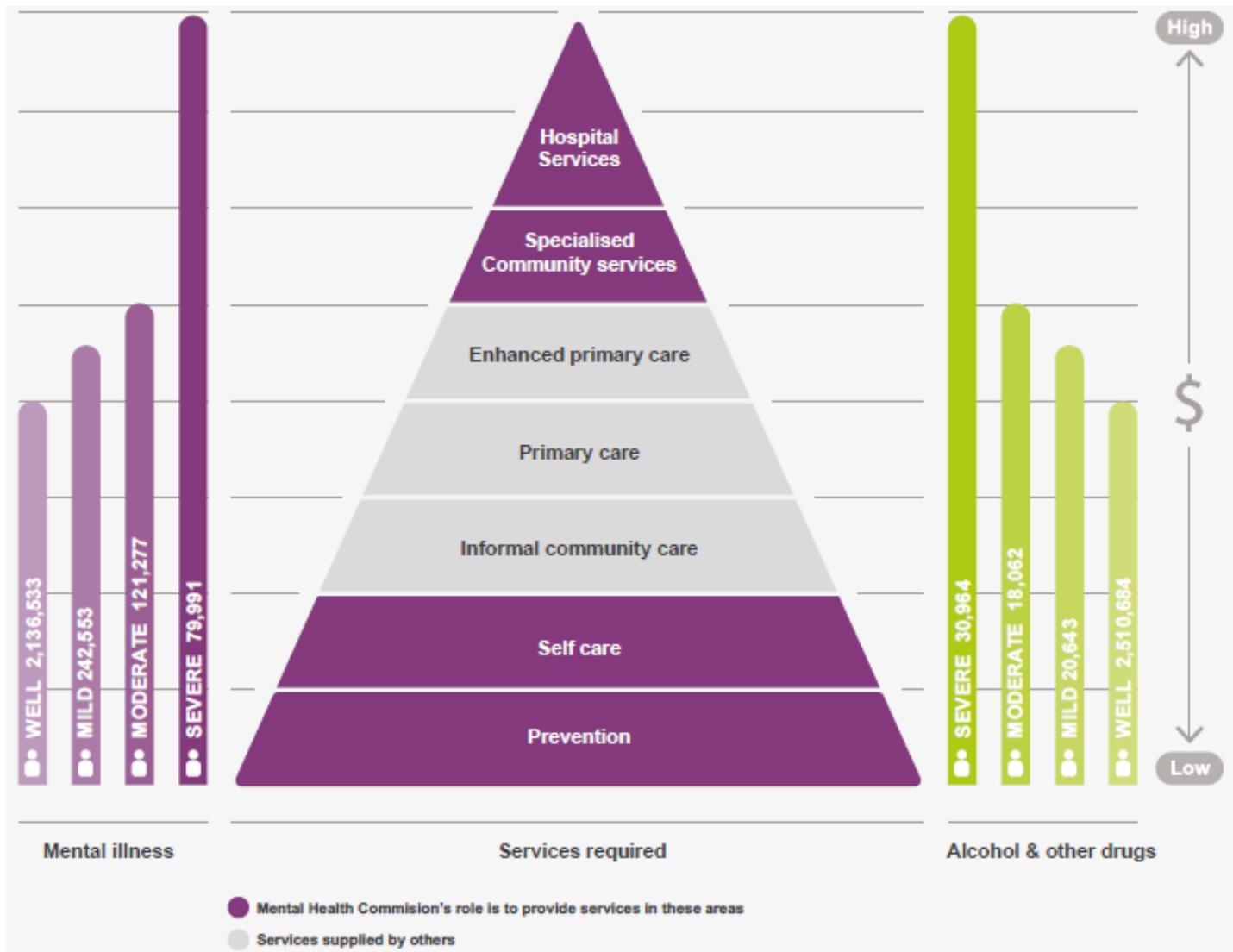


Figure 1: *Estimated number of the Western Australian population affected by mental health and AOD issues and focus of WA MHC funding*⁸

Aboriginal Community Controlled Health Services

Aboriginal Community Controlled Health Services (ACCHS) provide dedicated primary care services for Aboriginal people. ACCHSs are directly funded by the Australian Government for the provision of these services. In Western Australia, there are 22 ACCHSs, part of a national network of 144 such services across Australia. The Aboriginal Health Council of Western Australia (AHCWA) provides a range of advocacy, governance support, and service support functions for ACCHSs across the State.

A formal partnership between WAPHA, AHCWA and the ACCHS sector promotes understanding and collaboration between the two main Australian Government funding streams for primary care support in Western Australia. This conjoint commitment is reflected in the Memorandum of Understanding agreed by WAPHA and AHCWA, setting out guiding principles for working together in the interests of all Aboriginal Western Australians.

6. Repurpose model

Within Volume 2 of the Productivity Commission's Draft Report – Chapter 23 (*Federal roles and responsibilities*)³ – two options for reform have been proposed:

1. **Renovate model** – largely continues the path of recent policy direction within the mental healthcare sector by embracing current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs), albeit with better defined roles and responsibilities within a Council of Australian Governments National Mental Health and Suicide Prevention Agreement.
2. **Rebuild model** – under which State and Territory Governments establish Regional Commissioning Authorities that take on the mental health responsibilities of PHNs, commission mental healthcare from Local Hospital Networks, and commission psychosocial and carer supports outside of the National Disability Insurance Scheme.

WAPHA acknowledges the Productivity Commission's rationale for significant structural reform of Australia's mental health system, to ensure that services best meet the needs of consumers and carers. Similar concerns have recently been voiced within the WA Department of Health's *Sustainable Health Review* (SHR), which noted "the whole system requires sustained, holistic and transformational reform."⁹ Matters of concern consistently reinforced for the SHR Panel through their mental health consultations involved:

- A person's journey in the mental health system is often disconnected;
- Available services are often not visible or accessible;
- People are not treated for their physical symptoms and mental health concerns holistically; and
- The mental health system in WA is convoluted, with multiple providers at a Commonwealth, State and local level. This system is funding-centred, rather than people-centred, and the needs of the people have been lost in these confusing arrangements.

The Productivity Commission has indicated that the *Rebuild* model is the preferred choice for system reform, with State and Territory Governments responsible for establishing new Regional Commissioning Authorities (RCAs) that would subsume PHNs' mental health commissioning responsibilities, as well as commissioning mental health services from LHNs, utilising pooled Federal and State funding.³ The Productivity Commission has indicated that giving this role to State and Territory Governments aligns with the States/Territories' responsibility for the provision of mental health treatment services and, both within the Draft Report and during the Perth Public Hearing,² offered the WA MHC as an example of a State-based RCA.

WAPHA is encouraged that the Productivity Commission is promoting the continuation of a stepped care model within its call for reform, however we believe that the favoured *Rebuild* model poses a risk for primary care mental health, particularly for individuals experiencing mild-moderate mental illness. We highlight these risks below and suggest that the Productivity Commission consider an alternative approach based on the current Western Australian context (ie, WAPHA and the WA MHC), which we believe is transferrable on a national basis.

This proposed option is intended to facilitate strategic leadership in addressing the many problems people with lived experience of mental illness or suicidal behaviour, and their carers and families, currently face. These include fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision.

We call this option the **Repurpose** model, which comprises:

- A State/Territory PHN commissioning body that oversees the operational activities and strategic commissioning functions of all regional PHNs within the State/Territory (WAPHA);

⁹ Department of Health, Western Australia (2019). *Sustainable Health Review: Final Report to the Western Australian Government*. Perth.

- A State/Territory Mental Health Commission that is responsible for planning, strategy and purchasing of state-based mental health services. (WA MHC); and
- Development of an overarching COAG agreement between the States/Territories and Commonwealth that clearly defines the roles, responsibilities, and funding models for the two bodies, including the parameters of integrated regional planning and co-commissioning (eg, *National Mental Health and Suicide Prevention Agreement*).

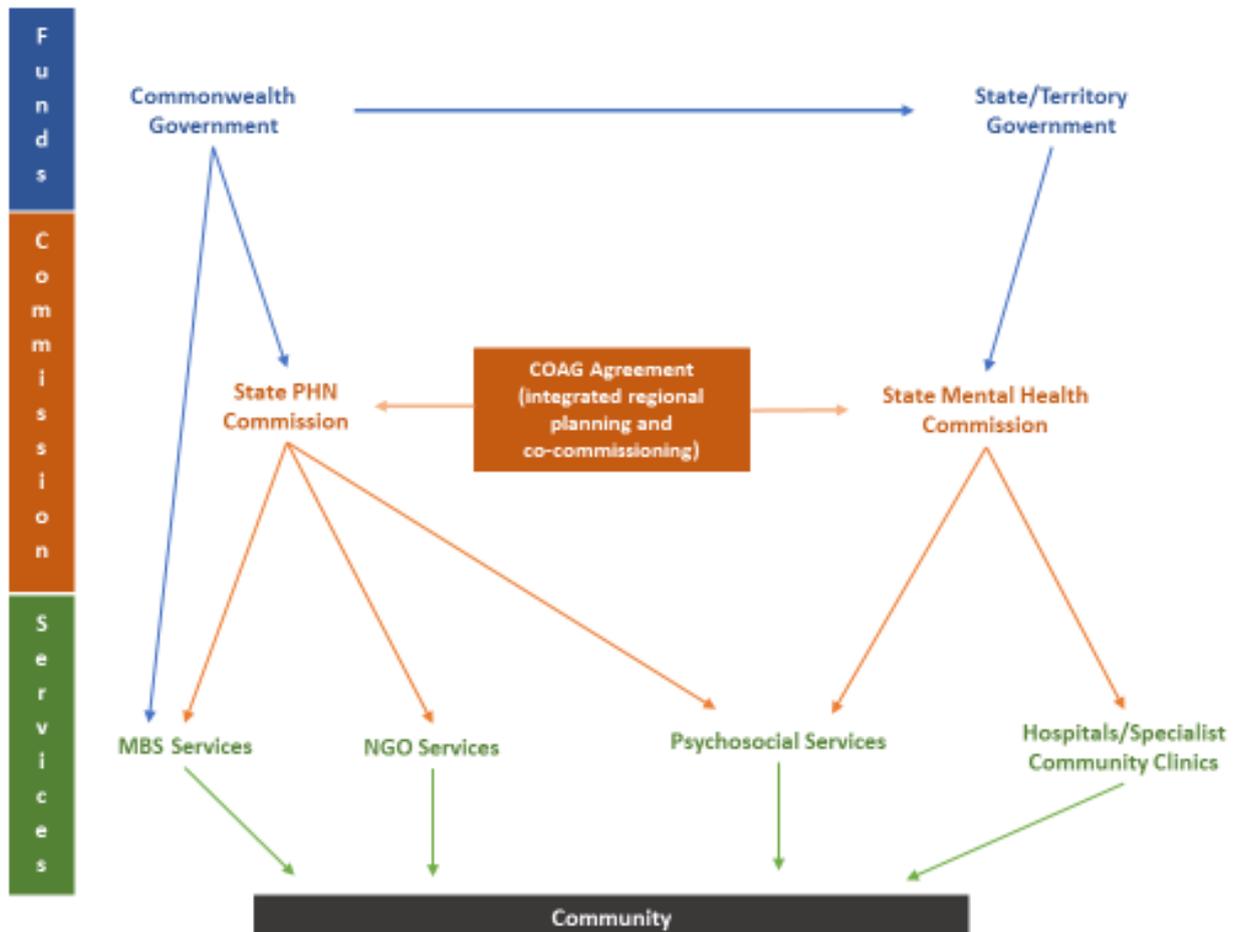


Figure 2: Schematic of the proposed Repurpose model based on the unique commissioning structures in Western Australia.

The **Repurpose** model would provide the architecture, authority and levers to enable joint regional planning for integrated mental health and suicide prevention services across the stepped care continuum, as required under the first priority of the Fifth National Mental Health and Suicide Prevention Plan and would extend to authorising pooled funding arrangements between the two commissioning bodies. The **Repurpose** model would also incorporate a whole-of-system measurement framework, extending the National Mental Health Performance Framework 2020¹⁰ to include primary care and incorporate KPIs for both parties to ensure they work in partnership with shared accountability for outcomes. This model also aligns to the four strategic priorities for health system reform identified under the 2020 -2025 National Health Agreement.¹¹

¹⁰ Accessed at: <https://meteor.aihw.gov.au/content/index.phtml/itemId/721188>

¹¹ Accessed at: <https://www.coag.gov.au/sites/default/files/agreements/heads-of-agreement-hospital-funding.pdf>

Rebuild model risks

Almost half of the adult population will experience a mental disorder in their lifetime, 20% in a given year, with anxiety or mood disorder the most commonly experienced.¹² For younger people aged 4 to 17 years, 14% are estimated to have experienced a mental disorder in the previous year, with Attention Deficit Hyperactivity Disorder, Anxiety and Major Depressive Disorders the most frequently reported.¹³

Not everyone experiences these disorders in the same way. For most Australians the most common manifestation is the presence of symptoms that do not meet diagnostic criteria but may interfere with some aspect of their life. This includes individuals in remission who are at risk of relapse without ongoing mental health care, and those with early symptoms at risk of developing a diagnosable disorder. For these individuals, prevention and early intervention through primary care (mainly general practitioners), digital mental health and self-help services are most relevant and primarily funded through the Commonwealth Government.

People with mild and moderate mental illness make up the next most prevalent groups, representing around 9% and 4.6% of the population respectively. These individuals are also predominantly managed in the primary mental health care system, with the bulk of services currently being provided through general practice and the Medicare Better Access initiative.

The smallest proportion of the population is found at the most severe end of the spectrum, accounting for 3.1% of the population, and usually have a diagnosed mental health disorder with significant symptoms and/or problems with functioning across everyday roles. State-based specialist acute and community mental health facilities tend to focus their services on individuals within this group.¹⁴

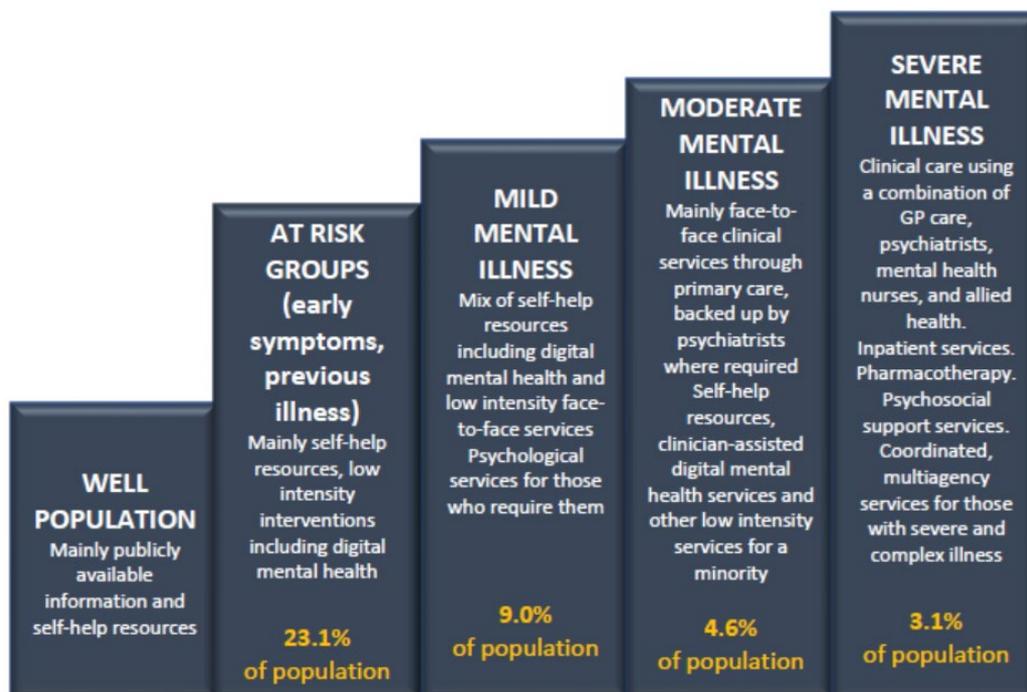


Figure 3: *Prevalence of mental illness and stepped care service requirements.*

¹² Australian Bureau of Statistics (2008). National Survey of Mental Health and Wellbeing 2007: Summary of Results, ABS cat. No. 4326.0. Canberra.

¹³ Lawrence D et al. (2015). The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.

¹⁴ Steering Committee for the Review of Government Service Provision (2018). Report on Government Services 2018. Productivity Commission, Canberra.

For the most part, as individuals move up and down the spectrum of severity, the intensity of service requirements also fluctuate. To address the full range of clinical needs in the population and prevent inefficiencies associated with both under-servicing and over-servicing, a stepped care approach has been recommended as a central focus of system reform.¹⁵

While the bulk of mental health funding is funnelled into State services, the majority of people experiencing mental illness do not come into contact with this intensive level of care. While 435,000 Australians received State-based community mental health care services in 2017-18, 2.5 million people received Medicare-subsidised mental health-specific services during this period, with GPs providing the greatest proportion of these MBS services.¹⁶ Indeed, GPs consistently report psychological issues to be the most common health presentations they manage,¹⁷ and they are the most frequently contacted health professional by those engaging in suicidal behaviour.¹⁸ Given that nearly 90% of Australians see a GP at least once a year,¹⁹ their role in the treatment of mental illness should not be surprising. Despite the prominent role of GPs in the stepped care model, the Productivity Commission is recommending mental health reforms that give commissioning responsibility to a State-based system that often overlooks, and to a large extent operates independently of, primary care.

The risks to the primary care system are evident in the recent Interim Report from the Royal Commission into Victoria's Mental Health System.²⁰ Although acknowledging that the State's mental health system has a heavy focus on inpatient and crisis care, which has led to missed opportunities to intervene earlier in the illness trajectory, the primary recommendation of the Victorian Interim Report is focused on increasing acute mental health beds via a State levy/tax to better service those with severe mental illness. The situation is similar in Western Australia. A recent review of State-managed adult mental health services by the Office of the Auditor General of Western Australia noted that between 2013-2017 a relatively small group of people were consuming the most care. Just 10% of patients utilised 90% of the hospital care provided and almost half of both emergency department (ED) and specialist community treatment services.²¹ Others have identified that WA's public mental health services are inefficient, with taxpayers spending more per person than anywhere else in the country but getting the poorest results. During a recent conference presentation in Perth, ANU's Dr Sebastian Rosenberg indicated that patients in WA have the highest hospital readmission rates in the nation, and the second-lowest amount of outpatient treatment.²² This has resulted in a hospital-centric mental health system that is dominated by a small number of patients, and an overall reduction in care for people accessing community treatment services.²¹

Western Australia is unique among States/Territories by having a state Mental Health Commission that is responsible for planning, strategy and purchasing state-based services from Local Health Networks (LHNs – referred to as HSPs in WA) and NGOs. To guide this work, the WA MHC published the State's 10-year Mental Health and AOD services plan in 2015.⁷ Central to the Plan, which was substantially based on the National Mental Health Service Planning Framework, was an urgent need to expand community mental health services to reduce system-wide dependency on costly hospital beds. However, since the Plan's launch there has been little progress in changing the funding-mix of mental health services, with a subsequent 5% increase in funding for hospital beds, and a corresponding decrease in prevention and community support initiatives despite a 17% increase in the number of

¹⁵ Commonwealth of Australia (2015). Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services. Department of Health, Canberra.

¹⁶ AIHW 2019. Mental health services – in brief 2019. Cat. no. HSE 228. Canberra.

¹⁷ RACGP 2019. General Practice: Health of the Nation 2019. East Melbourne, Victoria.

¹⁸ Pfaff, Acres, Wilson 1999. *The role of general practitioners in parasuicide: A Western Australia perspective*. Archives of Suicide Research;5:207-14.

¹⁹ Department of Health 2018. Annual Medicare statistics - Financial year 1984-85 to 2017-18. Canberra. 2018.

²⁰ State of Victoria 2019. Royal Commission in Victoria's Mental Health System, Interim Report, Parl Paper No. 87.

²¹ Office of the Auditor General Western Australia (2019). Access to State-Managed Adult Mental Health Services. Perth.

²² Rosenberg S. Presentation at the *Western Australian Mental Health Conference 2019*, 19-20 November, Hyatt Perth.

people accessing community treatment services.²¹ Such a situation places pressure on primary care mental health services by limiting access to treatment options when needing to step patients up who require more intensive interventions. Indeed, the Chief Psychiatrist of Western Australia noted in the Forward to his 2017-18 annual report, that *continuity and navigation across services and with primary care remains a challenge*.²³ This is despite a system-wide review of State mental health services in 2012 that highlighted that, *to improve patient continuity of care, close links between the mental health services and GPs are essential*.²⁴

Based on the ongoing focus of State-based commissioning and services toward severe and acute presentations, WAPHA believes that the Productivity Commission's promotion of the *Rebuild* model would be a regressive step for primary care and the implementation of the stepped care model by further limiting resources allocated for those experiencing mild-moderate mental health issues, and eradicating the gains made in this space by PHNs. It would also appear to be a contrary position to that reached by the National Mental Health Commission's 2014 *Review of Mental Health Programmes and Services*,²⁵ which concluded there was an ideal opportunity to build on PHN infrastructure to better target mental health efforts to meet local needs, and strongly supported PHNs acting as the key regional architect for planning and purchasing of mental health programs, services and integrated care pathways.

WA as prototype for a Repurpose model

The health care context differs across Australia, and the evolving roles of PHNs in each State and Territory will be influenced by these differences. The need to provide a strong organising focus around primary care acknowledges the fragmentation in the Australian health, welfare and social care systems. Without strong and coordinated action directed at building pathways and linkages between all services involved in responding to an individual's health and social care needs, people who often have complex care needs are left having to negotiate between different service providers, funding streams and networks of care. The ideal of seamless, person-centred care ultimately requires coordinated action and support for individuals across the full spectrum of their care needs.

WAPHA acknowledges several of the challenges for the PHN program identified by the Productivity Commission within the Draft Report. While PHNs have an important role in increasing access to services where markets are currently not meeting need, we concur with the Commission's opinion that funding mechanisms available to PHNs are limited and insufficient to cover the gap of those missing out on MBS-rebated mental services, while differing mandates, geographic boundaries and funding allocations with LHNs/HSPs can throw up barriers for co-commissioning with PHNs.³ Similar observations have been made by others, with the Grattan Institute similarly reporting that PHNs have limited budgets, authority, and capacity to plan, coordinate and influence the development of primary care.²⁶ We believe that such analyses are influenced by the fragmented nature of PHNs across States, which impacts on the program's economies of scope and scale outside of Western Australia.

PHNs are held collectively responsible for efficiency and effectiveness at a program level, however there is little transparent accountability built into the program or guidance material provided by the Department of Health to PHNs to enable an examination of performance and outcomes to collectively address unwarranted variation (ie, variation not explained by need or patient preference). Unwarranted variation in access, quality, investment, and outcome has significant consequences:

- a. overuse of low or no-value interventions, which wastes scarce resources and harms patients (albeit unintentionally); and

²³ Chief Psychiatrist of WA (2018). *Ensuring safe and high quality mental health care*. Annual Report of the Chief Psychiatrist of Western Australia. Perth.

²⁴ Stokes, B (2012). Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia. Government of Western Australia, Dept of Health and Mental Health Commission, Perth.

²⁵ National Mental Health Commission, 2014: *The National Review of Mental Health Programmes and Services*. Sydney: NMHC.

²⁶ Swerissen H, Duckett S (2018). *Mapping primary care in Australia*. Grattan Institute. Melbourne.

- b. underuse of high-value interventions, which always leads to poor or deleterious outcomes and amplifies rather than attenuates inequity.

These command our attention, individually and collectively, and need to be managed centrally as a responsibility of the Department of Health in the current structure. At a minimum, what is needed are program-level processes to enable PHNs to share and compare information on performance and outcomes with each other and commissioned providers, which are scalable to context and location. The absence or lack of access to such information on the variation in the performance of PHNs in terms of delivering value (allocative, technical and personal) is a significant limitation on the programs capacity to meet its objectives, notwithstanding the efforts of the 28 separate PHN commissioning organisations to achieve these common goals. To address this issue is fundamental to any reform process irrespective of the model implemented.

We have a unique situation in Western Australia with two state-wide commissioning structures in the WA Primary Health Alliance and the WA MHC, which covers the range from prevention through to primary care and specialist services. Each of us shares a vested interest in undertaking joint regional planning to make better use of existing mental health and AOD resources to meet needs, improve the quality of care and sustainability within the WA healthcare system. As WAPHA channels Australian Government funding support for primary mental health and drug and alcohol services in Western Australia, so does the WA MHC for State funding in the community sector.

As expenditure on mental health and drug and alcohol services accounts for two-thirds of WAPHA's total expenditure on services, a high priority is placed on integrated planning and service mapping, joint commissioning of services and the definition of mutual roles and responsibilities between WAPHA and the WA MHC. Mutual recognition between the two commissioning agencies is supported by a Memorandum of Understanding and joint working arrangements on a range of issues, and together with the State's five HSPs we are currently working to develop a foundational blueprint for shared decision making that will lead to localised integrated mental health service delivery, as part of our shared obligations under the Fifth National Mental Health and Suicide Prevention Plan (Priority One – Joint Regional Planning).²⁷ This will cover initiatives from prevention through to the interface with acute care, bringing together primary care and local public health services to achieve a health system that ensures those needing assistance can receive definitive care without delay. To ensure that our work remains consumer focussed, we have ensured that this developmental work is conducted in partnership with WA's peak consumer, carer and sector bodies so they can contribute and provide a level of oversight in the production of the plans. This has included a recent collaborative workshop facilitated by WAPHA and hosted by the WA MHC on 6 December 2019, where many of the participants commented that this was the first time that they had encountered such a gathering within the WA mental health system.

People who access healthcare services need us, as healthcare leaders, funders and providers, to work together to ensure services are connected and well-integrated. No single organisation or branch of government can achieve mental health reform and system transformation on their own, and all stakeholders within the complex mental health and social care system have a role to play. It is only through working together that we will be able to address fragmentation of services and support mental health, AOD and suicide prevention reform priorities at a regional level to achieve more effective, patient-centred care.

As the Productivity Commission aptly noted in its *Integrated Care* supporting paper to the *Shifting the Dial* report,²⁸ *the single most important message is that where there is a higher degree of integration across the primary care and hospital sectors there are larger impacts on the utilisation of health services and on the health of clients; and these larger impacts are achieved at less cost.* Within that paper, PHNs and LHNs have been identified as essential key ingredients to an Australia-wide

²⁷ Department of Health (2017). The Fifth National Mental Health and Suicide Prevention Plan. Canberra: Commonwealth of Australia.

²⁸ Productivity Commission (2017). *Integrated Care, Shifting the Dial: 5 year Productivity Review, Supporting Paper No. 5*, Canberra.

integrated care system, and WAPHA has demonstrated the principles of integrated care in its partnership approach to stewarding mental health reforms in WA. Our work on developing over 500 localised health pathways (including mental health), in collaboration with specialists, GPs and key stakeholders, is helping clinicians easily navigate their patients through the complex primary, community and acute healthcare system. Rebuilding the system, as currently defined by the Productivity Commission, poses a threat to integration by relegating the role of primary care within a specialist, hospital-centric view of healthcare. We believe the foundations of reform are already in place, and that offshoots of integration within the system are occurring organically as current programs and partnerships mature. The **Repurpose** model is a rational progression of this process that can strengthen the PHN program and ensure the gateway and gatekeeper to the mental health system – primary care – remains a prominent element of reform.

Annexure

The Productivity Commission requested further information from WAPHA via three questions on notice during the Perth Public Hearing Into Mental Health:²

1. More detail on the development of robust intake and assessment processes through GPs in particular, and the ability to link up with MBS and NGO services.
2. Accessibility of the PORTS service – with reference to issues of poverty and limited phone access, particularly in regional and remote areas; and
3. Filling the gaps in the rural and regional workforce.

More detail on the development of robust intake and assessment processes through GPs in particular, and the ability to link up with MBS and NGO services.

WAPHA is developing an Initial Assessment and Referral (IAR) service model in line with the recent Commonwealth guidance to PHNs²⁹ that will operate like the PORTS clinic. That is, it will be a single, whole-of-state virtual (i.e. not-location-dependent) clinic for GP referrals that will provide a standardised comprehensive initial assessment, formulation and referral recommendations at the point of entry into care, staffed by experienced and suitably qualified clinicians. The IAR will help GPs and their patients make informed treatment choices to improve the targeting of psychological interventions and treatment supports within an explicit shared decision-making framework. It will also establish the baseline measures for episode-level and full cycle of care outcomes. Referral options will be regulated so that GPs, patients and WAPHA as funder, can be confident that all referral options meet quality standards, with performance and outcomes reporting undertaken within an explicit monitoring and accountability framework. This will provide the necessary governance and accountability for independent MBS funded providers to offer bulk-billed services with standardised and mandated performance and outcome measurements built into the workflow. This will include Better Access Allied Health provision, but also MBS specialist psychiatry assessment where indicated.

The second benefit of having a single intake assessment that covers both clinical complexity and personal context is the recommended treatment offerings can be coordinated at the point of entry within a single multi-accessible care plan. Thus, the referring GP, the patient and the downstream services will be able to have clear line of sight of both what is being provided and progress toward common goals. In addition, this will be designed so it can be uploaded to My Health Record if this is optioned.

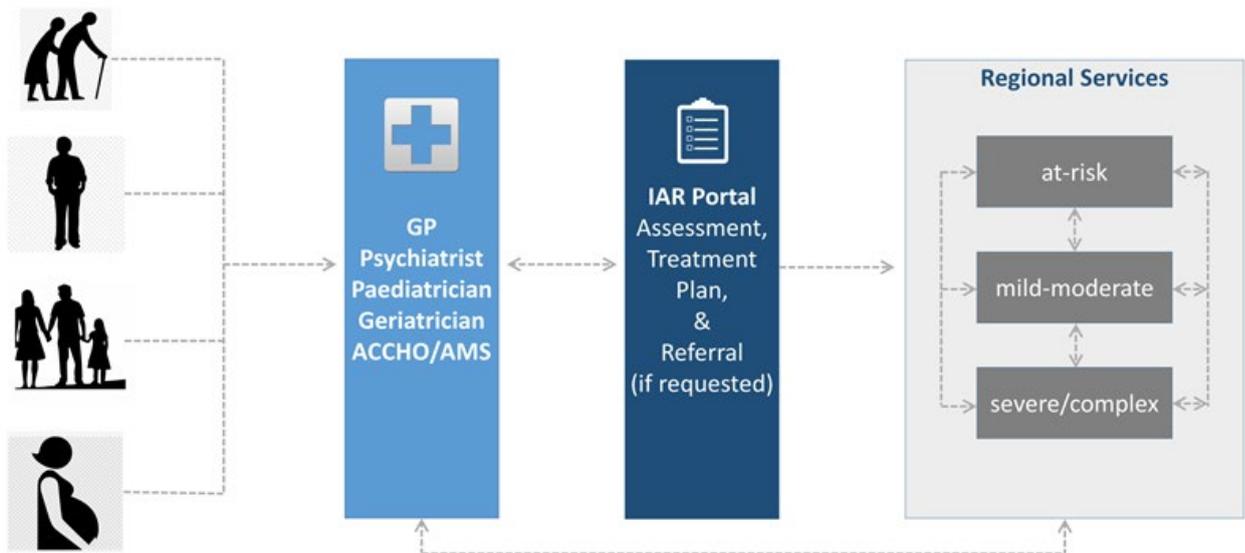


Figure 4: *Pathway to services through the IAR initiative*

We will design and locate our core commissioned services downstream of the IAR gateway with options for direct-referral (including by GPs and self-presentations to NGOs) to ensure legitimate alternative pathways to WAPHA-commissioned care services remain in place.

The IAR is not a one-way gateway from GPs into commissioned services but can also provide a link-back service for patients to their GP. For example, WAPHA currently funds two Emergency Department in-reach services within metropolitan Perth; ALIVE (a suicide indicated secondary-prevention service) (<https://www.360.org.au/Programs/ALIVE>) and Choices (targeting high volume service users)

²⁹ Department of Health (2019). National PHN Guidance – Initial Assessment and Referral for Mental Healthcare. Australian Government, Canberra.

<https://www.ruah.org.au/wp-content/uploads/2018/11/Choices-First-Evaluation-Report-October-2018.pdf>). Both services focus on providing time-limited wrap around support that enables good quality GP-care. Under current arrangements each service develops its own information and communication technology (ICT) architecture and related workflow processes. In the future, the IAR will (i) reduce the need for these types of services to separately develop dedicated specialist clinical resources to undertake transfer of care (ii) reduce the number of “gateway” services, and (iii) utilise a single GP interface; a significant incentive for GPs. Moreover, the common core IAR structures will provide a scalable, broadly distributable and appropriately governed central ICT and clinical infrastructure that can provide brokered access for smaller regional and sub-regional services/providers who lack the capability and capacity to develop a separate stand-alone resource. We see this as an important enabler of local service development and innovation.

In addition, we envisage the IAR clinic offering all patients the option of completing 90-day post treatment outcomes measures, an option only currently available for our PORTS patients, thereby allowing us to better understand and address unwarranted variation (ie, variation in outcomes not explained by need or patient preference).

The IAR offers us an opportunity to ensure all our commissioned mental health services are commensurable and aggregate patient-level performance and outcome data is used for open accountability that is contextual, enabling the equitable comparison of contracted services to optimise value (allocative, technical and individual) and reduce waste.

Accessibility of the PORTS service – with reference to issues of poverty and limited phone access, particularly in regional and remote areas.

PORTS is a GP referred service. It is not a panacea and there are limits on both its reach and suitability, albeit these are far less than traditional office-based face-to-face provision, and we are committed to developing the service to the maximum extent possible. In the current PORTS offering there is the option of using workbooks sent by post with telephone support for patients who do not have access to the internet. Nonetheless the reach of PORTS in its current design extends into all populated regions of the state (see Fig. 5).

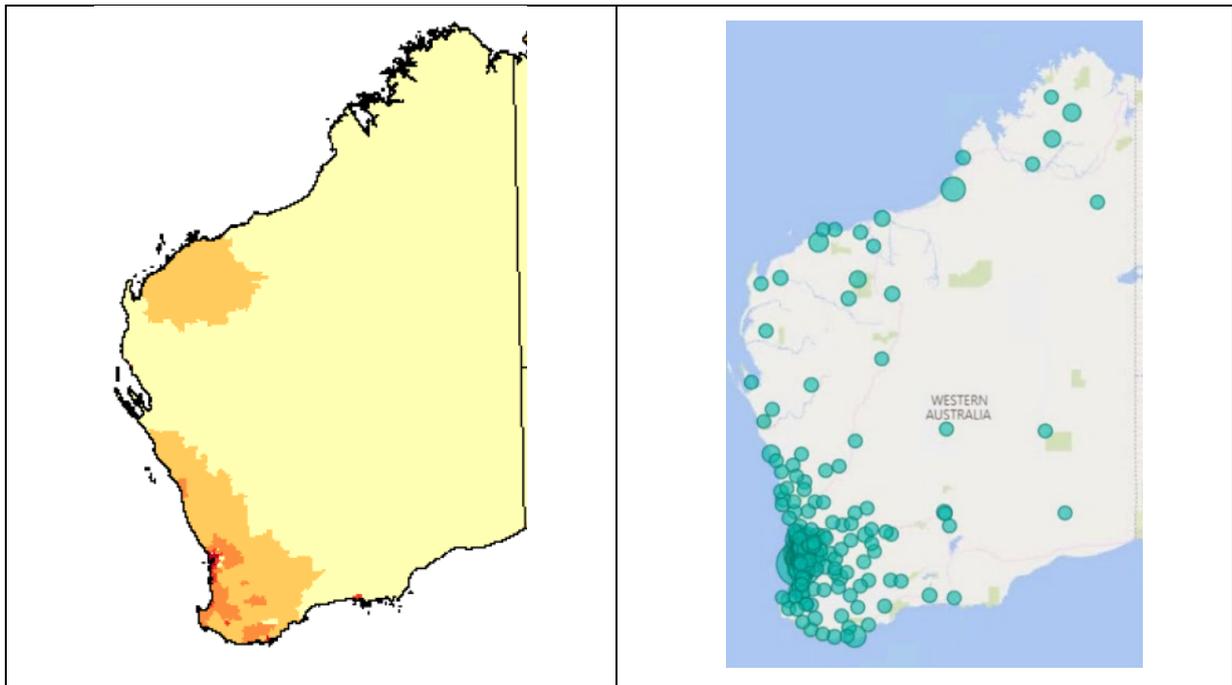


Figure 5: *Western Australia population density by SA2 (June 2018)³⁰ and PORTS service volume by location (July 2017 – Nov 2019).*

There are no current PORTS options that do not require some form of telephony. There are however several innovative approaches under consideration or in development. We are keen to incorporate telehealth video as an option (the information and communication technology capability is under construction), which will extend the scope of activities that can be hosted on the platform. This includes peer-to-peer capability.

In addition, extensive telehealth development has been undertaken by the WA Country Health Service³¹ to extend the technological footprint of their ICT capability, which now covers much of rural and remote WA and offers the possibility of aligned or joint-solutioning.

We are also investigating hybrid models that incorporates PORTS within existing in-situ primary care services. For example, where the patient attends a local clinic (including, for example, RFDS General Practice Health Care clinics) and the PORTS clinician links in via secure video conference. Alternatively, we can see the benefit of providing affiliated practitioners, for example local Aboriginal healthcare workers, with portable tablet devices to enable them to support facilitated access. We trialled an analogous approach at small-scale in Fitzroy Crossing with good results using the current PORTS system. Considerable development work however is needed to build such provision as a

³⁰ Australian Bureau of Statistics (2019). 3218.0 Regional Population Growth, Australia, 2017-18. Canberra.

³¹ <https://www.digitalhealthcrc.com/to-the-moon-and-backdigital-health-makes-giant-steps-for-rural-patients-in-wa/>

mainstay on the PORTS platform to ensure both clinical benefit and safety as well as cost-effectiveness. This requires a view of the service's development that extends beyond the current funding timelines that we operate within. We are committed to the ongoing development of PORTS with MQ Health (<https://www.mqhealth.org.au/>) as a key long-term strategic partner. We believe the PORTS service offers GPs and their patients access to high quality care that would otherwise be unavailable by any other means.

Filling the gaps in the rural and regional workforce.

Rural Health West is the State's rural health workforce agency and is funded by the Australian Government Department of Health and the Government of Western Australia's WA Country Health Service (WACHS) to deliver programs designed to attract, recruit and support medical and health professionals to rural Western Australia. Achievement of this mandate requires strategic partnerships with agencies including WAPHA, WACHS and the UWA Rural Clinical School.

There is a significant gap in the volume of in-situ provision and providers of primary care mental health in regional and remote WA compared to metropolitan areas.³² This is not within WAPHA's remit to resolve. Where we do have a key role is to ensure the service models we develop and commission are designed in a manner that does not create unnecessary dependence on specialist clinical and allied health providers being locally available where such provision is not viable and where virtual provision, such as PORTS, offers a more sustainable solution. There will be locations within WA where it will be essentially impossible for us to offer services. Digital and virtual approaches are important for extending the reach of core primary care services to rural and remote communities. They add capability and capacity to underserved locations, and there are promising hybrid models in development. However, they are not a suitable substitute for all forms of face-to-face service provision and a need for new rural workforce models has been proposed.³³

³² <https://www.aihw.gov.au/reports/health-welfare-expenditure/mbs-gp-and-specialist-attendances-2016-17/contents/summary>

³³ Perkins D et al (2019). *The Orange Declaration on rural and remote mental health*. Australian Journal of Rural Health, 27(5), 374-379.