



An Australian Government Initiative

Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health Primary Health Networks Submission

The Primary Health Networks (PHNs) welcome the opportunity to provide a submission to the Productivity Commission's Inquiry into The Social and Economic Benefits of Improving Mental Health.

Our submission outlines the role of PHNs in identifying and addressing needs of the community, the benefits of the stepped care model, our role and the benefits of better integration of mental health service provision and the investment required in workforce and data.

We have structured our submission under the following headings to align with the questions posed in the Productivity Commission's Issues Paper:

- Structural weaknesses in healthcare
- Specific health concerns
- Health workforce and informal carers
- Child Safety
- Coordination and integration
- Monitoring and reporting outcomes

STRUCTURAL WEAKNESSES IN HEALTHCARE

The Issues paper acknowledges the reforms over the past few years, including the role of PHNs in planning and commissioning primary care in concert with the State and Territory Governments and others. One foundational structural weakness has been the assumption that the Medicare principal of universality is equivalent to proportionate universalism, however it is well understood that this is not the case. Medicare and PHNs can be one step closer by supporting actions/interventions that, when combined, are universal and calibrated proportionally to the level of disadvantage, which is the definition of health equity.

PHNs believe there is further reform required and would like to see an overarching mental health 'architecture', supported by pooled funding arrangements between the states and territories and the Commonwealth. Place-based pooled funding for commissioned services, involving joint priority setting, single contracting tools, and common performance measures is urgently needed as part of any nationally-led reform.

This architecture would contain complete and timely data on mental health needs and services; provide a road map for workforce development; provide better investment in preventative care and early intervention and allow for the social determinants of health to be considered and addressed.

PHNs have a transformative role in the context of the Government's agenda to deliver better health outcomes for Australians. PHNs have formed strong relationships with health care and other service providers and are well placed to provide leadership and to support working with key partners on shared health priority areas to improve equity, access and health outcomes.

PHNs are embedded in their communities and provide support for the community based upon local needs. There is a strong focus on integrating services to improve the way the health system functions at the local level. Poorly integrated or coordinated services can compromise the quality of care for consumers and increase the frequency of avoidable hospitalisations, emergency department visits, and medication errors.

The role of PHNs in commissioning mental health services

PHNs provide integrated, co-designed place based solutions. Right care, right place, right time. Achieving better mental health outcomes for consumers through access to the right care, at the right time in the right place is fundamental to mental health reform and system transformation.

PHNs commission health services that meet the priority needs of the people in their regions to fill identified gaps in primary health care. An example of how PHNs use their regional planning to implement mental health reform action is at **Attachment A**.

PHNs work collaboratively to drive joined up, multi sector reform at the regional level; developing workforce and integrating health services at the local level to create a better experience for patients as they navigate the health system. Funding for PHNs needs to reflect the key role of PHNs as system reformers. Unsynchronised and time constricted contracts undermine PHN ability to build relationships, coordinate, integrate services, drive quality improvement, and effect long term change in the primary care sector.

Taking a holistic view of health including the physical, social, cultural and economic determinants of health acknowledges that mental illness may require a range of different interventions and supportive approaches at different times in the life of the consumer.

An important objective of reform should therefore be the provision of an integrated system that provides effective and efficient mental health services for individuals and families. The provision of more effective and efficient mental health care requires two levels of integration

- **Horizontal integration** within primary care that brings together physical and mental health care along with sectors outside of health such as community services, housing, employment, and education; and
- **Vertical integration** of the primary, secondary and tertiary health services through collaborative partnerships.

PHNs receive and distribute both quarantined funding for specific mental health services and a flexible funding pool for planning, integrating and commissioning other mental health services in each PHN's local community in accordance with the needs of that community. Nationally, in 2018-19, the flexible funding pool represents around 59 per cent of mental health funding to PHNs,

while 32 per cent of funding has been quarantined for youth psychosis and headspace initiatives and 9 per cent has been quarantined for Aboriginal and Torres Strait Islander mental health¹.

Commissioning is undertaken in partnership through co-design with consumers and carers, communities, clinicians and service providers. PHNs commission programmes that generate the best return on investment, with a focus on improving mental health outcomes and high quality service provision. Commissioned activities are planned, delivered, evaluated and evolved based on evidence and insight from its community.

PHNs monitor and evaluate the efficacy and effectiveness of commissioned mental health programmes by managing service provider performance against a specified mental health outcomes framework, demonstrating value for money and supporting continuous improvement processes.

PHNs acknowledge that it is important for consumers and carers to control, lead and participate directly in the decisions that affect them. People with lived experience inform and support PHN commissioned activities and evaluate the quality and efficacy of care provided, and drive best outcomes.

Stepped care model

Mental health services in Australia, particularly those funded through Commonwealth grants or PHN flexible funding, are predominantly commissioned based on the stepped care model of mental health service delivery. The inclusion of the stepped care model at the core of PHN regional planning, funding and commissioning is an important feature in improving quality service delivery.

In a stepped care approach, a person presenting to the mental health care system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least intensive level of intervention to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their requirements.

The role of General Practitioners (GPs) is critical to the stepped care approach as GPs are 'typically the first point of clinical contact for people seeking help for mental health problems and mental illness and are gatekeepers to other service providers. This is variable within rural and remote contexts where it is not always the GP that is the forefront of care delivery, but often that of a Registered Remote Area Nurse or Aboriginal Health Practitioner.

Thirty per cent of Australia's population live in regional, rural and remote areas of Australia where there is a further unmet need for mental health services. As stated in the National Mental Health Commissions Fact Sheet 03 the funding and services are not representative of the population need or of those who live in rural and remote Australia.

PHNs are identifying the gaps within communities to enable stepped care in local regional areas. The stepped care model is 'an evolution and a staged approach', it is therefore important that during the implementation that evidence based and effective services are kept in communities, rather than creating gaps by defunding existing services.

¹ Department of Health, *Submission to the Senate Inquiry into the Accessibility and Quality of Mental Health Services in Mental Health Services in Rural and Remote Australia*, Submission 30, pp. 4–5.

Across the funding continuum, the Australian Government including PHNs address needs of where people with mild-to moderate conditions comprising the majority of the population, while State-funded services provide care for people with severe end of the mental illness spectrum. A significant number of people fall in the middle range of this spectrum, with more complex needs than can generally be effectively managed by GPs and primary health providers but considered not 'severe enough' to be able to access specialist state mental health services. These people suffer combinations of moderate and complex mental illness, drug and alcohol issues, comorbid physical conditions and other social issues and are at risk of falling through the silos and divides of our health system. This group also includes the cohort of people with mental health conditions too complex for primary care but not severe enough to qualify for hospital admission or an NDIS package of care. Victoria's lack of investment in secondary mental health services has resulted in the pulling of resources from PHN procured stepped care services towards the moderate and severe end of the service continuum and in commissioning new services to provide access to secondary advice and consultation from private psychiatrists and mental health nurse practitioners.

A couple of Victorian PHNs are piloting service models that will increase access to psychiatrists. Eastern Melbourne PHN (EMPHN) has commissioned The Melbourne Clinic (a private psychiatric hospital) for psychiatrists to provide specialist support/advice and secondary consultation to GPs and commissioned mental health and AOD service providers. Primary consultation may also be available for complex cases, on a case-by-case basis and clinic-based education to General Practice teams offered. GPHN is currently commissioning a model similar to EMPHN, while WVPHN provides a telehealth service on request with two psychiatrists.

Funding service models to increase access by primary care providers to psychiatrists may address the needs of people in the aforementioned middle range of the mental health needs spectrum, with potential to reduce preventable hospital presentations and admissions, and more importantly, provide integrated and seamless care that is responsive to consumers' changing needs.

It should be acknowledged that a fully operational stepped care model will take time to implement across Australia, and may require flexibility in implementation for certain rural and remote areas. PHNs have found that the workforce requires development to be able to offer a suite of services whilst paying close consideration to what already exists and building on local services, particularly in the mentioned rural and remote context allow for a more equitable geographical distribution of care delivery.

Recommendation:

PHNs recommend the development of a fully integrated system to provide effective and efficient mental health services for individuals and families. This system needs to take a holistic view of health including the physical, social, cultural and economic determinants of health, acknowledging that mental illness may require a range of different interventions and supportive approaches at different times in the life of the consumer.

PHNs recommend further reform that includes an overarching mental health 'architecture', supported by pooled funding arrangements between the states and territories and the Commonwealth to fully support the role of PHNs system integrators.

Funding for PHNs should reflect the key role of PHNs as system reformers. Contracts should support the PHNs ability to build relationships, coordinate, integrate services, drive quality improvement, and effect long term change in the primary care sector.

SPECIFIC HEALTH CONCERNS

The prevalence of mental health issues, and the significant costs they impose on individuals, their families, the community and the economy make it clear that while there has been substantial reform over the past 30 years, further reform is needed.

Nationally, the statistics are well known. One in five Australians in any given year experience mental health issues and almost half the population experience mental health issues at some stage in their lifetime². Additionally many Australians (approximately 240,000) were carers for someone with a mental illness in 2015³.

However, like a lot of health conditions, the burden of disease is not spread evenly through the population. The onset of mental illness is typically around mid-to-late adolescence and Australian youth (18-24 years old) have the highest prevalence of mental illness than any other age group⁴. Suicide is the leading cause of death for people Australians aged 25-44 and second leading cause of death for young people aged 15-24⁵.

In 2007, people who were employed had the lowest prevalence of mental disorders (18.7%). However, the prevalence of mental disorders was similar for unemployed people and those not in the labour force (25.8 and 26.8% respectively). Those not in the labour force cover a broad range of people, including people in caregiving roles not in employment, retired people and those on long-term disability and sickness benefits. The prevalence of mental disorders was 24.9% for those who did not complete school compared to 20.2% for those with school qualifications only, and 19.5% for those with post-school qualifications. The prevalence of 12-month mental disorders was over two and a half times higher (53.6%) in this group compared to the general population (20.0%). People who reported a previous history of incarceration were twice as likely (41.1%) to have had mental disorders in the previous 12 months when compared to the general population (20.0%)⁶.

Mental illness is associated with a higher prevalence of other chronic conditions such as diabetes and cardiovascular disease, alcohol and drug use, homelessness, domestic violence and unemployment, reinforcing the need for broad based interventions and systems thinking. For example, there is clear evidence to indicate that people with a mental illness who experience homelessness have a high rate of service usage, with an annual inpatient expenditure of \$47,425 per person⁷. The 'whole of health approach' need to include strategies and approaches that increase communities' social cohesion and assets, proven to be effective in contributing to a consumer's recovery and ability to lead a healthy, meaningful and fulfilling life.

² Department of Health (2009) *2007 National Survey of Mental Health and Wellbeing Highlights* [http://www.health.gov.au/internet/main/publishing.nsf/Content/A24556C814804A99CA257BF0001CAC45/\\$File/mha2hig.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A24556C814804A99CA257BF0001CAC45/$File/mha2hig.pdf)

³ Mind Australia (2016) *The Economic Value of Informal Mental Health Caring in Australia: Summary Report*, Brisbane: Mind Australia

⁴ Black Dog Institute *The facts and Figures About Mental Health* https://www.blackdoginstitute.org.au/docs/default-source/factsheets/facts_figures.pdf?sfvrsn=8

⁵ Black Dog Institute *The facts and Figures About Mental Health* https://www.blackdoginstitute.org.au/docs/default-source/factsheets/facts_figures.pdf?sfvrsn=8

⁶ Department of Health (2009) *2007 National Survey of Mental Health and Wellbeing – Chapter 2* <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhaust2-toc~mental-pubs-m-mhaust2-2~mental-pubs-m-mhaust2-2-2#lab>

⁷ Bruce, J., McDermott, S., Ramia, I., Bullen, J., and Fisher KR. (2012) *Evaluation of the Housing and Accommodation support Initiative Final Report for NSW Health and Housing NSW*. Sydney: Social Policy

Different social demographics are found in different regions and to varying levels. PHNs Commission health services that meet the needs of the people in their regions to fill identified gaps in primary and mental health care.

Additional to the added complexity of social demographics and social determinants of health is the significant numbers of Aboriginal and Torres Strait Islander people living in rural and remote areas of Australia⁸. The Australian Medical Association have released information indicating almost one third of Indigenous adults have 'high or very high levels of psychological distress'⁹, putting them at nearly three times more likely as non-Indigenous adults to experience distress. Therefore, a fundamental part of mental health reform activities needs to ensure that local services are mapped and thus developed according to need in all areas of the country.

Early identification and intervention for women in the perinatal period is an area requiring greater focus and investment. This can positively impact the ongoing mental health for the mother as well as provide an optimal environment for the infant's brain development and psychological well-being.

An emerging and growing group at risk of mental ill-health is older women who are unemployed, retire without much superannuation, experience separation and divorce and are too young for a pension. This group are increasingly experiencing homelessness with its associated risks for mental health.

Recommendations:

The approach to mental health program definition and funding needs to recognise the complex set of health conditions and comorbidities that are known to be associated with mental illness. Flexibility is needed to enable responses to be tailored to the whole person, and not addressing a person's mental health issues in isolation.

PHNs recommend that an equity lens be applied to the current suite of mental health programs to ensure that disadvantaged population groups are provided with sufficient mental health and other services.

HEALTH WORKFORCE AND INFORMAL CARERS

The mental health workforce operates in silos. Emerging best practice promote integrated services delivery, but funding mechanisms, professional boundaries and reporting mechanisms present a barrier to integrated service delivery, both among clinical services and between clinical and non-clinical services.

The mental health workforce in rural and remote areas experience many challenges including fewer options for referral, lack of specialist services, lack of career opportunities, long hours with on-call requirements, and substandard accommodation. Inadequate remuneration, lack of professional

⁸ AIHW (Australian Institute of Health and Welfare) 2015 *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*

⁹ AMA (Australian Medical Association) 2018 Mental Health – 2018 <https://ama.com.au/position-statement/mental-health-2018> accessed 5th March 2019

development opportunities, loss of anonymity in small communities, lack of opportunities for spouses and children, and professional isolation also contribute to difficulties in the recruitment and retention of experienced professionals. Remote area workforce safety is also of concern, as staff may experience inadequate staffing levels, night calls and violence in the workplace.

General Practice

The Review of Mental Health Programmes and Services highlighted the need to better support the role of general practice through incentives and guidelines which could support a stepped care approach¹⁰. PHNs are working with general practice to upskill and improve confidence in identifying and providing care to people experiencing mental illness. Given general practice is the main “gate way” to primary mental health care the success of Primary mental health services in reaching and treating vulnerable community members is hinged on this workforce.

Aboriginal and Torres Strait Islander representation in the workforce

For Aboriginal and Torres Strait Islander people, strong Aboriginal community-controlled health services are important components of a culturally responsive mental health and social and emotional wellbeing system. Equally, culturally safe mainstream services and service providers are essential to provide culturally appropriate services for Aboriginal people wishing to access them.

Peer workforce

The mental health peer workforce is an important element of the wider mental health workforce and of the multidisciplinary team environment. The peer workforce represents an important evolution in workforce development and governance arrangements need further refinement to ensure proper utilisation of this valuable resource.

Finally, there is also a lack of national level data to monitor and evaluate the growth and effectiveness of the workforce.

Recommendation:

A fully developed and skilled Mental Health workforces is clearly required. PHNs recommend the development of a national data set to support the development of, monitor and evaluate the impact of policies on the mental health workforce.

A strategic response is required to ensure:

- a common understanding of future risks to the mental health workforce, particularly in the primary/community sector
- clear role delineation between different professional groups and skills development in working with mental health clients in an integrated care environment
- professional groups are able to work to their full scope of practice
- the rapid development of additional training and capacity to work with Aboriginal people experiencing mental health issues.

¹⁰ <https://www.mentalhealthcommission.gov.au/media-centre/news/national-review-of-mental-health-programmes-and-services-report-released.aspx>

- upskilling Aboriginal and Torres Strait Islander Health workers
- incentives to new graduates in relevant disciplines to work in rural/remote areas?

CHILD SAFETY

An effective approach to identifying need, is the system wide practice of consistent, timely and quality health assessments that meet the National Clinical Assessment Framework for children and young people in out of home care, with a dedicated health care coordination role working with the child protection system¹¹.

Led by Brisbane South Primary Health Network, Queensland PHNs funded by the Department of Child Safety, Youth and Women are implementing the *Strengthening Health Response to Children and Young People in Care* project in response to the Carmody Inquiry, Recommendation 7.7. The project aims to contribute to improved health outcomes for children in care through increased:

- access, timeliness and quality of health assessments for children in care; and
- integration between Child Safety, families, carer and health care teams

This is achieved through place-based strategies and digital health pathways across Queensland to improve clinical case coordination, integration and knowledge of working with children in care – with a specific focus on Aboriginal and Torres Strait Islander children.

This approach identifies and addresses mental health concerns on entry to the child protection system whilst simultaneously building the capacity of health providers and enabling system level integration between Child Safety, Health and Education sectors as a collaborative approach to the health needs of children and young people in care.

Block funded therapeutic services that meet the local demand to provide intensive trauma-informed psychological interventions for children and young people in the child protection system are the most effective in improving the mental health of people in contact with the child protection system. This overcomes multiple barriers of financial cost, time/session limitations, and skill level of practitioner of existing services.

Recommendation:

Consideration be given in other jurisdictions to funding and implementing a PHN led approach (similar to the Queensland Initiative) working closely with Child Safety and primary care teams to improve timely health assessments for children entering out of home care to identify risks or symptoms of mental ill health (and health more broadly).

PHNs recommend block funding for services for children and young people, particularly for those in the child protection system.

COORDINATION AND INTEGRATION

It is abundantly clear that greater coordination and integration of services around the patient is needed to provide the care that is needed, and to stem the ever increasing demand for acute services. KPMG, in their 2019 report *‘Investing to Save’* found that “Without targeted

¹¹ <https://health.gov.au/internet/main/publishing.nsf/Content/cyp-oohc-framework>

action, the rate of mental health-related emergency department presentations is likely to continue its dogmatic rise into the future¹². As a proportion of all emergency presentations, mental health conditions has risen 20 per cent between 2011-12 and 2016-17¹³.

Emergency Department presentations and hospitalisations are costly, and reducing avoidable presentations has the potential to benefit the patient and reduce costs to governments. A wide range of individuals with mental illness experience avoidable presentations and hospitalisations. The Emergency Department environment is an inappropriate location for the assessment and treatment of many people who present with complex mental health needs. This is evidenced by long lengths of stay in Emergency Department before MH patients are referred to/or are able to access MH services.

It is vitally important that the best intergovernmental governance and financing arrangements to achieve integrated social and mental health policies and services, and long term funding arrangements for them are identified through this inquiry, and implemented.

Funding arrangements

According to the Australian Institute of Health and Welfare, the total amount of national spending on mental health (excluding individual out of pocket expenses) was almost \$9 billion in 2015-16. Of that, about 60 per cent of spending (\$5.4 billion) was by state and territory governments, 35 per cent (\$3.1 billion) by the Commonwealth Government, and the remaining 5 per cent (\$466 million) by private health insurance funds¹⁴.

State and territory governments account for the largest proportion of all mental health spending in Australia. State and territory governments fund and deliver mental health services through:

- public psychiatric hospitals;
- psychiatric units or wards in public hospitals;
- community mental health services;
- residential mental health services; and
- commissioning of non-government organisations to deliver services¹⁵.

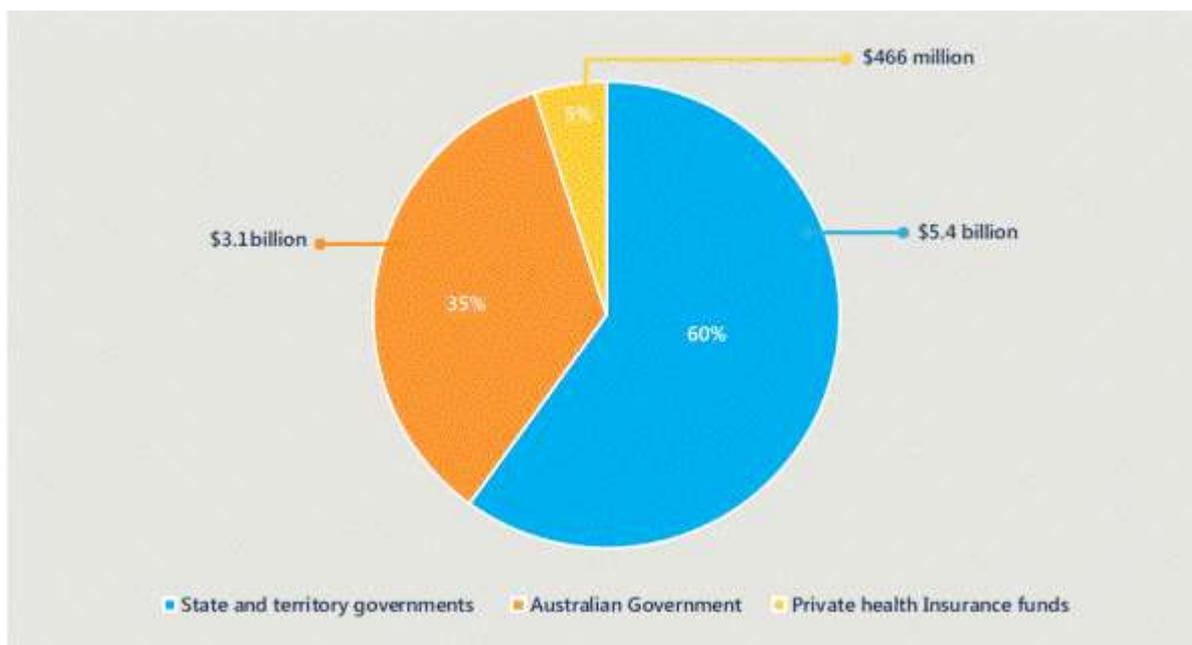
Figure 1—National spending on mental health services 2015-16

¹² KPMG and Mental Health Australia (2019) *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, KPMG and Mental Health Australia <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

¹³ Australian Institute of Health and Welfare (AIHW) *Mental Health Services in Australia: Table services provided in public hospital emergency departments*. 11 October 2018.

¹⁴ Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia: Expenditure on mental health services*, 11 October 2018, <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services> (accessed 25 October 2018). See also: Department of Health, *Submission 30*, p. 3.

¹⁵ AIHW, *Mental health services in Australia: Expenditure on mental health services*, 11 October 2018, <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services>



Aboriginal Community Controlled Health Services (ACCHSs) also play a significant role in providing federally-funded mental health services in rural and remote Australia. ACCHSs are primary health care services initiated and operated by local Aboriginal and Torres Strait Islander communities to deliver comprehensive and culturally-appropriate health care to their communities, and are controlled through a locally-elected board of management.

ACCHSs receive federal funding via the Department of Health and Department of Prime Minister and Cabinet, such as grants for the operation of the service, specific grants for targeted programs (such as child and maternal health), Medicare rebates, and other program funding through PHNs. ACCHSs also receive some grant funding through state and territory programs, for example, in 2017, NSW Health funded 16 ACCHSs for mental health projects in 17 locations¹⁶.

The level of Australian Government spending on mental health-related services, after adjusting for inflation, has increased by an average of 3.5% per year over the 5 years to 2015-16. Medicare-subsidised mental health-specific services increased by an average of 5.7% per capita per year in the 5 years to 2016-17¹⁷. However, the prevalence of mental health appears to have remained stable over time. This either indicates a growing identification of disease, or that the current programs are not having a material reduction in mental health conditions.

The nature of mental illness increases the likelihood that consumers (who engage with the health system) will interact frequently with multiple parts of the healthcare system.

Current funding models predominantly focus on the person's specific episode of care, not on the whole person care and continuing care. Achieving person-centred care requires consideration of the way care is viewed, planned, designed, delivered, arranged, contracted and funded, to encompass the whole person and their continuing care requirements.

¹⁶ NSW Government, *Submission to the Senate Inquiry into Accessibility and Quality of Mental Health Service in Rural and Remote Australia*, Submission 106, p. 13.

¹⁷ Australian Institute of Health and Welfare (2018) *Mental Health Services – In Brief*. Cat. no. HSE 211. Canberra: AIHW.

Commissioning can be utilised to integrate care and promote coordination. However, multiple commissioning organisations have the potential to fragment care and disrupt relationships between services. Multiple commissioners can contribute to system fragmentation when:

- They operate in the same sector but deliver parallel and unaligned initiatives, with different accountability requirements.
- They separate physical and mental health care for people with mental illness given they are inextricably linked.
- The services commissioned are too narrowly defined – allowing gaps to accrue.
- They encourage current partners to compete with each other for contracts.
- They commission based on cost at the expense of quality and outcomes (of which integration is a part).

New initiatives that fail to address the critical issue of system design can further add complexity to an already fragmented system. The Australian Government and some state governments have recently introduced a number of mental health initiatives separately or in parallel that have added complexity to an already fragmented healthcare system. These are the psychosocial support services and youth services in secondary schools as detailed in **Attachment B**.

Investment in prevention, promotion and early intervention

The greatest inefficiencies in the mental health system come from providing acute and crisis response services when prevention and early intervention services would have reduced the need for complex and costly interventions while also supporting people to remain in the community. The social determinants of health are acutely present in people with mental health conditions. Gaining a thorough understanding of the interface between mental health, alcohol and other drugs, housing, education, justice, child safety and employment systems is long overdue. The impact of policies that exacerbate social isolation, stigma and mental health needs should be understood and addressed.

Early intervention provides the best opportunity to reduce longer-term service costs by diverting the individual from factors that exacerbate issues and facilitates them to seek treatment for their mental illness. General practitioners play a key role in early intervention and prevention as the first point of contact for most people seeking assistance for health concerns, whether they are physical or psychological. Prevention and early intervention early in life, early in illness and early in episode across all ages (child, adolescent, aged) is vitally important.

PHNs are constantly told during our consultation work with providers, consumers, carers and community members that navigation of the system is difficult. The overarching architecture requested above should ensure a system is in place that is a one stop shop for information on treatment and services available across Australia. This could be transformative in people's experience in getting care when and where they need it.

Health literacy and the ability to navigate an overly complex system is also a key prevention activity. The World Health Organisation reports that the inability of individuals to find, understand and use information about health and healthcare is associated with poorer overall health outcomes. Poor

health literacy is attributed to an increased risk of adverse health events and higher healthcare costs.

Early in life

Early detection of mental health issues and mental illness (including relapse prevention), followed by appropriate, timely intervention and support can significantly reduce the severity, duration and recurrence of mental illness and its associated social disadvantage, no matter when in life the episode or episodes occur.

The National Mental Health Commission (NMHC) recommends embedding prevention and early intervention initiatives early on in life, through service models that integrate health, mental health, education and other relevant sectors, in the context of a stepped care system. Additional investment is required to provide mental health support in maternal and child health services and primary schools in order to embed prevention and early intervention early in life.

Early in illness

Early detection of mental health issues not only improves clinical outcomes, it also greatly improves the likelihood of completing education and training, opportunities for securing and retaining employment maintaining stable accommodation, and reduces adverse outcomes such as involvement with the corrections and justice system and disconnection from family and community. PHNs' youth initiatives include headspace and community-based services for young people with severe mental illness. However, there is an absence of joint initiatives to support and optimise the development and wellbeing of 0 -12 year old children.

Another identified gap is the difficulty in accessing specialist child and adolescent psychiatric specialists in rural areas who can assist general practitioners and other primary health professionals to provide early identification and intervention of mental health conditions in this cohort.

Early in episode

The early intervention and continuous monitoring of mental illness can maximize a person's chances of a fast recovery, self-sufficiency, and living a high-quality life including the possibility to pursue an education and maintain a stable job.

PHNs' mental health stepped care model provides a suite of mental health services across all ages, including evidence based psychological interventions to children and families. Stepped care services include access to and provision of the following:

- digital mental health services for the 'at risk groups' with early symptoms and/or previous illness;
- low intensity face-face psychological services interventions for people with mild mental illness;
- face-to-face clinical services in a primary care setting with support from psychiatrists as required for people with moderate to severe mental illness with collaboration with secondary and tertiary mental health services.

The range of interventions in the PHN mental health stepped care model is across the continuum of care, supporting consumers to move fluidly as needs and circumstances change, with ongoing reviews to determine whether a step-up or step-down is required. The stepping-up of services

requires an interface with tertiary mental health services and establishing and strengthening this interface with LHNs/HHSs has been challenging for PHNs.

Recommendations:

PHNs recommend increasing funding for early interventions: early in life; early in illness and early in episode. A greater use of funding in prevention in the primary sector will reduce costly acute service provision in the tertiary sector.

PHNs also recommend that government programs are reviewed with a view for outcomes – this review could use the quadruple aim approach to ensure cost, patient and clinician experience are considered. This would provide an assessment for value for money to determine if the large investment in some of these programs is providing a good outcome for clients and the community.

MONITORING AND REPORTING OUTCOMES

There is wide-spread agreement about the need to plan services based on a thorough understanding of regional needs, and strong support for achieving a more person-centred approach. Data and evidence are central to advancing and improving regional mental health planning and mental health reform.

Currently, there is not one set of mental health data from local, state/territory, national and global sources to gain a complete view of regional mental health needs. The creation of this data set will enable more effective policy development, planning and commissioning practices, and this will enable PHNs to target at risk populations and address gaps with a greater level of assurance.

There are rich information datasets at the national and state levels. However, this unfortunately is not consistently the case at regional and local levels, making planning and commissioning processes challenging. PHNs should be able to use regional and local data, including data from primary health care and Aboriginal Community Controlled Health Services as a part of their processes.

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) has committed all governments to work together to achieve regional integration in planning and service delivery for mental health and suicide prevention services. However, there can be a significant lag, sometimes of years, in receiving up-to-date data (e.g. about suspected suicides) and there is a need for improved national data sets for the mental health experience of Australians in general.

In some regions there is varying levels of data available on services provided by other providers, making a needs assessment (gap assessment) problematic. There remains a challenge for PHNs, as regional commissioners, to access relevant regional and local level data, as in some cases, the data does not exist at regional or local level, or is not shared by state and territory authorities, despite the commitment to the Fifth Plan.

Integration of regional data sources remains a barrier to accelerating a comprehensive view of population mental health needs. While there is a Minimum Data Set that applies to PHNs and other providers, its ability to facilitate meaningful comparisons on the outcomes of commissioned programs is limited as the reporting is siloed.

A greater investment in digital solutions for gathering patient data would be beneficial. One example of a digital solution that gathers data from patients in a timely manner is the Black Dog Step Care tool. This tool screens at a population level for anxiety, depression and Alcohol and Other Drug use¹⁸.

There is a need to harmonise data standards and data sets to enable comparable data to be collected by PHNs; include consumer, carer and family measures which can document improvements in care and treatment and increases in the choice of services available; and include this data in annual reporting.

Finally, the impact of the social determinants of health on mental health cannot be understated, however there is no routine linkage of data across health, housing, justice, tax and education or employment. A person who is homeless will be likely to focus on acquiring safe accommodation before addressing their mental health needs, however the impact of housing policies on mental health is difficult to estimate.

Recommendation:

That a complete and linked data set of housing, justice, taxation, education and employment is created and used with a harmonised data set of all mental health service provision across Australia. This data could be used to better target initiatives for clients and the community.

CONCLUSION

Mental health service provision has suffered as a result of constant review, rather than action. This inquiry provides an opportunity to reconsider investment in mental health with a view to improving outcomes.

PHNs recommend that government programs are reviewed with a view for outcomes – this review could use the quadruple aim approach to ensure cost, patient and clinician experience are considered. This would, in particular, provide an assessment for value for money to determine if the large investment in some of these programs is providing a good outcome for clients and the community. The current approach has not seen the sort of outcomes one might expect given the quantum on investment.

PHNs believe further reform of the Mental Health System is required, and would like to see an overarching mental health ‘architecture’, supported by pooled funding arrangements between the states and territories and the Commonwealth.

This architecture would contain complete and timely data on mental health needs and services; provide a road map for workforce development; provide better investment in preventative care and early intervention and allow for the social determinants of health to be considered and addressed.

Overall, a better resourced and less fragmented Mental Health System, will deliver better outcomes for people with mental illness which will enable them to reach their potential in life, and in turn, contribute to the lives of others.

If you have any questions about this submission, please contact Jodette Kotz, Executive Officer, PHN Cooperative, on 02 6287 8041.

¹⁸ <https://www.blackdoginstitute.org.au/clinical-resources/health-professional-resources/stepcare-service>

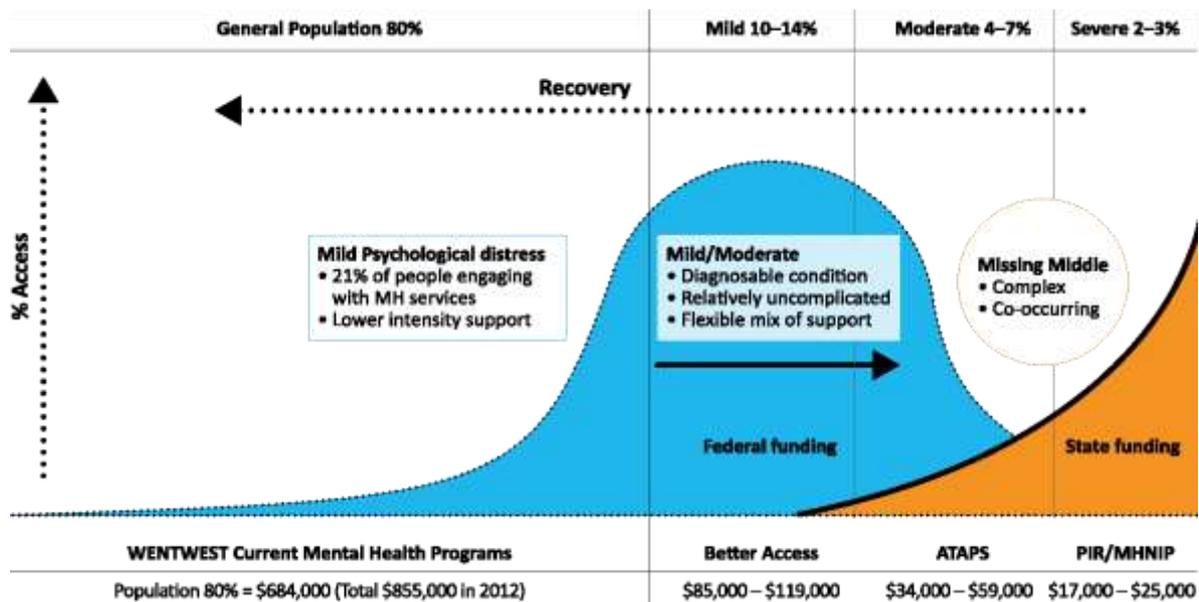
This case study illustrates how one PHN is using their regional needs analysis to implement mental health reform action, especially for vulnerable populations.

Case study: The missing middle and the challenge of primary mental health reform

A key part of recent Australian Government reforms to mental health was to place Primary Health Networks (PHNs) at the forefront of community mental health system design. All PHNs are required to develop a detailed mental health needs assessment. The aim of this is to develop a strong foundation from which to build a tailored response to regional mental health needs.

Western Sydney Primary Health Network (WSPHN) is a PHN based in Blacktown, New South Wales, that has demonstrated a strong interest in pursuing mental health reform. As part of its regional needs analysis, WSPHN considered national and regional trends in mental health expenditure using Medicare data from the Australian Government’s Better Access initiative¹. This analysis showed that the WSPHN is below the average national per capita spending under the Better Access initiative. It also found that the highest use of the initiative is, in fact, in the region’s wealthiest areas, and that the program is not getting to the people who need it most. Emergency department attendances continue to grow and place increased pressure on hospital admissions.

The following diagram shows WSPHN’s conceptualisation of the challenge of mental health reform across a continuum of need based on work undertaken with Synergia.



Looking across the funding continuum, from Australian Government– to state-funded services, WSPHN reports rising access rates for people with mild psychological distress and relatively uncomplicated mild–moderate mental illness. However, access levels are low for the vulnerable populations, who suffer combinations of moderate and complex mental illness, drug and alcohol issues, comorbid physical conditions and other social issues. This group has become known as the ‘missing middle’.

People in the missing middle have more complex needs than generally provided by unidimensional psychological support, yet are not considered ‘severe enough’ for constrained state mental health services. People in the missing middle are at risk of falling through the silos and divides of our health system.

WSPHN's analysis led to their contention that many hospital presentations could be prevented with well organised community mental health care. WHSPN has therefore proposed an alternative approach based on the development of three key tools: person-centred design, use of a general practice-supported stepped care system approach, and shifting funding to more efficient and effective upstream services and supports. WHSPN's mental health strategy aims to increase access to, and address inequalities of, services. To achieve this, they have set specific targets based on the number of general practitioners referring people to the Access to Allied Psychological Services program and the Mental Health Nurse Incentive Program, the response times by providers, and the establishment of financial management systems that allow control and visibility of the cost of service and management of funds.

WSPHN's 'quadruple' aim

WSPHN aims to drive mental health reform in primary care towards a system that meets four aims:

- improve population mental health and physical health outcomes
- better experience of mental health care and support for people
- better satisfaction for clinical partners, especially general practitioners, their practice team and the local network of providers
- improve value for money while meeting the needs of mental health consumer¹⁹.

¹⁹ National Mental Health Commission 2016 Report card <https://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2016-report-card/case-studies.aspx>

PHN Case studies: Psychosocial support services measure and youth services in secondary schools

Psychosocial support services

In the 2017-18 Federal Budget, the Australian Government committed \$80 million over four years for the National Psychosocial Support (NPS) measure to maintain community-based, non-clinical support services outside of the NDIS. All States and Territories have matched this commitment through agreements.

The NPS consists of psychosocial support services for people with severe mental illness who are ineligible for NDIS. The aim of NPS is to provide access to high quality, psychosocial supports that will build people's capacity to daily living, recovery, and social connectedness. The early intervention and continuous monitoring of mental illness can maximize a person's chances of a fast recovery, self-sufficiency, and living a high-quality life including the possibility to pursue and education and maintain a stable job.

The Victorian Department of Health and Human Services (DHHS) and Victorian PHNs have commissioned the psychosocial support services separately and in parallel. This parallel commissioning approach for the same psychosocial services, the same target population (people with severe mental illness not or not yet eligible for NDIS), with largely the same set of service providers had the potential to jointly commission and provide a more integrated and more easily navigable service for these vulnerable group of Victorians.

Youth services in secondary schools

Victorian PHNs commission and work closely with 26 headspace centres and with headspace lead agencies and consortia partners to improve access to care for young people and their families, especially to marginalised groups, notably LGBTQI and Indigenous young people. PHNs also improve the integration of headspace centres with the broader primary mental health care services, physical health services, drug and alcohol services, and social and vocational support services. PHNs are well placed to support the improvement of the headspace platform to recognise prodromal signatures of emerging mental illnesses and reduce the duration of untreated illness.

Two joint initiatives funded by the Victorian Department of Education and Training (DET) and implemented by the six PHNs include:

1. Doctors in Secondary Schools (DiSS) program to provide school-based health services to 100 Victorian secondary schools most in need; and
2. Enhanced Mental Health Support in Secondary Schools (EMHSS) to assist headspace centres to provide additional mental health clinical capacity to support secondary students.

These two programs aim to deliver prevention and early intervention:

- early in life, through early detection of mental health issues and mental illness (including relapse prevention), followed by appropriate, timely intervention and support can significantly reduce the severity, duration and recurrence of mental illness and its associated social disadvantage, and;

- early in illness, through early detection of mental health issues to improve clinical outcomes, and the likelihood of completing education and training, increase opportunities for securing and retaining employment maintaining stable accommodation, and reduce adverse outcomes such as involvement with the corrections and justice system and disconnection from family and community.

The service model design of both programs does not have strong provision to strengthen linkage and integration with the broader health and education sector environment resulting in implementation delays and the dilution of the programs' impact.

These two case studies unveil the structural weaknesses in the healthcare system such as:

- the existence of multiple commissioning bodies (e.g. State governments and PHNs) and the subsequent risk of parallel and disjointed commissioning approaches for the same type of services, resulting in complex navigation pathways, possible duplication of some service offerings and service gaps.
- the State Department's rigid commissioning approaches including tight timelines and limited community and PHN consultations resulting in siloed rather than more integrated, flexible and tailored initiatives responsive to local needs.