

Submission in response to the Productivity Commission's
draft report on the Social and Economic benefits
of improving Mental Health.

22nd January 2020

Some overall themes:

'A stitch in time saves nine'

(ie. 'do it right' first time, even if it takes a little longer)

and

'If no – why not'

(ie. agree some basic 'best practice' principles and
apply an 'if not, why not' approach to their application)

(in memory of our daughter: 1994 – 2017)

EXECUTIVE SUMMARY

Introduction

Thank you for the opportunity to comment on the draft PC report.

A lot of work has obviously gone into the report(s), which reflects the complexity of issues at hand and no doubt the large volume of submissions received.

This submission is a follow up to my initial submission (# 133), which was written from a Carer's perspective in relation to our extensive experiences with the Mental Health system with one of our children (22yo), who unfortunately ultimately took their life 3 years ago as a direct result of their struggles with poor mental health (Borderline Personality Disorder, BPD).

(I was very pleased to see a number of references to my submission in the draft reports, in particular the adaptation of our daughter's life trajectory in Fig 3.2 (reproduced at the end of this summary). Thank you.)

High level thoughts

Upon first reviewing the draft report(s) I couldn't help but feel that unfortunately the Productivity Commission had itself been drawn into the Mental Health vortex. There is an enormous amount of good material in the report(s) – but much of it is buried, and the overall headline, big ticket 'opportunities and benefits' and some simple actionable messaging seemed obscured.

After looking through the various sections and reviewing the clarity with which the Commission expressed itself in relation to the Superannuation review, I'm confident that a simple, actionable and measurable message will evolve.

But - I couldn't help thinking after reading section 1.4 '*What we heard from the Community*' (p. 127) – that what is required is quite clear. (The agreed points there aligned with the concept of '*integrated, collaborative, adaptive and openminded models of treatment*' suggested in my original submission.)

What appears to be holding us back are the systems and professions, unified by a common goal.

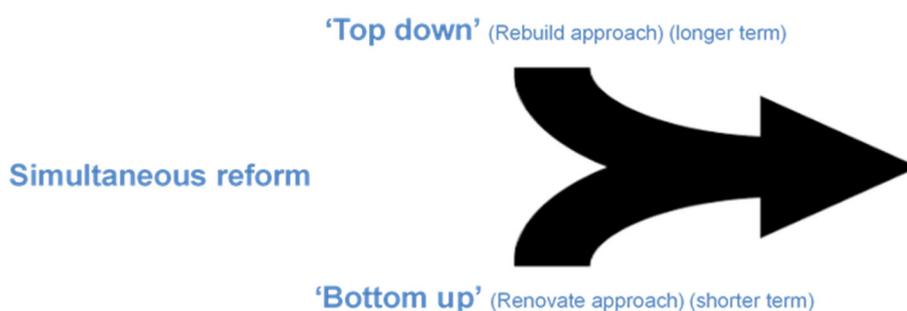
ie. it's not as though we don't know what to do – its more so that we are hamstringing ourselves by historic convention, law and bureaucracy, and for this reason I feel that something is missing from the report, and that the high-level recommendations may not be enough to be effective soon enough.

My response is in two parts:

1. A commentary on how some opportunities may be better constructed and communicated.
2. Specific commentary on the Information requests.

Key recommendations:

- a) Apply a simultaneous '*Top down and Bottom up*' reform approach, using a combination of the Renovate and Repair model concepts.



Key recommendations (cont.):

- **Bottom up** - ‘on the ground’ actions that can be implemented immediately and largely within existing frameworks. Particularly focussed on the application of some basic ‘best practice principles’ and the introduction of an active culture of collaboration and continuous improvement. (eg. a **Renovate** concept)
- **Top Down** – Focussed on simplification and increased effectiveness and efficiency of Governance and Funding channels (eg. a **Rebuild** concept) (Longer term focus, but involving the professional practice peak bodies / colleges as well as Government)

b) As key parts of the ‘Bottom up’ (renovate) approach:

- Adopt a **national Charter of Mental Health Principles**, along the lines of those in the WA Mental Health Act 2014, so everyone has a common goal and focal point.
- Agree some **basic ‘Best Practice’** principles to apply the ‘*What we heard from the Community*’ requirements and align with the Charter of Mental Health Care Principles:
 - Tiered or staged diagnosis (diagnosis is often not evident immediately)
 - Clinical staging of severity
 - Stepped models of treatment / care (to align with severity etc)
 - Identification of the ‘Treatment team’ (Psychiatrists, Psychologist, GP, Social worker, case management, OT etc)
 - Inclusion of Family / Carers in the ‘Treatment team’
 - Proactive collaboration and case management (Coordinating the Treatment team and ensuring implementation of the Treatment plan) – not just for complex cases.
 - Involvement of the ‘Treatment team’ in the design of the Treatment plan.
 - Inclusion of more information, including social and environmental factors in the Treatment plan (eg. expanded MBS funded Mental Health Plans).
 - Development of ‘what if’ scenarios in the plan – so there is a known approach and thresholds if symptoms don’t subside or in fact grow more complex. (often the diagnosis process is slower than the advancement of symptoms)
 - Application of ‘Supported decision making’ principles in the development of the plan (to ensure Consent and engagement from carers and supporters)
 - Alignment of Mental Health Act ‘Treatment, Support and Discharge plans’ with MBS funded ‘Mental Health Plans’ and other plans, to ensure Single care plans
 - Regular reporting and collaboration
- Ensure **MBS codes** are provided for all relevant practitioner activities above, and
- Introduce some simple additional concepts into **professional practice culture** to assist with the adoption and application of these ‘best practice’ principles by creating a culture of collaboration, respectful challenge and continuous improvement:

Suggested Professional practice culture:	What it means:
<i>‘A stitch in time saves nine’ ('Do it right first time')</i>	<i>Apply the basic ‘best practice’ principles – even if it takes a little longer. Prevention is better than the cure (p.186)</i>
<i>‘If not – why not?’</i>	<i>Continuous improvement approach to the application of the basic ‘best practices’. If not applying the basic ‘best practice’ principles – ask yourself this, or be prepared to be asked this.</i>

	<i>(similar to the approach to good Governance applied to ASX listed companies)</i>
<i>'What can I/we/you do better ourselves? (to meet my/our/your obligations under the Charter of Mental Health Care Principles).</i>	<i>A further approach to continuous improvement.</i>
<i>'How is what we are doing 'patient centric', 'person centred', or 'consumer oriented'?</i>	<i>Questions for everyone to ask themselves, their health professionals, or anyone involved in the provisions of services in the 'mental health industry' or supporting areas, if confronted with a limitation of the system or so. ('Respectful Challenge')</i>

(also encourage and incentivise co-location of services, like Headspace, as it will be easier to develop and cultivate the right culture and establish the communication channels required.)

c) As key parts of the 'Top Down' (rebuild) approach:

- i) Ensure that the professional practice peak bodies / colleges are involved in and sign off on the system redesign.
- ii) Potentially allocate an additional period of 6-12 months for refinement of the system redesign and simplification (after the PC's recommendations), led by the Productivity Commission working with the mental health professions and COAG via a 'steering committee' or 'working group' or so, to truly determine measurable costings, outcomes, timeframes and most importantly - accountabilities for higher level reform.

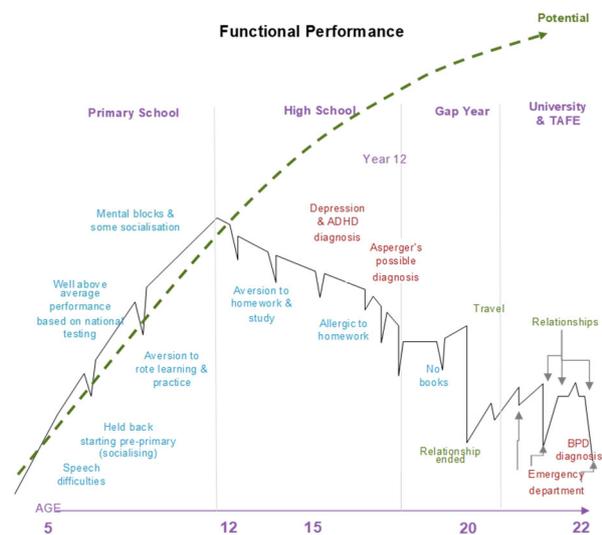
Particularly focussed on simplification, effectiveness and efficiency of Governance and Funding channels, but also alignment of each professional college's codes of practice, training standards etc in appropriate areas.

- iii) Preferably carry the Productivity Commission's 'oversight' role through until the intended new Intergovernmental Agreement is in place.
- iv) Follow that by a monitoring period – similar to that use within the ROGS (report on Government Services) reports, perhaps assessing the status of compliance with the Charter of Mental Health Care Principles as one central set of metrics.

This is a once in a lifetime opportunity and the PC's job should not be done until there is agreement between the Governments and the professional peak bodies, with targets, accountability and reporting obligations.

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Figure 3.2 Life's trajectory: the lived experience of one young person



Source: Adapted from Robert Davis, sub 133.

Thank you again for the opportunity to submit our thoughts. We hope this helps improve the social and economic outcomes for Australians with Mental Health issues and helps avoid other families having to go through what we have been thorough.

DETAILED COMMENTS

The following sections cover:

1. Draft Report construction
 - a) Change management approach
 - b) Reporting and prioritisation of recommendations
 - c) Costings, accountability, measurable outcomes and timeframes
 - d) Wellness and resilience, and positive mental health
2. Need a clear Model of the industry / system
3. Building blocks of a people-orientated mental health system
4. What we heard from the Community (Great Feedback)
5. Charter of Mental Health Care Principles (FOCAL POINT)
6. Introduction of basic 'best practice' principles
7. Enhanced Professional culture (and co-location of services)
8. Additional MBS codes (via a 'renovate' model, prior to a 'rebuild')
9. Comment relative to the Requests for Information
(Including comment on more comprehensive and effective Mental Health plans)
10. General additional comment
 - a) Suicide prevention strategies
 - b) NDIS interaction
 - c) Single Care Plans (essential)
 - d) Longitudinal reviews
 - e) Apologies

Appendices

- A – Marked up WA Mental Health Act: Charter of Mental Health Care Principles
- B – Orygen & Dr Chanen's Clinical Staging model
- C – Orygen's Team Treatment approach (marked up)
- D – Life Trajectory (Functionality vs Age history - marked up)
- E - 'Consumers respond differently to psychological therapy' (marked up)
- F – Feedback on WA Suicide prevention plan 2021- 2025

1. Draft Report construction

I genuinely found the report difficult to digest but I guess that may be to be expected in a draft report in such a complex subject area. I won't dwell too much on this but a few thoughts were:

a) Change management approach

- There didn't appear to be any big bang – cut through messages or reform items that could be followed up by the medium and longer term detailed structural and operational changes recommended. In essence, although this is a complex matter – if some elements cannot be broken down into bite sized, identifiable and allocatable responsibilities – nothing or not much will change.
- **Clear messaging, a common shared focus and quick wins** are usually key elements of a successful **change management** process. In one sense – the way the current draft is presented – there appears too much to do to be truly effective.
- *The Charter of Mental Health Care Principles is suggested here as a **common goal and focal point**, and a basic list of Best Practice' principles and alignment or professional practice cultural guidelines with business models are potentially achievable 'quick wins'*

b) Reporting and prioritisation of recommendations

- It was almost as though there were two approaches to reporting the **summaries and findings** (ie. in the Overview and the Draft Recommendations and Findings). These did not appear to be completely aligned nor hierarchically nested
- Both include similar but different list of recommendations (something like 63 recommendations in the Overview lists and between 200 and 300 recommendations in the Draft Recommendations, depending on how you count them).
- One may be a short list of the other – but this is not clear and there does not appear to be any criteria described for **prioritising and truncating** one list to the other.
- Further to this - there also did not appear to be '**bang for buck**' comparisons of the different options and priorities. The '**Value for money**' principle cited in the Terms of Reference appears to have been somewhat lost in the analysis. I expect many initiatives are in fact difficult to cost and value – but some assessment does need to be made to help prioritisation and realistic budget & resource allocation, otherwise the **rationalisation and prioritisation** is very opaque.

Figure 3 Assessment components



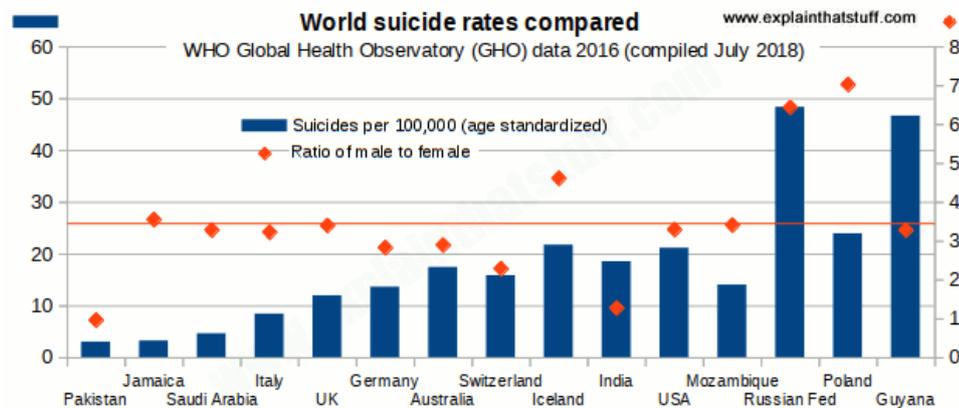
c) Costings, accountability, measurable outcomes and timeframes

- Further again – and I recall this is noted to some extent in the draft report(s) – more work needs to be done to more **clearly identify accountabilities, expected measurable outcomes and timeframes** not just for implementation, but also achievement of those outcomes.
- *Without costings, accountabilities, measurable outcomes and timeframes – the potentially for overall change and success is low. If more time is required – request it.*

d) Wellness and Resilience, and positive Mental Health.

- On a final note – perhaps one area I found under commented on overall were the notions of **Wellness and Resilience** and the concept of **positive Mental Health**, and what can be done at a national level to help bolster these, not just in the work place.

- It is somewhat surprising to find that many countries with low suicide rates, also seem to have circumstances that build high level of resilience.



- Social participation is one aspect of good mental health – but Resilience and the depth of skills to deal with challenge and adversity is potentially more important.
- Need to be careful that feeling of ‘learned helplessness’ does not pervade society due to talking too much about the negative aspects of mental health.
- Perhaps part of the report should be dedicated to considering the potential effectiveness, scope and impact of programs (nationally and local), positive messaging and on-going measurements to support these areas.

(Note: Section 3 following includes the concept of having a positive messaging and a culture of Resilience under pinning the entire mental health industry from structure and modelling perspective)

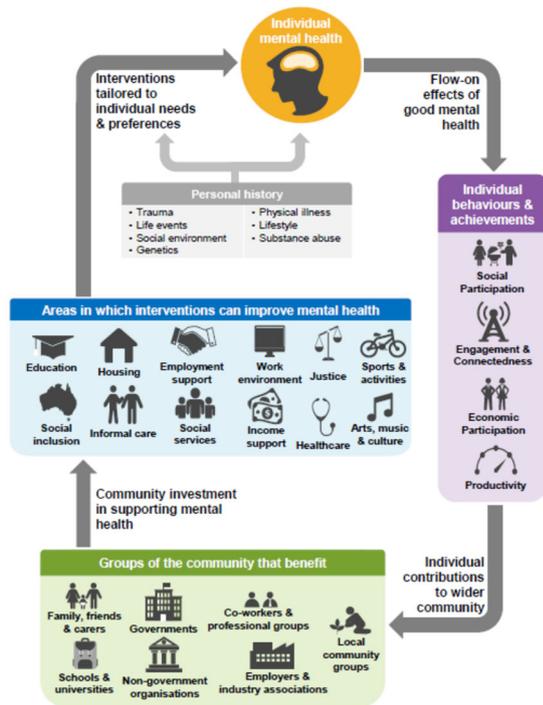
2. Need a clear model for the industry / system

I do have to ask – what happened to the simple flow diagram model you had in the Issues paper?

Figure 1 from the Issues paper seems to have moved from a simple diagram with a general ‘cause and effect’ flow process (that potentially allows you to identify intervention, responsibility and accountability points), to one in that looks more like someone **drowning in the middle** of a two concentric circles, perhaps representing life boats and life buoys just out of their reach?

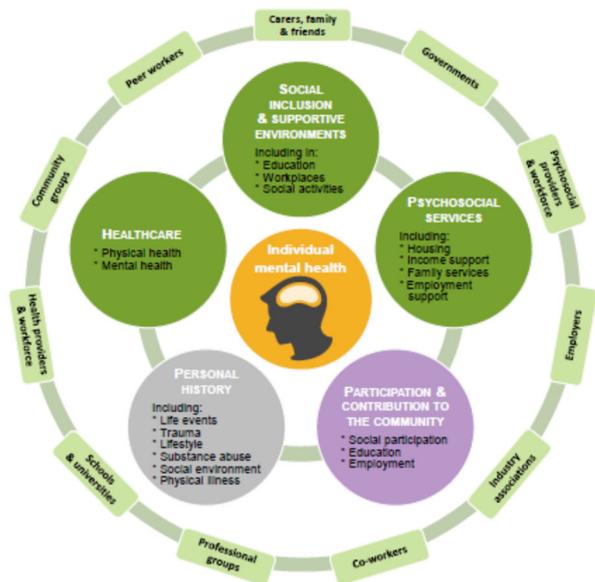
Tongue in check – perhaps – but my first reaction was ‘*what the heck does this new diagram mean?*’ How can we design a functional system with accountability etc, without a clear pictorial model where you can delineate boundaries?

Figure 1 Improvements in mental health can benefit both individuals and the wider community



Original diagram in ‘Issues’ paper

Figure 1.2 The many interconnected determinants of mental health



Revised diagram in Draft report p.119
(drowning in the middle??)

3. Building blocks of a people-orientated mental health system

I liked to concept of identifying the core building blocks of a ‘people orientated mental health system’ in Section 4.3. (p. 197).

However – I feel that some additions are required:

- Without some clear focal points and guiding principles (ie. a central Culture and Philosophy) (for example a Charter of Principles), we won’t get the reforms needed – regardless of the ‘top down’ designs features. (See further comment in following sections)

This is not just a jurisdictional problem. (ie. State vs Federal Government)

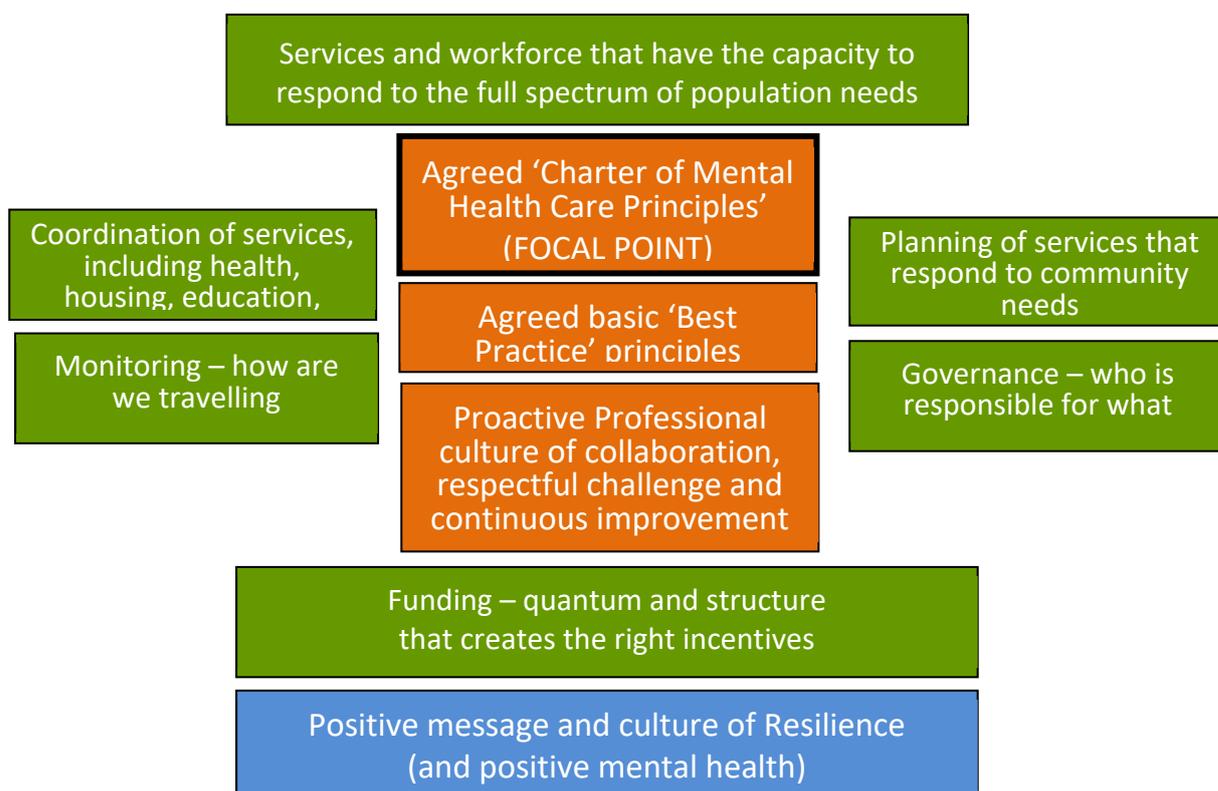
From our family’s direct experience, it also appears to be a result of siloing of professional practices and their guiding organisations, and a lack of alignment of the professional’s business models & funding, with their published codes of Practice or codes of Ethics.

- If we don’t have some basic agreed ‘best practice’ principles, we will make little progress.
- If we don’t have a proactive culture of collaboration between all professions in the Mental Health team, we will make little progress.

(Whilst I haven’t sampled all the professional organisation codes of conduct etc, the RANZCP, Medical Board of Australia, and APS all have Collaboration with other professionals as tenets in their codes of conduct / ethics – but it doesn’t generally occur in practice)

- If we don’t have funding structured (eg. MBS Codes) to suit the professional’s business models (already covered in principle in your model) and encourage co-located services, we will also make little progress.

Suggested modifications to Figure 4.2 Building blocks of a people-orientated mental health system



4. What we heard from the Community.

Section 1.4 (p. 127-131) – *What we heard from the Community is great!*

The follow extract from the report is also great:

Filling the gaps in existing services (Section 4.1 p 188)

... In this draft report, the Commission makes a number of recommendations to address service gaps, and create a consumer-oriented mental healthcare system. Such a system should be:

- ***responsive*** – *services should reflect the preferences of consumers, their families and carers, and be delivered in ways that are sensitive to consumers cultural backgrounds*
- ***accessible*** – *Australians should have timely access to care based on their needs, not ability to pay, in all regions*
- ***well-coordinated*** – *providing continuity of care, and coordination between mental and physical healthcare, psychosocial supports and other services. Service providers should articulate care pathways that support the recovery of people affected by mental illness*
- ***effective*** – *both in terms of using evidence-based treatments that are shown to be effective in improving consumers outcomes, and cost-effective, representing value for money for individuals and the wider community.*

These principles form the basis of a stepped care model for the delivery of mental healthcare.

The concept of stepped care, where the level and type of care matches individual needs at any particular time, is not new.

We just need a system to deliver them.

These principles should be perhaps be highlighted in the Key Points summary area of the final report.

5. Charter of Mental Health Care Principles (FOCAL POINT)

To take the above further, a formal Charter of Mental Health Care Principles – such as that used in the WA Mental Health Act 2014, should be adopted nationally as part of the ‘*bottom up*’ (**renovate**) approach, and endorsed by all relevant bodies (ie. Governments, peak professional bodies / colleges, and peak community groups.

- No mention of such a Charter nor agreed underlying principles appears to be recommended in the report (other than reference to the ‘No Wrong Door’ Mental Health Charter in South Western Sydney)
- The current Mental Health Statement of Rights and Responsibilities would seem to be too long and not go far enough. (eg. no mention of Collaboration etc)
- Without some clear focal points and guiding principles we won’t get the reforms needed.

A marked up version of the WA Principles is attached as **Appendix A**.

(The mark-ups are suggestions to some address some perceived gaps in the Charter)

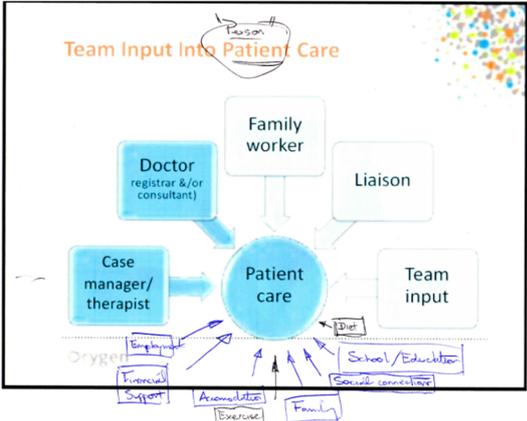
(Note: This is not to say that we feel the entirety of the WA Mental Health Care Act 2014 is suitable. Whilst the Charter is built into the Act, the threshold for compliance in some areas (eg. consultation with families and carers) could be considered to be relatively low and more practitioner centric than person / patient centred.)

6. Introduction of basic ‘best practice’ principles

Some agreed basic ‘best practice’ principles, as part of the ‘*bottom up*’ (**renovate**) approach, will help put the Mental Health Care Principles into action within existing structures and help deliver “*What we heard from the Community*”:

Suggested ‘Best Practice’	Comments
<ul style="list-style-type: none"> Tiered or staged diagnosis 	<p>For example using Dr Andrew Chanen / Orygen’s suggested model shown in Appendix B (and below)</p> <p>This recognises that diagnoses are often not immediately obvious, and for more complex conditions – early treatment needs to be provided whilst still confirming the ultimate diagnosis.</p> <p>The MHTP should identify if the diagnosis is confirmed or still be investigated, and a Team approach used to collate all relevant information to progress the diagnosis faster than the progression of the condition.</p>
<ul style="list-style-type: none"> Clinical staging of severity 	<p>Similar to Cancer staging, and again using a model like that suggested by Orygen, shown in Appendix B.</p> <div data-bbox="815 875 1342 1234" data-label="Diagram"> </div> <p>This will help with communication and coordination.</p>
<ul style="list-style-type: none"> Stepped model of treatment /care 	<p>Designed to align with the severity of the condition.</p> <p>However – it is suggested that Case management / care co-ordination be introduced at an earlier stage via MBS funded items to help:</p> <ul style="list-style-type: none"> in-experienced Families navigate the system, coordinate reporting and communication between practitioners. (can be done by practice nurses at early stages and them more experienced / skilled people at later or more complex stages) <p>Figure 4.1 Stepped model of care^a</p> <div data-bbox="805 1704 1316 2018" data-label="Figure"> </div> <p>(Bring forward basic case management and care coordination)</p>

6. Basic 'best practice' principles (cont.)

Suggested 'Best Practice'	Comments
<p>(Treatment team)</p> <ul style="list-style-type: none"> • Identification of the 'Treatment team' (Psychiatrists, Psychologist, GP, Social worker, case management, OT, school counsellors etc) • Inclusion of Family, Carers in the 'Treatment team' • Proactive collaboration and case management (Coordinating the Treatment team and ensuring implementation of the Treatment plan) – not just for complex cases. • Involvement of the 'Treatment team' in the design of the Treatment plan • Regular reporting and follow-up. collaboration 	<p>There are many models. The following is a marked up version of Orygen's model. (See Appendix C)</p> <p>The major requirement is a commitment to Collaboration and 'person centred' (not practitioner centred') approach to care and recovery, also recognising that schools, social services, families etc have a role to play.</p> 
<p>(Mental Health Plan)</p> <ul style="list-style-type: none"> • Inclusion of more information, including social and environmental factors in the Treatment plan (eg. expanded MBS funded Mental Health Treatment Plans). • Development of some 'what if' scenarios in the plan – so there is a known approach and thresholds if symptoms don't subside or in fact grow more complex. (often the diagnosis process is slower than the advancement of symptoms) • Alignment of WA Mental Health Act 'Treatment, Support and Discharge plans' with MBS funded 'Mental Health Plans' and other plans, to ensure Single care plans 	<p>See notes in following Section 9 on Mental Health Treatment Plans (MHTP) and Single Care plans.</p> <p>The Plans need to be more than 'tick box' exercises to satisfy bureaucracy' (p. 217 of draft report)</p> <p>Plans should be used a real tool and involve collaborative input for various 'treatment team' members.</p> <p>As much mental health is a health issue – it is principally a social issue – because it pervades all aspects of peoples' lives. If the health system (and GP's) are to be seen as primary gateways - (others being ED's, educational facilities, workplaces, sporting clubs and family homes), they need to consider mental health (and it's more optimistic cousin – Wellness) as principally social issues and act (assess, prescribe, treat etc) accordingly in a 'whole of life' circumstance.</p> <p>It may take a number of version or iterations to get all appropriate input, but that is what is required in a 'client / patient centred' system.</p>
<ul style="list-style-type: none"> • Application of 'Supported decision making' principles in the development of the plan (to ensure Consent and engagement from carers and supporters) 	<p>See the Australian Law Reform Commissions for some relevant commentary: https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/1-executive-summary-2/towards-supported-decision-making-in-australia/</p>

7. Enhanced professional culture (and co-location of services)

The Draft report highlights that one of the major barriers to the implementation of a person or patient is the culture of the of the mental health care industry itself.

10.3 Enabling the delivery of integrated care (p. 360)

Transitioning to a model of mental healthcare that is based on collaboration and integration represents a substantial cultural shift, compared to the siloed nature of existing services. Achieving such as cultural shift requires action on multiple fronts

One significant finding (10.2) was the benefit of the Co-location of services.

- We fully support any initiative that would enhance **Co-location of services** (like headspace)

However- for those non co-located services, we feel (from our experience) that some fundamental changes need to occur at a **professional practice cultural** level (reinforced with appropriate MBS codes etc), such that a culture of collaboration, respectful challenge and continuous (system) improvement becomes the norm.

- This would need to be driven from both a 'top down' – professional peak body/ college perspective, and well as 'on the ground' – 'bottom up' approach from practitioners.
- Interestingly, many of the professional colleges and associations have 'Collaboration' with other professionals as tenets in their codes of conduct / ethics and most practitioners are good people with their heart in the right – but collaboration doesn't generally appear to be applied in practice.
- The concept here is to Introduce some simple additional concepts (mantras, sayings ... etc) into **professional practice culture** to assist with the adoption and application of the 'best practice' principles. (might seem a bit naff – but simple concepts like this help convey culture)
- These professional cultural concepts (or adaptations of them) would assist in a process of both 'self checking' and 'respectful challenge of others' (rather than simple deference), which are important parts of any collaboration culture.

Suggested Professional practice culture:	What it means:
'A stitch in time saves nine' (<i>'Do it right first time'</i>)	Apply the basic 'best practice' principles – even if it takes a little longer. <i>Prevention is better than the cure (p.186)</i>
'If not – why not?'	Continuous (systems) improvement approach to the application of the basic 'best practices'. <i>If not applying the basic 'best practice' principles – ask yourself this, or be prepared to be asked this or ask others. (similar to the approach to good Governance applied to ASX listed companies)</i>
'What can I/we/you do better ourselves? (to meet my/our/your obligations under the Charter of Mental Health Care Principles). 'How is what we are doing 'patient centric', 'person centred', or 'consumer oriented'?	A further approach to continuous improvement. <i>Questions for everyone to ask themselves, their health professionals, or anyone involved in the provisions of services in the 'mental health industry' or supporting areas, if confronted with a limitation of the system or so. ('Respectful Challenge')</i>

- Collaborative leadership of peak professional bodies and colleges will be required.
- (Should there also be a 'Duty of Care' argument? (ie. the Duty is not being discharged if not using 'best practice'?)

8. Additional MBS codes (via a 'renovate' model, prior to a 'rebuild')

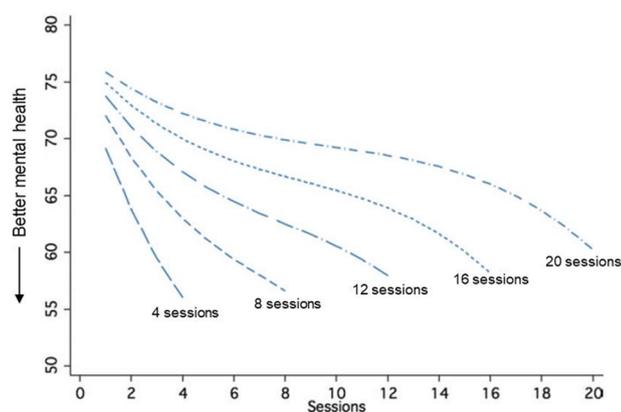
We note that the Commission recommends the introduction of additional MBS codes for a number of professional services.

- To ensure all bases are covered, it might be worthwhile **collating and reporting** all the suggested additional codes in one place in the report and cross checking them against some models of the industry to ensure all people, information flow, and key decision points are covered.

Prior to commenting further, we would like to introduce some information to help highlight **gaps in the current system** in this area (as relates to both MBS codes and the Mental Health Treatment Plans).

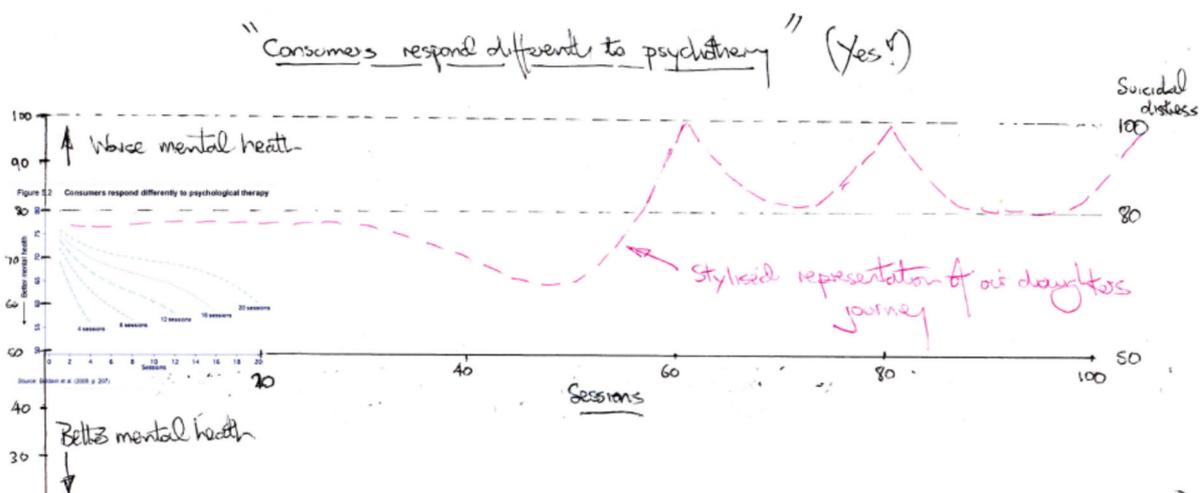
- Section 5.3 of the Draft report introduces the concept of different 'Consumers responding differently to psychological therapy'. We agree.

Figure 5.2 Consumers respond differently to psychological therapy



Source: Baldwin et al. (2009, p. 207).

- However - an expanded version of this diagram for our daughter would have looked something like below. **(See Appendix E for a full version)**. This tells quite a different story and should be viewed in conjunction with our daughter's 'life trajectory' in Appendix D

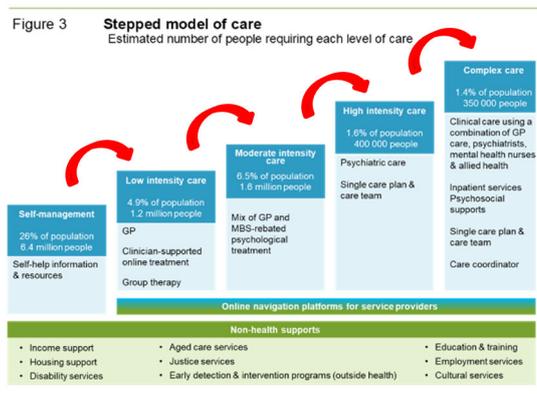


- **Our daughter's situation was complex** (Borderline Personalist Disorder).
- **Over 110 'sessions' were held over 6.5 years** (this excludes GP visits, extensive family support, and social support from a community services group)
- **The initial 20 sessions barely register at the front end!** and over the first 30 sessions or so, there was no real discernible improvement in condition.
- **The lesson for us in this was that there needed to be some triggers / thresholds along the way to somewhat automatically 'step up' the level of care & support.**

- Eg. We believe that treating someone with Borderline personality disorder could require ~160hrs of clinician time, either in a group setting, part group setting or a 'one on one' basis. This is significantly more than currently available under Medicare funded programs (eg. 10 session) and difficult to fund privately.
- However, without such treatment (to help fund a 'slow and thorough' approach, rather than trying to apply a series of independent 'patches' like we had) – people are likely to slide into a 'treatment resistant' phase before sufficient traction is gained with them. Becoming welfare dependent for a very extended period of time, or taking their life (as in our case) ... increasing the overall social and economic cost. (*A stitch in time saves nine ...*)

Therefore, before finalising the report it might also be worthwhile **cross checking** the MBS codes and MHTP's against a few things:

- How the stepped care model is intended to work. (ie. **how is care triggered from one level to the next?**).



- Can earlier Case Management assist?
- How the different entry and treatment pathways are intended to interact. (ie. **who needs to talk, to what extent and how are they funded to do so?**)

Figure 10.1 **The Commission's model of consumer pathways in the mental healthcare system**

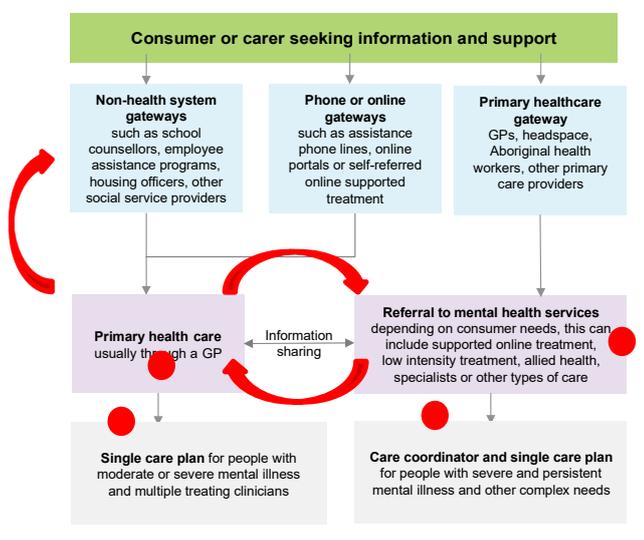
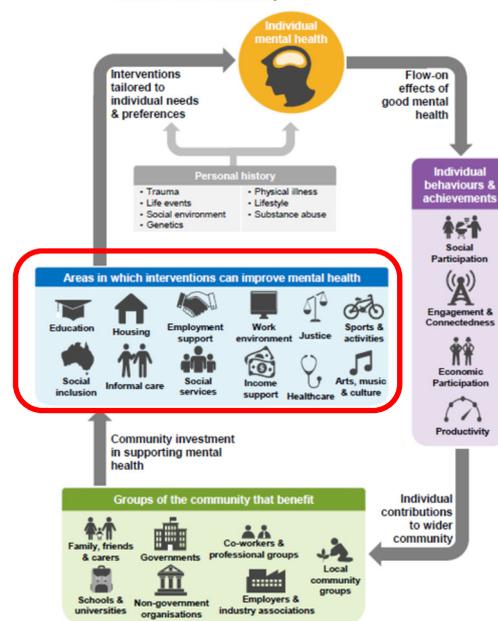


Figure 1 **Improvements in mental health can benefit both individuals and the wider community**



Below is some specific commentary on the PC's currently recommended MBS codes:

Recommendation #	Commission's wording	Comments
5.5	Changes should be made to MBS rules to encourage more group therapy.	Yes - Sounds reasonable and good practice.
5.4	MBS-rebated psychological therapy should be evaluated, and additional sessions (20) trialled.	Yes – but with better triggers / thresholds to step up, or change the care as the condition worsens, fails to improve or become obviously more complex.
5.7	change MBS rules so that videoconference can be used for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies	Sounds reasonable
7.2	introduce a new suite of time-tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended	Sounds reasonable
5.1	introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP.	Yes. But also include codes for psychologists and other practitioners communicating as part of the Treatment Team
10.3	amend the MBS to include a specific item to compensate a clinician overseeing a single care plan for their time. (elsewhere referred to as 'developing and progressing the single care plan')	Yes – very much so!
&	amend the MBS so that psychologists and other allied health professionals are subsidised: <ul style="list-style-type: none"> - to provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. - for consultations with carers and family members without the care recipient present (say 4 per yr?) 	Yes – but also include the concept of the sessions being as much as fact finding / diagnostic sessions at the front end to help develop a proper Mental Health plan, and case management & supported decision making meetings along the way. It is not all 'therapy'
24.1	provide additional funding to MBS-rebated out-of-hours GP services	Sounds reasonable
s.5.3 (p. 221)	MBS Review Mental Health Reference Group (2018, pp. 34-36) recommended a three-tiered system, with 10 sessions available annually for the first tier, 20 for the second tier, and 40 for the third tier.	Sounds reasonable (aligns with the Stepped care concept) - subject to the other comments here on Collaboration an establishing effective MHTPs
s.5.3 (p.231)	... trial an increase (from 6 to 10) in the maximum number of MBS-rebated sessions available with a single referral	Yes & No. The current concept of conducting a Review after a few sessions would seem to be a good thing from a Collaboration perspective. 10 sessions without a reference back to the referring GP sounds somewhat like 'siloing' and should only be done after a clear diagnosis is reached and an effective MHTP in place.
s.10.2 (p.351)	The Commission considers that the MBS review (MBS Mental Health Reference Group) is best placed to consider the broader question of case conferencing rebates.	We firmly believe that earlier and more effective Case conferencing and Case Management is required and should be funded
s.13.4 (p.495)	MBS Review Mental Health Reference Group (2018) recommended adding family interventions to the list of approved interventions that can be delivered by allied health professionals	Yes – makes very good sense.

9. Comment against Requests for Information

(Including comment on more comprehensive and effective Mental Health plans)

- *INFORMATION REQUEST 5.2 — MENTAL HEALTH TREATMENT PLANS*
How should the requirements of the Mental Health Treatment Plan (MHTP) and MHTP Review be changed to ensure that GPs assess, refer and manage consumers in line with best practice (as laid out in the Australian Department of Health’s guidance)?
- Key focus is to make MHTPs useful tools, not just “tick box” exercises to satisfy bureaucracy’ (p. 217)

Commission’s information request	Comment
<p>What should be added to the MHTP or MHTP Review to encourage best-practice care?</p>	<ol style="list-style-type: none"> 1. As assessment of the presenting mental health score using the Kessler K10 psychological distress scale for example, to be assessed and recorded at each Treatment Team member’s session. 2. An assessment and rating of the ‘Stage / Severity’ of the Mental Health Condition’ (so it can be easily be determined if the appropriate Stepped level of care is being provided). 3. An assessment of the ‘Status of the Diagnosis’. Eg. Is it exploratory, preliminary or confirmed? This should focus the attention of the assessment and treatment teams on Collaborating to collect the information required to confirm a diagnosis and apply the appropriate treatment – whilst also applying initial ‘treatment’. 4. More specific prompts to collect ‘Other Information’ covering other potentially relevant information. Each with a rating scale to determine a total score. (Occupational Therapists should have a suitable rating system for GP’s to use here) Eg. <ul style="list-style-type: none"> - Accommodation status - Financial status - Primary occupations status (education, job, other ...) - Social engagement - Transport access - Diet - Alcohol use - Sleep characteristics - Emotional support - Relationship status - Exercise status - Secondary occupation status (personal enjoyment activities like hobbies, gaming, sport, volunteering etc) <p>A more complex condition may become evident far more quickly and earlier with this type of comprehensive assessment. Relevant information should be cross referenced & critically assessed and not necessarily taken at face value.</p>

	<p>'Other information', particularly longitudinal reviews looking for patterns, may need to be collected from OT's, school counsellors / psychologists, family members etc. (ie. whatever sources are required) as part of the initial 'treatment plan' to help expand, clarify and elevate the scope and status of the diagnosis. (The OT professional approach is likely to be useful here in many cases)</p> <p>5. Identification of the Case Manager and complete Treatment Team, including relevant family members and carers (and an assessment of their roles and capacity to assist).</p> <p>6. Consideration and engagement with social services, outreach support or low intensity therapy coaches (and inclusion in Treatment team) as required to complete self-directed goals for those with limited ability. (do not set self-directed goals that won't be achieved without support)</p> <p>7. Identification of thresholds for further action by the Treatment team if no improvement or deterioration of condition occurs within reasonable timeframes. (not just crisis or relapse plans), to help avoid the situation where the diagnostic or treatment process is slower than the advancement of symptoms</p>
Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?	Not aware.
Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focused Psychological Strategies?	Happy to leave this in the GP's hands initially. Focus initially should be on beginning some therapy but at the same time, confirming diagnoses.
Should consumers continue to require a MHTP for therapy access if being referred by a GP?	Yes. There should always be a plan active. (why would any practitioner not want one? Would sound like 'siloining')
What new clinical thresholds, if any, should be introduced to access additional sessions beyond the first course of therapy?	This should be based on the combined clinical judgement of the assessing and treating teams, taking into account if the current therapy is being effective or if the situation appears more complex than initially considered.
Should these be part of or separate to the MHTP Review?	I guess my reaction to this is that the question appears to be posed from a rigid practitioner focussed, 'tick a box' process perspective, rather than one of doing the best by the patient. The plans need to be always viewed, developed and maintained as effective proactive tools, not as something to be avoided. (otherwise – diagnoses can be missed or significantly delayed). Reviews should really be on a needs basis (per below)
Should a MHTP Review be required to access additional sessions, instead of just a new referral?	The concept of a Review should always be live. Ie. The need for a review should be more 'client' needs based, rather than be simply based on having completed a number of sessions.

How could audits be used to ensure that clinicians are assessing, referring and managing patients in line with best-practice and the stepped care model?	Good question. A little beyond my expertise – but presumably there are existing independent audit processes for the quality of other medical / health activities. Certainly, even simple compliance with the basic ‘best practice’ principles and a periodic check of those, should improve mental healthcare considerably
What information should clinicians be required to give the consumer when completing a MHTP or MHTP Review?	As much as possible (unless it is likely to be detrimental to the consumer’s health)
Should they be required to give the consumer the completed and reviewed Plan?	Ideally – yes. Or at least the most ‘responsible family member or carer’ of the consumer. The family and carer should be considered part of the Treatment Team and should therefore be ‘fully in the tent’. (as long as they have the mental capacity and make up to not make matters worse – in which case – an independent advocate should be provided with the plan to review it on the consumer’s behalf, and the family members dealt with under and intervention process per the MBS Mental Health Reference Group (2018)
Should GPs continue to receive a higher rebate for MHTPs and MHTP Reviews than for standard consultations?	Yes. Perhaps MHTPs need to be considered as special appointments and the consumer brought back in for a long (1hr if necessary) consultation to obtain the necessary information. Again – the initial plan should be assessed as to whether it is an exploratory, preliminary or confirmed diagnosis. A preliminary or exploratory diagnosis should be reviewed after only 1 or 2 external sessions with a psychologist and the parallel collection of relevant ‘Other information’ from OT’s, school councillor / psychologist, family members etc. (ie. what ever sources are required) to clarify and elevate the status of the diagnosis. A more complex condition may become evident far more quickly and earlier with this type of assessment

General note: The concept expressed in Recommendation 11.5, registering specialist mental health GP’s, would appear to have merit. They could be the ‘go to person’ for other GP’s in the practice – or a particular area, and you would imagine, significantly improve the quality of MHTPs and mental health care.

- **INFORMATION REQUEST 5.1 — LOW-INTENSITY THERAPY COACHES AS AN ALTERNATIVE TO PSYCHOLOGICAL THERAPISTS**

Commission’s information request	Comment
<p>We are seeking information on the gains from having a greater share of treatment provided by low-intensity therapy coaches. This includes:</p> <ul style="list-style-type: none"> - improvements in mental health outcomes and/or the cost-effectiveness of therapy for consumers and the wider community 	<p>We support the notion of low intensity therapy coaches providing services – particularly community based outreach type services for those with severe and complex mental health conditions. 2-3hr sessions are often required to</p>

- the groups of consumers that would most benefit.	improve mood and provide or reinforce skill development.
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- **INFORMATION REQUEST 7.1 — FREEING UP PSYCHIATRISTS FOR PEOPLE WHO NEED THEM MOST**

Commission’s information request	Comment
What additional steps, if any, should be taken to support private psychiatrists to increase the number of consultations involving new patients?	Unsure of what steps could be taken but would support measures that allow people with their first significant episode of mental health to get to see a psychiatrist within 2 weeks

- **INFORMATION REQUEST 14.1 — INDIVIDUAL PLACEMENT AND SUPPORT EXPANSION OPTIONS**
The Productivity Commission is seeking further information about the pros and cons of the two distinct options for expanding the Individual Placement and Support (IPS) model of employment support. The options are:

- a) *direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding*
- b) *a new Australian Government-administered contract for IPS providers, based on fee-for-service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a State and Territory Government community mental health service).*

Commission’s information request	Comment
What are the pros and cons of each option? <ul style="list-style-type: none"> - Which is your preferred option and why? - If the direct employment option is pursued, how should State and Territory Local Hospital Networks be funded to deliver the service? 	Preference would be for Federal Government employment of the specialists – directly within Centrelink, so there is no gap or extra step to take in gaining access to the services.

- **INFORMATION REQUEST 14.2 — INCENTIVES FOR DSP RECIPIENTS TO WORK**
In relation to the Disability Support Pension (DSP), the Productivity Commission seeks feedback on the costs, benefits and risks of:

Commission’s information request	Comment
increasing the income threshold at which recipients begin to lose their payments and the value of the taper rate after that threshold	Yes. Can’t provide specifics as am not aware enough of the thresholds etc – but in principle there needs to be an incentive to work (particularly for those with complex conditions) and steep taper rates effectively apply a penalty ‘tax’ which can act as a mental disincentive and therefore counter therapeutic.

increasing the weekly hour limit above which no DSP is payable from 30 hours to 38 hours (ordinary full time hours of work), but retaining the requirement that a person will lose eligibility for the DSP if they work for more than 30 hours per week for more than two years.	Sounds reasonable – although even the 30 hours per week seems reasonable – depending on the pay rate and productivity of the work.
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- *INFORMATION REQUEST 19.2 — PERSONAL CARE DAYS FOR MENTAL HEALTH*

Commission’s information request	Comment
Would designating a number of days of existing personal leave as ‘personal care’ to enable employees to take time off without medical evidence to attend to their personal care and wellbeing improve workplace mental health and information on absenteeism due to mental ill-health? If so, what would be needed to make this provision effective?	Possibly – but would tend to try to avoid it. Need to be careful that a feeling of ‘learned helplessness’ does not pervade society due to talking too much about the negative aspects of mental health.

- *INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM*

The Productivity Commission has proposed two distinct models for the architecture of the future mental health system:

- a) The Renovate model, which embraces current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs).*
- b) The Rebuild model, under which State and Territory Governments would establish ‘Regional Commissioning Authorities’ that pool funds from all tiers of government and commission nearly all mental healthcare (Regional Commissioning Authorities would take over PHNs’ mental health commissioning responsibilities and also commission more acute mental healthcare) and psychosocial and carer supports (outside the NDIS) for people living within their catchment areas.*

At this stage, the Rebuild model is the Commission’s preferred approach.

Commission’s information request	Comment
How could the Rebuild model be improved on? Are the proposed governance appropriate?	See below.
Should RCAs also hold funding for, and commission, alcohol and other drug services?	Most probably, but ... see below
If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.	My belief is that a combination of the Renovate and Rebuild models are required. Getting the Rebuild right model right is likely to take time, and in the meantime – on the ground adjustments can be made to the existing model via a Renovate approach

- **INFORMATION REQUEST 24.1 — REGIONAL FUNDING POOLS**
The Productivity Commission is seeking further feedback on its proposals for implementing draft recommendation 24.1.

Commission’s information request	Comment
If the Commission were to adopt the Renovate model : What would be the pros and cons of our proposal to implement this recommendation by linking PHN mental health funding with projected MBS-rebates for allied mental healthcare?	As I don’t work directly in the healthcare industry, I don’t fully understand the current workings of the PHN’s and provision of MBS rebates – but it would seem reasonable if there was to be coordination between the funding for GPs and allied mental healthcare.
Do you have another proposal for how draft recommendation 24.1 might be implemented?	No.
If the Commission were to adopt the Rebuild model , our preference would be to link RCA mental health funding with projected MBS-rebates for allied mental healthcare. Is there any reason that funding linkage should be undertaken on a different basis?	Not that I’m aware of.

- **INFORMATION REQUEST 25.2 — PROPOSED INDICATORS TO MONITOR PROGRESS AGAINST CONTRIBUTING LIFE OUTCOMES**

Commission’s information request	Comment
The Productivity Commission is seeking information on what additional indicators should be considered to monitor progress against Contributing Life Outcomes and whether routine data is available for the Commission’s proposed indicators.	Can’t comment on whether routine data is available – but monitoring should be conducted around positive measures such as of Resilience and Positive Mental Health (per our comments in section 1 and 3) Need to be careful that a feeling of ‘learned helplessness’ does not pervade society due to talking too much about the negative aspects of mental health.

Thank you again for the opportunity to submit our thoughts and we hope this helps improve the social and economic outcomes for Australians with Mental Health issues.

----- End -----

10. General additional comment

a) Suicide prevention strategies

I note at the end of the Reform Area 5 there is a recommendation of a new National Suicide prevention strategy.

- This should be commended ... but, I would also caution on how the strategy is brought together and expressed.
- WA recently release a Draft Suicide prevention plan 2021-2025.
- My conclusion was that although well meaning, it would not be effective.
(see Appendix F for the feedback provided on the WA draft)

b) NDIS interaction

There needs to be very strong and seamless coordination between the psychosocial aspects of the NDIS and any treatment, diagnosis or other interaction with the Primary care system and or other mental health system. This appears to be recommended by the Commission, but would need careful consideration – particularly under the Rebuild model.

c) Single Care Plans (essential)

These must be central to any new system - otherwise we are perpetuating a system of 'silos'. (including NDIS vs Primary Care Vs ED's)

d) Longitudinal reviews

Likewise, the concept of looking beyond what's immediately in front of practitioners and undertaking longitudinal reviews looking for patterns should be promoted. (OT's are great at this)

- A more complex condition may become evident more quickly and earlier.
- Thus avoiding the situation where the diagnostic or treatment process is slower than the advancement of symptoms.

e) Apologies

Please accept my apologies for not commenting on other recommendations etc. I had intended to comment on all but got a little overwhelmed by the number of them.

- I believe the PC has done a good job in bringing this together, but as you probably know - much is not new.
- The really challenge like other times, is to find a path through.
- This is a once in a lifetime opportunity.

Thank you again for the opportunity to submit our thoughts and we hope this helps improve the social and economic outcomes for Australians with Mental Health issues.

----- End -----

APPENDIX A

Marked up Charter of Mental Health Principles

Schedule 1 — Charter of Mental Health Care Principles

[s. 11, 12, 320(2)(f), 333(3)(d) and 351(1)(b)]

Purpose

- A. The Charter of Mental Health Care Principles is a rights-based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness.
- B. The Charter is intended to influence the interconnected factors that facilitate recovery from mental illness.

Principle 1: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

Principle 2: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

Principle 3: Person-centred approach

- 3.1 A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support.
- 3.2 A mental health service must promote positive and encouraging recovery focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

Principle 4: Delivery of treatment, care and support

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

Principle 5: Choice and self-determination

A mental health service must involve people in decision-making and encourage self-determination, cooperation and choice, including by recognising people's capacity to make their own decisions.

(suggestion ... and if necessary if their decision making capacity is limited, being supported in their decision making by their family member, carer or other personal support person)

Principle 6: Diversity

A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Principle 7: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

Principle 8: Co-occurring needs

A mental health service must address physical, medical and dental health needs of people experiencing mental illness and other co-occurring health issues, including physical and intellectual disability and alcohol and other drug problems.

Principle 9: Factors influencing mental health and wellbeing

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

Principle 10: Privacy and confidentiality

A mental health service must respect and maintain privacy and confidentiality (suggestion ... but at the same time aim to meeting all the Principles. ie. privacy and confidentiality should not be unnecessarily used to a bar to meeting other Principles) -

Principle 11: Responsibilities and dependants

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependants.

Principle 12: Provision of information about mental illness and treatment

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

Principle 13: Provision of information about rights

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance and uphold their rights.

Principle 14: Involvement of other people

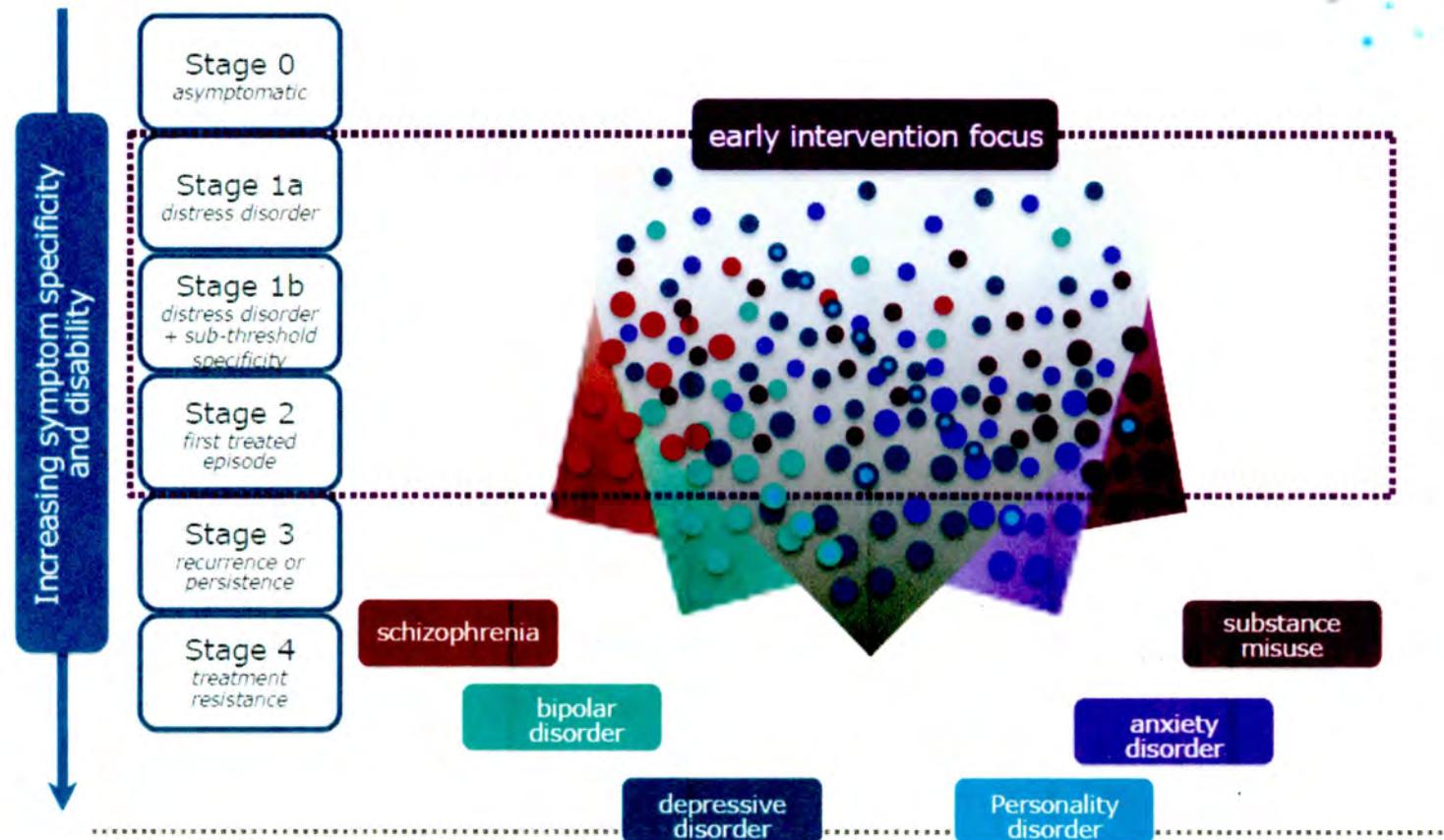
A mental health service must take a collaborative approach to decision making, including involving people's existing mental Health Professional team and Mental Health plan, and respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating and improving their treatment, care and support.

Principle 15: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons, and people's existing mental Health Professional team.

APPENDIX B – Orygen and Dr Andrew Chanen’s Clinical Staging model

Clinical Staging: Diagnostic utility and stepwise care



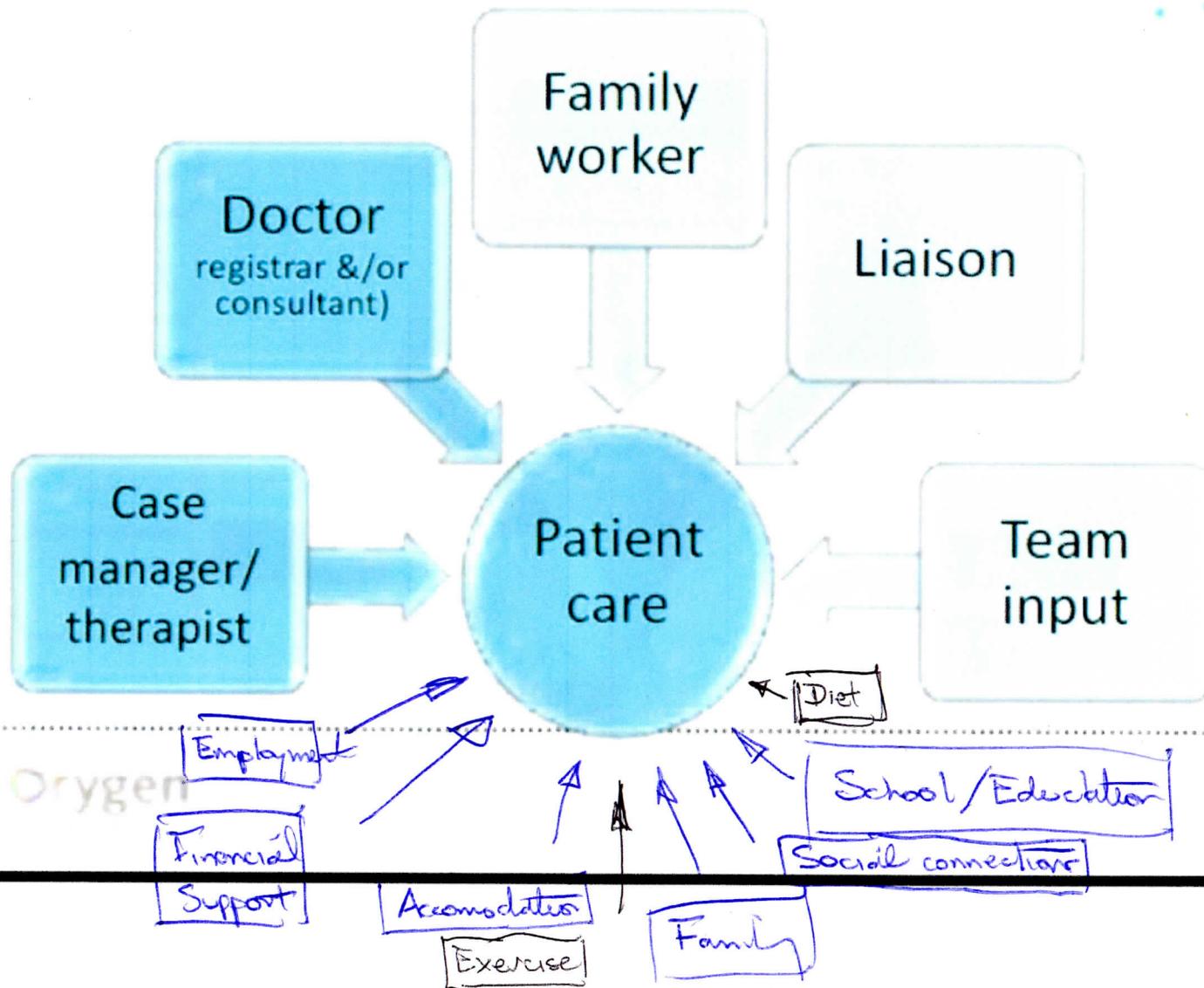
Orygen

Dr Chantel
Orygen Youth Mental Health

APPENDIX C – Orygen’s Team Treatment approach (marked up)

Team Input Into Patient Care

Person



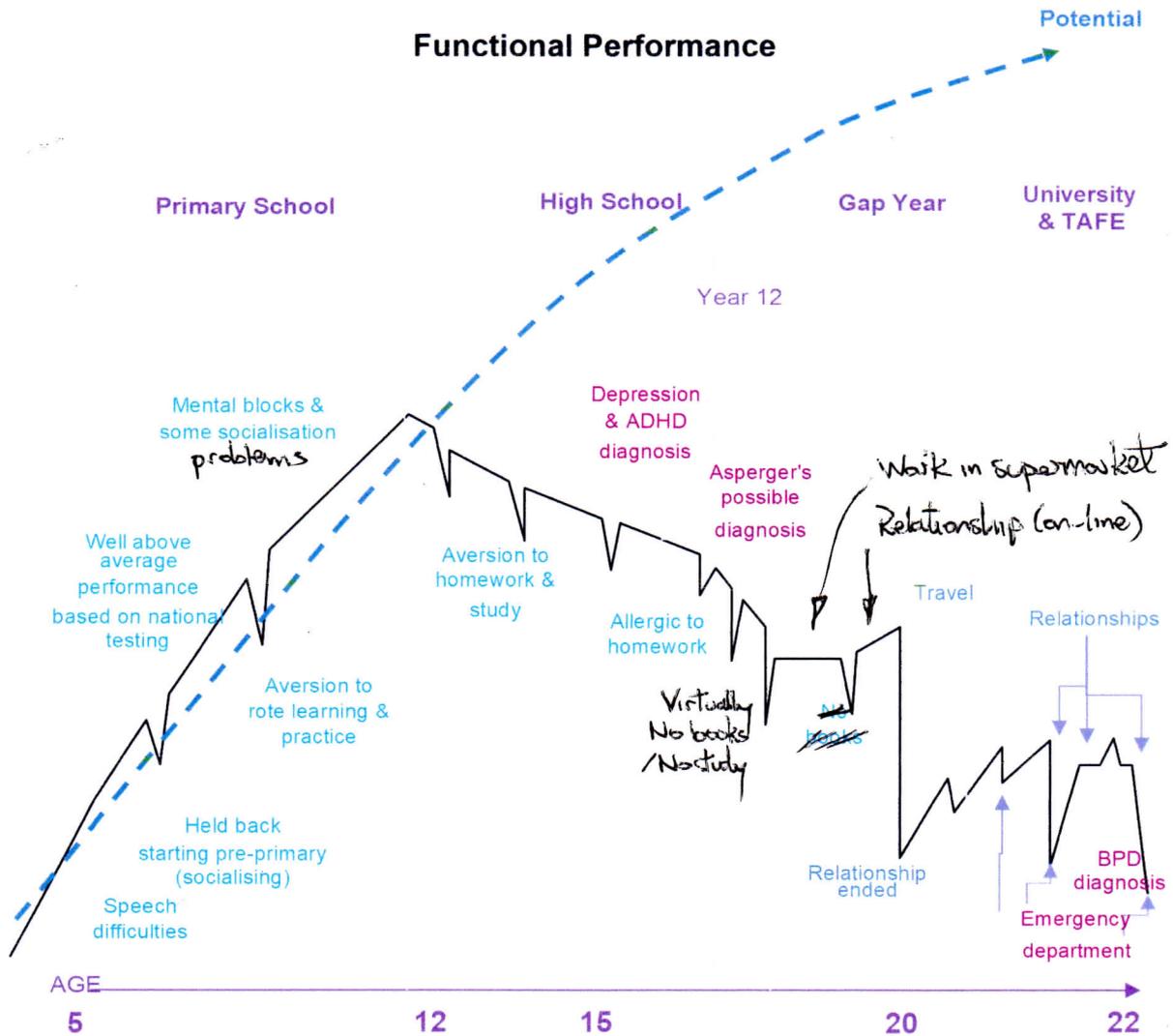
APPENDIX D –

Life Trajectory
Functionality vs Age history (marked up)

Masked up classifications.

(Thank you for creating this)

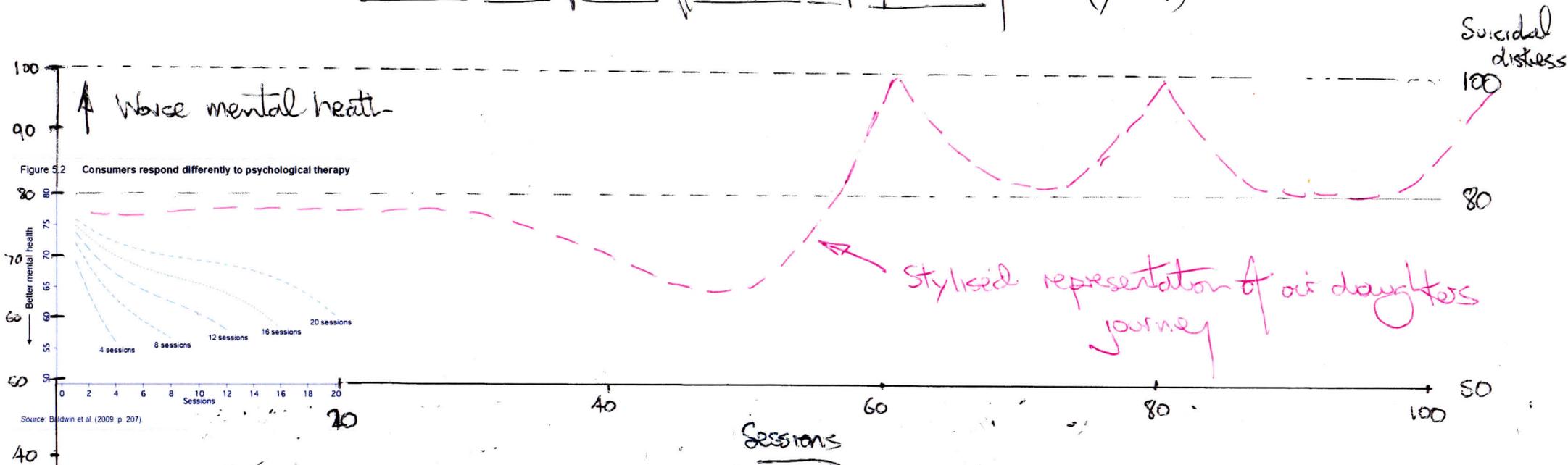
Figure 3.2 Life's trajectory: the lived experience of one young person



Source: Adapted from Robert Davis, sub 133.

APPENDIX E – ‘Consumer’s respond differently to psychological therapy’ (marked up)

"Consumers respond differently to psychotherapy" (Yes!)



Better mental health
↓

	Age	Year	Sessions/Yr
Yr 1	16yo	2011	22
Yr 2	17yo	2012	13
Yr 3	18yo	2013	7
Yr 4	19yo	2014	12
Yr 5	20yo	2015	36
Yr 6	21yo	2016	19
Yr 7	22yo	2017	3

Total of 110+ Sessions over 6 years (excluding GP visits)
(and extensive social support from a community service group)

5 x Psychologists

3 x Psychiatrists

4 x ED admissions

1 x Private clinic

APPENDIX F –

Feedback on WA Suicide prevention plan 2021-2025

Feedback on WA Suicide prevention plan 2021-2025

Feed in via website 20th Oct 2019

Overall - the action plan does not appear to allocate responsibilities & accountabilities (important for any plan), nor set out resource allocations (\$s and people), nor goals and expected outcomes, nor measures for those. Due to these factors and due to the complexity of matter, the probability of making a significant impact would not appear to be particularly high

The only suggested change to the title would be the timeframe. 5 years is likely to not be enough to get significant change. While some things can happen in that timeframe - there are things such as resilience in children and communities that will take a long time to flow through

Vision. Would prefer that it said 'positive' mental health rather than 'optimal'. Optimal seems a bit lame and not really ambitious.

Goal. Is not specific enough. An interim target level and time frame should be selected.

Principles. Word such as Proactive, seamlessly stepping up and down in care and across services, and mention of Families and Carer being important in the care process should be mentioned

Enablers. Could include 'clear models that work' (ie. models of care, intervention, prevention etc)

Priority areas. would like to see some mention of the expected level of resources (\$'s and people) and expected outcomes (ie reduction in suicide rate and timeframe) for each of the initiatives. That would help further prioritise them and improve accountability.

Also. Would like to see more mention of Resilience. Wellbeing is one thing, but being Resilient allows the state of Wellbeing to be held longer when under adversity.

Would also like to see some consideration of the availability of assistance. I would imagine that most suicides don't occur during normally working hours. Access to therapists and care workers on weekends and after hours is likely to be important. (ED is not really sufficient)

Possibly also have some form of Risk assessment tool that can help flag in the 'system' if people are likely to be suicidal and who to contact and how to respond if the present to ED, police etc.

Overall - Would not appear to be sufficient attention given to accountabilities, resource allocations and expected outcome. Likelihood of significant impact is therefore low.

Rob Davis