

Response to Productivity Commission's draft mental health report

The first section of this submission provides comments against each of the five key reform areas identified in the draft report.

The second section provides comments against some of the draft recommendations and findings.

Key reform areas

In its draft report, the Productivity Commission proposes five key reform areas:

1. Early help for people
2. Improving people's experiences with mental health care
3. Improving people's experience with services beyond the health system
4. Increasing the participation of people with mental illness in education and work
5. Reforming the funding and commissioning of services and supports.

The actions that have been identified by the Productivity Commission against each of these reform areas apply to a range of organisations and governments at a state/territory and Commonwealth level – not just primary health networks (PHNs).

Primary Health Tasmania notes that many of the proposed actions/suggestions have appeared in different strategies and policy documents in the recent past.

Primary Health Tasmania agrees with the overall thrust of the Productivity Commission's draft report into the current state of the mental health system in Australia and the recommended changes put forward by the Commission to achieve "a path for maintainable long-term reform". However, we are of the view that a number of the recommendations require further consideration based on differing population socio-demographics and mental health need; jurisdictional 'politics' and geography; and the current status of health system readiness within each region.

We have focused our response on areas where the Commission's recommendations refer to, or relate directly to, the current work of PHNs and where we believe we can add value.

1. Early help for people

National stigma reduction strategy

Any national campaign should include the ability for the messaging to be adapted to reflect local context while still reflecting national branding. This includes the use of local imagery, spokespeople and delivery mechanisms. Messaging also needs to be tailored to meet the needs of different target audiences (e.g. culturally and linguistically diverse people; Aboriginal and Torres Strait Islander people; young people).

Indigenous organisations empowered as preferred providers of the suicide prevention activities for Aboriginal and Torres Strait Islander people

It is critical that care is taken to ensure that in any desire to provide self-actualisation, we do not lose service integration as a key goal. Also, that we do not forget that in some jurisdictions there is a proportion of the Indigenous population who choose to use the mainstream sector to source services.

In addition, some Aboriginal community-controlled health organisations/Indigenous organisations may actively choose not to lead this type of activity; they would rather partner with others. The requirement to be a preferred provider should be place based, recognising that a 'one-size fits all' approach may not be suitable in all circumstances.

2. Improving people's experience with mental health care

Establishment of a peer workforce should be a 'start now' activity

This activity should be advanced to add further depth and capacity to an already challenged workforce. Training of new providers takes some years to initiate and establish. A potential peer workforce already exists and could be much more quickly trained, activated and engaged. The adoption of a peer workforce strategy has already gained traction in a range of current state and national policies.

Universal access to aftercare

Any national aftercare programs (including the Way Back Support Service) should be implemented in such a way that they reflect local needs and don't duplicate or replace existing programs where these are found to be evidence based (in line with the CRESF reporting findings) and delivering good outcomes.

3. Improving people's experience with services beyond the health system

Funding cycles for all psychosocial services to be at least five years

Primary Health Tasmania supports these recommendations with a caveat that there be alignment of funding streams to ensure all relevant work streams commence and end at the same time. One of the biggest barriers to successful stepped care service procurement is the different commencement and termination dates of funding contracts within the broader mental health commissioning space.

Improving eligibility requirements, availability and suitability of psychosocial supports

It is abundantly clear that the implementation of the NDIS and the reshaping of the psychosocial support system to work alongside this will take some time to bed down. Giving PHNs greater flexibility to work with consumers, carers, providers and state governments to identify gaps in the new system and implement activity to address these gaps is critical.

4. Increasing the participation of people with mental illness in education and work

Primary Health Tasmania is supportive of the recommendations put forward by the Commission and has no feedback under this heading.

5. Reforming the funding and commissioning of services and supports

Primary Health Tasmania agrees that system reform within the mental health sector is vital to achieve lasting improvements and the successful attainment of the preferred consumer health outcomes cited in the Fifth National Mental Health Plan and other Australian Government strategic policies and frameworks.

The Productivity Commission draft report proposes two options:

1. Option 1: Renovate model – Continuation of the current approach with some changes to give PHNs greater flexibility.
2. Option 2: Rebuild model – Creation of Regional Commissioning Authorities (RCAs) that would be responsible for the administration of all mental health funding (state/territory and Commonwealth).

The Commission had indicated its preference for Option 2.

Primary Health Tasmania does not support the Commission's Option 2 preference. We see that the creation of regional mental health commissioning authorities can only result in a separation and siloing of mental health commissioning responsibilities from other health domains (e.g. alcohol and other drug treatments, chronic condition interventions, etc). This appears contrary to the ethos of the Fifth National Mental Health Plan, which highlights the importance of an integrated approach taking into account the relationship between good mental health and wellbeing and the attainment and maintenance of better physical and emotional health and wellbeing.

It should also be noted that in general, PHNs have worked hard to build a level of commissioning maturity and capability that could not be simply developed or established overnight by another entity.

Primary Health Tasmania, a single PHN for a whole state, is already heavily involved in joint system and service planning with the Tasmanian Department of Health. In partnership, we have:

- initiated a state-based agreement on regional mental health and suicide prevention planning and application of a stepped model of care within our jurisdiction, and
- developed a community complex care model.

To discard the work already applied to establish this strong and shared stakeholder relationship in the belief that the rebuild model would be capable of providing anything more in its first few years would be, in our view, very short sighted.

It is Primary Health Tasmania's strong view that there needs to be a focus on continuing to build upon current system successes and that application of the renovate model can achieve what the rebuild model sets out to do without the significant restructuring of the current PHN model in jurisdictions such as ours, where there is a single PHN working collaboratively with single state counterparts (Department of Health and Local Hospital Network).

This approach would be less disruptive, but success would require inclusion of binding requirements in the COAG-driven healthcare agreements, these agreements must require all parties to actively participate in the development and implementation of jointly purchased and procured community-based services and system improvement interventions. In turn this process must be underpinned by co-design and co-commissioning and built upon a jointly planned system, with short, medium and long-term performance measures.

Primary Health Tasmania would also like to draw the Productivity Commission's attention to an issue that does not appear to have been addressed in the draft report. This is the ongoing funding of national bodies by various Commonwealth departments (Department of Health, Department of Social Services, Department of Prime Minister and Cabinet) without consideration of, nor reference to, existing programs operating at a state or local level within PHN jurisdictions.

Organisations including Beyond Blue, headspace and Wesley Mission receive funding from various Commonwealth departments to develop initiatives at a national level and implement them at a state level. The seeming lack of flexibility and recognition of local initiatives can, and often does, result in duplication of services, services not meeting local needs, and a lack of local ownership.

For example – the Way Back Support Service is an evidence-based and evaluated program that Beyond Blue has sought and been given funding to roll out across Australia. However, the implementation of this model across multiple jurisdictions has not been flexible enough to enable the program to integrate with or complement existing state government/PHN-funded programs.

Primary Health Tasmania recognises that national programs can afford improved efficiency and effectiveness, including cost benefits. But the implementation methods should be flexible, recognising local initiatives and needs. Any new programs should complement and support existing working programs, rather than replace or duplicate.

Draft recommendations and findings

In relation to the Productivity Commission's draft recommendations and findings, Primary Health Tasmania provides the following additional comments aligned to specific recommendations.

- **Draft recommendation 11.4 – Strengthening the peer workforce.** This is an area where PHNs can play a significant role. PHNs have the capacity to support the implementation of the National Mental Health Commission's peer workforce development guidelines within the primary care space, as well as develop some consistency in how peer workers are supported and engaged. We suggest that PHNs are included in this recommendation as an enabler.
- **Draft recommendation 12.2 – Guarantee continuity of psychosocial supports.** This should include giving more flexibility to PHNs to enable them to use their funding to develop programs that provide greater access, fewer barriers, and more targeted support to people not seeking to or not eligible to access the NDIS.
- **Draft recommendation 19.4 – No-liability treatment plan for mental health-related workers compensation claims.** Recommendation includes a time period of no greater than six months for clinical treatment through Workcover. This should be amended to include a review clause so that people who need longer support are able to access it.
- **Draft recommendation 20.1 – National stigma reduction strategy.** Any national campaign should include the ability for the messaging to be adapted to reflect local context while still using national branding. This includes the use of local imagery, spokespeople and delivery mechanisms.
- **Draft recommendation 22.5 – Building a stronger evaluation culture.** Evaluation, particularly at a national level, is fractured, confusing and not well structured. Different institutions are funded to undertake evaluation of the various parts of the mental health system simultaneously, creating significant pressure on local organisations to participate. There needs to be a review of all of the current funding streams enabling multiple research activity at a state and national level, and thought given to a more systematic and coordinated approach to the funding of national evaluation programs.
- **Draft recommendation 23.2 – Responsibility for psychosocial and carer support services.** Recommendation suggests that all psychosocial services (other than the NDIS) be delivered by state/territory governments, requiring the current Commonwealth funding to be transferred to state/territory governments. The natural tendency for state and territory governments with respect to investment within the community health sector is to direct their attention toward addressing the ever-present tensions at the step-up, step-down interface with the hospital sector. This focus, while understandable, does result in service gaps within the primary health domain. It is a key objective of PHNs to address these gaps. It is therefore recommended that a proportion of the National Psychosocial Support (NPS) Measure funding continues to be directed to PHNs to develop and implement activity that meets the emerging needs of people and address service gaps that invariably will arise.

The needs of carers in the new psychosocial environment is missing and greater emphasis should be placed on ensuring carers and family members have improved access to appropriate supports in a timely manner, less they become a consumer of mental health and other services themselves.

- **Draft recommendation 24.2 – Regional autonomy over service provider funding.** We agree that PHNs should be given greater flexibility in how they can use available funding in partnership with other state/territory organisations to better meet the priority areas identified within needs assessments. If PHNs do agree to commission national programs (e.g. headspace), the national programs should have greater flexibility to support localising their programs without losing model integrity.