

# **Response to the Australian Productivity Commission's Draft Report on Mental Health**

*from the*

## **The Consortium of Australian Psychiatrists and Psychologists (original submission 260)**

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## Recommendations

Across four chapters, we argue for the following recommendations in order to address the high levels of need among consumers with severe and persistent mental illness:

1. We recommend a national network of Specialist Mental Health Centres in each State and Territory, which would involve consumers, carers, clinicians, and researchers working together to improve the treatment of severe mental illness around the nation. The first of these proposed Centres is being established in Victoria, as recommended by the Royal Commission into Victoria's Mental Health System and announced by the Victorian Government.
2. We recommend significantly increased levels of community and inpatient mental health care should be provided in Australia and that minimum levels of care should be mandated at the Commonwealth Government/COAG level. These levels should be determined on the basis of a wide range of expert inputs, not confined to those provided by the National Mental Health Service Planning Framework. In particular, we recommend moderate increases in acute, forensic, and non-acute mental health beds for the general adult population to bring Australia toward the median level of mental health bed provision in OECD countries. We also recommend establishing mandated minimum levels of service provision, as have successfully been in place in Germany for nearly three decades.  
We make these recommendations in the light of the fact that mental health systems in Australia, especially the components serving the needs of people with severe mental illness, have been in crisis for many years<sup>1</sup>.
3. We strongly support the Productivity Commission's recommendations about the role of research, clinical quality registries, and a national clinical trial network in improving the treatment of patients with severe and persistent mental illness.
4. We strongly endorse the Productivity Commission's recommendations about Individual Placement and Support (IPS), especially for people with severe mental illness.
5. We recommend the establishment of a National Mental Health Reform Committee, led by the Chief Medical Officer, in order 1) to coordinate, drive, and maintain the reform agenda based on the final and endorsed recommendations of the Productivity Commission, and 2) to set minimum standards for the provision of mental health care in Australia.
6. We support the Productivity Commission's plans for reforming Australia's mental health governance (strongly preferring the *Rebuild* model of reform).

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<sup>1</sup> As reflected by the description of Victoria's mental health system, by the Chair of the Royal Commission into Victoria's Mental Health System, Ms Penny Armytage (November 28<sup>th</sup> 2019) at the launch of the Commission's Interim Report – "...the State's mental health system has catastrophically failed to live up to expectations. ... Past ambitions have not been realised or upheld and the system is woefully unprepared for current and future mental health challenges." <https://www.youtube.com/watch?v=fShPYQmwrnU&spfreload=5>

## Introduction

Our Response to the Productivity Commission Draft Report on Mental Health (hereinafter ‘the PC Report’) strongly supports the consumer-focused reform agenda for Australia’s public mental health sector – where the consumer assesses the value of public mental health services so that treatment is provided how and when the consumer wants. To emphasise this, the PC Report (p. 8) includes as one of five broad areas of reform: “improving the consumer and carer experience of the mental healthcare system to ensure the care received is timely, is consistent with treatment needs and does not impose undue burden on either the consumer or their carer”.

We note that the PC Report did not comment on our consumer-focused proposal to establish an essential new element for the care of people with severe and persistent mental illness: “a network of Centres with integrated clinical care, education and research as per the world-leading exemplar, the Mayo Clinic, and embedded community care and placement services.”<sup>2</sup> The Royal Commission into Victoria’s Mental Health System considered a similar proposal and subsequently recommended establishing a new entity: the Victorian Collaborative Centre for Mental Health and Wellbeing. This Centre will “Drive exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system”<sup>3</sup>, and act as a centre for transitional research into severe and persistent mental illness.

Our current Response seeks to draw the Productivity Commission’s attention to Recommendation 1 of the Royal Commission into Victoria’s Mental Health System about the Victorian Collaborative Centre for Mental Health and Wellbeing, which has been accepted by the Victorian Government with preliminary planning already underway.

We suggest that the Productivity Commission’s Final Report on Mental Health should consider this Recommendation’s likely positive impact on the care of consumers living in Victoria, and whether consumers around the nation may also benefit from similarly excellent levels of mental healthcare (Chapter 1 of the current Response). We propose that the Productivity Commission should consider recommending that other states and territories establish similar Centres (which we call Specialist Mental Health Centres), leading to the creation of a unified national network of centres for world-leading clinical care, education, and research for consumers with severe and persistent mental illness.

Why are we focusing on this group: consumers with severe and persistent mental illness? We acknowledge that adult consumers with severe and persistent mental illness represent a small percentage of the Australian adult population (approximately 0.4% or about 60,000 Australians in 2015), however their needs are extremely high. Consumers with severe and persistent mental illness require a disproportionately high volume of multiagency services, and use a very large proportion of public sector community, emergency department, and inpatient specialist mental healthcare.

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<sup>2</sup> Submission 260 to the Productivity Commission inquiry into Mental Health: Consortium of Australian Psychiatrists-Psychologists, p. 2.

<sup>3</sup> Royal Commission into Victoria’s Mental Health System: Interim Report, November 2019, p. 391.

Consequently, the Productivity Commission’s efforts to improve the consumer and carer experience of Australia’s public system needs a stronger emphasis on the small percentage of consumers with severe and persistent mental illness. We recommend that the PC Report should explicitly acknowledge that this core group of consumers represents a significant majority of service usage in our mental health system.

Precise statistics of the service needs of consumers with severe and persistent mental illness are difficult to provide: few Australian linked datasets are available to accurately quantify the proportion of mental health services used by these consumers. But the broad picture is clear. In a recent report to the Western Australian Parliament, the Auditor General (<https://audit.wa.gov.au/>) used linked data to identify that 10% of the total number of mental health consumers (21,000 people over a 5-year period) used 90% of WA’s inpatient care and 50% of all emergency and community mental health services. The high utilising cohort (0.8% of WA’s total population) could be considered to be the core consumers of WA’s mental health services.

Within the high-utilising consumer cohort, the WA Auditor General’s Report found that an even smaller group of 1,500 adult mental health consumers had hospital inpatient stays of 100 days or more during 2013–2017. While diagnostic and risk profiles were not reported, this cohort included adult consumers with severe and persistent mental illness, and older adult consumers with cognitive impairment and aggression. Of these, 126 consumers stayed for 12-months or more in acute beds, reducing available capacity by 83,000 inpatient days at an estimated cost of \$115 million, and another 158 consumers had multiple acute admissions that totalled 365 days or more.

The PC Report emphasises the huge impact of long inpatient stays in reducing the available capacity of Australia’s acute wards; and that the treatment needs of this core cohort of adult consumers who require long inpatient rehabilitation stays would be better met in more suitable non-acute settings. We strongly agree with the PC Report on this point, but in Chapter 2 we challenge the PC Report’s bed modelling, in particular the proportion of acute and non-acute beds allocated to the hospital and community residential sectors. We believe that the PC Report’s bed modelling is not fit for purpose for hospital-based mental health requirements, as it is based on unjustified assumptions about reducing demand in hospital settings.

In relation to longer term assumptions about the likely demand for mental health care for people with severe mental illness, we note that the PC Report places a very strong emphasis on early intervention and prevention, with the inference that this may reduce demand for treatment of mental health disorders later in life. This emphasis is best crystallised by the subheading on page 186 of the Report – “Prevention is so much better than a cure”. While this might be a correct and worthy sentiment in the broadest sense, severe mental illnesses can neither be prevented<sup>4</sup> – in the primary sense – nor cured. We firmly support research seeking to change these limitations on our current capabilities; but until substantial breakthroughs are made, we must base the planning of mental health care provision

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<sup>4</sup> Reducing risks for mental disorders, Mrazek PJ, and Haggerty RJ (editors), Institute of Medicine, National Academic Press, 1994. The conclusion by the Institute of Medicine, in one of the most definitive books on risk reduction in mental health is still current, namely - “universal and selective interventions to prevent the onset of schizophrenia are not warranted at this time” (p 153). [https://www.ncbi.nlm.nih.gov/books/NBK236319/pdf/Bookshelf\\_NBK236319.pdf](https://www.ncbi.nlm.nih.gov/books/NBK236319/pdf/Bookshelf_NBK236319.pdf)

for people with disorders such as schizophrenia and bipolar disorder on the presumption that we cannot prevent or cure these conditions.

We strongly support calls for early intervention for psychiatric disorders at every life stage and, when possible, ameliorating risk factors which may predispose people to develop such disorders (such as poor physical health, psychological and sexual trauma, socio-economic disadvantage, and being in the Child Protection system). We support these calls for many reasons, including the fact that doing so is of primary and direct benefit to the affected or at-risk person. We would, however, highlight that there is a difference between modifying the risk factors associated with a disorder and demonstrating that such modifications reduce the subsequent incidence of the disorder.

It is clearly worth testing the hypothesis that risk factor reduction also reduces the incidence of severe mental illness later in life, but the outcomes of these modifications may not be known for decades – so any planning assumptions about mental health care delivery systems for adults will not be able to be predicated on preventative interventions in childhood and adolescence being effective until unequivocal evidence of the validity of such assumptions is provided in years to come.

### **Chapter Summaries:**

Chapter 1 further develops the case for establishing a network of Specialist Mental Health Centres, particularly to support the needs of people with severe and persistent mental illness.

Chapter 2 discusses the problematic assumptions of the NMHSPF, and calls for nationally mandated minimum standards of service provision and bed numbers.

Chapter 3 supports the PC Report's recommendations about Individual Placement and Support (IPS) services, and details some specific advice about implementing a national trial based on Associate Professor Geoffrey Waghorn's specific expertise in this area and on lessons drawn from the final report on the headspace trial of IPS.

Chapter 4 supports the Rebuild model of governance reform, and recommends establishing a national Mental Health Reform Committee led by the Chief Medical Officer, a Severe and Persistent Mental Illness Committee, Mental Health Integration Hubs, Mental Health Regions, and other governance reforms.

## Chapter 1: The case for Specialist Mental Health Centres

One significant recommendation that was not addressed in the PC Report was to establish a network of Specialist Centres with integrated clinical care, including inpatient care, education and research as per world-leading exemplars such as the Mayo Clinic, and embedded community care and placement services.<sup>5</sup> In this Response we term these centres: Specialist Mental Health Centres. This core recommendation is an important opportunity which we strongly urge the inquiry to consider. Specialist Mental Health Centres would deliver economies of scale and drive service synergies which could play a fundamental role in meeting many of the challenges this inquiry seeks to address. The Centres would also provide particular care for people with severe and persistent mental illness, who represent those most in need of multiagency services.

We recommend at least one Specialist Mental Health Centre per state (~1 centre per 2 million population), and the creation of a unified national network of facilities for world-leading clinical care, education, and research. By synergistically combining large numbers of expert clinicians, researchers, and patients under one roof, we can enable world-class research, inpatient and outpatient care, and workforce training. These linked facilities would each serve as an integrated local clinical, scientific, and physical node, providing the foundations for an interstate system of national mental health governance.

The recommended Specialist Mental Health Centres would function much like the specialised and highly successful Peter MacCallum Cancer Centre, Royal Children’s Hospital, and Royal Women’s Hospital – embedded within or alongside metropolitan hospitals, attracting high-quality researchers and staff, ensuring best-practice care and outcomes, and serving as hubs for research. Specialist Mental Health Centres would supplement rather than replace existing mental health services within general public health services. Since we need to increase the supply of mental health beds (see Chapter 2), many of the new beds could be housed in these new comprehensive and collaborative facilities.

Momentum for university affiliated Specialist Mental Health Centres has grown substantially since the initial round of submissions to this inquiry, as the Royal Commission into Victoria’s Mental Health System (RCVMHS) recently recommended “that the Victorian Government establishes a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing.”<sup>6</sup> The Victorian Government has accepted and will fund this and all the other RCVMHS interim recommendations.

The RCVMHS argues for the unique benefits of specialist, large-scale, university affiliated centres (i.e. an SMHC):

Comprehensive and collaborative centre models have been adopted globally to advance efforts to improve life expectancy and develop responses to pressing health challenges in areas such as cancer, cardiac disease and communicable diseases. These models are based on the idea that integrating people and organisations that have a shared purpose—a specific disease or health challenge, for

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<sup>5</sup> Submission 260: Consortium of Australian Psychiatrists-Psychologists, p. 2.

<sup>6</sup> Royal Commission into Victoria’s Mental Health System: Interim Report, November 2019, p. 391.

example—will produce greater benefits more rapidly than an individual or a single organisation could achieve alone.<sup>7</sup>

Victoria has already invested in this type of specialised collaborative model for cancer, with the Victorian Comprehensive Cancer Centre (VCCC).

This novel approach is already changing the way we tackle cancer in Victoria. The VCCC’s success has been driven by commitment to a shared goal: to deliver better outcomes for Victorians. It is this collective focus that enables system level change and makes this alliance greater than the sum of its parts.<sup>8</sup>

## Specialist public hospitals in Victoria

Data primarily obtained from 2017–18 Annual Reports



### The Royal Women's Hospital

Annual expenditure: \$267m  
 Inpatient beds: ~200  
 Inpatient activity: 32,113  
 Outpatient visits: 77,559



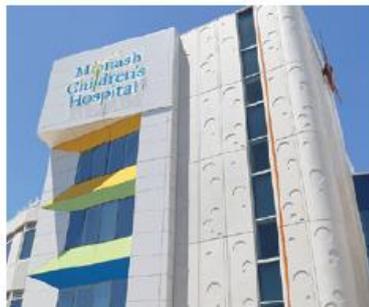
### Mercy Hospital for Women

Annual expenditure\*  
 Inpatient beds: 314  
 Inpatient activity: 23,063  
 Specialist clinics: 47,473



### Joan Kirner Women's and Children's Hospital

Opened May 2019  
 \$200 million facility  
 Inpatient beds: 237



### Monash Children's Hospital

Annual expenditure: \$120m  
 Inpatient beds: 180  
 Inpatient stays: 13,162  
 Outpatient visits: 47,355



### The Royal Children's Hospital

Annual expenditure: \$668m  
 Inpatient beds: ~250  
 Inpatient activity: 58,368  
 Specialist clinics: 143,886

- Women's and babies' hospitals
- Women's and children's hospitals
- Children's hospitals

# Inpatient activity is measured as Weighted Inlier Equivalent Separation (WIES) – as defined by Victoria's Department of Health and Human Services.

\* The expenditure of the Mercy Hospital for Women is integrated within the total expenditure of Mercy Hospitals Victoria Ltd.

<sup>7</sup> *Ibid.*, p. 394.

<sup>8</sup> *Ibid.*, p. 398.



**Olivia Newton-John Cancer and Wellness and Research Centre**

Annual expenditure\*\*  
 Inpatient beds: 84  
 Day oncology treatments with overnight stay: 12,306  
 Outpatient visits: 28,822



**Peter MacCallum Cancer Centre**

Annual expenditure \$480m  
 Inpatient (overnight) beds: 96  
 Day beds: 85  
 Inpatient activity: 22,596  
 Outpatient clinic activity: 85,104



**Calvary Health Care Bethlehem**

Annual expenditure: \$24m  
 Inpatient beds: 32  
 Admissions: 498  
 Bed days: 8,992



**Royal Victorian Eye and Ear Hospital**

Annual expenditure \$108m  
 Inpatient activity: 16,940  
 Outpatient visits: 159,913



**Victorian Heart Hospital**

Expected date of completion 2022  
 ~ \$560m investment estimated  
 Inpatient beds proposed: 195



**Thomas Embling Hospital/Forensicare**

Annual expenditure: \$88m  
 Inpatient beds: 116

- Cancer hospitals
- Palliative care hospital
- Eye, ear, nose and throat hospital
- Cardiac hospital
- Forensic psychiatry hospital

\*\* Expenditure of the Olivia Newton-John Cancer and Wellness Centre is integrated within the total expenditure of Austin Health.

The Victorian Heart Hospital, the Peter Doherty Institute for Infection and Immunity, the Melbourne Children’s Campus, and many more (see above) are further examples of substantial investment in such specialist centres in other areas of healthcare in Victoria. Yet when it comes to mental illness, Australia’s investment in comparable centres has been extremely limited.

There is a powerful ethical argument here for “parity of care”<sup>9</sup>: Australians suffering with mental illness are entitled to the same quality of care as those suffering from physical illness. Parity of care demands that mental health – ranked just behind cancer in Australia’s top four burden of disease groups – ought to receive the same standard of dedicated, specialist infrastructure as these other health domains. This moral demand for parity of care is arguably justification enough, yet there is an additional strong rational argument for the synergistic efficiency of a national network of integrated SMHCs: it is equitable, innovative, and far-sighted.

### **Inpatient and community mental health services:**

In Chapter 2 we express concerns with the PC Report’s proposed ratio of increases in acute and non-acute mental health beds. However, what is not disputed is the vital need to increase bed-based services.

Many consumers will continue to miss out on the care they need until there are sufficient specialist community mental health services. Remediating this requires ‘filling the gaps’ in current community ambulatory and non-acute bed-based services provided by State and Territory Governments. (PC Report, p. 282)

Despite the often-prevailing view that inpatient psychiatric care should be seen as a method of last resort – a regrettable necessity – evidence on inpatient care demonstrates that it is critically important and plays a positive and constructive role in mental health care. Inpatient psychiatric care is both life-saving and life-enhancing. Properly supported acute care is invaluable, as expert staff do not just perform crisis resolution (an important first step): they provide therapeutic benefits that support recovery. They provide comprehensive diagnostic formulation (key to understanding and managing mental health problems), assessment, biological and (ideally) psychological treatments, respite, carer and family engagement, and comprehensive discharge planning.<sup>10</sup>

There is a clear and compelling need for inpatient psychiatric care. Many serious mental illnesses are relapsing and remitting, so the need for periodic hospitalisation is common. Inpatient care should be seen as an integral and critical part of a continuum of comprehensive psychiatric treatment. Hospitalisation with 24-hour nursing and readily available medical and allied health care provides the opportunity to assess, diagnose, and stabilise complex and comorbid psychiatric illnesses.

Inpatient beds are needed in mental health care, just as they are for persons with medical and surgical problems. They are crucial when dealing with problems which are life-threatening. Also, some patients require procedures which can only be carried out in hospital, or they need a large team – which cannot be assembled in the outpatient setting – to assess or treat their illness. Sometimes patients require long periods of observation while they are receiving treatment, or if they are trying stepwise procedures or alternative treatments.

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<sup>9</sup> The Adult Psychiatry Imperative: Achieving parity of care, Submission to the Royal Commission into Victoria’s Mental Health System, July 2019, p. 1. [https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/2915/6765/3776/The\\_Adult\\_Psychiatry\\_Imperative.pdf](https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/2915/6765/3776/The_Adult_Psychiatry_Imperative.pdf)

<sup>10</sup> Sharfstein, Steven S. “Goals of Inpatient Treatment for Psychiatric Disorders.” *Annu. Rev. Med.* 60, no. 1 (2009): 393-403.

We argue for a significant increase in both inpatient and community mental health bed-based services; but whatever the ratio, these bed-based services will need to be housed somewhere. With their synergy of clinical expertise, innovative research, and integrated services, the proposed Specialist Mental Health Centres would be ideal locations for providing some of the recommended new bed-based services and infrastructure.

If these new beds were instead dispersed across disparate locations, the inefficiency would be inherent: the workforce and infrastructure would be diffused, reducing synergies of staffing, experience, and infrastructure.

### **Research, clinical quality registries, and the national clinical trial network:**

The PC Report's Draft Recommendation 25.9 states: "The Australian Government should fund the establishment of a national clinical trial network in mental health and suicide prevention" (p. 1036). We recommend that this national clinical trial network should be embedded in the proposed national network of SMHCs. These state-of-the-art, integrated, university affiliated centres would provide an ideal collaborative research/clinical environment for hosting large, multi-centre clinical trials.

Analogous (though cancer-focused) "comprehensive and collaborative centres" in the United States, Europe, and the United Kingdom "have been successful in bridging gaps between research and clinical care, and they derive considerable benefit from having access to sizeable cohorts of patients, high rates of recruiting patients to trials, and access to national evidence review groups to enable rapid implementation on a large scale".<sup>11</sup>

King's College London and the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) together host the NIHR Maudsley Biomedical Research Centre – an excellent example of the type of co-located integrated clinical care and research we are recommending.<sup>12</sup> The Institute is Europe's largest centre for research and postgraduate education in psychiatry, psychology, and basic and clinical neuroscience – producing more highly cited publications in psychiatry and mental health (Scopus, 2016) than any other university in the world. In the 2014 Research Excellence Framework they were judged to have the second highest research power in the UK for Psychology, Psychiatry and Neuroscience; the impact of their work was 100% world leading or internationally excellent; and its research environment judged as 100% world leading.

In strong alignment with the proposed national network of university affiliated SMHCs, the National Health and Medical Research Council (NHMRC) recently announced a new program entitled the NHMRC Special Initiative in Mental Health. Described as:

a funding call to support a multidisciplinary and nationally focussed team to establish a national centre for innovation in mental health care as a collaborative network across Australia (involving key institutions, existing national networks in mental health, and other relevant bodies). The NHMRC Special Initiative in Mental Health will undertake innovative, high quality implementation research into improved health outcomes and outlooks for people living with mental illness. The centre will operate as a virtual network across Australia, coordinated by a single institution acting as an

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<sup>11</sup> RCVHMS Interim Report, p. 395

<sup>12</sup> <https://www.slam.nhs.uk/research>

administrative hub. The centre will include flagship programs to focus the network's activities on each of the identified research themes. Flagships, which may be based at participating institutions, should be open to a broad membership of researchers, clinicians, carers and consumers in mental health to facilitate innovative service delivery across Australia.<sup>13</sup>

This NHMRC program will lay the groundwork for enhancing nationally collaborative mental health research, with a virtual network across Australia. Adding a substantive physical national network of university affiliated Specialist Mental Health Centres would leverage and work synergistically with this virtual research network, providing the integration of research and clinical care that delivers world-class outcomes (such as the IoPPN has achieved).

Draft Finding 25.1 states that:

Monitoring and reporting at the provider level can improve transparency and accountability, and potentially service quality, through:

- publishing data that informs consumer choice and drives self-improvement
  - benchmarking analyses, where services are able to regularly compare their performance relative to similar services, that prompt discussions and information sharing.
- (PC Report, p. 1027)

To this end, we also recommend that the Specialist Mental Health Centres should host linked clinical quality data registries, which would in turn inform and support the national clinical trial network. According to the PC Report (p. 1027), one key barrier to implementing national benchmarking is data quality: "In particular, variation in the completeness of provider data (due to variable compliance with data entry) and comparability of data (due to varying protocols, processes and definitions) challenge broader implementation of benchmarking analysis". The recommended national network of Specialist Mental Health Centres would prioritise excellent standards of compliance with data entry since integrated clinical care and research are fundamental to their purpose. Moreover, the SMHCs' nationally integrated nature would ensure harmonisation of clinical trial data protocols across the country, as each node would be designed from the outset to be integrated into the broader network.

The PC Report (p. 1033) notes another concern with mental health research:

Where 'practical' research does exist, governments and service providers have not been making the best use of it to improve treatments and services. Econtext (2014) pointed to a lack of capacity within governments and among service providers to assess and apply the results of research.

A network of large-scale Specialist Mental Health Centres would provide ideal locations for expert clinicians to implement innovative treatments, while co-located researchers effectively assess the results. This creates a virtuous cycle as clinicians work with patients to inform the researchers of what practical research is needed, and researchers conduct studies to deliver new treatments and

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<sup>13</sup> <https://www.grants.gov.au/?event=public.FO.show&FOUID=7506793C-CB01-8CEE-00EFB588493FFB8B>

practices – which clinicians can then trial and come back with practical questions for further research. This process is facilitated by having researchers, clinicians, and patients all in one place.

### **Co-located services:**

Following the model of exemplars such as the Peter MacCallum Cancer Centre, the proposed Specialist Mental Health Centres would be embedded within or alongside general hospitals and other allied services. According to the PC Report (p. 363):

The key benefit of co-located services is that they bring together multiple services into one location — in effect, a ‘one stop shop’ — making it easier for consumers to access services they need. Other possible benefits of co-located services include:

- facilitating coordination and cooperation and improving information and resource sharing between staff and services
- enabling clearer and easier referral pathways between services, and potentially reducing the need for consumers to tell their story multiple times
- improving staff knowledge of other types of sectors and services (for example, mental health workers can gain a better understanding of the services provided by employment service providers) (EMHSCA 2017).

...Co-location of services is not sufficient on its own to deliver coordinated services. Providers also need to put in place specific processes, such as the use of single care plans (see above) to maximise the benefits of services working together (Mauro et al. 2016).

We fully agree with the PC Report’s assessment of the benefits of co-location, as well as the final caveat: co-location of Specialist Mental Health Centres with hospitals or other allied services would provide substantial opportunity for coordinating services, but they would need to be designed from the beginning with specific processes for service integration.

### **Workforce:**

Increasing the size of the mental health workforce is an important priority acknowledged by the PC Report (p. 367). The proposed modern, dedicated, specialised, prestigious, high-quality facilities would provide an appealing incentive for more people to join the workforce: “Reducing negative perceptions of mental health as a career option” (PC Report, p. 367).

The Specialist Mental Health Centres would also be an ideal place to deliver enhanced training and education, contributing to the need for “Training more psychiatrists in Australia by raising the number of training placements and availability of supervisors for trainees” (PC Report, p. 367).

### **Philanthropy:**

SMHCs can be the focus of major philanthropic activities in mental health – in a way that having multiple medium-sized mental health wards in general hospitals will never enable due to the fragmentation of such an approach. Examples of these benefits in other areas of health are the Royal Children's Hospital and the Peter MacCallum Cancer Centre, respectively raising ~\$25 million and ~\$46 million per year in specialist charitable funding.

The potential to attract major philanthropic funds to the mental health sector is particularly feasible when the organisational setting is substantial, trusted, associated with universities, and the cause is strong. For example, in 2014 philanthropist Ted Stanley donated \$650 million for research on psychiatric disorders to the Broad Institute, a unique centre which:

brings together faculty from Harvard University, the Massachusetts Institute of Technology, and the five major Harvard-affiliated hospitals: Beth Israel Deaconess Medical Center, Boston Children's Hospital, Brigham and Women's Hospital, Dana-Farber Cancer Institute, and Massachusetts General Hospital... Together, the Broad Institute community uses industrial-strength technological capabilities to take on challenges too great for any single lab or institution to tackle.<sup>14</sup>

For an Australian example, the Turner Institute for Brain and Mental Health received nearly \$50 million from the late David Winston Turner.<sup>15</sup>

Yet of total gross charitable income, only 0.8% is directed toward mental health.<sup>16</sup> This contrasts with cancer charities that receive five times as much, despite similar levels of burden of illness on the Australian community. 85% of the philanthropic sector recognises that mental ill-health is a critical issue, yet only 28% of private funders donate funds to mental health charities. How can we explain this disparity?

The Future Generation report identified six key reasons why private funders are “holding back:

1. Mental illness is complex and the mental health sector is convoluted.
2. There is significant duplication across mental health delivery.
3. Most mental health charities have little profile and their messages are not resonating.
4. Measuring outcomes is a requirement for funding.
5. They are not aware of their place in the mental health sector.
6. There are not enough leaders encouraging other funders to invest in mental health.”<sup>17</sup>

Large-scale Specialist Mental Health Centres would help to address these six problems. They would be centralised, integrated hubs within an otherwise convoluted sector (reason 1), and would reduce duplication of mental health delivery (reason 2), thus providing a clear focal point for charities to rally behind. They would be university affiliated, leading exemplars of best practice, building the profile or brand (reason 3) of associated charities. And they would include national data linkage and clinical quality registries (described above), which would enhance measurement of empirical outcomes (reason 4) and hence enable philanthropists to invest with greater confidence in the benefits of their contributions. Furthermore, embedding Specialist Mental Health Centres in mental health services ensures an integral local and national role in the mental health sector (reason 5) and

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<sup>14</sup> [https://news.harvard.edu/gazette/story/2014/07/broad\\_psychiatric\\_research\\_gift/](https://news.harvard.edu/gazette/story/2014/07/broad_psychiatric_research_gift/)

<sup>15</sup> <https://probonoaustralia.com.au/news/2019/07/record-donation-to-make-mental-health-headway/>

<sup>16</sup> <https://probonoaustralia.com.au/news/2019/10/australian-mental-health-charities-miss-out-on-philanthropic-dollars/>

<sup>17</sup> Australia's Mental Health Crisis: Why private funders are not answering the call. Future Generation and Ernst & Young 2019, p. 2.

provides a fertile ground for leaders to be developed from within the sector to engage with policy-makers and funders (reason 6).

### **Summary of benefits**

This national network of Specialist Mental Health Centres would generate crucial health, social, and economic benefits:

- Health benefits for individuals – via the care of the Specialist Mental Health Centres themselves, and research outcomes generating best practice care standards and novel treatments translated to individuals nationally and internationally.
- Increased efficiency through targeted, precision patient care – underpinned by registry data, which could include real-time monitoring for adverse outcomes so that swift intervention is possible to restore health.
- Increased participation and employment for people with serious mental illness – Specialist Mental Health Centres focus on both symptomatic and functional recovery, and have embedded placement services within the Centres to help people get back to work.
- Reduced burden for carers – a significant and often overwhelming burden of care for people with serious mental illnesses fall to their families and other carers. Appropriate specialised care centres for people with serious mental illness would reduce this burden, allowing families to participate in the community in other ways, such as employment.
- Increased capacity of the healthcare workforce – through training of the next generation of highly skilled staff across psychiatry, psychology, mental health nursing, allied health, social work, and employment services.
- Research and R&D investment from schemes including the Medical Research Future Fund (MRFF) and the National Health and Medical Research Council (NHMRC), as well as philanthropy and commercial sources – driving discovery research that will underpin future innovations in mental health care.
- Commercialisation returns from intellectual property licencing, spin-out, or other commercial outcomes based on research outcomes.

### **Conclusion**

Large-scale specialist hospitals are common across nearly all categories of health, except for mental health. There is a reason these specialist hospitals exist: they bring together a critical mass of expert clinical care, research capability, and education and training that has proven worth the investment.

Specialist care is invaluable across all areas of health care; mental health care is no different. Currently, people with serious mental illnesses are often marginalised when contrasted with those with only general health care needs, and we believe – from an equality and human rights perspective – that this marginalisation should not be allowed to continue.

Moreover, given the economic magnitude of the mental health challenge – “\$43 to \$51 billion per year... [and] an approximately \$130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health” (PC Report, p. 2) – we urge this inquiry to consider the long-term efficiency dividends generated by a national network of large-scale SMHCs.

This network would be the foundational infrastructure of a newly reformed national mental health system, providing better integration of services, data linkage, registries, clinical trials, synergistic expertise, world-class inpatient/outpatient care, workforce training, and a focal point for philanthropic investment, all tied together with a unified governance structure.

Investing in such large-scale infrastructure is an achievable vision; in fact, Victoria has already begun to make one of these Specialist Mental Health Centres a reality. Its new purpose-built facility will position the state as a national leader in mental health care, but we need the other States and Territories to follow suit if we want to deliver an integrated national network of Specialist Mental Health Centres capable of fundamentally changing the way we tackle the national crisis within our mental health system.

## Chapter 2: The provision of public mental health community treatment services and acute and non-acute mental health bed-based services in hospitals

Public hospitals play a vital role in the continuum of care for severe and persistent mental illness. Yet Australia's public hospitals are facing a major crisis. As the PC Report (p. 303) indicates, the crisis is most evident in emergency departments (EDs), where "Restricted access to acute inpatient mental health beds has led to problems such as long waiting times to be admitted through an ED, and pressure on hospitals to discharge people early to free up beds". This follows from concerns expressed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australasian College for Emergency Medicine (ACEM) that people with severe mental illness are suffering excessive waiting times in EDs around the nation.

Despite this accurate analysis of the ED crisis, the PC Report does not recommend either substantially increased public acute mental health beds in hospitals or a maximum ED wait for admission. These recommendations could easily have been justified. As the PC Report notes, Australia's per capita numbers of psychiatric beds (42 acute and non-acute psychiatric beds per 100,000 people) is far below the OECD average (71 beds per 100,000). To reach the OECD average, Australia would need to increase the per capita supply of mental health beds by 69%. This could be achieved by increasing mental health's share of total hospital inpatient expenditure, which is low by OECD standards.<sup>18</sup>

In discussing Australia's position in the OECD rankings for psychiatric beds, the PC Report (p. 315–16) correctly notes the OECD's praise for Australia "leading the way in innovative approaches to delivering mental health services, including a decisive shift away from hospital care". However, it is important to also acknowledge that the OECD warned Australia to pay attention to the 'tricky balance' of hospital and community services, and accurately predicted the problems that consumers and carers are now experiencing with restricted access to inpatient care.<sup>19</sup> Hence, we suggest that Australia should invest in a more balanced and complementary mental health system, where major expansions in the community programs need to be matched by equivalent investments in hospital care – in order to correct the 'tricky balance' of Australia's mental health system. As we discuss below, the service modelling in the PC Report could lead to a more imbalanced system with greater problems in the EDs.

We highlight that Australia's psychiatric bed mix is *different to most other high-income countries*. Australia's pathway to deinstitutionalisation has left relatively few mental health beds in stand-alone hospitals: Australia has 10 hospital-based non-acute beds per 100,000 persons compared to a median of 31 beds per 100,000 in stand-alone mental health centres in other high-income countries. Europe has a median of 34 beds in stand-alone hospitals per 100,000.<sup>20</sup> As noted in the PC Report, Australia's relatively low numbers of non-acute rehabilitation beds in standalone hospitals could be

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<sup>18</sup> Rosenberg S and Hickie I. No gold medals: Assessing Australia's international mental health performance. *Australasian Psychiatry* 2018.

<sup>19</sup> Allison S, Bastiampillai T. Mental health services reach the tipping point in Australian acute hospitals. *The Medical Journal of Australia*. 2015 Dec 14;203(11):432-4.

<sup>20</sup> World Health Organization Atlas.

related to ED access block, if patients needing long stay admissions remain on acute wards for months due to the lack of these non-acute beds.

Even though restricted access to acute beds is a national problem, Draft Recommendation 7.1 suggests a strictly regional approach, in particular that “acute mental health beds are provided on an ongoing basis at the levels determined by regional service planning to be necessary to meet specific needs of each region” (PC Report, p. 303). This recommendation appears to have been written partly with the intention of addressing the national crisis associated with ED access block, but it provides inadequate guidance to the States and Territories on acute and non-acute bed number requirements; it may not correct or could even increase variation in access to acute and non-acute inpatient care across the country.

### **NMHSPF bed modelling**

The PC Report uses the National Mental Health Service Planning Framework (NMHSPF). Because the bases of the assumptions underlying NMHSPF’s modelling of Australia’s bed numbers aren’t publicly available, it isn’t possible to readily engage in a fact-based debate about them. However the outputs in the PC Report make it clear that the NMHSPF model *assumes* that large increases in specialist mental health community treatment services and subacute/non-acute community residential mental health bed-based services will reduce acute demand on public hospitals.

Based on this assumption, minimal increases in public acute mental health beds in hospitals would be required (see Box 8.1). The model indicates that Australia needs only 3% more acute beds than existed in 2016–17 (PC Report, p. 314), despite the PC Report’s finding that restricted access to acute inpatient care is increasing the pressure in the EDs and inpatient wards. According to the NMHSPF model, the vast majority of the new investment should occur in community ambulatory care (45%) and community residential, which should increase by 2,185 beds with only a small number of additional hospital-based non-acute beds (231 beds). We support increases in community mental health ambulatory care, including by means of outpatient services, as outlined in The Adult Psychiatry Imperative submission to the Royal Commission into Victoria’s Mental Health System, but our suggested increases are more modest than those proposed by the NMHSPF.

#### **Box 8.1**

#### **Benchmarking public sector mental health services**

3% more acute beds than existed in 2016-17

81% more non-acute beds than in 2016-17

45% more community ambulatory (outpatient) services (measured in terms of full-time equivalent workers providing services) than in 2016-17.

The estimated number of needed acute beds in 2019-20 was calculated on the assumption that readmission rates remain around the average over 2015 to 2017.

In purely practical terms, it will prove difficult to increase the size of the community mental health sector by nearly a half, due to workforce constraints. The PC Report does not specify how

community staffing could be increased by 45% given the existing challenges with mental health workforces, especially psychiatrists and mental health nurses across the Commonwealth.<sup>21</sup>

Yet even if this increase can be achieved, how strong is the evidence that substantial increases in community programs can reduce the pressures on public hospitals? Unfortunately, the PC Report provides limited information drawn from the States and Territories. The contents of Box 7.7 indicate that this information came mostly from opinion, surveys, and various government reports often using out-dated material (e.g. from 2004), without studies of the actual effects of acute bed closures where there can be unexpected results<sup>22</sup>. There are obvious gaps in the evidence provided. For example, the reply from South Australia reports the findings of a Census day in 2004 that 505 inpatients could have been discharged immediately if community beds were available.

However, the South Australian reply fails to detail that over the following decade the State Government closed acute beds and funded community residential beds, which resulted in ED access block for several years because the community beds were unable to reduce the pressures on acute hospitals.<sup>23</sup> Nor is there evidence that this strategy (using step up/ step down community beds to replace hospital beds) has worked in other jurisdictions. Having already seen the dire consequences of this faulty assumption in the South Australian context, *we are deeply concerned about the PC Report (p. 293) accepting – without more robust evidence – the assumption that roughly 30% of hospital inpatients could be discharged to community services.*

As noted above, Australia is well below the WHO median for beds in standalone hospitals (10 vs. 31 beds per 100,000 persons), and lacks the flexibility of providing acute and non-acute admissions in these settings. This unusual bed mix is related to the pressures on acute hospitals, as patients cannot be discharged from acute wards to hospital settings that have more flexibility for providing longer stay admissions. Hence, we suggest that Australia may need more hospital based non-acute beds than the NMHSPF model indicates.

*In terms of the real-world effects of increased community expenditure on hospital demand, we also question the Productivity Commission's interpretation of Figure 7.5 (below), which examines the relationship between expenditure on community mental health services and mental health ED presentations.*

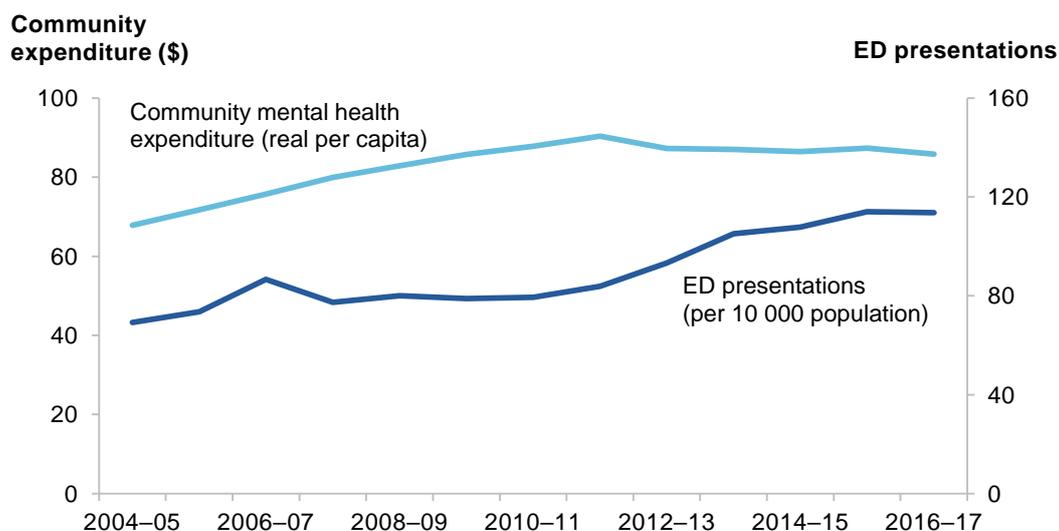
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<sup>21</sup> <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce/psychiatrists>

<sup>22</sup> Allison S, Bastiampillai T. Mental health services reach the tipping point in Australian acute hospitals. *The Medical Journal of Australia*. 2015 Dec 14;203(11):432-4.

<sup>23</sup> Allison S, Bastiampillai T, Licinio J, Fuller D, Bidargaddi N, Sharfstein S. When should governments increase the supply of psychiatric beds? *Molecular Psychiatry* 2018 April;23(4): 796-800.

Figure 7.5 **Community mental health services expenditure and ED**



Source: AIHW (2019v, table ED.1, 2019e, table EXP.4).

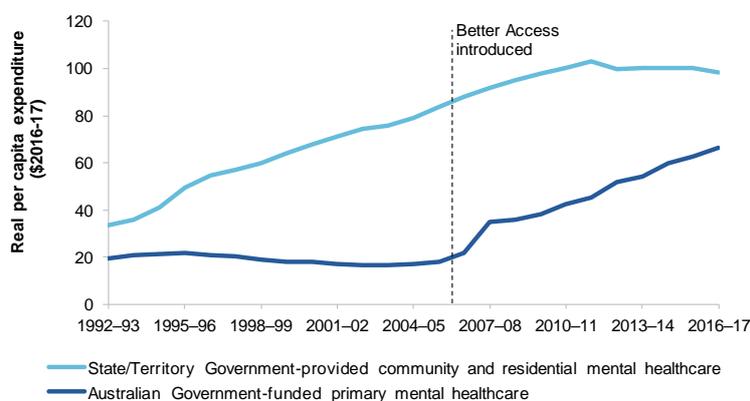
This line of argument is crucial to the thrust of the PC Report’s argument on clinical care: that greater spending on the spectrum of community care will reduce the demand on public hospitals. The interpretation given of Figure 7.5 was:

Between 2004-05 (the earliest year for ED data) and 2011-12, per capita community mental health expenditure was rising, and mental health ED presentations were fairly stable. But from 2011-12 to 2016-17, community mental health expenditure decreased, and mental health ED presentations increased. This suggests that greater community expenditure does reduce ED presentations. However, other factors have also been driving more mental health ED presentations up. (PC Report, p. 291)

However, Figure 7.5 provides an incomplete picture of additional spending on the continuum of community programs over the period, as it does not include the substantial increases in Australian Government expenditure on headspace and Better Access. During the period, Australian Government spending on Better Access to primary mental healthcare was increasing rapidly, as shown in Figure 23.1 of the PC Report (below).

Figure 23.1 Expenditure on community-based mental healthcare<sup>a,b</sup>

By level of government, 1992-93 to 2016-17



<sup>a</sup> Australian Government expenditure comprises expenditure on Medicare Benefits Schedule rebates to psychiatrists and allied health professionals, and Department of Health-managed national programs and initiatives. <sup>b</sup> State and Territory Government expenditure on community ambulatory mental healthcare services and residential mental healthcare services, inclusive of Australian Government transfers to State and Territory Governments.

Source: Productivity Commission estimates based on AIHW (2019o).

The provision of more youth-focused care in headspace and more primary mental healthcare through the Better Access program was projected to reduce ED presentations, but as shown in Figure 7.5, ED presentations were rising despite increased expenditure on the Better Access program. If these costs were added to Figure 7.5, it would provide a more complete picture of whether increased community spending in both primary care and community mental health might be able to reduce ED demand. Our inspection of the data suggests that total expenditures were rising over the whole period after 2011–12, but there did not appear to be a sustained decrease in ED demand.

*In terms of the more formal research evidence*, we draw the attention of the Productivity Commission to a recent Royal College of Psychiatry report which includes a review of the systematic reviews and Cochrane reviews published over the last 5 years on whether community programs can reduce hospital demand (as assumed by the PC Report’s bed model). Their review found “the evidence of the effectiveness of community mental health teams (CMHTs) was mixed, although it is acknowledged that the form and function of CMHTs has evolved considerably since this evidence was published”.<sup>24</sup> And “Crisis resolution teams may be effective in crisis management and admission avoidance, however most of the evidence comes from low quality studies”<sup>25</sup>. In summary the Royal College of Psychiatry concluded, “It should be noted that the quality of evidence on which we were able to call was mixed, and often reliant on poorly constructed evaluations”<sup>26</sup>.

Based on these various lines of evidence, we suggest that the main assumption of the NMHSPF model (that large increases in specialist mental health community treatment services and subacute/non-acute community residential mental health bed-based services will reduce demand on

<sup>24</sup> Exploring Mental Health Inpatient Capacity, The Royal College of Psychiatrists, p. 4

<sup>25</sup> *Ibid.*

<sup>26</sup> *Ibid.*, p. 58.

Australia's public hospitals) is suspect, and should be carefully re-examined in the Productivity Commission's Final Report.

Since there is limited evidence for the Productivity Commission to model the possible future effects of increased community programs on hospital demand, we recommend that the Final Report should not use the NMHSPF as the sole basis for estimating the needs of consumers in Australia's public hospitals. A better approach would be for the Productivity Commission to model consumer needs based on current actual demand, and include a direct model of the supply of acute mental health beds in hospitals that would be required to meet current demand, *without any assumptions about how much future community programs might be able to reduce future hospital demand.*

This direct model would be based on the 'Observed Outcomes' approach<sup>27</sup>: inputting current hospital key performance indicators (KPIs) such as numbers of ED presentations, admission rates from EDs, average ED lengths of stay awaiting admission, mental health bed occupancies, mental health inpatient lengths of stay, and readmission rates at the national, State, and Territory levels. For example, take the PC Report's statement that "Restricted access to acute inpatient mental health beds has led to problems such as long waiting times to be admitted through an ED, and pressure on hospitals to discharge people early to free up beds" – these KPIs (long ED waiting times and short median inpatient LOS) would be two inputs into a direct model that would undoubtedly increase the estimated supply of public hospital psychiatric beds required to meet the demand on the EDs.

The NMHSPF appears to rely purely on opinion rather than data to model the critical ratio of community to hospital-based non-acute beds. In the NMHSPF, "the division between residential and hospital care is set at 80%: 20% to reflect the Expert Working Groups' views of the preferred service model".<sup>28</sup> The Final Report should acknowledge that the recommended 80%:20% split is not evidence-based, varies widely from the WHO benchmark for high-income countries which tend to have many more acute and non-acute beds in standalone hospitals (median 31 beds per 100,000 vs. Australia's 10 beds per 100,000), and that the effects of this imbalanced non-acute bed ratio are unknown.

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<sup>27</sup> O'Reilly R, Allison S, Bastiampillai T. Observed outcomes: an approach to calculate the optimum number of psychiatric beds. *Adm Policy Ment health*. 2019 Feb.

<sup>28</sup> NMHSPF Care Profiles, p. 95

## **Cross comparisons between WHO, OECD, Sainsbury report, AIHW, and NMHSPF bed number calculations**

In addition to NMHSPF modelling, we suggest the Productivity Commission looks at cross-country comparisons in more detail for planning purposes. On top of the OECD data, this would include analysing bed numbers from the World Health Organization, the estimates from expert groups such as the Sainsbury Centre for Mental Health (England)<sup>29</sup>, and the current Australian state by state provision. We would suggest looking at the following sub-divisions firstly – acute beds, non-acute beds, and residential beds in a similar format to the table that we have provided below.

The Sainsbury Centre report that is referenced in the PC Report provides a detailed breakdown of bed numbers<sup>30</sup>: recommending 35 acute beds per 100,000; 16.4 non-acute beds per 100,000; and 12 residential beds per 100,000 population – similar to The Adult Psychiatry Imperative (TAPI) submission to the Royal Commission into Victoria's Mental Health System which recommended 30 general adult acute beds per 100,000; 15 non-acute beds per 100,000; and 16 residential beds per 100,000.<sup>31</sup>

The key differentiating points between NMHSPF and the WHO, OECD, Sainsbury, and TAPI (for further details see Table 1 below) are:

- The lower numbers of total hospital-based beds per capita in the NMHSPF model (28 beds per 100,000) compared with all the comparators recommending or currently commissioning above 45 public sector beds per 100,000.
- The lower numbers of non-acute beds per capita in NMHSPF modelling (8 beds per 100,000) versus WHO median for high-income countries, the Sainsbury model (12 beds per 100,000) and TAPI recommendations (15 beds per 100,000).
- The considerably lower number of acute beds per capita in NMHSPF modelling (20 beds per 100,000) versus Sainsbury (35 beds per 100,000) and TAPI recommendations (30 beds per 100,000).

The NMHSPF modelling does approximately agree with Sainsbury and TAPI in one area – the number of community residential beds – but WHO High income and WHO European have much higher numbers of residential beds actually provided.

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<sup>29</sup> The Sainsbury Centre for Mental Health, which was referred to in the Productivity Commission's Draft Report (p. 618), is now the Centre for Mental Health. The Centre's data and planning have been widely used, one example being in the development of proposed mental health planning norms for Queensland by Harris et al. 2012. ("Planning estimates for the provision of core mental health services in Queensland 2007 to 2017", Harris M, Buckingham W, Pirkis J, Groves A and Whiteford H, Australian & New Zealand Journal of Psychiatry, 46(10) 982–994, 2012).

<sup>30</sup>[https://www.researchgate.net/publication/237232951\\_Delivering\\_the\\_Government%27s\\_Mental\\_Health\\_Policies\\_Services\\_Staffing\\_and\\_Costs](https://www.researchgate.net/publication/237232951_Delivering_the_Government%27s_Mental_Health_Policies_Services_Staffing_and_Costs) – page 42 table

<sup>31</sup> The Adult Psychiatry Imperative: Achieving parity of care, Submission to the Royal Commission into Victoria's Mental Health System, July 2019. [https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-cvmhs.files/2915/6765/3776/The\\_Adult\\_Psychiatry\\_Imperative.pdf](https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-cvmhs.files/2915/6765/3776/The_Adult_Psychiatry_Imperative.pdf)

**Table 1:** Comparative average psychiatric bed numbers per 100,000 of the population – actual, modelled and proposed – from WHO (2017), OECD (2017), Sainsbury Centre, AIHW (2016/17), NMHSPF, and TAPI. Actual data are those relating to WHO, OECD, and AIHW. Modelled and proposed data are those relating to the Sainsbury Centre, NMHSPF, and TAPI.

	Acute	Non-acute	Acute plus non-acute beds	Residential 24 hour	Total	Total excluding 24 hour residential
WHO High income (excluding forensic)			45.8	23.3	69.1	45.8
WHO Europe (excluding forensic)			48	42.4	90.4	48
OECD (including forensic and private sector beds)						71
Sainsbury centre beds per 100,000 (excluding high secure forensic)	35	16.4	51.4	12	63.4	51.4
TAPI General adult bed numbers per 100,000 (excluding forensic)	30	15	45	16	61	45
AIHW per 100,000 (excluding forensic)	19.5	7.2	26.7	6.9	33.6	26.7
NMHSPF per 100,000 (excluding forensic)	20	8.1	28.1	16	44.1	28.1
% increase NHMSPF versus AIHW (excluding forensic)	3%	13%	5%	132%	31%	5%

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We would specifically recommend that the Productivity Commission’s Final Report produces a clear final table providing relevant cross-country comparisons and explanations for the differences between NMHSPF modelling versus the Sainsbury Report’s model, for example. Furthermore, we would also like the Final Report to include a complete table of NMHSPF bed number outputs (acute, non-acute, and residential) specifically for Child and Adolescent, General Adult, Older Adult, and relevant subspecialties (Forensic, Eating Disorder) and compare this with current AIHW data at both the state and aggregated national level.

## Conclusion

On the basis of our analysis of psychiatric bed number requirements using a combination of approaches including expert consensus, normative data (WHO and OECD), ‘Observed Outcomes’, and the Sainsbury Centre for Mental Health modelling, we believe that Australia needs the following minimum number of psychiatric beds (see TAPI submission<sup>32</sup>) for the General adult population (excluding forensic beds): 30 acute beds per 100,000; 15 non-acute beds per 100,000; and 15–16 community residential beds per 100,000.

It is our view that the optimal service mix of different bed configurations and community resourcing should be reviewed on a 3–5 year basis using a range of measured outcomes – including emergency department wait times, inpatient length of stay, inpatient readmission rates, rates of homelessness, rates of incarceration for patients with severe mental illness, rates of suicide, quality of life measures, and symptomatic and functional outcomes. We propose that the national Mental Health Reform Committee (please see Chapter 4) would set minimal levels of both standards and service provision for beds and community mental health resourcing.

The PC Report’s (p. 316) stance on this issue is somewhat ambiguous:

The precise number of beds required is a technical issue for clinical and planning experts and may vary between regions, so this inquiry has opted not to recommend a specific level. The benchmarks generated by the NMHSPF suggest that, in 2019-20, a total of 11 075 public sector mental health beds are needed (4874 acute and 6201 non acute).

This conflicting pair of sentences appears to both recommend a specific level (11,075 total), while simultaneously claiming not to recommend a specific level. The second sentence may not *in fact* be a recommendation, but it is easy to misinterpret as a statement in favour of a specific level. We urge the inquiry to be clearer on this important issue. We also wish to clarify our own position: we agree that the inquiry should not recommend the “precise number of beds required” for each region; but that is not the same thing as recommending a *minimum* number of beds required. Local decision-makers and planning experts will still vary in their exact number of beds – based on local context – as they should. But the number of beds (and corresponding staffing) we recommend is intended as a minimum standard, below which any region would begin to see negative consequences. Even if our recommended minimum levels are not accepted, *some* minimum standards should still be set at the Federal level (see Chapter 4’s discussion of the German mental health system for further discussion).

Specifically relating to the NMHSPF modelling, we differ from this by recommending approximately 10 more acute beds per 100,000 and 7 more non-acute beds per 100,000, but align with their proposed residential bed number requirements (see table).

It is likely that various states and regions will trial novel ideas and approaches, incorporating an agreed-upon evaluation framework. We anticipate that the regions will also have the opportunity to

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<sup>32</sup> The Adult Psychiatry Imperative: Achieving parity of care, Submission to the Royal Commission into Victoria’s Mental Health System, July 2019. [https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/2915/6765/3776/The\\_Adult\\_Psychiatry\\_Imperative.pdf](https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/2915/6765/3776/The_Adult_Psychiatry_Imperative.pdf)

learn from each other, based on accessing the data and outcomes of different approaches and service complements. We expect a nationwide process of collaboration and cross-learning to inform significant changes in policy and strategy (including increases or decreases to the minimum number of beds as further evidence is collected) at both the local and national level. We recommend that the cross-learning at the national level be informed by policy developments in mental health systems in other parts of the world, as well as outcomes data in response to changes in those systems and to those in our country.

### Chapter 3: Individual Placement and Support (IPS)

We strongly endorse the PC Report's (p. 527) Draft Recommendation 14.3, particularly emphasising the noted requirement for a gradual rollout of IPS services – with ongoing evaluation – to make sure its benefits at the small scale can be maintained at the much larger scale. We recommend the Australian Government begins with a trial of around 20 IPS sites using a mental health team to host the integration of 1–2 employment specialists into the team at each site. 20 sites would approximate the DSS headspace trial of IPS, and it is also around the most sites that can be implemented at one time while guided by one small but centralised technical support team – an important component as we have learned from the final evaluation report of the headspace IPS trial<sup>33</sup>, discussed below.

At larger sites where demand is likely to increase rapidly, up to three FTE employment specialists may be needed. Also, since recruitment and training of employment specialists can be challenging in some locations, sites should be allowed to over-recruit initially to ensure all the funds are spent in the first year. Underspensing was also an issue in the headspace IPS trial.<sup>34</sup>

There are several ways to set up a high-fidelity network of 20 services. For example, the Australian Government could establish a central technical support, fidelity review, training, and governance centre to recruit, contract, and establish 20 sites quickly. Since timing is critical, priority should be given to 'early adopter' locations with existing demand, a person in mind to fill the job, and already established relationships relevant to the program. Sites with access to someone who has completed IPS training in the USA who can also support the employment specialists could also be prioritised.

The PC Report (p. 528) has also requested the following:

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#### *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:*

- direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding*
- 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).*

*What are the pros and cons of each option? 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?*

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<sup>33</sup> Department of Social Services, Final Report for the Evaluation of the Individual Placement and Support Trial. June 2019.

<sup>34</sup> *Ibid.*

We recommend that both the partnership approach and the direct employment approach should be included in the initial trials. Excluding one or the other approach could preclude some very good operations that are already established, such as the team of IPS employment specialists managed by STEPS on the Sunshine Coast. This team is a good example among about 80 other employment specialists currently delivering IPS<sup>35</sup> integrated with both youth and adult mental health services. STEPS is a DES accredited agency working in partnership with and co-located with mental health teams on the Sunshine Coast, Nambour, Maryborough, Bundaberg, and Townsville. Using only a direct employment model could inadvertently exclude several successful existing partnerships.

Under the DES contracting system, the direct employment model was unfortunately excluded because State government administered mental health services were not accepted as qualifying agencies to deliver DES services. Allowing the definition of a provider of IPS services to be either a mental health agency or an NGO will permit mental health services to directly employ employment specialists to deliver IPS services, or to contract their employment to an external NGO provider under a partnership agreement. While direct employment might sound simpler and more attractive, it can have a downside. One example is that when the employment specialist is a State Government health service employee, they may have fixed hours and limited capacity to work outside standard office hours without expensive overtime. External NGOs can often provide more flexible support to client workers across a wider range of working hours because their Enterprise Bargaining Agreements can be less restrictive.

To be cost effective, funding for the new IPS services across the nation needs to be outcome based, and to come from one single source contract. For example, each participating mental health agency could be contracted to the Federal Department of Health. The alternative – which we recommend against – would be to enable each State or Territory government to run their own IPS contract. That would lead to failure at many locations because the States will each have a different contract, with potentially conflicting requirements, making evaluation and fair comparison nearly impossible. However, we recognise the importance of State-based integration and coordination, which could be lost when the IPS contract exists at the Federal level. This concern adds further support to the need for what we recommend in Chapter 4: Mental Health Integration Hubs to coordinate such complex integration between State and Federal governments and local service providers (e.g. IPS).

Having one central Federal contract can encourage adoption of IPS costed as a 2-year episode of rehabilitation care per person. However, payments for the defined activities of IPS can also be linked to the mental health agency's performance. This can be done by paying agreed amounts for employment milestones, say when commencing employment and at 4 weeks, 13 weeks, and 26 weeks of continuing employment.

Another point to emphasise is that lessons from the headspace trial of IPS need to be learned. This means each site will need good technical support, coordinated management, a contract with minimal conflicts with respect to the IPS model, ongoing performance evaluation, and IPS training for clinical

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<sup>35</sup> Waghorn, G., Killackey, E., Dickson, P., Brock, L., & Skate, C. (2019, June 17). Evidence-Based Supported Employment for People With Psychiatric Disabilities in Australia: Progress in the Past 15 Years. *Psychiatric Rehabilitation Journal*. Advance online publication. <http://dx.doi.org/10.1037/prj0000370>

staff and for employment specialists. The contracts will need to specify appropriate eligibility criteria, define employment outcomes, and reduce potential conflicts with DES and Centrelink.

One significant lesson from the headspace trial is that while good fidelity was attained at almost all the 13 sites reported, site performance appeared to remain sub-optimal rather than improve. The underlying reason may have been due to a reduction in high-quality and ongoing problem-solving support to each site (that followed regular fidelity reviews) when the key leader of this support became unavailable around the middle of the trial. This key leader was USA trained and had established the IPS support role at Western Australian Association for Mental Health (WAAMH) over the previous five years. This support is important because it begins with external reviews of fidelity then explores any issues or problems to ensure that high fidelity, once achieved, translates into high performance. To avoid this problem as IPS services expand across the country, we need to ensure that a central technical support team is in place to provide tailored problem-solving assistance to each site coordinated with external fidelity reviews, training, and governance support.

Potential conflicts between IPS services and Centrelink and DES can be avoided by making participation in IPS sufficient to fully meet the work test (therefore no further information would be needed by Centrelink). Conflicts with DES can be avoided by not permitting dual participation, and by permitting eligible mental health clients to stay with DES (and not be part of IPS) or enabling transfer to IPS. Similar to DES obligations, the IPS service can be obligated to notify Centrelink if the person becomes lost to contact and cannot be located or re-engaged in the IPS program.

As the PC Report (p. 526–7) notes, when the trials reveal more about the program’s effectiveness with particular sub-groups, eligibility criteria can be specified to ensure the program remains well targeted. It may be necessary to specify eligible diagnoses and severity of work-related impairments. For instance, someone with a diagnosis of stable bipolar affective disorder and a trade qualification – who can thus return to that job anytime – could be appropriately defined as ineligible for IPS on the basis that they do not need IPS help right now.

Given the PC Report’s (p. 512–14) concerns that Centrelink’s Employment Services Assessment (ESAt) and Job Seeker Classification Index (JSCI) instruments can misclassify people with significant mental illness, these imperfect instruments can be avoided if eligibility for IPS is defined so that all people meeting the following criteria are eligible: (1) non-employed clients (in, say, the last three months); (2) receiving case management from a mental health service; (3) with a diagnosis of a moderate to severe mental health condition. Alternatively, JSCI and ESAt measures can continue to be administered for research purposes only, provided their use does not delay entry to and progress within the IPS program.

Temporarily excluded clients can be those without a current employment goal. It is important that this exclusion is temporary because the absence of an employment goal is often influenced by stigma and by the lack of a peer role model. Hence, it is not unusual for an effective IPS program to rapidly generate new demand among other mental health service users who previously expressed no interest in employment. For those continuing to report no employment goals, other forms of rehabilitation assistance can be organised outside of IPS. Such assistance outside of IPS should include help with education goals or vocational training, self-employment goals, voluntary work, or participation in other community or recreational activities that also facilitate personal recovery.

## Chapter 4: Governance

### Setting minimum service and staffing levels in the Australian mental healthcare system

We recommend that the Productivity Commission considers the example of Germany's national mental health system as a model for Australia.<sup>36</sup> For context: Germany's system has been highly successful and stood the test of time for the last 30 years. Since 1990 Germany has adopted a methodology for improving the quality of hospital treatment for the mentally ill through a Federal Directive known as Psych-PV (Psychiatrischen Versorgung, Psychiatrie-Verlag, Bonn / *Ordinance on Standards and Principles for Staffing requirements in Inpatient Psychiatry*). Through this Directive, psychiatric staffing levels were stipulated on a per patient basis according to the category of mental illness displayed, together with treatment options for specified categories of patients. The guidelines on time allocations per patient were designed for maximum cost benefit and were supposed to be rigorously applied.

Psych-PV's aim was to improve the quality of hospital treatment by increasing and standardising staffing levels – previously staffing indices were defined without regard to the seriousness of a patient's condition. It was a binding standard applied to funding agencies, psychiatric hospitals, and psychiatric units in general hospitals alike.

One of the notable differences between the Australian and the German mental health systems is that Australia does not set minimum levels of service provision<sup>37</sup>. The prescriptive character of the German system “obliges hospital services and health insurances to apply its norms.”<sup>38</sup> We believe the Australian language of ‘goals, aspirations, and targets’ is too lenient for ensuring accountability of mental health services. We need a nationally mandated minimal level of service provision, including face-to-face clinical time (as exists in Germany).

One of the significant upshots of the German mental health system is that the general public's attitudes toward psychiatric hospitals has improved considerably, with the public “now more inclined to regard psychiatric hospitals as similar to other hospitals, more ready to expect effective treatment in psychiatric hospitals, and less inclined to support the stereotype that psychiatric hospitals are primarily places where patients are locked away.”<sup>39</sup>

In 2014, the Economist Intelligence Unit (EIU) developed a Mental Health Integration Index<sup>40</sup> which looked at 30 European countries' medical provision together with factors such as human rights,

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<sup>36</sup> Following our presentation to a Public Hearing of the Productivity Commission on 18 November 2019, we forwarded detailed information about the German mental health system – especially the Psych PV and Psych VVG to the Productivity Commission – to Mr Ken Quach - at the request of Professor Harvey Whiteford.

<sup>37</sup> See the Fifth National Mental Health and Suicide Prevention Plan, <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf>

<sup>38</sup> Bauer M. et al., Psychiatric reform in Germany, *Acta Psychiatr Scand* 2001; 104 (Suppl. 410): 27–34, p. 31.

<sup>39</sup> Angermeyer, M. et al., Has the public taken notice of psychiatric reform? The image of psychiatric hospitals in Germany 1990–2011, *Soc Psychiatry Psychiatr Epidemiol* (2013) 48:1629.

<sup>40</sup> “Mental Health and Integration: Provision for supporting people with mental illness: a comparison of 30 European countries”, 2014. The Economist Intelligence Unit Limited

stigma, ability to live a fulfilling family life, and employment. They found that Germany led the index with the highest overall score: its strong general healthcare system and generous social welfare provision help with good integration.

### **Mental Health Reform Committee**

We agree with the summary from the PC Report (p. 897) that there is a fundamental lack of role clarity and confusion between the Federal and State governments with respect to policy, strategic planning, accountability, mechanisms for clinician and consumer engagement, and a robust model for evaluation.<sup>41</sup>

Given the goal to achieve major reforms within the mental health sector over the next five years, we recommend that a new entity – the Mental Health Reform Committee – is established to explicitly focus on leadership, oversight, and implementation of the reforms recommended by the Productivity Commission’s Final Report. The “Current” and “Proposed” diagrams of national mental health governance structures (Figures 1 and 2 below) show how this Reform Committee would fit into the existing structure. The new committee may only be needed for five years as the changes are being implemented, or it could become a permanent fixture. Either way, it should be chaired by someone such as the Chief Medical Officer with the clout and influence to lead this important reform agenda.

Having Australia’s Chief Medical Officer leading this Committee would not be unprecedented. Consider the COAG Energy Council Hydrogen Working Group as an exemplar, which managed to quickly and effectively implement substantial national reforms. This Working Group was composed of experts and led by Australia’s Chief Scientist (Dr Alan Finkel): both an influential figure and a subject matter expert. The group received unanimous support for its recommendations by the COAG Energy Council, and within a year of its deliberations resulted in an allocation of over \$380 million toward the new policy.

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<sup>41</sup> Looi J, Allison S, Bastiampillai T. Commonwealth of common mental health: the need for a comprehensive overhaul of corporate governance in mental health care in Australia. *Australasian Psychiatry*, 2019.

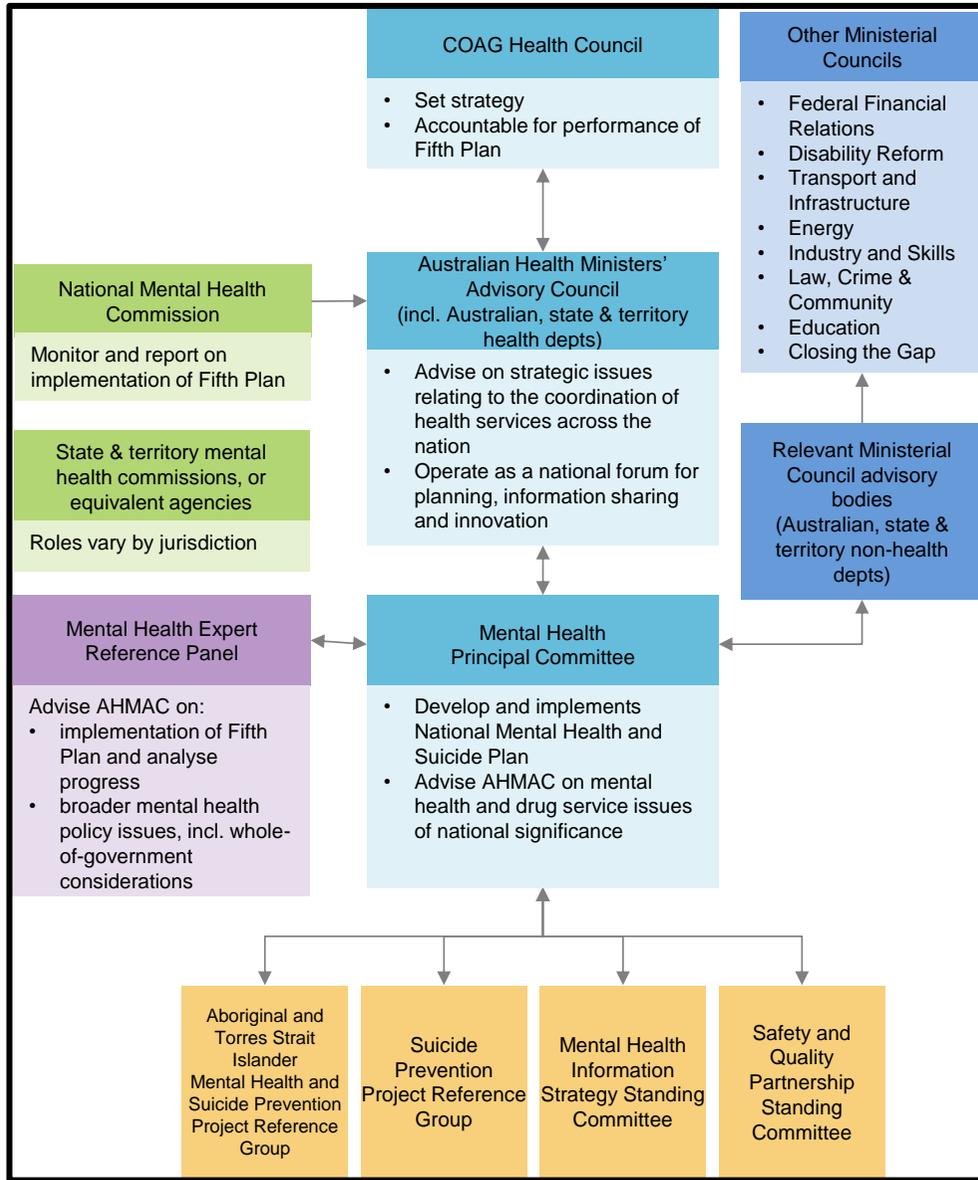


Figure 1 – Current governance structure (PC Report, p. 892)

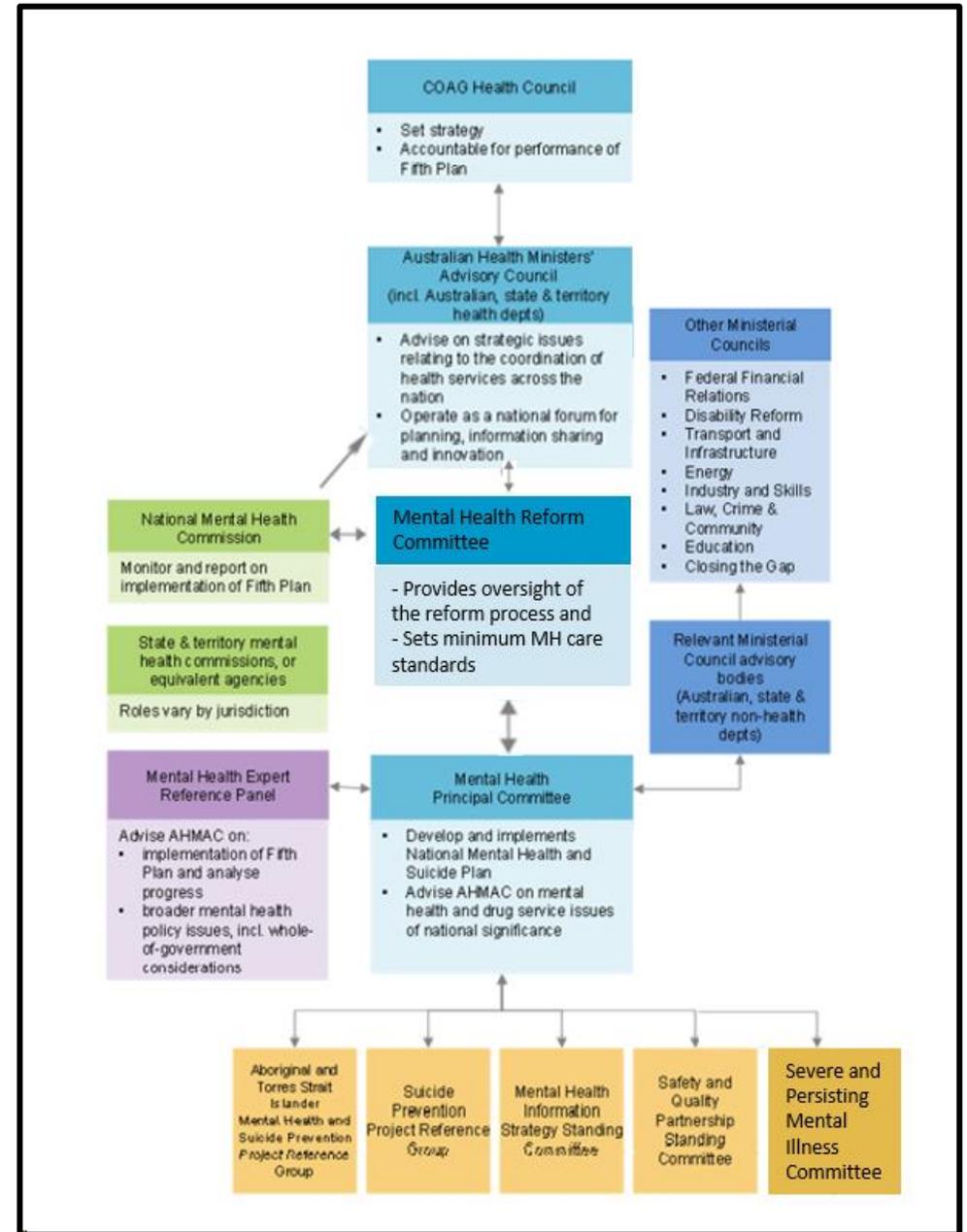


Figure 2 – Proposed governance structure

## **Other Federal governance bodies**

Given the importance of severe and persistent mental illness (as we have emphasised throughout this submission) we also suggest that a Severe and Persistent Mental Illness Committee be established (see Fig. 2) to specifically focus on this policy issue. For example, the United States has an Interdepartmental Serious Mental Illness Coordinating Committee ([ISMICC](#)) and a [Clinical Support System for Serious Mental Illness](#), both funded at the Federal level. ISMICC was “established to make recommendations for actions that federal departments can take to better coordinate the administration of mental health services for adults with a serious mental illness or children with a serious emotional disturbance.” Australia could benefit from a similar committee to ensure the needs of this high utilising cohort are appropriately supported.

Additionally, we would also suggest that a mental health-focused Health Services Research and Evaluation Committee be established, reporting to the National Mental Health Commission.

Our group agrees that there should be a National Mental Health and Suicide prevention agreement as articulated in Draft Recommendation 22.1 (PC Report, p. 902).

In response to Draft Recommendation 22.5 (PC Report, p. 930), we support the concept of an independent research and evaluation unit that will lead the program evaluation of both Commonwealth- and State-funded mental health programs. The Productivity Commission proposes that this should be the responsibility of the National Mental Health Commission and for this to be set up as an interjurisdictional body.

We suggest that this unit also needs to have strong affiliations and collaborations with the university sector, the Australian Bureau of Statistics, Australian Institute of Health and Welfare, and the Australian Commission on Safety and Quality in Health Care. In order for the research and evaluation unit to be effective it will require the availability of linked data through clinical quality registries.

We recommend that the National Mental Health Commission should also have strong formal links with a network of State-based Specialist Mental Health Centres (as described in Chapter 1). Such collaborative centres of mental health and wellbeing are also recommended by the Royal Commission into Victoria’s Mental Health System.

## **Regional Commissioning Authorities**

The PC Report (p. 104) proposes two possible architectural models for mental health policy and commissioning at the local level – Rebuild and Renovate – and requests input on which model is preferable.

We firmly support the Rebuild model, creating Regional Commissioning Authorities (RCAs) as described in Box 23.10 and 23.11 (PC Report, pp. 967–969). We support the concept of the RCAs being primarily administered by State and Territory health departments, pooling funding from both the Commonwealth and State governments to deliver regional mental health planning; administer funds; and purchase primary, secondary, and tertiary mental health services. We also support drug

and alcohol services being an integral part of the RCA's policy and commissioning remit, enabling better integration with mental health services at the local level.

Our view is that the boards of the RCAs should have proportionate representation of Commonwealth and State governments based on funding provided by these respective tiers of government. We also suggest RCA boards need to have specific expertise in relation to housing, corrections, and research.

### **Integrating mental health services: Mental Health Integration Hubs**

Mental illnesses are mostly episodic or chronic conditions that vary in severity and associated disability over time, across all developmental stages of human life. Health and related services need to be able to provide continuity of service provision at all developmental stages and ages throughout life, and across the many providers of those services.

It is common for multiple health services to be required at the same time, including physical and mental health and social services. Shifts occur between services as individual needs change, and for different levels of services – primary, secondary, tertiary – to be required, alone or sometimes in combination, at various times. Integrating such services and ensuring seamless transitions between them is a complex matter with plenty of opportunities for individuals to 'fall between the cracks'.

Integration is complicated by the fact that services are often at different geographical locations and involve different organisations (or different entities within those organisations) that are governed and/or funded separately. Other government services of high importance to mental health include housing, employment, child protection, disability support, education and training, and others. Effective mental health care requires a dynamic integration and coordination of the disparate elements of this complex system to meet individual needs over time. How can this be done?

We propose establishing Mental Health Integration Hubs: demand and capacity coordination systems similar to the successful Integrated Cancer Services (ICSs) that have been key to implementing the cancer reform agenda across Victoria. The ICSs were given four main responsibilities to start with:

1. Introduce multidisciplinary planning for cancer patients
2. Improve coordination of care
3. Increase supportive care for cancer patients
4. Reduce variations in care

Modelling these key functions, the proposed Integration Hubs will use sophisticated software and real-time data-acquisition systems to match people's mental health needs with appropriate care providers in both private and public health systems, and with other service providers – such as housing, social welfare, and legal advice. These Integration Hubs will track and guide patients coming in and out of various mental health services and other related services.

At the same time, general practitioners, emergency department staff, and many others in the mental health workforce can use the Integration Hubs themselves to determine where there is outpatient availability, where specialised services are offered, or other key information for supporting their patients.

Ideally, all mental health consumers would be eligible for this support, but it may be pragmatically necessary to limit eligibility to the core group of longer-term consumers with severe and persistent mental illness. Mental Health Integration Hubs should provide this group with lifelong monitoring, and lifelong support to navigate the numerous components of Australia’s mental health system. Given that people with severe and persistent mental illnesses have ongoing (often lifelong) interactions with the mental health system, it is inefficient and confusing to treat each such interaction as a one-off, standalone event.

How would these Hubs fit into the broader governance structure? We propose a couple of options. One way would be for the Integration Hubs to have their own boards of directors, which report to their State and Territory Departments of Health. The benefit of this would be that the Integration Hubs could have an overarching whole-of-state coordination role that would cross RCA boundaries, helping consumers to find specialist services they need which may not be available in their own RCA region. The potential issue with this approach is that the Integration Hubs need to facilitate integration with housing, social welfare, education, legal advice, and many other domains that fall outside the Department of Health. They also need to integrate with Commonwealth Government agencies. Systems would be needed to ensure effective cooperation and integration of these Hubs with other services beyond the Departments of Health to whom they would report.

The other option would be to have Integration Hubs based in and reporting to each RCA. Accordingly, the RCAs would *commission* mental health services in each region, and the Integration Hubs would be a subsection of the RCAs providing the *coordination* between those services (and others such as housing, etc.). The potential challenge with this approach is that there could be some conflict of interest between Integration Hubs (their role, while mostly about coordinating care, may also involve provision of care) and RCAs (their role is to direct money to providers). It is important to minimise conflicts of interest between the commissioning and provision of care. The governance structure would need to be set up to ensure a “wall” between RCAs and the Integration Hubs which would sit within the Authorities, so that RCAs are not responsible for directing funding to their own Hubs. Allocation of funds to the Integration Hubs would thus need to be determined and provided either at a Federal or State level. One possibility to make this work would be for the proposed Mental Health Reform Committee to be responsible for determining funding for the Hubs.

### **Geographical alignment with RCAs, PHNs, and LHNs**

We broadly recommend geographical alignment of RCA boundaries with existing health service boundaries. For most states that alignment should be with Local Health Network (LHN) boundaries to enable better integration between primary, secondary, and tertiary mental healthcare. For Victoria, which does not have the same arrangement regarding Local Health Networks as most other States, an alternative proposal would be to align the Mental Health Regions with existing Commonwealth

government Primary Health Networks (PHNs) – as described in detail in section 8.5, pp. 83–86, in The Adult Psychiatry Imperative submission<sup>42</sup> to the Victorian Royal Commission.

It will be important for there to be integration across the lifespan, aligning child, adult, and older age psychiatry boundaries within Mental Health Regions, thereby facilitating smoother transitions between these age divisions. They should incorporate whole-of-life treatment – children, adolescents, adults, and old-age – so that patients are not managed by different governance structures as they grow older. Also, since not every Mental Health Region will be able to have local specialist treatments (e.g. eating disorder centres), it will be important for RCAs and service providers in MHRs to work collaboratively with RCAs and service providers in neighbouring MHRs.

### **Funding pools for RCAs**

We agree with the proposed pooled funding of Commonwealth and State mental health programs as outlined in table 23.4 (PC Report, p. 957): \$2.6 billion for public hospital-based mental healthcare; \$2.4 billion for community mental healthcare; \$0.4 billion for PHN-funded primary mental healthcare; \$0.5 billion for psychosocial supports; and \$0.1 billion for carer supports. In addition to these nominated funding pools there should be consideration for specific funding pools in relation to the following:

- Policy – the Productivity Commission places considerable responsibility on the RCAs to develop mental health services and programs that are responsive to the mental health needs within their regions. This will require funding for a knowledgeable and expert policy development workforce.
- Health service research, program evaluation, and data registry infrastructure – a central tenet of the Productivity Commission’s Draft Report and of our submission is the need to base service provision on outcomes. These need to be continuously monitored and assessed, which will require funding.
- Specialist Mental Health Centres: establishing these centres will require substantial capital and operational funding. We propose that the capital funding should be primarily allocated from a combination of Commonwealth and State and Territory Governments, but that operational funding will need to be allocated by the RCAs.

### **Funding from PHNs/RCAs for agencies such as headspace**

We support Draft Recommendation 24.2 (PC Report, p. 979). Competition between service providers leads to improved efficiency and outcomes, so PHNs (or the new RCAs) should have the discretion to fund whichever mental healthcare agencies can deliver optimal services, based on value for money, efficiency, efficacy, and other criteria. No mental health provider should be guaranteed funding on an ongoing basis (whether that be headspace or other service providers).

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<sup>42</sup> The Adult Psychiatry Imperative – submission to the Royal Commission into Victoria’s Mental Health System [https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/2915/6765/3776/The Adult Psychiatry Imperative.pdf](https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/2915/6765/3776/The_Adult_Psychiatry_Imperative.pdf)

## Overall Summary

Despite our broad agreement with the recommendations of the PC Report, we believe the Productivity Commission's Final Report needs to be more ambitious in its recommended reforms of Federal, State, and Territory Mental Health Services, especially if these reforms are to sufficiently improve the care for consumers with severe and persistent mental illness. Australia is lagging behind other countries, and one of the main reasons is the lack of Specialist Mental Health Centres.

Fortunately, after the Royal Commission into Victoria's Mental Health System, the Victorian Government is acting to create Australia's first Collaborative Centre for Mental Health and Wellbeing. Rather than Victorian consumers being the only ones with access to this quality of care, Australia should seize the opportunity to turn this into the first step of a unified national network of facilities for world-leading clinical care, education, and research.

The facilities would provide ideal environments to deliver an increase to Australia's comparatively low bed numbers – helping to prevent emergency department access block. They would provide infrastructure and expertise to support the PC Report's recommended national clinical trial network and clinical quality registries. In turn, this research and evaluation infrastructure will provide currently lacking functionality to ensure our mental health system receives ongoing, evidence-based evaluation and improvement.

Our submission recommends a substantial increase in the resourcing of community and inpatient care for consumers with severe mental illnesses, with balanced emphases on both components of care. We recommend that a minimum level of mental health treatment bed numbers per capita be determined at the Commonwealth/COAG level on the basis of a broad range of observed outcomes, and that the recommendations provided at the central level are not exclusively determined by those in the NMHSPF. From our detailed consideration of Australian mental health service needs and of overseas levels of care provision, we propose for the General Adult population that those minimums should be (excluding forensic beds): 30 acute beds per 100,000; 15 non-acute beds per 100,000; and 15–16 community residential beds per 100,000.<sup>43</sup> These minimum levels of provision should form a baseline upon which regionally-specific modifications can be made, based on local service needs.

We also recommend the Commonwealth government establishes minimum levels of mental health staffing per patient per time period, as has been successfully implemented over the past 29 years in Germany – a country which is recognised to have one of the best integrated mental health systems in the world.

We concur with the Productivity Commission's support for Individual Placement and Support services as a key component in enhancing the employment outcomes for people with mental illness. We strongly support the IPS trials that have been endorsed by the Commission, and recommend a

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<sup>43</sup> The Adult Psychiatry Imperative: Achieving parity of care, Submission to the Royal Commission into Victoria's Mental Health System, July 2019.

gradual rollout of the program to ensure that its benefits at the small scale are maintained at the larger scale.

Mental health governance needs major reform to overcome a range of problems which stand in the way of implementing systemic and long-lasting improvements in outcomes for mental health consumers. Of the two models of reform discussed within the PC's Draft Report, we support the Rebuild model, and anticipate that the introduction of a commissioning/provider framework will significantly improve the governance of mental health services.

We also recommend establishing a national Mental Health Reform Committee, to be chaired by the Chief Medical Officer, who is the principal medical advisor to the Minister for Health, in order to drive and maintain systemic improvements in the provision of mental health care across Australia.