

Northern Territory Primary Health Network

Productivity Commission Inquiry

The Social and Economic Benefits of improving Mental Health

Northern Territory Primary Health Network (NT PHN) is the Primary Health Network for the Northern Territory (NT). One of 31 Primary Health Networks Australia wide, its charter is to improve health outcomes for the Northern Territory's population, through building local partnerships and directing resources towards an integrated, high quality primary health care system.

NT PHN, a not-for-profit company, is governed by a membership of three – the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the NT Government Department of Health (NT Health) and the Health Providers Alliance Northern Territory (HPANT). By virtue of this membership coverage – Aboriginal community controlled, public, and private health sectors – it considers it is well placed to foster cooperative and integrated service delivery.

Recognising that the Inquiry's terms of reference are very extensive, NT PHN has chosen to restrict its commentary to areas where it considers it can provide input based on its experiences in the working environment. The submission will endeavour to provide commentary covering what the NT PHN considers are matters of key importance:

- Mental Health Care System and structural weaknesses
- Health Workforce
- Reporting and Monitoring

Additionally, acknowledging the submission made by the PHN Cooperative, NT PHN's submission will seek to complement some of that commentary while providing a Territory 'lens' to the issues of concern.

Mental Health Care System and structural weaknesses

Achieving closer coordination of health, mental health and non-health services

The current status of the mental health system has been characterised by the National Mental Health Commission as fragmented and that in order to achieve mental health system reform there needs to be a new system architecture. Despite a clear understanding that this is required, efforts to achieve the necessary reform may be considered piecemeal.

Agencies that operate across the mental health funding and service spectrum acknowledge that there are inconsistencies of treatment availability and disparity of access. Further, there is general consensus that the current system requires a significant overhaul to ensure that allocated funding is utilised to best advantage; that services are better integrated and coordinated; and, that service users and the people that care for and support them are having their mental health care, support and treatment needs met.

Additionally, evidence related to the co-occurrence of mental ill health and other chronic conditions such as diabetes, cardiovascular disease, excessive alcohol consumption and drug use reinforce the need for holistic person-centred care. The consideration of the social determinants of health and mental health such as the influence of poor housing, homelessness and unemployment, add weight to the need for regionally based planning that has 'buy in' from across government departments i.e.: housing, justice and education as well as the Aboriginal Community Controlled Sector.

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) provides a comprehensive implementation plan that commits PHNs to work in partnership with State and Territory Governments over the coming years to achieve joint regional planning. The regional planning agenda is targeted toward enabling the system and service sectors to provide integrated mental health and suicide prevention services.

One of the challenges to achieving closer coordination of health, mental health and non-health services relates to the fact that approaches to mental health service delivery can vary across settings. For example, clinical perspectives interpret mental illness through traditional medical models that are geared toward diagnosis and symptom management, in contrast to some non-clinical settings that may view mental ill health through a social and cultural lens. The development and commissioning of the social and emotional wellbeing model across clinical and non-clinical is one of the strategies being rolled out by the NT PHN in the NT.

There are a host of challenges and barriers to improved mental health system coordination and service integration. These challenges and barriers highlight the gap that can exist between what is possible through collaborating opportunities and what is often realised in practice. The gaps include:

- Administration and Reporting Issues

Disparate reporting and data collection requirements attached to different funding streams coupled with internal institutional or organisational administrative requirements complicates and impedes clarity on the reporting and performance of services and outcomes across the system and this impacts collaboration and integration across organisations. These structural barriers are not always directly related to health funding and reporting and may involve other intersection points such as housing and justice.

- An absence of dedicated funding to support collaboration planning and effort.

Services are often commissioned with the expectation or requirement for service integration and coordination often without dedicated funding. In some instances, collaboration may only occur at the most basic levels. Dedicated funding for collaboration could enhance the amount of time that service providers are able to put into planning their collaboration approach.

- Service delivery reporting – lack of interoperability

Service providers report outputs to commissioning bodies utilising a variety of IT systems which do not necessarily support consolidated data and reporting. This is further complicated by varying interpretations of KPI data across the reporting organisations, which leads to inconsistent outputs and difficulty in accurately measuring and analyzing outcomes at a regional level.

- Limited communication between collaborating organisations.

Communication between organisations may be ad-hoc unless more dedicated communication pathways are embedded in formal collaboration partnerships or agreements. This might include handover protocols between stepped care levels, inter-jurisdictional transfer or appropriate referral pathways between different service types. This has the potential to adversely impact client outcomes if care pathways are not streamlined and information is not shared in a timely manner and with the consumer at the centre of the process.

Availability of timely data

Structural barriers also exist in the area of mental health data. Access to timely and accurate data, including baseline data, is impacted by lag times in receiving up-to-date data on, for example, hospitalisations or suicide and self-inflicted injury data, particularly for regional and sub-regional planning. Timely access to all of the relevant mental health data will assist greatly with evidence based planning and commissioning. Increasing the availability of accurate, up-to-date data is a key issue and should be considered as a priority.

The availability of the National Mental Health and Suicide Prevention Service Planning Framework provides a valuable benchmark for estimating mental health need and service provision. It's applicability in the NT has been limited by the lack of modelling for rural, remote and Aboriginal populations, however this is expected to improve in the near future.

Funding

Consistent with the national PHN submission to this inquiry and in line with the National Mental Health Commission's recommendation that there is a need for a new system architecture, the NT PHN supports the idea of an overarching mental health architecture that incorporates Commonwealth, State and Territory funding sources. This could operate in line with a regional strategy informed by evidence based mental health and suicide prevention regional planning.

There are at times challenges in lack of flexibility of Commonwealth mental health funding and how this may be delivered to meet needs in rural and remote communities or Indigenous communities where locally tailored and culturally appropriate models may be needed to deliver effective outcomes. This is of specific relevance to the NT PHN, noting that there is recent evidence from the Australian Medical Association (AMA) indicating that one third of Indigenous adults have high or very high levels of psychological distress, making this cohort three times more likely than non-Indigenous adults to experience distress.

One of the key challenges to achieving better mental health outcomes is an acceptance of the importance of providing greater resources to prevention, promotion and early intervention. The current system is fragmented because of the number of 'players' involved and is also unbalanced by the dominance of funding support for acute and crisis support services over that directed to prevention. Early intervention provides the best opportunity to reduce service costs in the longer term. Early intervention needs to be understood in its broadest context: early in life detection, early in illness and early in episode. The National Mental Health Commission (NMHC) has strongly recommended the embedding of prevention and early intervention initiatives within service models that integrate health, mental health and education within the context of a stepped care system.

From an NT perspective there is a significant gap in being able to access child and adolescent psychiatric specialists who can assist GP's and other primary health professionals to provide early identification and intervention. This is a glaring weakness in the current system and something that needs to be addressed ensuring that the front-end health workers can access the support they require.

Health Workforce

There are many issues relating to health workforce shortages in regional and rural areas which require a concerted effort to address. Of fundamental importance is the need to ensure that the length of Government funding periods be increased thereby providing greater surety to service providers and staff. The matter has been continuously identified for years and requires urgent attention. As a minimum, established program funding (as opposed to pilot programs) should be allocated for 3 years.

Creativity and flexibility are also considered to be key underpinning factors in efforts to address staff shortages in rural and remote areas. In this context it is suggested that there could be advantages in looking at a range of initiatives including:

- Innovative and supportive approaches to supervision.
- Better peer networking and support opportunities.
- Tailored support packages including but not limited to retention incentives such as financial and educational.

Complementing recruitment efforts, a retention focus is also required. As part of this access to Continuing Professional Development (CPD), good internal systems of support (comprehensive orientation, development of cultural competence, sound HR practices, clinical governance) need to be developed and maintained. What is also important in this space is to look at establishing career development opportunities.

The initiatives mentioned do not in essence provide a longer term solution to the health workforce shortages and there is need to consider how this could be integrated with a planned approach to improving the 'local pipeline' enabling the NT (and other regional localities) to develop its own Indigenous workforce which is crucial to long term sustainability. This is a view shared by the current Rural Health Commissioner, Professor Paul Worley.

As part of this, there is a need to consider developing programs to encourage school students into health careers including tertiary education with training available in the NT, with dedicated positions for NT and Indigenous students and with Indigenous and remote curriculum content. This would be complemented by regional/remote student placement, support for organisations to offer professional placements access to supervision and post graduate education in rural/remote and Indigenous health. Concomitant with this is the need to build the community support workers (local 'Health Coaches') based on community to ensure completion of the loop.

The use of technology is often cited as a panacea for overcoming workforce issues and certainly increased availability to online learning modules will be advantageous. RACGP and other providers are already offering opportunities in this area and further developments must be encouraged. It has the potential to greatly assist

but in a regional context and particularly relating to indigenous communities, clinical and culturally appropriate considerations need to be factored in. Local health services need to have adequate capacity to support the learner and the telehealth provider. There needs to be recognition of the inappropriateness of placing additional requirements on such entities without adequate resourcing.

There are numerous issues that prevent greater remote provision of services including:

- Lack of access to adequate staff housing.
- Cost of travel - particularly charter flights - to facilitate 'on community' consultation.
- The existence of siloed 'funding buckets' hindering opportunities to maximise the viability of funding local roles.
- A lack of remuneration for GPs and other health professionals (except psychiatrists) providing consultations by telehealth. Currently telehealth services are largely dedicated to providing psychiatric services focusing on the extreme end of the severity spectrum missing the opportunity for primary preventative care.
- Difficulty in attracting the right people with an understanding of the unique service delivery context in remote roles.
- The capacity of remote primary health care services to adequately support visiting mental health professionals by providing essential support for example consult rooms, vehicles, cultural liaison and clinical support.

Another key consideration relates to health professionals accessing CPD. In the regional/remote context there needs to be an understanding of the time, travel and accommodation costs associated with accessing CPD. This same value understanding needs to be applied to the challenges faced in accessing mentorship, networking and peer support for remote practitioners. Related to this has been the development of a 'community(ies) of practice' or 'small group learning' networks which is spoken about very favourably by those that are engaged. This initiative refers to a supervised (senior clinician) and facilitated regular discussion meetings where clinicians can bring cases for review in a confidential environment.

There is a clear opportunity to share CPD resources and opportunities across Government funded services, Non-Government Organisations, Aboriginal Community Controlled Health Services (ACCHS), private practice, professional bodies and tertiary educational institutions. Put simply the NT is not large enough to viably run CPD opportunities in isolation and a collaborative approach would be further enhanced by offering multi-disciplinary training resulting in the further promotion of information sharing across professions and potentially a reduction in communication barriers.

While there are some concerns about existing scope of practice restrictions, it is generally felt that these are appropriate. However there are potential opportunities which could help reduce the impact of restrictions to the scope of practice. Typically, these involve health professionals undertaking further training. In the regional and remote areas, the need for health professionals to be as highly credentialed as possible is decidedly advantageous and something that works to the advantage of service providers and the communities they serve. For example, GP's undertaking specific mental health training enables them to add a scope of practice

around Cognitive Behavioural Therapy. Mental health workforce capacity could also be enhanced through expanding Trauma Informed Care practices.

On a related note there appears to be a major skills and knowledge gap between almost every health profession and social workers, particularly when it comes to understanding the complexities of welfare and social support mechanisms. The concern here is that without in-house social work staff it is difficult to access the very important knowledge and skills that social workers could provide. In the NT for example it is rare to be able to access a social worker for a client outside the ACCHS sector and consequently there is a concern that clients may never be made aware of supports that that they may be eligible to receive.

The importance of using a peer workforce, thereby utilising the 'lived experience', is a potential workforce resource that has arguably not been well utilised. It represents an important evolution in workforce development providing a level of support that the health profession is not able to provide and its potential importance to those suffering from mental health should not be underestimated. The success of a lived experience workforce will rely on the appropriate development and support provided within a peer network. Related to this is the recognition of the importance of embedding Trauma Informed Care practices within the workforce.

Measuring and Reporting Outcomes

It is important to recognise that the analysis of monitoring and reporting data does not tell a simple or direct story about the effectiveness of the performance of a service or the delivery of an intervention per se. It will only provide a gauge on whether a service is meeting their Key Performance Indicators (KPIs) which are typically outputs based, as outcomes-based performance is highly dependent on the context of care and patients' needs.

Outcomes need to be measured and monitored at a range of levels; at the service delivery level and at a broader level, including organisational, stakeholder, cost-benefit, sub-regional and strategic levels. Outcomes measured at a range of levels are better able to inform evidence-based planning and investment. What needs to be recognised is that large scale population-based outcomes data may not specifically relate to mental health service delivery which endeavours to be responsive to the changing mental health needs of clients within their social as well as cultural context.

It is important that a monitoring and reporting framework should be linked with questions pertaining to how policy, public funding and evidence-based best practice is doing in regard to influencing outcomes for the consumer and other relevant domains. Mental health outcomes need to be contextualized around the social determinants of health, recovery-based models of mental health care, equity of access to services, and other specific place based issues. It is necessary to clearly define what a 'mental health service' is and recognize that there are a range of clinical and non-clinical, public and private services that make up the mental health system and sector; including private psychologists, General Practice, hospital-based services, NGOs, peers, consumers, carers and informal carers as well as other sectors such as education, housing and employment services that also play a key role. Monitoring and reporting frameworks should ideally be able to interpret some of this system and sector complexity.

Evaluation of outcomes against performance indicators should ideally be undertaken by an independent body (independent from service providers and commissioning bodies). However, this may not always be practical. This should not discount the role that service providers, commissioning bodies and other stakeholders play in utilising available data, including output data, for the purpose of informing their future planning and working toward service improvement.

Improving the measurement and reporting of outcomes would be of great value to inform planning and performance as some of the current approaches result in broad and generalisable interpretations of outcomes and outputs. Their relevance in terms of evidence-based planning may be perceived as inadequate. For example, use of the K10 assessment tool in the Primary Mental Health Care Minimum Data Set is forcing the application of a specific mental health psycho-metric tool, regardless of the patient's presenting issue, in performance measurement. It has been identified that this measurement tool is not suitable in all settings and may not be appropriate for use with Aboriginal and Torres Strait Islander populations.

What also needs to be noted is that discrepancies currently exist across mental health service provision related to the type of assessments and data that is reported across commissioning bodies and government entities. There would be considerable value in having consistent reporting measures and databases across funding agencies thereby building a reliable and consistent evidence base. To enable this to be achieved the establishment of an appropriate independent agency engaged to oversee a nationally consistent approach to evaluation, measurement and reporting particularly related to outcomes may be warranted.

Conclusion

Mental Health system reform needs to focus on systemic change and collective impact with clear mechanisms. The following are some of the guiding principles that should underpin the new system:

- Fostering organisational cultures that prioritise holistic person-centred care
- Clearly define integration and collaboration
- Recognize the importance of flexibility in the system – one size does not fit all.
- Foster cultural safety that legitimises and validates content and context expertise
- Monitor and evaluate coordinated care, service integration and provider collaborations

To be able to achieve the desired coordination and integration of services there must be a recognition of the importance of pooling funding and working within an agreed strategic framework. The Australian Government's Fifth Mental Health and Suicide Prevention Implementation Plan, in particular the development of Regional Mental Health and Suicide Prevention Plans across PHN regions, provides a timely opportunity for all participating stakeholders to plan, coordinate and integrate service delivery through the identification of regional evidence based needs.

The mental health system is a complex 'space' which in order to operate more efficiently requires evidence based collaborative planning aimed at embedding and sustaining a new system architecture. Some of how that might be achieved is described above.

Le Smith
Acting CEO
Northern Territory Primary Health Network