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SUBMISSION TO THE PRODUCTIVITY COMMISSION

RESPONSE TO THE DRAFT REPORT, OCTOBER 2019

PREFACE

Friends of Callan Park (FOCP) welcomes the opportunity to comment on the *Mental Health Productivity Commission Draft Report*, October 2019.

FOCP commends the Commission for its conclusion that the system is in urgent need of reform and for identifying the strategies outlined in the Report necessary across all levels and ministries of the Australian and State and Territory governments to achieve such reform.

Callan Park is owned by New South Wales Department of Health. The NSW Minister for Planning and Public Spaces (DPIE) and his office have care, control and management responsibility for Callan Park, including oversight of the Callan Park (Special Provisions) Act 2002 which permits health and community uses at Callan Park.

Callan Park, formerly Rozelle Hospital, closed when the last patients were moved out in April 2008. It remains an important cultural landscape of 61 hectares just 6 kms from the centre of Sydney, with more than one hundred empty buildings. Callan Park during wartime was also amongst the largest military hospitals in the country, treating scores of returned service men and women.

Friends of Callan Park is a not-for-profit community advocacy group which has worked for more than twenty years to retain Callan Park as public land and resist sale for private residential development and the relocation of multiple government service agencies by successive state governments.

FOCP has consistently supported the need for better community mental health services, which as the Report (and many preceding reports) identified, have not been properly implemented and funded, dating back to the Richmond Report and the processes of de-institutionalisation. We refer to the Report.

The rate of mental health presentations at EDs has risen by about 70% over the past 15 years, in part due to the lack of community-based alternatives to ED.¹

¹ Mental Health Productivity Commission Draft Report (MHPCDR), Volume 1, p23

One of FOCP's key objectives is to see mental health services (non-acute/sub-acute/psychosocial) established at Callan Park, which provides an ideally therapeutic environment for recovery and respite. The local community overwhelmingly and has consistently supported the use of Callan Park for the provision of mental health services.

FOCP is encouraged that the Commission has identified ways in which reformed funding models could ensure that State and Territory governments are no longer incentivised to prioritise and prefer treatment for mental health consumers in acute (hospital) settings, rather than establishing and funding transitional or preventative services in the community.

FOCP notes the urgent need to address the 'missing middle' of services whereby many mental health consumers are 'falling through the cracks' as clinical and psychosocial services are inadequate or inaccessible to them for a variety of reasons, which the Report identifies.

Callan Park provides the perfect setting (61 hectares of north-facing softly undulating land bordered by Sydney Harbour and to the south by a minor suburban road) with most of the un-used buildings on site located well away from road traffic, yet still within the community.

Callan Park's landscape and greenery were recognised in the 1870s as a therapeutic location in which to provide psychiatric care. In the twentieth century the medical director exploited the influences of the visual environment and the garden - which remains today.²

The economic benefits of adapting solid brick buildings owned by NSW Health (some constructed in 1990, unused for 12 years) for step-up/step-down community mental health support is self-evident. Remodelling existing buildings could be quickly achieved and relatively inexpensively in comparison to establishing new facilities.

Extensive international research into the benefits of blue spaces (water) and green confirm both have a marked impact on people's mental health. A significant literature review commissioned by NSW Health into the effect of built and natural environments of mental health units supports the benefits of remodelling wards and states the natural landscape setting significantly ameliorates stress and improves clinical outcomes.³

Callan Park has access to both green space, with its landscape setting, and blue space, with its harbour frontage to Iron Cove, Sydney Harbour. FOCP notes the Commission's finding that the introduction of the NDIS has further disadvantaged many mental health consumers and that there has been an underspend on psychosocial services as a result. We also note that there is a Federal review of the NDIS currently underway and one of the issues to be addressed is a better, faster assessment process for people experiencing episodic mental illness.

FOCP notes that the NSW Health Ministry spends less per capita on community mental health services than any other State or Territory.⁴

² Obituary, Sydney Evan Jones, *The Medical Journal of Australia*, 26 June 1948, pp806-807

³ *The effect of the built and natural environment of Mental Health Units on mental health outcomes and quality of life of the patients, the staff and the visitors*, NSW Department of Health, North Sydney, 2005, Chapters 5 and 6

⁴ MHPCDR, p287

FOCP comments on specific elements of the Report and Recommendations follow:

VOLUME 1

- **Stepped Care⁵ and Single Care Plans**

FOCP agrees that the ‘missing middle’ of consumers would greatly benefit from the introduction of co-ordinated step-up and step-down services, for people at risk of or transiting out of acute care. We believe that a bricks and mortar presence is required for co-location of clinical and psychosocial services, to avoid the ‘merry go round’ that consumers currently have to endure as providers are often in discrete (and distant) locations and receive funding based on services provided, rather than providing a ‘one stop shop’ which consumers and carers can readily access, and which allows for a case management or co-ordination model of care. We note that the Commission has identified a need for Care Plans, which we believe are crucial to the wellbeing of a large number of consumers (and their carers) to prevent the need to ‘re-tell their stories’.

Note that this approach would not preclude the use of e-mental health portals or ‘digital’ consultations as also recommended by the Productivity Commission. However, face-to-face consultations (along with proper intake and/or discharge processes) should be the first access point, particularly for people with chronic or severe mental illness that is episodic in nature or for people accessing mental health services for the first time.

The ‘bricks and mortar’ or physical co-location of services would be particularly useful for consumers and carers without residential proximity to acute care facilities (eg those accessing remote services such as rural and regional dwellers where equivalent services are not available locally). Proximity to acute care facilities such as hospitals, where possible, would be desirable.

Callan Park is located 3.9 kms from Royal Prince Alfred Hospital and the Professor Marie Bashir Centre in Camperdown, NSW.

Ideally, these mental health services would be co-located (or have cross-referral protocols and processes in place) with AOD facilities, as the Commission has identified the common issue of substance use comorbidity.⁶

- **Draft Finding 16.2 - Police as ‘first responders’**

The correlation between mental ill health and homelessness has been well documented in multiple enquiries over the past decade. The lack of appropriate community mental health supports for homeless people exacerbates the likelihood that they will be ‘dumped’ in hospital EDs and (whether or not they have received treatment) be discharged into homelessness and without support or care planning.

Unless there is a ‘place’ (or triage process) other than a hospital ED for police to take consumers, the situation will continue. A major causal factor is that there is an inadequate crisis response or triage service, staffed by mental health professionals, that would or could in many cases, avoid the need for the police to be ‘first responders’.

⁵ MHPCDR, Volume 1, p17

⁶ MHPCDR, Volume 1, p26

RECOMMENDATION: We note this in order to elaborate on the Commission’s Draft Finding 16.2. and to suggest that the Commission **explore this inadequate crisis response process further and make a recommendation on it.**

○ **Support for people to find and maintain housing⁷**

We agree with the many organisations and individuals that have reiterated the need for specialist supported accommodation for chronically mentally ill people. We commend the Commission’s Draft Recommendation 15.2 and the need for increased funding for programs such as the HASI program, which has a proven track record of supporting mentally ill people to maintain tenancies with appropriate health and psychosocial supports.

○ **Chapter 7 – Specialist Community Mental Health Services**

FOCP has long advocated for the proper funding and establishment of community mental health services for non-acute/outpatient care. We are particularly supportive of the Commission’s views on Community Mental Health and the findings regarding the lack of non-acute services which could prevent hospitalisation, or provide a ‘safe’ re-entry after discharge, promoting recovery or at least stabilisation of their health for many consumers.

We are gratified that the Commission has signalled the urgent need for major reform in this area.

This appalling lack has been identified in many previous inquiries, reports and surveys. We appreciate, however, that in this Report the Commission has identified that funding mechanisms and transfers from Australian to State and Territory governments **provide a disincentive for State and Territory governments to fund non-acute services** – and recommended changes that could manifestly improve the situation.

It is a stark and distressing finding of the Commission, that **one third of mental health patients in hospitals do not need to be there**, which quantifies the consequences of this lack for consumers, carers and the broader community:

We note the Commission’s finding that

*‘30% of people in hospital with mental illness could be discharged if suitable accommodation, clinical and community supports were available...this would support the recovery of those consumers, as well as freeing up capacity in hospitals for others who need to be admitted’
And ‘There are hundreds of people in acute hospital beds whose admission could have been avoided, or who could be discharged if the less acute services they needed were available.’⁸*

Callan Park – a site owned by NSW Health - has dozens of buildings which could be adaptively reused for sub-acute/step-up and step-down temporary residential care at a reduced cost to government. In 2019 NSW Health staff unfamiliar with Callan Park were shocked to discover the existence of such and questioned why NSW Health is paying to rent additional buildings in suburban locations when these buildings are owned by NSW Health. This is not a question FOCP is able to answer, but we appreciate the economic rationale.

⁷ MHPCDR, Volume 1, p76

⁸ MHPCDR, Chapter 7, p277

FOCP commends the Commission's recommendation that as a priority, more community ambulatory services and subacute/non-acute bed-based services be provided.

- **Care co-ordination and case management are essential, but not facilitated by the current system**

Whilst care co-ordination, case management and planning are identified as processes essential to improve outcomes for consumers, current Medicare funding models do not properly address this need AND where State and Territory models could co-ordinate care among multiple providers, there is a dearth of community mental health centres.

The Commission notes that:

'Consumers needing specialised clinical services almost always need services from multiple providers. (And) ... those with the most complex or severe illnesses might need additional services (such as mental health nurses, social workers, peer workers and employment and housing support workers).'⁹

FOCP comments that although the 'no wrong door' objective has been identified as a priority in many reports and enquiries, efforts to establish and mitigate the causes for consumers' common experience of being 'shoved from pillar to post' and having to tell their stories over and over have been unsuccessful, as evidence of this experience remains.

A comprehensive intake process and care co-ordination process that is properly funded by a responsible (lead) agency (where team care is required) or clinical lead is essential. Team members must be incentivised for collaborative practices that demonstrate co-operation between agencies and providers for the good of the client. It is evident that in many cases different agencies (particularly CMOs) compete for funding and are therefore unlikely to cross-refer to other agencies to address multiple needs.

A stepped care model is unachievable without early interventions, assessments and proper (client focused) intakes and funding for them. Costs would be offset by a reduction in the frequency of hospital admissions (as identified).

Beyond that financial consideration would be the improvement in quality of life and better outcomes of recovery or stabilisation for consumers, as well as a vastly improved experience for carers (dealing with one responsible entity or clinician).

We note that the 'Health Pathways' system discussed on page 344 of the Report does not address a care co-ordination or collaborative care model of service. It does not provide a system that would facilitate cross-referrals within its scope. It presumes that initial assessments will be done by a Clinician when we know that in many cases, the consumer comes into the system via other intake 'doors'.

⁹ MHPCDR, Chapter 7, p279

- **Reallocation of Federal funding from acute care to community care**

Recommendations for reallocation of Australian government acute hospital funding into more community-based psychosocial, primary and community mental health services have been made in a succession of inquiries and need to be implemented as a matter of urgency.¹⁰

- **New South Wales lags behind other states in the provision of community mental healthcare and step-up/step-down services¹¹**

The Report quotes the MHCC and the NSW Mental Health Commission statements that

‘...there are ‘only a handful’ of step up/step down facilities available in NSW (MHCC, sub. 214, p16). The NSW Mental Health Commission (NSW MHC 2014a, p55) has noted that New South Wales is ‘overly reliant on hospitals in the delivery of mental healthcare, spending less per capita on community mental healthcare than any other State or Territory’.

FOCP notes the Commission’s recommendation that

‘the sole responsibility of the State and Territory Governments for providing community ambulatory and non-acute bed-based care should be clarified. This would make it clear who needs to address current service gaps, promote integration of services, and minimise overlap between services provided by different levels of government. (chapter 23)

FOCP comments that mental health consumers in NSW should not be disadvantaged by a lack of equivalency in treatment and care potentials and **requests that the Commission recommends increased expenditure and an accelerated program of implementation of these recommendations by NSW Health** to ensure equivalency of per capita community mental health spending across the country.

- **9.2 Substance use comorbidities – co-location of services**

FOCP concurs with the comments contained in the Report that there is a crucial need for co-ordinated approach to Dual Diagnosis treatments and programs given the high correlation between mental ill health and substance addiction.

Ideally, as the Commission has found, these services should be co-located, or at least have a seamless ability to cross-refer. We note the model adopted by WHOS (We Help Ourselves), which operates residential addiction treatment programs, managed by staff who have all completed a Cert IV in Mental Health (at minimum). This residential program has been successfully run and managed in the grounds and buildings of Callan Park for twelve years.

FOCP notes that the Commission has identified this (co-location) as a key enabler of integrated care programs in Section 10.3.

Where co-location is not possible or practical, efficient (and explicit) cross-referral programs would improve the system navigation process.

¹⁰ MHPCDR, p285

¹¹ MHPCDR, p287

- **Co-location or community hubs**

FOCP concurs with the findings of the Report which draw together recommendations from many Inquiry respondents recommending the use of community hubs to provide integrated services where services are co-located. There is a need for such 'hubs' to be funded to accommodate 'walk-ins'.

Funding models currently make this approach difficult, because they are competitive in nature, particularly in the psychosocial sector. As previously stated, funding needs to be provided for the 'intake' service or clinician to provide care co-ordination and cross-referrals, so that the totality of the consumers' needs can be addressed.

Privacy issues are often cited as a barrier to such collaborative treatment programs and systems need to be introduced that overcome this barrier and ensure data security.

Disincentives to collaborate and cross-refer can be overcome by adoption of protocols such as that contained in the 'No Wrong Door Mental Health Charter' (page 364).

- **12 Psychosocial support is essential for the majority of consumers**

FOCP welcomes the Commission's findings regarding a) the crucial need for better access to psychosocial support programs and b) the problems with multiple channels and ad hoc funding for such services and c) the barriers to access to such services under assessment guidelines for the NDIS.

We believe that successful, evidence-based programs such as PHaMs, D2DL and PIR should be funded sufficiently (both inside the NDIS parameters and out) so that all consumers who would benefit can access them. Referral pathways should be available through both clinical and non-clinical intake processes and encounters in order to facilitate the 'no wrong door' approach.

CMOs who deliver psychosocial services require funding certainty in order to properly resource them and enable them to retain a skilled workforce.

The competitive nature of tendering urgently needs to be re-assessed.

- **Better Community Mental Health options would prevent discharges into homelessness and help to ensure continuity of care**

As identified in the Report, the correlation between homelessness and mental ill health is well understood. FOCP commends the Commission's recommendations regarding the need for improved transitional arrangements, which we advocated in our original submission (#198). We agree that Step-up and Step-Down services, as well as supported social housing programs are crucial 'planks' that are currently under-resourced, particularly in NSW.

We also agree with other submissions to the Inquiry regarding the urgent need for formal, nationally consistent policies of no exits into homelessness. (page 567)

- **16.2 Criminal Justice system**

FOCP welcomes all findings here and notes that there is a high rate of over-representation and recidivism for those experiencing mental ill health.

We note that In NSW the recidivism rate is over 50% - the highest in the country. This can arguably be correlated with the lack of per capita spending on community mental health in NSW (as an incarceration prevention strategy). The New South Wales Law Reform Commission's assertion (2012, page 39) that:

'prison is a high-cost intervention which is ineffective in reducing subsequent offending and inappropriate as a setting for effective mental healthcare' is self-evident.

We also note the Commission's finding that

'Police interactions have been increasing over time. For example, in New South Wales, police involvement with Mental Health Act related events increased over eight-fold over the 10 years to 2009).

As noted earlier in this document, we **strongly urge the Commission to insist on a better crisis response, to decrease the incidence of police being the first responders to a mental health incident or episode and to encourage de-escalation strategies thus helping to avoid (expensive and ineffective) institutionalisation as a result.**

We concur with criticisms expressed by others that CAT (Crisis Assessment and Treatment) services do not currently provide an adequate or timely response in NSW. Training NSW Police Crisis Intervention Teams is a good start but is not a substitute for the availability of a team of mental health professionals capable of triage and referrals to services (other than to hospital EDs or jail).

At a minimum co-response teams are required. This need should be self-evident from the Commission's Report and extensive trials of such systems should not delay implementation by State governments.

VOLUME 2

○ **Section 23 – Federal Roles and Responsibilities**

FOCP welcomes the Commission's finding that changes to federal roles and responsibilities are necessary and that State and Territory governments must be responsible for resourcing more and better community mental health services.

Specifically, we advocate for the 'Rebuild' model preferred by the Commission.

Additionally, we agree with the recommendation that in addition, the State and Territory should take on sole responsibility for psychosocial and carer supports outside of the NDIS, supported by additional Australian government funding (page 933).

○ **Responding to Information request 23.1**

FOCP has no ability to respond to the question of whether the Regional Commissioning Authorities proposed in the 'Rebuild' model should *'hold funding for and commission alcohol and other drug services'*. However, as previously acknowledged in this Report, the 'silo' approach to treating and caring for people with Dual Diagnosis is not working, and in many cases, provides a barrier to people being treated for EITHER diagnosis. Others will no doubt respond appropriately to this question, however, FOCP believe that even if funding streams are not merged, there must be a system put in place that prevents exclusion on the basis of DD.

- **Draft Recommendation 24.5 – Private Health Insurance and Funding of Community Based Healthcare (page 996)**

FOCP notes the recommendation and make the comment that whilst it may be desirable (after careful consideration and consultation by the Australian government) for ... *‘private health insurers to fund community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions’* – private health insurers should NOT be permitted to also be providers of such services.

Service provision would represent a clear conflict of interest: the best interests of consumers will not be the key consideration if those consumers also present a revenue stream for private health insurers. Also, CMOs should not be forced to compete for staff with large national and multinational insurers thus dissipating their effectiveness and minimising the potentials for collaborative practice and cross-referrals.

- **Addressing unmet demand for community services reduces demand for more expensive alternatives¹²**

FOCP reiterates our concern that ‘unmet demand’ exists nationally, and that NSW lags the field in terms of investment in the community mental health sector.

We refer to the MHCC submission regarding cost-savings that could be realised by NSW Health should additional step-up, step-down services be introduced.¹³

CONCLUSION

The shortfalls and inadequacies of the mental health system post-deinstitutionalisation have been well documented over the decades. Experts in the field have spent countless hours consulting with various Inquiry bodies to identify the ‘cracks’ through which consumers continue to fall, in many cases with fatal consequences to themselves or others.

Meaningful reform has not been successful or achievable in the past, principally because of conflicts of interest and a lack of accountability from the top down. It is heartening that the Productivity Commission is recommending large-scale funding reforms and a proper allocation of responsibility to governments, as well as an acknowledgement that thousands of consumers (and their carers) as well as the broader community will benefit if (and only if) the system is improved.

The economic benefits that will flow from a reduced reliance on Hospital ED admissions, better intervention and prevention strategies and (in the medium to longer term) greater workplace participation, have been well stated.

¹² MHPCDR, p1054

¹³ For example, additional step-up, step-down services in New South Wales were expected to reduce hospitalisation rates by 16%, shorten length of hospital stays by 7 days, and reduce the risk of ED presentations by 40%. Additional provision of these services was estimated to pay for itself over time, yielding savings of \$9,480 per person per year. (MHCC 2018, p13)

Callan Park is owned by NSW Health which, with its small suburb of buildings (requiring some renovation and adaption), could reduce the economic cost of establishing mental healthcare and step-up/step-down services in the community in new facilities – addressing the ‘missing middle’. The economics of provision of such care are estimated to pay for themselves over time and yield savings of almost \$10,000 per person per year.¹⁴

The wellbeing benefits and improved outcomes for the community and mental health consumers and their carers and loved ones cannot be overstated. It is a national disgrace that mental illness prevalence in our community is greater than the OECD average. Action (rather than rhetoric) is required urgently to rectify this sad situation.

FOCP welcomes the Commission’s thoughtful and considered response and recommendations for some very practical and achievable actions that we hope governments can, and will, implement without delay. We are enthusiastic about the potentials for the ‘Rebuild’ model to produce better, happier outcomes and sincerely appreciate the opportunity to comment on the Commission’s Report.

¹⁴ MHCC 2018, p13