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April 2014

AHCRA response to Mental Health Commission Review Survey

Mental health system working well

1. Please provide an example from your own experience (or that of your organisation) of a service, programme, policy or initiative demonstrating value for money (cost-effectiveness):

AHCRA believes that the most cost-effective approach to providing mental health services is to see mental health care as an integral part of a health system centred around high quality and accessible primary health care. We believe that the primary health care sector is critical to the overall performance of our health system. In particular, primary health care is vital to meeting the health care challenges of our ageing population and in dealing with multiple physical and mental morbidities. If we can improve primary health care and increase the focus on prevention, we will spend less overall on both mental and physical health care and achieve better health outcomes.

Within the current Australian health system and siloed funding arrangements it is difficult to develop an integrated, preventive-focussed and cost-effective service. However, AHCRA believes that good examples of cost-effective services can be found in many Aboriginal Community Controlled Health Services (ACCHS), such as Wurli-Wurlinjang Health Service in Katherine. It is also evident in some Victorian community health services, e.g. Inner South Community Health. This latter service provides a wide range of mental health, alcohol and drug and primary health and support services in an integrated manner, avoiding the need for many clients of a disjointed system of care among multiple providers, ultimately a more expensive option for funders.

2. An example of an innovative approach to funding, organising, or delivering mental health support:

For much of the non-acute mental health system, mental health, alcohol and drug, and physical health issues are considered separately, and the latter poorly. AHCRA sees this as an unacceptable and flawed division, based on historical needs of providers and funders, not of people with mental health conditions. A more integrated model needs to be developed to address the very low life expectancy of people with mental health conditions.

AHCRA believes that the funding model for ACCHSs helps these organisations provide an integrated and comprehensive service able to support the holistic conception of Aboriginal and Torres Strait Islander health, which includes social and emotional wellbeing. While funding for ACCHSs is not always adequate to provide the comprehensive range of services required, they are able to provide a greater range of services than most primary health care organisations, including: primary clinical, 24 hour emergency care; the provision of essential drugs; and management of chronic illness; population health/preventive care; and mental health care. A report outlining ACCHS' social and emotional wellbeing programs (The Mental Health and Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples, Families and Communities supplementary Paper to A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention Prepared by Chris Holland, with Pat Dudgeon and Helen Milroy for the National Mental Health Commission March 2013) also highlighted the role of Aboriginal Family Support Workers, alcohol and substance abuse workers, social workers and psychologists in providing their programs. This report noted that ACCHSs can also offer traditional and innovative contemporary healing practices as culturally secure services, along with mental health promotion, short and long term counselling harm reduction and suicide prevention.

Among non-Aboriginal services, AHCRA also considers that a strong community-managed recovery-oriented system is required to augment the need for acute care. However many services have a narrow focus. Good practice among services such as Prahran Mission in Melbourne includes providing a range of training, employment and housing options as well as ongoing support, activities and art therapy, all within the one service. This recognises both the need for care to be integrated but also the crucial importance of addressing the social context in which people live.
Lastly, a number of services employ trained Peer Support Workers (with lived experience) to support other clients, a role highly appreciated by clients.

3. An example of good integration, joint working, or collaboration with other services, programmes or initiatives:

AHCRA believes that mental health should be considered as an essential component of overall health and well-being and that mental health issues are best addressed through an integrated approach which treats both mental and physical health problems in conjunction. We support an active role for Medicare Locals at the community level to support integration and coordination between services providing mental health prevention, treatment and support. Without the Medicare Local infrastructure, coordination of individual services and programs would be extremely difficult.

Currently, MLs deliver or fund a range of programs targeted at supporting people in their local communities with mental health conditions. They also provide support to GPs, Allied Health Professionals and Community Sector Workers around referral pathways and patient or consumer resources.

Some of the programs implemented through MLs and general practice are:

- Access to Allied Psychological Services (ATAPS)
- Better Access
- Mental Health Nurse Incentive Program (MHNIP)
- Partners in Recovery Initiative (PIR)
- Mental Health Services in Rural and Remote Areas (MHSRRA)
- headspace

One example of where a Medicare Local (ML) is working to coordinate existing services and to fill a gap in service provision is the Far West Medicare Local in NSW. This ML works closely with all general practices in the area to provide support to people who are affected by Mental Health illnesses and disorders. The program includes a range of service providers, including:

- Counselling Psychologists
- Child Psychologists
- Registered Mental Health Nurses
- Aboriginal Mental Health Workers

The key target groups being serviced by the Far West NSW Mental Health program are people who live in rural and remote locations, Aboriginal and Torres Strait Islander people, Women experiencing Perinatal Depression, Children, and people who are at risk of suicide.

Another example is the North Brisbane Partners in Recovery program which supports people who have a severe and persistent mental illness with complex support needs that require a response from multiple agencies across different sectors.

4 An example of a service or initiative which supports the needs of the whole person (e.g. physical health, housing, education and training):

Apart from the example above of Prahran Mission, the StrongBala program run by the Wurli-Wurlinjang Health Service provides culturally appropriate support for Indigenous males—including the homeless—by providing a males-only facility which delivers a broad range of facility-based services, including clinical services, and health education and promotion activities. ACHRA believes that this initiative is a good example of how the needs of the whole person can be supported within the context of a specific health program.

The StrongBala Program empowers Aboriginal men to step up and make meaningful contributions to their family, their community, and their culture. The program is specifically focussed on young school leavers and those transitioning between school and work, as well as young males referred by the NT Department of Justice. It includes activities that promote healthy lifestyle, hygiene, proper nutrition, cultural security, money management, CDEP, work skills training, and employment programs. Role models visit often, including Elders, Indigenous achievers and other mentors.

An Alcohol and other Drugs counsellor delivers an AOD program and talks to men about healthy lifestyle choices. Traditional skills and art are among the many subjects taught at StrongBala. A male Senior Aboriginal Health Worker delivers daily health care services, a male doctor visits once a week and more regularly as required, a male mental health counsellor delivers counselling on site and a sexually transmitted disease specialist Aboriginal Male Health Worker is based at StrongBala. All provide psychological support and health promotional advice in addition to the services delivered by their various disciplines.

5. Up to 2 examples of services, programmes, policies or initiatives which effectively target and meet the mental health needs of specific communities:

One example of an effective service targeting both the mental and physical health needs of Indigenous Australians is the Number 34 Aboriginal Health Service in the North West of Tasmania, an area with many gaps in service provision. The service is a collaboration between Tasmania Medicare Local (TML) and the Six Rivers Aboriginal Corporation. Through the Number 34 Aboriginal Health Service, TML provides:

- Closing the Gap services
- chronic disease care coordination
- outreach workers
- Aboriginal health program officers
- primary health care services
- social work services – youth and family support
- aged care services and support
- mothers and babies programs
- health and wellbeing programs
- access to visiting health professionals under the Medical Specialist Outreach Assistance Program – including midwifery, diabetes education, nutrition/dietetics, exercise physiology, podiatry and psychology services
- support to mainstream health providers in their provision of services to Aboriginal people.

AHCRA is of course aware of *headspace*, the National Youth Mental Health Foundation, which helps young people aged 12–25 with mild to moderate mental health issues receive early treatment that responds to their needs. Young people are a particularly vulnerable group as many mental illnesses present for the first time during this stage of life. In particular, AHCRA supports the integration of research programs and clinics which enables the translation of research outcomes into improved healthcare practice and policy.

6. An example of effective and efficient use of reporting:
AHCRA is not providing a response to this question.

7. An example of a service, programme, policy or initiative which is not subject to unnecessary red tape (e.g. approvals processes, extensive forms, reporting etc.):
AHCRA is not providing a response to this question.

8. An example of effective monitoring of outcomes and experiences to drive service improvement:
AHCRA is not providing a response to this question.

9. An example of meaningful involvement of people living with mental health problems and/or their families/supporters (for example, in the planning of services, decision-making, or feeding back views):

There are many good examples of consumers and their carers influencing their care in Victoria, and on the national stage. Indeed, in some ways, this is an area where the mental health sector is more advanced than in the rest of the health system. Good examples include the employment of Consumer Consultants (e.g. Thomas Embling Forensic, Prahran Mission, Alfred Psychiatry, Transcultural Unit working with CALD clients at St Vincent's Hospital), Carer Consultants (Mind), Consumer Educators involved in training of staff (e.g. Alfred Psychiatry), specific Community Advisory Committees (Eg ISEPIC, Hume Medicare Local).

Capacity building to underpin these activities is also crucial. Health Issues Centre also runs two nationally accredited training courses in Consumer Leadership (for consumers) and another in Consumer Engagement (for staff in facilitating consumer participation). Many consumers and staff from the mental health sector have undertaken these courses successfully.

AHCRA certainly believes that the current health system has been predominantly designed and developed around professionals' needs, not those of consumers. Re-orienting the health system to reflect the needs and priorities of the community will result in a more efficient health system which delivers better health outcomes for all. And there is good evidence that stronger consumer participation results in better outcomes from consumer.

Future action should include strengthening the requirements for health services to involve consumers in decision-making and move towards more consumer-centred care; funding research which develops the notion of consumer-centred care and more effective consumer participation; developing mechanisms for stronger citizen engagement in discussing/guiding health system of the future (before health budget grows out of control); and increasing the community's health literacy, and especially that of more disadvantaged populations.

10. An example of clear public accountability for the outcomes of investment:
AHCRA is not providing a response to this question.

11. An example of regular and effective use of evaluation or research to inform evidence-based practice:
AHCRA is not providing a response to this question.

12. An example of effective workforce planning, development or training:
AHCRA is not providing a response to this question.

13. An example of the use of technology to improve the experience or effectiveness of services:

ACHRA is aware of the development of online tools for some mental health problems, such as Moodgym, targeted at early-stage and mild to moderate depression and anxiety. We support the ongoing development and evaluation of these tools as part of an evidence-based approach to mental health service delivery. In particular we recognise the potential for innovative information technology tools to be useful in addressing current gaps in service provision, such as in rural and remote areas, and/or meeting the needs of specific consumer groups, such as young people.

14. Any other example of a service, programme, policy or initiative which has proven to be efficient and effective and has resulted in good outcomes for people experiencing mental health problems and/or their families:

AHCRA is aware of the NewAccess program, based on a successful UK initiative and currently being piloted by Beyondblue. NewAccess is an early intervention program intended to provide easily accessible, free and quality services for people with mild to moderate depression and anxiety who are currently not accessing mental health services. The program aims to support hard to reach groups like men, of whom only 1 in 4 seek support. ACHRA supports the ongoing evaluation of this program to determine whether or not it meets consumers' needs and is cost-effective.

Examples of where the Mental Health system is NOT working well

1. Please provide an example of services, programmes, policies or initiatives (from your own experience or that of your organisation) which demonstrate or encourage inefficiency in organisation or delivery of services:

AHCRA believes that the current fragmented health system does not provide high quality or efficient care to many people with complex physical and mental health issues. For example, there is a significant disconnect between primary health care services and mental health services, egg between GPs (and many community health services which don't have mental health staff) and the mental health system at acute or recovery levels.

Additionally in some cases there are significant cost barriers to many consumers in accessing basic mental health services, such as counselling. This can create a disincentive to seek early intervention for emerging mental health issues leading the development of more serious (and more expensive) problems. There is also a lack of integrated planning and delivery of mental health services between the Federal and State/Territory Governments. This leads to service gaps at the community level , some of which are being addressed through Medicare Locals.

In addition the fee for service model is a major barrier to integration of services and to professional development as it encourages individual providers to work alone and leaves integrated professional development a funding orphan. In many cases it also is the reason for cost barriers (co-payments), and contributes to the poor distribution of providers leading to a lack of services in poor and rural and remote areas.

2. An example of an inappropriate balance or prioritisation of funding:

Overall, AHCRA believes that the current balance of funding within the health system is weighted too much in favour of hospitals and specialist services and too little towards prevention and primary care services. In the area of mental health, we would support a significant increase in the funding currently allocated to mental health promotion, suicide prevention and primary mental health care in order to increase the prevention and early identification of mental health disorders. We also support increased consumer into resource allocation processes so that they reflect consumer views and priorities.

3. An example of where different services, programmes, policies or initiatives are not well integrated or don't communicate with each other:

One example of poor integration of mental health care is the lack of systematic coordination of care between primary health care services and acute care hospitals. For example, when consumers move from a community based health care service, such as a general practice, to an acute care setting (hospital) and then back to the general practice, it is often very difficult for the GP to obtain information about the services provided to the consumer while in the hospital. Even such basic information, such as the expected date (or actual date) of discharge and any medication changes, are not routinely conveyed to the GP making it very difficult to provide high quality and coordinated care to the consumer.

4. An example of the needs of the whole person not being effectively addressed or met (e.g. physical health, housing, education and training):

Within our current health system, which is focussed on providing short-term and episodic care on a fee-for-service basis, it is very difficult for health professionals to address the needs of the whole person. To achieve this aim would require a health system that is oriented around multi-disciplinary and comprehensive primary health care provided by a range of health and community care professionals working in collaboration. An alternative funding system, such as one which pooled existing Commonwealth, State/Territory and local government funding, would also be required to move away from the current fee-for-service system and enabled health care providers and services to provide planned and integrated multi-disciplinary care over the long term.

5. An example of practices which result in people living with mental health problems and/or their supporters having a poor experience:
AHCRA is not providing a response to this question.

6. Up to 2 examples of services, programmes, policies or initiatives where the specific needs of particular communities are not effectively recognised or met:

The Better Access to Mental Health Services program has been shown to have been accessed more by people from affluent backgrounds than those from disadvantaged groups, including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse peoples, people living in rural and remote Australia, people who identify as lesbian, gay, bisexual, transgender or intersex, people who experience substance use difficulties, people living with intellectual disability.

7. An example of excessive red tape (e.g. unnecessary and burdensome reporting requirements taking resources away from service delivery):

AHCRA is aware that many ACCHS receive funding from multiple sources and have extremely complex reporting requirements that take up valuable resources that could otherwise be diverted to service delivery.

8. An example of failure to use outcomes monitoring as a quality improvement tool:
AHCRA is not providing a response to this question.

9. An example of failure to meaningfully involve people who use services in their design or delivery (e.g. by incorporating their feedback):
AHCRA is not providing a response to this question.

10. An example of unclear or opaque accountability for outcomes:

AHCRA is concerned that the resources provided to carry out service provision in the mental health sector seldom have sufficient or allocated funds for evaluation, especially given that many of the outcomes can only be measured several years from initiation of a program. Often the tools to appropriately evaluate a specific program have not been developed when the program is implemented, often because of a lack of funds for the research required. This undermines accountability for mental health funding and makes it difficult to know whether or not funds are being used to achieve maximum outcomes.

11. An example of a locality/area where there is duplicated provision of services or programmes:

AHCRA is not providing a response to this question.

12. An example of an area, state or territory where there are gaps in services or programmes:

AHCRA is aware of the difficulties many people living in rural and remote areas have in accessing mental health services (as well as general health services). There are few dedicated mental health services in rural and remote areas and primary health care providers in these areas are generally extremely busy and unable to dedicate the time required to provide high quality mental health care. There is an urgent need to increase the availability of mental health services in regional and rural Australia. ACHRA is also aware that many people from diverse cultural and linguistic backgrounds have difficulties in accessing culturally and linguistically appropriate mental health services.

13. An example of where research activity is poorly prioritised, funded or organised:

ACHRA believes that the role of social determinants in improving mental health has been inadequately prioritised and funded. There is good evidence that issues such as unemployment, homelessess and cultural dislocation have a profound impact on mental health. However there is little research undertaken on how a social determinants of health approach to policy making can improve mental health status. There is also little research undertaken on the mental health impact of rising income inequality in Australian society over the past 30 years.

14. An example of poor use or planning of workforce/human resources:

ACHRA supports a health system oriented around comprehensive primary health care. This should include a broad range of primary health care providers, working with and supporting general practitioners. Currently, ACHRA believes that the role of practice nurses and nurse practitioners within general practices is being under-utilised. We believe that there is potential for both practice nurses and nurse practitioners to take on a greater role in both mental health promotion and service provision (with appropriate training and support).

15. Any other example of a service, programme, policy or initiative which has proven to be inefficient or ineffective and has not resulted in good outcomes for people experiencing mental health problems:

AHCRA is not providing a response to this question.

Improving the mental health system

1. One practical step to improve things in the mental health system would be:

ACHRA believes that the most important step towards improving our mental health system would be to reform the current funding and service delivery arrangements to establish a single funder and point of accountability for all health services in Australia. This would facilitate joint planning and resource allocation and support a more transparent and accountable health system. It would also support greater consumer input and the re-orientation of our health system around a strong primary health care sector (in line with international evidence). Ideally, funds would be allocated on a regional basis based on the needs of the population in each region. This would provide a solid foundation for the provision of high quality, accessible and preventive community-based mental health care.

2. A second practical step to improve things in the mental health system would be:

A second practical step to improving mental health services would be to significantly move away from a fee-for-service funding system throughout the health system, in particular for primary mental health care. A fee-for-service system reduces the capacity of individual providers to provide high quality mental health care and creates an episodic and fragmented approach to service provision. An alternative funding system that supported the provision of best practice care (such as a capitation funding system) would result in higher quality outcomes and a more efficient allocation of resources.

3. A third practical step to improve things in the mental health system would be:

A third practical step to improving the mental health system would be to adopt a social determinants of health approach throughout all areas of Federal Government responsibility. This could be similar to the 'Health in all policies' approach taken by South Australia, which promotes the consideration of health issues in all government legislation, policy and service delivery. This approach would enable the mental (and physical) health implications of all Government policies and programs to be considered as part of their development and contribute to the development of a society much more supportive of good mental health.

Additional Comments

1. Comments on specific areas of service provision

AHCRA is not providing a response to this question.

2. What is your/your organisation's view about the current provision of support for Aboriginal and Torres Strait Islander people's mental health?

AHCRA believes that closing the current health gap between Indigenous and non-Indigenous Australians should be our nation's highest health care priority. We support the model of community-controlled health care organisations in addressing the complex causes of ill health and disability within Indigenous communities and believe that support for Aboriginal and Torres Strait Islander people's mental health should be delivered primary through these organisations.

3. What is your/your organisation's view about the current provision of mental health support in remote and rural Australia?

AHCRA is aware that people living in rural and remote Australia do not have the same access to mental health services as do people in urban areas. We are aware of a number of programs and services addressing the specific needs of people in rural areas with mental health issues, in particular the work being done by rural Medicare Locals to integrate local services and fill service gaps. We believe that the best way of meeting the needs of people in rural Australia for mental health services is a combination of support for local, community based organisations, such as Medicare Locals and a continued investment in innovative services using technologies which bring mental health services to rural Australia.

4. What is your/your organisation's view about the current funding, organisation and prioritisation of mental health research

AHCRA believes that there is a role for increased consumer input into the allocation of research funding into mental health research. We also support increased research into the role of the social determinants of health in mental illness and research into primary health care mental health programs and services.

5. What is your/your organisation's view about the current way mental health workforce development and training is carried out in Australia?

AHCRA supports an efficient use of our health workforce. Currently we believe that in many areas we are under-utilising skilled health care professionals, such as nurse practitioners. We support an evidence-based, increased role for non-medically trained primary health care providers where this reflects consumer needs and priorities.