



Response to the Productivity Commission Mental Health Inquiry Draft Report

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Introduction and Summary

We have been concerned about the lack of consensus on the definition of efficiency in mental health services and we have proposed a working definition. We have specifically commented on funding and payment systems, as you get exactly what you pay for, so the payments need to incentivise quality and best practice recovery, with minimum waste.

We have also specifically addressed:

- Integrated Care & Unitary Regional Strategic Plan
- Efficiency & Real-world Outcomes
- Payment Systems: poor evidence for, and lack of equity on regional & population basis
- Regional Commissioning Authorities
- Headspace primary care model (Recommendation 5.3)
- Developmental trauma
- Structural reform (Recommendations 23.1, 23.3 and 24.2)
- National Mental Health Commission (Recommendations 24.4, 25.4)
- National Mental Health Service Planning Framework
- Essential Components of Care compendium & tool
- National Role Delineation Guide for mental health services
- Rural, Remote, Telehealth and e-Mental Health



- Indigenous issues – Information requests 11.1 and 21.2
- National Accountability for Quality
- Assertive Community Treatment teams in conjunction with the NDIS
- Workforce Development (recommendation 11.1 and 11.4)

Efficiency Definition

The most relevant definition of efficiency for mental health services has to be that a defined outcome is achieved with the least waste. What is assumed in any dictionary definition is that you start by knowing the outcome to be achieved. In mental health services the expected outcomes are generally not defined or are about activity that bears no real relationship with functional or consumer recovery goals, apart from whether you are in or out of hospital.

There are several problems in applying this definition to mental health services. Recovery and maximal social functioning are generally agreed to be the desirable outcomes, but the very wide range of disorders due to genetic and epigenetic factors (developmental trauma, life events, infections etc), ongoing interactions with physical health, behavioural reactions to current stress and social determinants of health, means that many models of care and desired outcomes have to be defined for a specific segment.

However, this can be done by designing models of care for each segment, both in terms of functional and satisfaction outcomes agreed by consumers, carers and the community, and delivery process outcomes in terms of benchmarking activity levels and adherence to fidelity tools. An example is the Early Psychosis Prevention & Intervention Centre model designed by Orygen Youth Health for first episode psychosis in the youth age group (12-25), with 16 components of care, implementation manuals and a fidelity tool with inspections. This can be considered best practice and other programs should be benchmarked against it. However, even it would benefit from better definition of desired recovery outcomes, and for this reason the current services are experimenting with tools such as the Recovery Star, which repeatedly rates 10 domains of life in full collaboration with the young person. The existing required measure, the HoNOS is clinician rated only and not designed as an outcome measure but as a clinical status measure, based largely on current symptoms, which can be highly variable in the short-term, so does not provide robust outcome trends, and is not considered adequate by consumers and many clinicians. An evidence based functional outcome tool is essential to determine ongoing trends in outcomes. The Life Skills Profile, designed in Australia, with worldwide applications, can be rated by clinicians, support workers or family carers, and provides a robust and reliable measure of ongoing functional ability and impairment, and is used as an outcome measure for both clinical and functional rehabilitation services (including public, some NGO and now also NDIS mental health services). It also could be synergised with a measure such as the Recovery Star, which is self rated (against written prompts) and fully collaborative, but also has a clinician observation rating.



Experience shows that to provide a clear model of care requires a) a strong evidence base for cost-effectiveness of suites of skilled interventions, b) intense education (not adequately provided by University courses), c) on the job skills based training (e.g. Orygen supplied manuals and 20 two hour online interactive modules) and d) onsite maintenance via fidelity criteria monitoring and clinical supervision (to prevent reversion to previously learnt attitudes and behaviours, and manage endless staff turnover).

The major criticisms of current outcome measures are that they are mostly based on occasion of service activities or time limited episodes of care, as defined for activity based funding, which rely on very erroneous assumptions:

1. State services are providing adequate quality care, whether inpatient or community based. The National Mental Health Service Planning Framework (NMHSPF) shows that all jurisdiction fall short in providing sufficient inpatient and community based beds for those that need supervised care, let alone sufficient community based services, no matter the funder or provider (e.g. WA Mental Health Commission Plan in a state with the highest per capita expenditure).
2. The only outcome that matters is a reduction in service use and cost. Relentless population growth means that even CPI increases are not sufficient to keep pace. Mental health services need to cover the whole of life and there are clear phases of development of mental health disorders, as used by the NMHSPF. In economic terms, expenditure in those phases need to be considered appropriate to the desired outcomes. In children, youth (12-25) and adulthood before retirement, the effects of interventions should be considered as investments, as the many significant studies show not only reductions in personal, family and social pain, but also great returns on investment. The returns are increased tax collections and reduced use of treatment and support services across the spectrum, particularly in preventing chronic physical health conditions. It used to be said that 80% of health expenditure is in the last two years of life, and that could be seen as dead money rather than investment in children and youth.
3. Medical treatment services in mental health can be seen, funded and evaluated in isolation from the social needs and determinants of health.

Real World Outcomes

If we are going to be honest in assessing efficiency, we need to look at the real world drivers of decision making by systems and clinicians, that result in hidden outcomes, as mental health patients are often ignorant about what they should be receiving, or not able to articulate and complain about poor outcomes. What can seem to be efficient, can be hiding ongoing dysfunction and quiet mental



illness in the community. The following behaviours have been observed and not controlled by current methods:

1. State public sector provider real outcomes seen: – do not come wanting an admission, as we cannot cope with the demand from people we are obliged to admit, do not create a public nuisance, if in need, bother someone else! Keep LHN funding pooled so that diversion to general medicine/surgery can be hidden.
2. Private fee-for-service provider desired outcomes: – attend on time, take medication/psychotherapy, hoping that you guess as to the right medication/ psychotherapy (a problem with DSM5 diagnostic categories) and that it works at least partially. The treatments, while usually having statistically significant value in large controlled trials, still usually have low effect sizes compared to placebos, due to the high levels of confounding factors, the lack of specificity in DSM5 diagnoses, and comorbidities. Often 40-45% of people in a trial of medication or psychotherapy do not get better during the trial. Many people do not achieve desired outcomes, but fees will still be paid from tax-payers funds – an obvious waste.
3. Private hospitals often admit people who could be managed at home, and they may stay until their insurance limit is reached. The more severe end of the spectrum are then referred to the Local Health Networks (LHN) for admission or community follow-up, without responsibility.
4. Non-Government Organisation (NGO) community based services – get the next contract. The current contracts have variable levels and models of care and outcomes defined, but usually outcomes are more activity based than measurable health/life benefit outcomes. The problem of market competition is a tendency to contract with the lowest bid, rather than evidence that the quality outcomes are actually likely to be achieved. It is difficult for NGOs to achieve quality due to fragmentation with many discrete contracts and variable lengths of contracts, considerably lower rates of pay in national awards, damaging to recruitment and retention of quality staff. This adds to real costs through continuously needing to run orientation, education, training and supervision programs. Reducing these costs leads to reduced quality from inexperienced and poorly trained staff.

The right outcomes will not occur unless the incentives change, through better model of care designs, fidelity tools, outcome measures and payment systems. How good is current efficiency?

Payment Systems

We are concerned by the lack of evidence on the benefits of different payment systems. There are pros and cons, and in our view the system should provide incentives to achieve the recovery outcomes desired by consumers and carers, as they are also the outcomes that lead to more



productive, meaningful lives and less burden on the state. That is efficiency in mental health services. Below is commentary on the current payment systems.

Fee For Service

There is little evidence that private services are generally providing efficient care, or adequate quality of care, whether inpatient or community based. Fee for service rewards, seeing people for as long as the money lasts, whether or not the desired outcome is achieved.

Medicare fee for service rebates fail to achieve efficiency for several reasons:

- Failure to ensure the equitable distribution of providers. When we were able to get Medicare data under FOI, analysis showed that the highest per capita rebates in NSW went to the wealthiest areas (was Malcolm Turnbull's electorate) and the least to the Mt Druitt electorate, where there is high public housing and need. Thus any pooling of funds and cashing ought to correct these imbalances, not perpetuate them, and provide at least the per head of population average (see section on integrated care pooling).
- Failure to provide an equitable access to the providers that are available, due to varying ability to pay the gap. The freezing of Medicare rebates, or the less than CPI increases over many years, have made bulk billing progressively less attractive.
- Failure to contain costs to the taxpayer (uncapped budget – diminishing resources available to more targeted investments) and to the consumer (providers find the gap they can get away with charging and just increase their fees by the amount the rebate is increased – e.g. when psychologists gained access to Medicare).
- Based on historical charging behaviours with no relationship to the value of the service provided.
- Based on the historical model of individual clinicians in an office behind closed doors, when there is ample evidence that quality mental health care is team based and changes to Medicare items trying to improve this are not effective.
- Failure to achieve quality – The US Institute of Medicine major study on “Improving the Quality of Health Care for Mental Health and Substance-Use Conditions” basically concluded that it was not possible to ensure quality with fee for service systems without clear models of care and supervision.
- Fee for service payment systems ignore demographic and ecological differences. Data in Blacktown in the 1990s showed that the rate of psychiatric admissions to the local public inpatient unit went from 250 in 1992 to over 900 by 1999, due to the manufacture of amphetamines and delivery by the Bikie gangs, and the growing of cannabis by people copying market gardeners, who also grew lettuces by hydroponics. The data showed that if you had a public housing address, you had twice the chance of an admission. High concentrations of indigenous, refugees and other non-English speaking people create increased need and required adapted models of care in Western Sydney. Clearly regional, rural and remote areas also require customised funding ratios and delivery vehicles, as the population does not have



the money for out of pocket costs and clinicians do not like the clients, preferring to see people of their own class.

- Fee for service payment systems currently only apply to specific disciplines and the payments are not fair for the value of the inputs (psychologist versus occupational therapist, exercise physiologists etc) and the important addition of workers with lived experience – peer workers. If we are to remain with fee for service payments, they need to be radically overhauled for effectiveness and efficiency

Demonstrated effectiveness of services to achieve desired outcomes is the priority, before assessment of efficiency through reducing waste. We are still waiting for evidence that fee-for-service payments to clinicians provides efficiency.

Activity Based Funding

As recorded in the draft report, there are real problems with the use of activity based funding for community based mental health services. While two of our group have been involved in the previous and current IHPA attempt to develop a workable model, as we have observed the process, it has become clear that for mental health, the whole premise is wrong. ABF may work in hospital settings where there is a single disorder in focus, such as a myocardial infarction or an appendicitis needing surgery, where the treatment is well defined and there is low variability in outcomes, compared to mental health, where the diagnosis is a minor component of variance and a wide range of interventions are required, whether clinical, psychosocial, relational, and/or attending to neglected physical health care, beyond the narrow direct health intervention of medication etc.

Once a package is defined, say by phase of care, and the classes defined, the current services are costed against those classes and the average computed and weighted to provide a price. There is no consensus even within the IHPA Mental Health advisory networks, as to the definition or description of these phases, as deliberations continue as to whether ABF for episodes and phases should pertain to traditional episodes or phases of care, e.g. prolonged in-patient or maintenance care, and whether they should encourage contemporary evidence based good practice: that is whether there should be incentives to provide less life disruptive and more cost effective contemporary, recovery oriented, proxies for these phases in the community. But in this process, the outliers are trimmed – e.g. Queensland provides more occasions of service per person, so they will not be funded for those extra occasions, whereas an evidenced model of care would support them. If the prices are determined based on costing average state services that operate with no evidence based model of care, with well known significant underfunding and with very limited recovery services (even if only compared to the NMHSPF), then the process just cements into place poor quality outcomes. It could mean that the Western Australian attempt to fund on a rational basis would be undermined.

Our concerns remain, though pursued since 2012, that ABF is too explicitly hospital centred in its identity (e.g. IHPA only specifies hospital related pricing), and the list of community proxies that it now proposes to price and fund, (following strong advocacy) of community services which are likely



to be employed instead of hospital care, is very limited and incomplete. See: Rosen A, McGorry P, Hill, H, Rosenberg S, The Independent Hospital Pricing Authority and mental health services: it is not a matter of "one size fits all". Medical Journal of Australia, 196 (11) 18 June 2012: 675-677.

If ABF was to be used, then the high diversity of needs actually requires a very diverse range of skills and interventions, so there would have to be hundreds of classes properly costed on best practice case projections. This can be overcome by commissioning defined models of care and benchmarking against fidelity, outcomes and activity, taking account of the local demographics and ecology, with supervision by the Regional Commissioning Authority and overseen by the National Mental Health Commission.

ABF would only support efficiency if the prices pay for best practice inputs, so that the desired outcomes are achieved. The services able to demonstrate fidelity to the model of care and benchmarked outcomes, would then be rewarded with adequate funds to continue. Where is the waste if services are properly funded to achieve the desired outcomes?

Block Funding

There is a place for block funding, as there are processes that are not readily managed through fee for service activity. Once a model of care had been designed, there are issues of critical mass in providing the range of services that should be integrated in house rather than externally purchased. There is considerable variability of demand, such as the surge in acute disorders and suicidality, particularly in Spring and in acute disorders, somewhat in Autumn, leading to increased community demand, emergency department assessment demand and bed blockage, with overflowing unwell patients parked around general hospital wards (unsafe). Some services have a drop in demand at times of school holidays.

The issue of inefficiency, with a low proportion of time recorded for direct care, patient present or not present, is due to the fact that most block funded services are for patients who are ambivalent about receiving what they perceive as stigmatising services, are young or homeless people who avoid most health, mental health and welfare services as much as they can, or are under community/forensic treatment orders and are reluctant to attend appointments.

The data, for example, from one early psychosis service showed that despite assiduous attempts at engagement and a preparedness to see the patient anywhere in the community, there has been a 12% no-show rate and a 27% cancellation rate, but only achieved appointments and failed home visits are recorded in the national data collection. The model limits the case load to 20 per case manager (psychotherapist) and a case load weighting tool is used to balance workload, as working with the youth age group can be quite intense and demanding, with a need for a lot of time spent in case review meetings with the psychiatrists and multidisciplinary recovery team, and additional support from the Mobile Assessment and Treatment Team (extended hours 7 days). Evidence shows that over 80% with first episode psychosis have significant developmental trauma and so are vulnerable to substance use to try to reduce their high anxiety, and to feel better in spite of low self esteem and



unhappiness/depression. Their brains are dysregulated and so they are disorganised, dysfunctional and often also physically unwell. They mostly do not fit private practice psychiatry or psychology, and they are beyond the skills of GPs. There is evidence this is also true across many mental illness diagnoses, where severity has a dose-wise correlation with developmental trauma.

Block funding is currently the only way that comprehensive recovery services can be provided, including peer and family peer workers and specific skills for engagement and socialisation (Individual Placement and Support model for completion of education and employment, art therapy, music, body work, and a wide range of group programs) particularly important in the key early intervention periods of child and youth. These staff need to be embedded as part of the clinical team for effectiveness.

Block funding will be the only way that innovation can flourish to address new solutions and so achieve better outcomes and thus efficiency. The British evidence on return of investment for early intervention in psychosis was 17.97 to 1 (Martin Knapp et al), and this will be improved with current plans to address the developmental trauma component. How good is that return on investment?

Hybrid Payments

We support the idea of experimenting with new funding and payment models (Recommendation 24.4). The key issue is to ensure that the service design properly includes all the components of an evidence based, or promising, model of care, to ensure quality and the desired outcomes for the target group. As best practice models of care services should also be the training sites for clinicians, rather than narrow hospital based experiences, education and training components need to be built in for both students and graduates. There is evidence that there should be ongoing supervision of all staff, via a range of methods, and multidisciplinary case review meetings for the required teamwork. These processes appear to be better funded by block funding at this time. However, despite the problems of engagement and attendance at appointments, there could be Medicare rebate payments to encourage engagement and attendance for any face to face sessions. There could also be incentive payments for proposing and achieving model and process improvements. This could include process and outcome performance thresholds and targets as specified in service agreements and funding contracts, similar to those operated by the WA MH Commission.

We suggest this should be managed by the enhanced National Mental Health Commission, as a core part of its proposed statutory role.

Integrated Care (Proposals 10.1-10.4 and 24.1)

The section on Integrated Care in the draft report focuses mainly on improving consumer relevant information (10.1) access to services through on-line navigation programs (10.2) the development of multi-provider single care plan(10.3) and care-coordination (10.4). Chapter 10 also makes reference to provider collaboration mechanisms through MOUs. Again there are useful references to integrating



and making funding more flexible (24.1). The proposal to rebuild funding and commissioning structures function through the establishment of RCAs supports the development of integrated mental health care at the highest functional level.

All of these proposals are strongly supported. However, while many reports and plans including the National Mental Health Standards (2010) have grappled with the problem of what services and consumer focused activities should be integrated, few have articulated how this could be done. Therefore, while excellent recommendations have been made at the micro/clinical and macro levels of the system, this needs to be an important component of the PC draft report. This should include in an overall framework for understanding the scope of what integrated care should involve and initiatives based on the implementation science available for it to be effective.

The draft Report indicates that to achieve integrated care all stakeholders (including policy makers, funders, providers, consumers and carers) need to go beyond “good will” and suggests joint MOUs and co-location of services as ways of doing this. However the report is vague about how integration should be achieved across the system as a whole in terms of funding, planning and service delivery. There are references to the work of some PHNs, but little in terms of frameworks and formalised, shared systems of governance that could be used by RCAs, PHNs and providers alike to form comprehensive, integrated networks of mental healthcare.

Examples of this approach have been undertaken internationally and described in the literature. These include the “Collective Impact” framework developed by Standford University in the US and initiatives promoted by the International Foundation of Integrated Care (IFIC) through conferences, webinars and its International Journal for Integrated Care. Locally “Integrated Mental HealthCare Networks” of funders, providers (Public and NGO), consumers and carers have been established in the Central Coast PHN and the St Vincent’s (Sydney) mental health catchment and reference is made in the PC report to the multi-agency collaboration in Melbourne (Eastern Mental Health Service Coordination Alliance – EMHSCA).

In terms of the draft Report, the recommendations for the Macro and Micro levels of the system are very good starting point. However, at the meso-level of the system, while co-located services and MOUs between organisations are supported, the implementation of provider driven, regional “Integrated Mental Health Networks” (IMHNS) initiatives involving the mapping of services (Romero-Lopez-Alberta 2019) and the utilisation of “Collective Impact” principles and strategies would, we believe, enhance service and consumer outcomes including the efficiency of existing systems of Mental Healthcare. For example, at the Meso level IMHNS would jointly develop Care Pathways, Shared Care processes, Quality Assurance Mechanisms, Clinical Governance and Quality Improvement Mechanisms, Education and Training, IT enhancements and Evaluation and Research initiatives.

There is a growing literature related to the development of integrated mental healthcare in Australia involving contributions from several research groups over the last 2 decades and involving authors such as Burrows (2007) Eagar (2005), Perkins (2014) Whiteford (2014) and others. Pointing to the benefits but also the challenges of integrating mental healthcare, the work in this field has been very



“start-stop” in nature which may account in part for the lack of progress cited so frequently in national Mental Health reports including the draft PC report.

So what is needed to change the current and long standing trajectory?

1. In addition to what is already documented in Chapter 10 of the draft report, a clearer statement needs to be made in a Section on Implementation, that integration needs to be comprehensive and occur both vertically and horizontally involving micro, meso and macro levels in the system.
2. The reasons for recommending this approach referenced to whole systems approaches and the contribution of implementation science to effective implementation, needs to be documented.
3. Thirdly local examples, mentioned above, should be referenced. The Central Coast summative evaluation is available on the Web.
4. Initiatives including those already referred to in the draft report could be written up in a table referring on the one hand to Macro, Meso and Micro level and on the other to Planner/Funders, Providers (Public, Private and NGO), Consumers and Carers and Joint initiatives.

Recommendations: Integrated Care:

- 1. 10.1-10.4 and 24.1 are supported**
- 2. Mechanisms to integrate mental funding, planning and service-delivery, within and between macro, meso and micro levels of care should be implemented**
- 3. With regard to meso-level, inter-organisation initiatives, integrated networks of provider-driven mental healthcare, should be established, funded and held accountable by RCAs.**
- 4. Large system processes of efficiency analysis, such as those undertaken now, should be repeated to identify progress and opportunities for systems change where relevant.**
- 5. A unitary /single MHS Regional Strategic Plan, including all public, NGO, fee-for-service or other private mental health, welfare or support services, to be commissioned and contracted by the RCA, will be co-designed by the RCA, in consultation with representatives of all stakeholder groups, and employed as a basis for RCA's to contract all components of a regional MHS.**

A program that worked in this direction was the National Mental Health Integration Program (Prof. Harvey Whiteford chaired the reference group) and the lessons included that involving private practitioners (including psychiatrists, psychologists and other allied health clinicians) and having the means to design payments to achieve integration goals, lead to shaping of behaviours that increased the quality of care. Thus any use of Medicare rebates should be progressively shaped to improve



integration of interventions and support services, within team structures that provide easy ongoing communication, case reviewing, supervision and continuing education and training as the evidence evolves. In the major integration project in the Illawarra, the funding pool was made up of the average state and Commonwealth expenditure per head of population. Medicare claims were paid out of this pool and any left over funds could be used to purchase services that were geographically missing. The local private practitioners were happy and there was no political flack. The results were positive on every measure, but despite prior promises from both levels of government to continue the program if positive, it died from the loss of the champions in the two health departments. This project should be repeated with a wider series of project sites, urban, regional and rural/remote, under management and evaluation by the National Mental Health Commission.

Eagar K, Pirkis J, Owen A, Burgess P, Posner N, Perkins D (2005) Lessons from the National Mental Health Integration Program. Australian Health Review, Vol 29:2

Perkins DA, Roberts R, Sanders T, Rosen A, Sanders T, Roberts R et al. Far West Area Health Service mental health integration project: model for rural Australia? The Australian Journal of Rural Health 2006: Vol 14 , 3 pps. 105-10

Rural & Remote Mental Health Services

As many community mental health services have become depleted and partially dismantled they are being incrementally and surreptitiously replaced by essentially fee-for-service Medicare subsidized services with gap payments, private and corporatized telepsychiatry, telehealth, and e-health services. This is a form of tacit cost-shifting to the Commonwealth and the privatised gap payments. Many of these practitioners do not ever visit these regions and do not liaise intermittently with GPs, community mental health teams, families or others who will have to cope with the crises of the individuals they assess and treat.

Mild disorders may respond well to e-health websites, checklists, subjective ratings and therapies, especially with young people, people who are more comfortable seeking services via internet, and those who are shy or wary of personal engagement with service providers. Individuals with **Moderate** disorders may need "hybrid combinations" of in-person, telehealth and on-line mental health services (Yellowlees P & Shore JH, APA, 2018) while individuals and Families with Acute, **Severe and Complex** psychiatric disorders usually respond best to inclusive in-person engagement and interdisciplinary teamwork (eg. Hickie I, ABC-RN, 1 April 2019) with well coordinated and integrated division of labour, and high level ongoing team support.

Resources for public in-person community mental health services should not be compromised or sacrificed for telepsychiatry, other telehealth and e-health programs, which may ultimately increase case-finding and demand for in-person services. Some governments and mental health administrations may be tempted or persuaded to incrementally, or rapidly, replace in-person community mental health services mainly with telehealth services and e-health facilities. We need



both, and a well-integrated and carefully monitored balance between them. It is probable that both components will require further government enhancements.

Recommendations:

- A. Troubled Individuals and families with mental health problems in remote regions should not have to just rely on telepsychiatry, other telehealth counselling and e-Health strategies, individual allied professional counselling, or support workers for help with mental health related issues for individuals, families and communities, sometimes without ever seeing them in person, and often in isolation from and uncoordinated with familiar local health and mental health professionals.**
- B. Community mental health teams in rural and remote regions need re-investment, restoring full team complements, providing upskilling and supervising of staff, pastoral mentoring and stabilisation, so they can work across their regions to a repertoire of proxies for evidence based interventions and service delivery systems.**

e-Health Mental Health Interventions.

Automated digital services can provide a much larger scale of reach at the population level, and can be most effective as primary screening & secondary prevention strategies, and can be very effective as interventions alone, particularly for milder to moderate disorders. This may lower demand for in-person services for milder disorders by GP's, community mental health teams, and private psychiatric and psychology services. But it could also uncover latent population demand for in-person services for moderate to severe disorders, which cannot be met with existing workforces.

When individuals accessing e-health mental health hubs need escalation for higher severity and acuity, and/or perceived danger of harm, automated escalation is not sufficient nor always reliable or safe. Explicit protocols need to be systematically applied to ensure formal confirmation of acceptance of hand-over of duty of care, at an appropriate level of urgency. This needs to be assured and communicated both ways, verbally and with documentation, between identifiable service provider persons. Monitoring and management of this and of peak flows of demand for escalation are issues for integration mechanisms between services, including formal service agreements. Public mental health services, and particularly Community mental health staffing levels and mobility, should be reviewed to ensure that sustained increases in demands via these portals can be met.

Telepsychiatry and other Telehealth mental health services

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with intermittent in-person psychiatric consultations and reviews, optimally by the same psychiatrist or by the same rostered and collegiate group of psychiatrists, providing local team and GP consultation, and clinically hand over to each other. Such a combination should provide better engagement, greater accuracy of assessment and review, better appraisal of physical health needs, better communication and clinical supervision with local GPs and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming



highly valued components of mental health services for rural and remote communities, it should be part of a mixed and balanced economy or well integrated spectrum of mental health services. It should not be offered as a stand-alone service, particularly in rural settings, without firm Commonwealth, Medicare and RANZCP requirements to act in close and regular clinical communication with GPs, community mental health teams, and families, especially if agreed by the initial service-user. It is often community mental health teams who have to deal with ensuing crises and acute admissions, sometimes by complete surprise, as telehealth practitioners are not required to do nor are they separately reimbursed for such regular communications.

Recommendation: Telepsychiatry:

Medicare subsidized doctor and psychology/allied health telepsychiatry and Telehealth Mental Health Services, where needed for the regional mix of clinical services, should be strictly contracted and regulated by Regional Commissioning Authorities. Under these provisions they should be obliged to:

- a) eliminate or severely limit gap co-payments,
- b) liaise regularly with GP's and in rural & regional settings with community MH teams if risk of presentation to public services, and with families (with permission of the service-user if voluntary),
- c) be governed by a single regional MHS plan integrating all public, NGO and any privately contracted MHS. This plan should have some formal obligation status such as strictly operated contracting, rather than just a loose in principle service agreement (see Integrated Care, recommendation 5).

These arrangements should underlie regional pooling & commissioning and should replicate the WA MH Commission method of ensuring delivery of contracted services, whether with public, NGO, private institutional or fee-for-service sectors, with monitoring and auditing of both budgets and expenditure acquittals to ensure no shifting of resources to non-contracted or non-MHS services, or funding will be promptly withdrawn.

Headspace Model (Recommendation 5.3)

The primary care headspace centre model is excellent in being a safe place for youth to self present, but is flawed, as direct observation of several centres shows it relies on very junior clinicians to triage, diagnose and formulate, and then relies on altruistic psychologists to provide psychotherapy on bulk billing rebates (less facility fee) and a few other clinical disciplines. The young people walking through the doors have not been pre-selected as mild to moderately disordered (the program target) and so the whole spectrum of disorders and severity arrives. They often have significant developmental trauma and other disorders that are way beyond the competency of the staff, but they cannot find anywhere to refer them to (rejections from LHN services and private practitioners wary of the age group). There is not a skilled diagnostic and formulation component on site and attempts to include GPs and psychiatrists in the process have often failed. With the high no-show and cancellation rates, psychologists and GPs often do not stay for long, and so there is also very limited psychotherapy



available, even for the targeted mild to moderate conditions, leading to long waiting lists. The funding is so tight (no regular inflation increments) that they often cannot cope with intake demand.

We do not believe **recommendation 5.3** is the full answer to the problem, as a major difficulty is effectively treating the more severe end of the spectrum and those that do not respond to online programs and/or medication. The centres really need more funding, with psychiatrists added on salary, or with guaranteed income if Medicare is charged, including funding to cover staff education, training, case reviews and holidays, if the market is to be met and staff recruited and retained, especially with the current uncertainties of contract employment. All staff need to receive pay and conditions equivalent to the state funded mental health services awards to retain the skilled staff required for good outcomes (huge staff turnover). Without the benefits of permanent employment, Psychiatrists mostly expect to be paid at Visiting Medical Officer rates, as occurs for contracted specialists on the LHNs in NSW. The centres cannot substitute for the lack of properly funded community based services needed (see NMHSPF) and especially for the recently recognised high prevalence of young people with significant developmental trauma looking for help. While online treatment programs have a role for some and headspace staff could be better educated in how their young people could use them, in this youth age group most need one to one care and way more than 10 sessions (many documented and evaluated models of care). If there were properly funded stepped care services available for the moderate to severe, we are sure that appropriate referrals would be made.

Efficiency will come when the headspace centres are actually resourced properly to do the job in an integrated care system with all the referral components available.

Developmental and later Trauma

This is our greatest unsolved public health issue (US Centres for Disease Control)!

It needs specialist action, starting with the most severe and trickling down, rather than starting with the mild to moderate and expecting to learn how to deal with the most severe, personally painful (3/4 of achieved suicides), socially painful (e.g. almost everyone in custody) and expensive outcomes.

Due to failures of the treating professions and academics, assessing and treating trauma needs a commissioned investment in developing and evaluating the promising treatments. Incremental improvements are too slow – the costs of slow action are huge. It should get higher priority than cancer or cardiovascular disease, but there are no commercial drivers, as medication is not the answer, new treatment technology (qEEG recording, analysis and neurofeedback operant conditioning) requires extensive learning, and the treatments are time consuming (but can be permanent). But the prevalence is high – at least 17% have significant developmental trauma and the Dunedin cohort study showed rates of PTSD of 13.7% by the age of 38, and PTSD is only a subset of trauma responses. The effects of the brain dysregulation on physical health are as bad or worse than on mental health. Have the experience of 5 or more types of trauma and your life span is reduced by



20 years. It is much more prevalent and damaging than any other determinant of illness. We refer you to the attached paper on developmental trauma.

Once you see traumatised young people and know what can be done, but you cannot do it, is very painful for a caring clinician. Most clinicians prefer to ignore it, as they do not know what to do and just fit the person into a DSM 5 diagnostic category, which is confounded by not having taken account of developmental trauma in its formulation.

Developmental trauma needs to be addressed with age based cohorts – perinatal, early and later childhood, adolescence and youth, and the legacy in adults. We should be screening for it at all levels. The evidence is that clinicians do not ask, but the earlier you ask, the more you are told.

Recommendation: Developmental Trauma

We recommend that the Commission actually acknowledge the issues around developmental trauma and make a recommendation that significant resources be allocated to address it under the management of the National Mental Health Commission.

Draft Recommendation 23.3 – Structural Reform is Necessary

Information Request 23.1

Ideally need to reform the constitution, but now have to address the effects of the fiscal imbalance (Twomey & Withers 2007), where the Commonwealth raises 82% of taxes and the states only 18%, while the states need at least 40% of tax revenue to provide the services intended under the constitution. This is the cause of the creeping intrusion into service provision by the Commonwealth, for short term political gain, rather than as part of an integrated and comprehensive service plan. In fact this advent has fragmented services further, as successive Commonwealth Governments have not trusted the states to provide these largely support (rather than clinical) services directly. The Commonwealth have wanted to retain control of the enhancements it is funding, probably for both party political purposes, and because the states have misdirected previous enhancements. It is the reason state health services need to find ways to cost shift to the Commonwealth. Both levels of government try to push the responsibility for rationing decisions to arms-length organisations (LHNs, PHNs) dressing it up as a local decision-making virtue. Here and internationally, mental health services have been vulnerable everywhere their funding has been pooled with physical health funding, unless there are very tight controls.

Historically State and Commonwealth mental health service funding decisions have been made in secrecy (the bane of our Westminster form of government and public service culture). The public service has poor levels of knowledge (Commonwealth public servants expected to rotate every couple of years to entirely different roles) and consultation processes are often superficial, so that poorly designed programs are announced and then not changeable because the Minister has announced them. Experienced managers responsible for actual implementation are rarely consulted.



The lack of clarity of roles and planning for integration has given us the missing middle, between highly constrained state services and the fee for service single practitioner market with all its distortions and perverse incentives. Only a structure with control of funding and payments will be able to progressively shape behaviours through trialling and evaluating new funding and payments methods. This needs a structure at arms length from the political pressures of vested interests. Pooling of state and federal funds could ameliorate conflicts over responsibilities, but there is still the problem of which government is accountable. Ideally the National Mental Health Commission would hold the national mental health funds and procure the mental health services up to and including the services provided by the LHNs as in Western Australia. Because of the need for whole of government responses to mental health consumer needs, well beyond medical care, the NMHC should report to Prime Minister and Cabinet, not the Commonwealth Department of Health. Budget bids need to go directly to the Treasury and Finance, and not get caught up in the competing bureaucratic silos.

Thus the structural reforms need to be integrated horizontally and vertically to get the best results, as discussed above. The National Mental Health Commission, as a statutory body, needs to be strengthened to provide expert leadership in collaboration with State Mental Health Commissions, Regional Commissioning Authorities and NGO planners, to provide advice to governments and guidance to Regional Commissioning Authorities. In order to have competent providers to tender for commissions, there needs to be involvement by them in co-design of local commissions, even if they then compete, as there is greater clarity of what is required, and reasonable performance expectations etc, in adapting the design principles for a specific model of care to the local ecology. This model has been successfully used in Victoria.

We support the view that the mental health (and substance use) commissioning needs a specialist organisation with a wider view than the current PHNs and with the critical mass to support more specialised and complex commissioning, including relevant social services. The size of the catchment area should be relevant to the needs of the region. For example, it has been important that the WA Mental Health Commission has covered the whole state at this phase of development, commissioning the LHNs as well as NGO providers in a very diverse ecology. There are real dilemmas in designing very specialist services (e.g. forensic) to achieve local access and also efficiency.

As you get exactly what you pay for, holding the whole budget provides real tools to ensure integration vertically and horizontally. There has been too much reliance on illusory "good will". Ideally the Regional Commissioning Authorities should have the pooled State and Commonwealth funds for mental health service and alcohol & other substance use funding to purchase from the LHNs as well as NGO and other providers, for the full suite of health and social services. RCA's for larger states and cities would need to be divided into regional commissioning entities.

We agree with the comment that the Commonwealth Department of Health should not be telling Regionally Commissioning Authorities what to do (**recommendation 24.2**) but that is because it is politically driven rather than based on expertise. We do believe that there needs to be good advice, and at times clear guidelines, based on the current evidence for the design of models of care, including specific interventions and service delivery vehicles, and adherence to fidelity. With the



integrative processes of planning above, central dictatorship is much less likely to occur and there should be checks and balances built into the structural design to value the layers of contribution to commissioning outcomes. Good commissioning in mental health needs high level expertise, and 31 PHNs are unlikely to have that capacity.

Observers of New Zealand noted that their best period of commissioning was when the country was divided into 4 zones of about a million population, with the expert commissioning teams advised by the Mental Health Commission plan and connected to the health ministry. This gave the politicians the confidence to invest a lot more, so that their services became much better than those in Australia at that time.

The British experience has been similar, in that the best improvement came when there was a national planning framework with principles to be followed, including the evidence based models of care and delivery vehicles available at the time. The fact that the public sector providers were specialist Mental Health Foundation Trusts meant that funds were not diverted, but the commissioners, based with primary care trusts, required a lot of support to commission well.

Recommendation 24.2 should be amended to ensure that clear and evaluated models of care do not have their fidelity destroyed by local decision makers unaware of the consequences.

Some may criticise the proposed rebuild on the basis that it requires yet another bureaucracy, but with an integrative approach, it could bring together currently dispersed streams, occupying the time of scattered bureaucracies, so bringing the many streams together and including new streams of social services, would actually create greater efficiency through greater effectiveness, with no material increase in overall staffing costs. Giving the NMHC and state MH Commissions real involvement in planning and implementation, rather than being exercises in public relations, would be much more efficient. Considering the life-long value of effective mental health and substance use services, a critical mass of people to provide expert advice, support innovation and evaluation, and manage funding would be a great improvement on current methods. To continue as we have been, and to expect a different outcome, is more than just unwise.

Recommendation 23.3 should be amended as follows:

The Australian Government and State and Territory Governments should work together to reform the architectural framework of Australia's mental health system, to clarify federal and state roles in planning, funding and implementing integrated mental health care, so that governments can be incentivised to invest in services that best meet the needs of people with mental health illness and their carers. There should be a greater vertical and horizontal balance in planning and decision making, for the implementation of evidence-based models of care, as well as mandated integration, liaison and cooperation between commissioned services. The National Mental Health Service Planning Framework should be made publicly available to enable expert inputs for progressive improvements that will assist the reforms.



National Mental Health Commission (Recommendation 25.4 and 24.4)

While it would be difficult to get the NMHC to become the national mental health services fund holder in the short term, in the meantime, we support the upgrading of the NMHC to a statutory authority to include the capability to:

- Provide knowledge management – hire expertise, commission research, accumulate evidence for interventions and delivery vehicles, consult across the sector, propose new models of care to be piloted and evaluated and have sufficient discretionary funding to do these tasks directly.
- Work closely with state and territory mental health commissions and national and state government departments to receive their advice on issues relevant to that state or territory, and collaborate on planning with them. Mental health requires integrated whole of government programs to be optimal.
- Support planning processes and proposed national rolling plans for implementation, make proposals to government on priorities for investment.
- Advise Regional Commissioning Authorities on the models of care and commissioning principles to be followed, plus monitor and evaluate the commissioning practices to ensure fidelity and the commissioning of quality and financial integrity.
- Review and propose new funding and payment methods, to progressively overcome the deficiencies in the current arrangements.
- Collect and analyse data to enable the above.

What is missing from the current **recommendation 25.4** is the important inclusion of the need to provide knowledge management expertise and the power to make service proposals and to have the funds to commission research and pilot services for new or amended models of care, as there is no other mechanism to effectively do this. **Recommendation 24.4** should include the NMHC itself being able to propose pilot programs and then involve the relevant RCA in the process and contract management. The NMHC must also ensure that it has the expertise specifically in mental health services planning, commissioning, practical implementation and leadership of comprehensive community-based regional mental health services. Note that there is little expertise at present in the NMHC with these skills.

As part of accountability and auditing the NMHC should commission regular qualitative pathways studies-- such as studies of the personal experiences of service users and families to ensure that they are not being excluded by inflexible eligibility criteria, experiencing unnecessary hurdles in accessing early, or ongoing services as required, or falling through the gaps between services.

Regional Commissioning Authorities

Pool as much funding as can be achieved from Commonwealth, State and ? insurance sources to cover mental health medical, psychological, recovery inputs and components of social supports. They should be able to purchase supports that the NDIS model is not able to effectively and locally provide,



due to a lack of provider expertise and the critical mass to make a specialist service viable for potential providers in the marketplace. There are various at-risk minority and special population groups, such as co-occurring psychiatric and alcohol and other substance disorders, vulnerable youth, homeless people, prisoners, brain injury, eating disorders, LGBTIQ, indigenous, refugees, first responders etc, and their families, that could benefit from a more granular approach. For example, around 22% of the young people walking through the doors of primary care headspace sites present sexuality issues, but just when they need support to come to terms with their sexuality and to establish their place in society, the relevant organisations do not have the funding to help locally.

After the Richmond Report in NSW, the Dept of Health was given capital funding to “purchase” properties from the Dept of Housing, enabling them to build or purchase additional housing stock. In Blacktown we were flexibly able to obtain houses for group homes while vulnerable people waited for long term placements, and to swap houses if local problems arose. Pooled capital funding is also necessary, as essential facilities may not be available.

Thus the Regional Commissioning Authorities need to be able to commission towards the integration of services with the right skills and distribution for their demographics and ecology. Regional Commissioning Authorities also need to have a large enough catchment area for critical mass for the more specialist requirements.

National Mental Health Service Planning Framework (NMHSPF)

Should be made public and available for critiquing and improving, as it is 7 years old and the science has moved on. The product of the millions spent on it belongs to the taxpayers, not any secretive government afraid of revealing the service deficits. The Western Australian Mental Health Commission used it in its planning and published the results, with no political crisis. It is scandalous that the National Mental Health Commission has not been allowed access to it. Australia needs the best possible data for planning and this has been the best attempt so far. To set rational targets for improvement and equity of distribution of resources, the NMHSPF must be available to the NMHC to advise the Commonwealth Government, which controls 82% of the tax revenue. The state governments should welcome the truth about needs, to better negotiate with the Commonwealth Government with public support.

TAMHSS' Essential Components of Care [ECC] Tool for Regional Prioritizing of Evidence Based Interventions & Service Delivery Systems

ECC is a comprehensive tool for choosing priorities for wider implementation in particular regions, from among evidence based interventions and service delivery subsystems, which are of established cost effectiveness. It could be further developed by the National Mental Health Commission in co-design with all stakeholder groups and academics, and employed cooperatively to provide a menu and repertoire from which to choose priority services, which RCA's may decide to pilot further and/or bring to scale.



Recommendation:

Essential Components of Care (ECC) will be considered for implementation nationally, following alignment with National Mental Health Planning Framework, which can detail some important subsets of such services, and National MHS Mapping, which can pinpoint service duplications, overlaps and gaps. The ECC, as a national evidence-based planning tool, developed for Australian conditions, is potentially the keystone for assuring fidelity in practice and the skeleton to which resources can be attached, and with which service systems can be comprehensively audited.

National Role Delineation Guide for mental health services.

In NSW Health, the Role Delineation Guide for public health services is a core planning and evaluation tool for public health services, has recently been updated, and is used in various iterations around Australia. Clinical Service Planning (excluding Mental Health) at health service and hospital level is coordinated around this guide, but there is no equivalent for Mental Health. Despite our state mental health leadership recognising the need for something like this at the time, there was no support for inclusion of Mental Health within the Ministry when it was developed.

Recommendation:

The Productivity Commission could recommend, or task a group, to develop such a Role Delineation Guide for mental health services for consistent national use, to support planning, service development and multiple standardized forms of evaluation and comparison. Comprehensive evidence based tools and models such as the ECC could be a core component of such a nationally applied Role Delineation Guide for mental health services.

Indigenous Mental Health Provisions.

PD Information Request 11.1

The Productivity Commission is seeking information from participants on any barriers impeding career progression for Aboriginal and Torres Strait Islander health workers, including barriers to the ability to move to broader health professions, such as mental health nursing.

The PD should recommend appropriate cultural provisions for members of Aboriginal & Torres Strait Islander communities with mental health and co-occurring clinical problems,

- a) This includes ensuring culturally safe and appropriate mental health service provision for those who live outside Aboriginal communities e.g. in public or private housing, those who have been caught up in prolonged droughts and bushfire emergencies, whether as victims, threatened residents, volunteers or responders.
- b) More Aboriginal Elders, Traditional healers and Aboriginal Mental Health workers should be employed in mental health services, and involved in co-design of culturally appropriate



services, in service planning and everyday service delivery. Elders should be paired with senior managers to provide cultural consultation (M. Wright, Telethon Institute of Child Health Research, Perth, and Murdoch University, Fremantle, Western Australia).

PD Information Request 21.2: Does Empowerment lower suicide rates?

The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities.

- c) Ensure, for better outcomes, that Aboriginal MH Professionals are appointed to both specialty mental health teams and in primary health teams run by AMS Aboriginal controlled programs, but also need Aboriginal people involved on staff and on boards running other agencies, including police, corrections, family & housing services, fire & ambulance etc.
Evidence e.g. Chandler & Lalonde 2013, British Columbia
Expert/Authorities: Prof Pat Dudgeon, Director of the Univ West Australia Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP), Dept Indigenous Studies, UWA, W A.
A/Prof Christopher Lalonde, University of Victoria, British Columbia , Canada.
- d) Ensure training, supervision and mentoring and pastoral care of Aboriginal Mental Health Workers (AMHW). The most prominent sound practice model is the Djirruwang Program, Charles Sturt University, Wagga Wagga, which has been the only University degree program to qualify Aboriginal mental health worker (AMHW) professionals in Australia. It had been envisaged that Edith Cowan University in WA would be the 2nd hub location for this course in the future. Restore the AMHW Mentorship Program which in NSW was successfully run for 10 years by Western NSW LHD and Far West LHD MHS, but was then defunded despite a 5 year evaluation demonstrating its effectiveness. Mentorship was shown to contribute to course retention and completion at degree level. **Authorities:** Dr. Faye McMillan Associate Professor - Director – Djirruwang Program/Clinical Coordinator, Mr Tom Brideson, NSW Aboriginal MHS Coordinator, NSW MH Commission Deputy Commissioner, Chair National Mental Health Leadership Group, Professors Alan Rosen & Maree Teesson.
- e) Ensure provision for uninterrupted ventilation, personal narratives and story-telling, rather than rapid-fire clinical questioning as a means of assessment, clinical reviews and trauma debriefing. **Authority:** Prof Helen Milroy, UWA, Commissioner, Royal Commission on Institutional Child Abuse.
- f) Routinely involve either Aboriginal Traditional Healer or Aboriginal Mental Health Worker in determining safe alternative placements to involuntary orders, before resorting to an involuntary order with Aboriginal people in crisis or emergency presentation. **Precedent:** as per provisions in the WA Mental Health Act.



- g) Implement "Two Ways" or "Two Worlds" of living, and Gayaa Duwii Declaration on Aboriginal Mental Health. Authorities: Mason Durie, NZ, Charles Perkins (dec'd) & Tom Brideson, NSW (above).
- h) Implement Language Revival as factor contributing to reducing and/or ameliorating mental illness and suicide In Aboriginal communities-under investigation with Barngarla People, South Australia, Brown A, Zuckerman G et al 2018-23. If successful, this initiative should be brought to scale with other Aboriginal peoples.
- i) Response to 2019-20 Bushfire Season and Thereafter: As mental health conditions, anxiety and depression, psychological trauma, drug and alcohol dependency, family and communal violence and suicidal vulnerability can be precipitated or exacerbated by the stress of extreme environmental adversity, more investment must be made in ameliorating these, not just for farmers, town business people and their families, but for all those affected, especially the most vulnerable sections of communities, and specifically Aboriginal peoples. This should include particularly providing more essential community services controlled by Aboriginal community members themselves, with additional Aboriginal mental health workers, healers, mental health educators, peer workers and Aboriginal liaison officers, working alongside other mental health, health and social service professionals. Aboriginal people need stable local employment opportunities in their communities. From now on, we should take up nationally a huge opportunity to further develop traditional fire management alongside western science, creating and consolidating more valued jobs and respected land management roles for Aboriginal rangers, vital for the future of both Aboriginal and wider communities.
- j) Aboriginal communities also need a more preventive, whole-of-life approach to social determinants, lifestyle factors, trauma and political decisions associated with compromised neurodevelopment, and increased subsequent incidence and severity of mental illnesses in their communities.

Reference:: Gynther B, Charlson F, Obrecht, K, Waller M, Santomauro D, Whiteford H, Hunter E, The Epidemiology of Psychosis in Indigenous Populations in Cape York and the Torres Strait, EClinical Medicine, The Lancet, 2019, <https://doi.org/10.1016/j.eclinm.2019.04.009>

National Accountability for the Quality of Mental Health Services.

Reference: Rosenberg S & Salvador-Carulla L. The Journal of Mental Health Policy and Economics, 20, 29-45 (2017) Accountability for Mental Health: The Australian Experience.

Our appraisal is based on some additions and amendments to the framework of this paper, which provides a timely call to all Australian governments, especially the Commonwealth Government, to take responsibility for assuring:



- a) consistent comparative measurement of key performance indicators,
- b) the choosing priorities from a menu of the most proven and promising evidence based interventions and service delivery systems to bring to scale [see Essential Components of Care document attached].
- c) reconcile real mental health budgets, real mental health expenditure or acquittal and real accountability for them, on a consistent and comparative basis nationally.

Their initial conclusions detail several accountability subsets, which we have amended slightly and we have provided our specific recommendations.

- (i) **Financial accountability:** Does the system operate efficiently?

This must also include comparative national auditing of jurisdictional nominal budget & acquittal, real per-capita spend, real proportion of health budget spent on mental health, real community compared with hospital based spend (we should count hospital outpatients as hospital rather than as community spend, as currently done) and acute vs rehabilitation spend for both hospital & community].

Recommendation:

A national annual audit of actual expenditure/acquittals by all jurisdictions of resources on mental health services. Provide Commonwealth incentives to the jurisdictions to stop cost-shifting to the Commonwealth and to the NGO's; to stop siphoning LHD mental health budgets to make up for overspends in medical and surgical procedures; and to reverse the favouring of hospital over community expenditure on mental health services. In terms of parity, calculate expenditures on mental health as proportion of all health expenditures, compare with other high income countries and raise towards 14% proportion of disability burden due to mental illnesses.

- (ii) **Service Quality accountability:** Does the system meet quality standards of access, mobility and timeliness, etc? Are there effective processes of quality improvement?

Recommendation:

Update National Mental Health standards and link them to appraisal & rating systems for whether they are adhering to fidelity criteria for evidence based service delivery subsystems.

[Our group includes 2 co-authors of the National Mental Health Service Standards 1st and 2nd versions, which are way overdue for updating for facility LHD, PHN, private or NGO facility accreditation purposes and streamlining to make them more concise and relevant to an evolving environment including LHD's, NDIS, PHN's, e-health and digital gateways as well as engagement in evidence based educational, vocational and relational interventions].

- (iii) **Outcome accountability:** Do consumers and carers say that the system meets their needs? Does this service +/- or its partners apply expertise gleaned from diverse non-evidence based consultants and inexpert sources, or rather from the evolving international evidence base of both clinical and functional outcomes, and service-user recovery orientation and satisfaction research?



Recommendation:

To ensure completion and validity of ratings, these outcome measurement tools should be routinely used in negotiating individual care and recovery plans with service-users, and in regular clinical and functional reviews. The key outcome variables should not be symptomatic, but levels of functioning and recovery, measured both at arms length and subjectively, in working towards restoring “a contributing life” and full citizenship in the community. The latter should be employed to determine the most cost-effective and congenial service delivery systems and interventions to all at appropriate level of care.

(iv) **Policy accountability:** Does the system meet stated policy objectives, for example in relation to equity, parity and special populations, including those with co-occurring disorders, Aboriginal, transcultural, rural and remote, gender diverse and forensic communities?

We agree with the Accountability article authors' final conclusion: "The Commonwealth Government needs to provide the critical national leadership to drive the development of this new discipline.... This is not a job for individual jurisdictions."

Assertive Community Treatment [ACT] teams need to be restored nationally with co-located NDIS funded Support teams

ACT teams are required for individuals who qualify for the highest tiers of NDIS Mental Health packages as a more humane alternative to lifelong hospital tenure or revolving door admissions. The clinical component should be funded by the jurisdictions, but many have genericized such teams in the illusory quest to save money. In fact, when dismantled, the pressure on ED and hospital beds rise enormously for these sub-populations. The model was designed as 50% clinicians and 50% support workers so they also need a co-located support team component which could be provided by the NDIS. This may well need block funding by the NDIA, but can be made completely compatible with existing personal packages.

Recommendation:

The Commonwealth should provide clear financial signals, via offers to the jurisdictions of partnerships and cost-sharing arrangements that they can't refuse, sending the strong message that the Commonwealth want them to provide non-sedentary active-response, home-delivery mental health teams with established evidence of better outcomes. These will demonstrate that personalised packages and some block-funded services are compatible, and that a balance between them should be sought, e.g. in the NDIS. [Such a proposal, matching jurisdictionally funded Assertive Community Treatment [ACT] teams with co-located support teams funded by the NDIS, has been considered by the NDIA, for 5 years now, but has not yet led to the foreshadowed processes of modelling and piloting by the NDIA, though pilot sites have been identified and are amenable].

A detailed proposal with costings for this initiative is available from Professors Alan Rosen, AO, Brain & Mind Centre, at University of Sydney and A/Prof Roger Gurr, School of Medicine, Western Sydney University.



Workforce Development & Sustainability:

The PC report is inconsistent in its description of the allied health workforce.

In section 5.3 it notes that psychological therapy can be delivered by psychologists, social workers and occupational therapists in private practice and that this could also be delivered by allied health professionals under the current PHN programs.

Many psychologists have raised their gap fees to clients well above the Better Access payment, whereas in general the other professions have not, thus making social workers, occupational therapists and nurses more affordable.

Later in the report the skills of social workers and occupational therapists are described minimally. Allied health professions include social workers, occupational therapists and psychologists (clinical or not), and each discipline is of equal value. Each has skills in psychological therapies as well as their own speciality skills. The definitions of occupational therapists and social workers need better defining, preferably by each of the professions themselves. For instance, occupational therapists have capabilities to assist people across a wide spectrum of their lives e.g. their physical, emotional, social health. Hence occupational therapists are experts, for example, in helping a person with complex trauma. They are able to assess and treat the person physical, emotional and social needs.

“Allied health professions are university qualified practitioners with specialist expertise related to physical or mental health. They include psychologists and the following professions.

***Occupational therapists** assist people with daily living and work skills.*

***Social workers** help people deal with personal and social issues through counselling and community engagement.”*

The report notes that “some consumers do not establish the necessary therapeutic rapport with the psychological therapist to which they are referred, and then drop out”. The recommendation is for the consumer to have more choice of therapist. Does choice mean simply choosing another different psychologist, in which case it may be more of the same. The choice offered should include other allied health therapists such as social workers and occupational therapists with specialty skills not offered by psychologists.

When considering raising the number of Better Access sessions that are rebatable, the report suggests that: “those consumers identified as likely to require the additional sessions be referred to clinical psychologists (Littlefield 2017)”. Where is the evidence that clinical psychologist’s client outcomes are better than social workers or occupational therapists? In fact the more practical therapeutic approach of occupational therapists may lead to better outcomes for many clients.

We wholeheartedly agree with the recommendation:

“Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent this workforce, and a program to build support for the value of peer workers among other health professions”. The mental health field needs to have the voices of



consumers heard. A peer worker has walked down the same path as the person needing mental health care and can be a guide, a companion, a support and an advocate for that person.

Recommendation:

A Federally funded Australian National Institute of Mental Health & Alcohol & Other Drugs [ANIMH+AOD] encompassing a National Mental Health Implementation Research Institute and Workforce Resource Centre should be implemented in parallel development in each jurisdiction with national coordination and curriculum development. It should then provide standardized evidence-based training materials and skills mental health and AOD enhancement courses for first responders of all kinds, including all clinical professionals, support workers, transcultural, indigenous and mental health workers, whether in public, fee-for-service, private or NGO sectors for all age groups, complementing the existing National Workforce Centre for Child Mental Health (www.emergingminds.com.au) ANIMH+AOD should then provide nationally consistent professionals & support workforce categories, training curricula, courses and qualifications in each workforce category, including peer workers. Also ANIMH would provide a nationally consistent supervision, mentorship and pastoral care framework. A detailed proposal with costings for this initiative is available from Professors Maree Teesson, AC, Matilda Centre, & Alan Rosen, AO, Brain & Mind Centre, at University of Sydney. (see also separate submission to Productivity Commission Inquiry).



RANSFORMING AUSTRALIA'S MENTAL HEALTH SERVICES INCORPORATED



TAMHSS Network recognises the cultural diversity of the many Australian communities, and the importance of engaging them in awareness of their own mental health and prevention and early intervention of mental illness, related stigma and discrimination. We also recognise the many special needs for services to deal with complex disorders.

THE OBJECTIVES OF THE TRANSFORMING AUSTRALIAN MENTAL HEALTH SERVICE SYSTEMS (TAMHSS) NETWORK ARE TO:

1. Provide a means for the Australian Community to become involved in the transformation of our mental health service systems.
2. Promote the rights of all consumers and families to receive services they need.
3. Promote a wide and consistent range of high quality mental health services across all age groups and throughout the country.
4. Promote interventions which are based on best practice as determined by both quantitative and qualitative evidence.
5. Promote a service delivery system that is integrated at every level including participation of all service sectors (public, private & NGO).
6. Promote the right of equity of access to all.
7. Promote a regional funding system and methodologies that provide adequate quality, control of both budget and expenditure, and transparent accountability, all of which should be independently monitored.
8. Promote recovery-oriented service systems which focus on the goals of social inclusion and citizenship.