Mental Health Coordinating Council

The National Health and Hospitals Reform Commission - ‘A Healthier Future for all Australians’

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Mental Health Coordinating Council
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MHCC is the state peak body for non-government organisations (NGOs) in NSW representing the views and interests of over 200 organisations specialising in the provision of services and support for people with disability as a result of mental illness. We provide leadership and representation and seek to improve, promote and develop quality mental health services to the community, facilitating effective linkages between government, non-government and private sectors, and participating extensively in public policy development.

The Commission's request for feedback was extremely clear in stating a requirement of no more that 1000 words (2 pages) on the Report's Reform Directions. MHCC suggest that it is impossible to respond meaningfully to this very large and complex document identifying 15 areas of reform directions with multiple sub directions. Whilst we acknowledge the need for brevity, we suggest that such a limit to the consultative process negates the purpose for which feedback was asked. In our view the reporting timeframe to Government should not be to the detriment of the best possible health planning and outcomes.

MHCC support many of the Reform Directions outlined and only comment where necessary.

Reform Directions

1. Building good health and wellbeing into our communities and our lives

1.10 We propose that health literacy is included as a core element of the National Curriculum and that is it is incorporated in national skills assessment. This should apply across primary and secondary school.

a) We encourage this core element refer to stigma and de-stigmatisation as described under the Mental Health Strategy 2006-2011.

2. Creating strong primary health care services for everyone

2.3 We want young families and people with chronic and complex conditions (including people with a disability or a long-term mental illness) to have the option of enrolling with a single primary health care service to improve care. To support this, we propose that:

b) Services for people with mental illness must embody *Recovery Principles* representative of the dimensions and characteristics of the recovery process:
    - Recovery is based in the fact that people can and do recover from mental illness;
    - Recovery is born out of hope;
    - Recovery is a journey defined by the individual;
    - Recovery needs a supportive environment to thrive;
    - Recovery is an active and ongoing process;
    - Recovery is a non- linear journey;
    - Recovery skills can be learnt;
    - Recovery involves a person educating themselves about their illness; and
    - Recovery involves dealing with both internalized and external stigma and discrimination.

We favour a psychosocial approach in both helping to understand causation and ways of working with and moving the person forward.

- *there will be grant funding to support multidisciplinary clinical services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions.*

  c) Any grant funding to clinical services must not preclude the funding and development of community based services, providing support services that go beyond a clinical approach to recovery and social inclusion agendas.

  d) We do not support a solely medical model of clinical service delivery which on its own is inadequate to assist people with disability arising from mental illness.

- *there will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population.*

  e) We adamantly do not support reward payments for good performance. This does not sit well with the model of Quality Improvement we advocate. Clinical services must aim to meet or exceed Quality Performance standards. The adoption of a business model sets the wrong ethos around the provision of care.

  f) NGOs are obliged to undertake their roles and perform to KPIs without performance incentives. There must be equity across service delivery streams.

- *over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to existing fee-based payments.*

  g) This managed care model will be very difficult to apply to characteristically complex pathways of mental health and recovery. It cannot be managed like a broken leg - each case is an individual journey.

2.4 We support embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention and quality care.

  h) Ditto items e) and f) above in relation to performance payments.

2.5 We support improving the way in which primary health care professionals and specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions.

  i) Whilst we agree there is an important role for primary health professionals, what needs to be emphasised is the role of the community based NGO sector in providing ongoing support and management, and the resources necessary to sustain this arrangement. Support provided by an NGO can keep many people from requiring repeated visits to GPs resulting in substantial cost savings to the health system overall.

2.6 We believe that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of primary health Care, evolving from or replacing the existing Divisions of General practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.

  j) This places too much emphasis on the clinical perspectives. We also believe it is outside the capacity and expertise of the Divisions. Size is not the issue. It places too greater onus on GPs as the dominant providers and planners of health care services. To date GPs have had little success in coordination with community organisations and other health sectors, so it is unclear why they are considered appropriate to manage in these areas.

4. Ensuring timely access and safe care in hospitals

4.2 A share of the funding potentially available to public hospitals should be linked to meeting (or improving performance towards) the access guarantees and targets, payable as a bonus.

k) Ditto items e) and f) above p.4.

4.3 We propose there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of discharge information including details of any follow-up care required.

l) Ditto items e) and f) above p.4.

4.10 We propose a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines.

m) We do not support a systemic clinical approach across all health settings without reference to the value and effectiveness of the Recovery and Social Inclusion agendas necessary for good health and sustained outcomes.

5. Restoring people to better health and independent living

5.1 We want to increase the visibility of, and access to, sub-acute services through more directly linking funding to the delivery and growth of sub-acute services. A priority focus should be the development of activity-based funding models for sub-acute services (including the cost of capital), supported by improvements in national data and definitions for sub-acute services.

n) We support the funding of early intervention sub-acute services.

In mental health services a model for achieving this is the Victorian Prevention and Recovery Care (PARC) service model. PARC presents a step-up and step-down alternative to hospitalisation for people with complex health and social problems and is a partnership between NGO community mental health services (i.e., provides individual support, psychosocial rehabilitation, therapeutic group activities) with 24-hour community clinical services (i.e., provides clinical treatment and support through at least twice daily visits to the PARC and access to other clinical services as needed). "Step-up" occurs when a person is becoming unwell. The client will enter PARC and receive early intervention services to avoid a hospital stay. "Step-down" provides short-term transitional support after discharge from an acute admission, providing supported discharge, to minimize problems associated with early discharge. The focus during a PARC stay is on encouraging participants to explore four key life areas: living; learning; socialising and working and establishing goals to address their areas of need. Staff working individually with participants can enable transition into employment, housing, education and community life. This model aims to intervene early, and so prevent admission to acute mental health inpatient care.

5.2 We support a dual approach to funding of sub-acute services, comprising a mix of activity-based funding with the use of incentive payments related to improving outcomes for patients.

o) We do not support incentive payments unless this refers to matched funding by the States to Commonwealth payments.

5.3 We propose that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and other settings. Incentive funding under the national partnership payments could be used to drive this expansion in sub-acute services.

p) Ditto item o) above

10. Supporting people living with mental illness

10.2 We propose that the early psychosis prevention and intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

r) In this regard, it is important that there is not an over emphasis on medication and adherence to a medical model to the exclusion of other more socially determined approaches. Medication is not the only management option for psychosis. CBT and other therapeutic models are effective guards against pathologising people, particularly the young. It is imperative to consider developmental stages of childhood, adolescence and young adults and assess functional ability and provide alternatives to medication. A good example of this are the interventions used for eating disorders in teenagers.

10.4. We propose that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

s) We are highly supportive of the use of existing partnership models with NGOs that have a strong evidence base (ref item n) p.5).

10.5 We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally included as part of accreditation processes.

t) This must be expanded to include the NGO sector which also requires resources to support workforce training and professional development.

10.7 We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

u) It is necessary to enhance capacity of employment services in the community sector to provide for those with mental health problems not accessing clinical services.

10.8 As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

v) Ditto re item q) above p.5.

10.11 We propose a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

w) Whilst we support a national campaign approach, evidence tells us that there is greater impact if local level campaigns are undertaken. We suggest a small grants program scheme to engage people at the local level to provide awareness and de-stigmatisation projects.

10.12 We propose there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

x) Mechanisms for consumer and carer participation must be in place to include involvement in policy and systemic reform at all levels of government.

12. Strengthening the governance and health care

12.2 We propose that the Commonwealth should take responsibility for policy and funding of all primary health care.

12.3 We propose to give further consideration to the following three options for reform of governance:

(A) Shared responsibility with clearer accountability. Retain both Commonwealth and state and territory involvement, but re-align responsibilities between them, with the Commonwealth:

- *becoming responsible for all primary health care funding and policy;*
- *paying to states and territories a significant proportion per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and*
- *paying, using a case-mix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments. This would be established through a national health strategy covering all health policies and programs, underpinned in turn by eight bilateral agreements between the Commonwealth and each state and territory.*

y) We would not support single dominant responsibility to the Commonwealth. It is necessary to have a mix of responsibility and accountability, acknowledging the benefit of local knowledge and experience.

(B) Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities. Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing and funding:

- *regional health authorities to take responsibility for former state health services such as public hospitals and community health services, in parallel to continued national programs of medical and pharmaceutical benefits and aged care subsidies.*

(C) Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery. Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing:

- *a tax-funded community insurance scheme under which there would be multiple, competing health plans for people to choose from, which would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care.*

13. Raising and spending money for health services

13.5 We believe that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements. This will involve a mix of:

- *activity-based funding (e.g. fee for service or case-mix budgets). this should be the principal mode of funding for hospitals;*
- *payments for care of people over a course of care or period of time. there should be a greater emphasis on this mode of funding for primary health care; and*
- *payments to reward good performance in outcomes and timeliness of care. There should be a greater emphasis on this mode of funding across all settings.*

We further propose that these payments should take account of the cost of capital and cover the full range of health care activities including clinical education.

z) Ditto items e) and f) above p.4.

13.7 We believe that additional capital investment will be required on a transitional basis to facilitate our reform directions. In particular, we propose that priority areas for new capital investment should include:

- *the establishment of Comprehensive primary health Care Centres; an expansion of sub-acute services including both inpatient and community-based services; investments to support expansion of clinical education especially in new and underdeveloped settings; and targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care; and*

- *capital can be raised through both government and private financing options. The ongoing cost of capital should be factored into all service payments, as outlined above.*

aa) Ditto items a), c) and d) above pp. 3 - 4.

14. Working for us: a sustainable health workforce for the future

14.1 We propose supporting our health workforce by:
- *improving workplace culture, management and leadership skills at all levels of the system. We would welcome feedback on proven mechanisms to achieve this; and*
- *implementing models that formally involve all health professionals in guiding the future directions of health reform and place value on their ongoing commitment to delivering care (e.g. Clinical senates and taskforces).*

bb) In order to improve workplace culture and implement models that guide future directions, the NGO sector must included in support processes .

14.2 We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:
- *Medicare rebates should apply to some diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.*

cc) It is important to expand on pathways for access to the MBS Better Access (BAI) to Psychological Services. The inability of allied and mental health professionals offering a wide variety of skills and therapeutic approaches to provide ongoing care in the community is a significant under utilisation of trained specialists. The BAI needs to be more flexibly accessible by offering a range of services through the community sector, using a broad range of mental health and allied professionals, such as counsellors, psychotherapists providing individual and group work. We advocate the Commonwealth support the accreditation of allied professionals through State and National Professional Associations to provide suitably qualified practitioners with accreditation for BAI and ATAPS Schemes.

14.4 We propose the establishment of a national Clinical education and training Agency:
- *to promote innovation in education and training of the health workforce;*
- *as an aggregator and facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia to perform tasks and address health needs met by other health professionals in major metropolitan areas; and*
- *to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.*

dd) The NGO sector is well placed to promote education, training and accreditation to/for the NGO health workforce (including clinical and non-clinical community services), provided they are provided with all the resources necessary to undertake this role.

15. Fostering continuous learning in our health care system

15.5 To help embed a culture of continuous improvement, we propose that a standard national curriculum for safety and quality is built into education and training programs as a requirement of course accreditation for all registrable health professionals.

ee) Ditto item dd) above

15.7 to drive improvement and innovation across all areas of health care, we believe that a nationally consistent approach is essential to the collection and comparative reporting of indicators which monitor the safety and quality of care delivery across all sectors. This process should incorporate:

- *incentive payments that reward safe and timely access, continuity of care (effective planning and communication between providers) and the quantum of improvement (compared to an evidence base, best practice target or measured outcome) to complement activity-based funding of all health services.*

ff) Ditto items e) and f) above p.4.

Other items not identified in the Reform Directions.

- **Victims of childhood sexual, physical and emotional abuse**

Sexual, physical and emotional abuse and neglect have significant mental health repercussions. Research studies consistently demonstrate that adult survivors of all forms of childhood abuse manifest high rates of mental illness: depressive and anxiety symptoms, substance abuse disorders, eating disorders, post-traumatic stress disorders, suicidality as well as poor physical health.

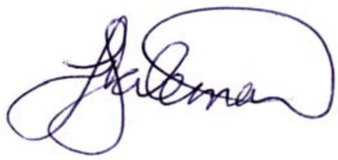
Child abuse and neglect are the root cause of many of Australia's social ills – substance abuse; welfare dependency; homelessness; crime, relationship and family breakdown; chronic physical and mental illness. If not effectively targeted, the life-long impact of child abuse will continue unabated, putting increased pressure upon already stretched government health and social services.

Access to psychologists and social workers through the MBS scheme is not (in most cases) appropriate for the long-term psychotherapeutic needs of adult survivors. We strongly urge Government to acknowledge the mental health needs of this long neglected group of clients. Central to removing long-term barriers to access, is a need for consumers to have the option to be referred directly via community services rather than necessarily via clinical services. We propose that in line with the Government's social inclusion agenda and a strong theme of prevention and early intervention, there needs to be an unambiguous acknowledgement of the absolute necessity to provide a wide range of services operating collaboratively to provide for the complex needs of people with mental illness in the community. This should not exclude adult victims of childhood abuse.

- **Other groups at risk**

  - HIV sufferers
  - Domestic violence victims
  - Veterans and their families
  - Carers
  - Gender specific
  - People with co-morbid mental health and substance abuse issues, intellectual disability and brain injury in the criminal justice system.

MHCC thank the Commission for their interest in these matters and look forward to the outcome of the Government's deliberations. For further comment on this submission please contact Corinne Henderson, Senior Policy Officer at corinne@mhcc.org.au or Tel: 02 9555 8388 ext 101



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