



Consumers Health
Forum **OF** Australia

SUBMISSION

**Response to the Productivity
Commission Mental Health
Draft Report**

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Consumers Health Forum of Australia (2020)
*Response to the Productivity Commission
Mental Health Draft Report* Canberra Australia

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Executive Summary

Australia has a universal mental health system in principle but not in practice, and we need to begin a process of significant investment and reform to change this. The Consumers Health Forum of Australia (CHF) supports the detailed set of recommendations developed by the Productivity Commission in their Draft Report and urges governments to commit to implementing the final recommendations as a comprehensive package. Picking and choosing some elements will not achieve the level of transformation needed to achieve a more responsive, person-centred and better coordinated mental health system for all Australians.

While we have not responded directly to every recommendation in the Draft Report, we have expressed broad support for the direction of the Report as a whole and highlighted those recommendations that we think need to be prioritised or those areas where we suggest changes. Overall CHF supports a shift towards prevention, early intervention and coordinated community support through the primary health care setting. We support a stepped model of care, with the capability to step up into higher intensity services where required, but with a focus on providing low intensity care at an early stage to prevent deterioration where possible.

CHF believes that services are best planned, coordinated and integrated regionally and for this to be facilitated by local governance and pooled funding arrangements. This submission considers the different commissioning and funding models proposed by the Commission and supports a continued and expanded role for Primary Health Networks (PHNs) as system integrators. We believe any commissioning arrangement must support integration between the public and private systems, and crucially across mental and physical health services to support seamless care for the increasing numbers of consumers with multimorbidity.

We also strongly support the broad approach this inquiry has taken to recognise that social determinants outside of the health system have a significant impact on mental health outcomes. By addressing the underlying contributors to poor mental health, we can deliver more effective care for consumers and reduce pressure on health services.

CHF views this Report as a once in a generation opportunity to reform our mental health system. In order for that to occur, we believe that the Final Report must outline a clear set of priorities to governments, including changes that can be achieved quickly and those that must be started now in order to see results in the longer-term. From CHF's perspective, the following recommendations are the key priority points from the Draft Report:

- **Draft Recommendation 22.1** – develop a National Mental Health and Suicide Prevention Agreement between Australian, State and Territory Governments
- **Draft Recommendation 23.1** – allocate clearer roles and responsibilities for mental health across levels of government and provide greater regional control and responsibility for mental health funding
- **Draft Recommendation 11.4** – strengthen the peer workforce
- **Draft Recommendation 11.7** – make working in rural and remote areas a more attractive option for health professionals

- **Draft Recommendation 8.1** – provide better alternatives to emergency departments, support for paramedics and improvements to the emergency department experience for mental health consumers
- **Draft Recommendation 24.3** – significantly increase the quantum of funding for housing and homelessness services under the National Housing and Homelessness Agreement.

Additionally, CHF sees the following five recommendations as ready for immediate implementation, and therefore we call on governments to act on these as a first step and as a sign of commitment to this process:

- **Draft Recommendation 5.4** – redesign and restructure the Better Access program including increasing the number of MBS-rebated psychological therapy sessions available
- **Draft Recommendation 5.7** – expand eligibility for psychology consultations via videoconference to include metropolitan, regional and large rural areas
- **Draft Recommendation 5.8** – amend MBS regulations to include a requirement for consumers to be informed about their right to choose their provider, including a different specialist or allied health provider to the one listed in their referral
- **Draft Recommendation 12.1** – extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years
- **Additional recommendation** – increase the rate of Newstart, Youth Allowance and related payments by \$95 per week and ensure these payments are indexed in the future in line with wages

We highlight these recommendations not to negate the importance of other areas, but to emphasise the need for the Final Report to give governments a clear pathway forward. CHF applauds the Commission for the detailed and thorough report it has put forward but acknowledges the risk that if the scale of the task appears too large then it is unlikely to be achieved. We recognise the allocation of short, medium and long-term priorities throughout the Draft Report and call for the Final Report to build on this to provide a clear pathway to implementation across a 2-5-10 year outlook.

We hold great hope that the Final Report will give the necessary clarity and impetus to turn many years of reports and recommendations into the much needed reality of a patient-centred mental health care system for consumers, carers and the community as a whole.

Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health consumer affairs. We have around 200 members reflecting a broad spectrum of organisations including state-based consumer peaks, condition-specific groups, volunteer patient groups, professional associations, Primary Health Networks (PHNs) and the research community. We work in collaboration with our members, national partners and research collaborators to influence policy, programs and services to ensure they are in the consumer and community interest. CHF is pleased to make this submission in response to the Productivity Commission's Mental Health Draft Report.

Multiple reports and the experiences of consumers and carers in the system over many decades highlight many problems and possible solutions to the challenges of mental health. CHF welcomed the direction proposed in the Commission's Draft Report, including the call for more responsive, person-centred and better coordinated systems of care for people with mental ill health. The Draft Report outlined the scale of the problem, finding that those who seek help are not getting the necessary level of care and that many people are not accessing care due to stigma, cost and the complexity of the system. This highlights the need for substantial, long-term reform, which requires a significant investment of time, resources and effort.

Overall CHF supports the reform agenda laid out by the Productivity Commission in the Draft Report. This submission comments on the key themes and recommendations from CHF's perspective and proposes changes in some areas. We also comment on the process for implementation and how the final report can provide governments with a clear roadmap for reform. We see this inquiry as a significant opportunity to improve the mental health system, not only for consumers and their carers, but also for the economy and society as a whole.

Our approach to this submission

Our submission is structured around the five broad reform areas which the Commission's recommendations fall into:

1. Early help for people
2. Consumer and carer experience of the mental health system
3. Looking beyond the health system
4. Education and employment
5. Behind the scenes arrangements

We do not respond to all 87 draft recommendations in the report. Instead we take the position of supporting the Commission's recommendations as a whole and have commented specifically where we see a need for change or adjustment. We have also commented on some recommendations that we support without change as they relate to CHF's areas of interest and/or we believe they should be priorities for implementation.

A major issue for our constituency is physical and mental health comorbidity and the management of multimorbidity, which is becoming increasingly commonplace and is not well

managed in the current health system. Many consumers' experience of the system is one of fragmented, disconnected services and care, and CHF has long advocated for a shift to coordinated, multidisciplinary clinical and non-clinical care. We have therefore commented on the governance and funding arrangements that can support a more coordinated approach.

We also know that mental ill-health can result from, and be worsened by, biopsychosocial factors and social determinants. We were pleased to see a strong focus on investments beyond health services to address some of the other issues which are important in people's lives in the Draft Report. This submission reflects on these recommendations and also notes some additional social determinants that impact on mental health outcomes.

In CHF's submission to the Commission's Issue Paper in April 2019, we drew on responses to our *'Survey of the Mental Health Lived Experience'* in order to maintain a strong focus on the people who are the end users of the system, rather than the system itself. In this submission we call for a commitment to service co-design that involves consumers and carers in meaningful ways including as leaders and change agents. This approach ensures that people with lived experience are involved in all stages of policy and service development.

Response to the draft recommendations

Early help for people

As the National Mental Health Commission (NMHC) found in 2014, the biggest inefficiencies in our mental health system come from providing acute and crisis response services when prevention and early intervention services would have reduced the need for more expensive services, maintained people in the community with their families and enabled more people to participate in employment and education.¹ This has been a consistent theme across mental health reports over many years.

There seems little debate that early intervention should be a fundamental principle of health care to try to deal with problems at the outset and stop them from escalating and becoming more serious. The challenge is how this can best be achieved, and part of the solution lies in a shift in focus and investment towards preventative health and integrated primary health care in community settings. This was the finding of CHF's 2018 White Paper *Shifting Gears – Consumers Transforming Health*,² and this approach is particularly relevant in mental health.

Reducing stigma

The Commission's finding that most people with mental illness report experiencing stigma is consistent with consumer feedback that stigma and discrimination are often experienced and

¹ National Mental Health Commission (2014) *The National Review of Mental Health Programs and Services*. Sydney: NMHC.

² Consumers Health Forum of Australia (2018) *Shifting Gears – Consumers Transforming Health*: https://chf.org.au/sites/default/files/181125_shifting_gears_-_consumers_transforming_health.pdf, accessed 7 January 2020.

have significant impacts on consumers' ability to engage fully with society. In our previous submission CHF called for a multidimensional approach which included more education in communities and workplaces about the realities of living with mental ill-health, alongside institutional and structural changes to support real and lasting cultural change.

In particular, CHF supports the Commission's call for stigma reduction programs to include interactions between health professionals and mental health consumers on an equal footing outside of a clinical setting. This approach is currently being implemented through the Collaborative Pairs Program. Collaborative Pairs brings together health providers and consumers to build skills in developing collaborative partnerships and to break down the cultural barriers that often exist between those providing the services and those receiving them. A national demonstration trial has recently been completed in the Australian context and further information is available through the literature review³ and external evaluation.⁴

National leadership and strategy to reduce stigma

CHF believes that reducing stigma requires more than just individual attitude and behaviour change. We agree with the Commission that effective stigma reduction requires an ongoing commitment over a long time period to achieve the sort of culture change that will reduce stigma as a barrier to accessing treatment and improving mental health outcomes.

CHF supports **Draft Recommendation 20.1** – the development and implementation of a national stigma reduction strategy, led by the NMHC. It is crucial that the strategy is informed by and developed with consumers, carers and people with lived experience. We support the call for the strategy to rely on the leadership and direction of people with lived experience, including as national ambassadors for mental health. This approach demonstrates a strong commitment to co-design and the involvement of consumers and carers in meaningful ways, including supporting them to serve as leaders and agents of change.

Suicide prevention

CHF recognises the need for a range of dedicated suicide prevention strategies and activities alongside broader efforts to improve access to mental health services. This must include targeted programs for high-risk communities that are developed with and delivered by members of those communities. Additionally, the appointment of Christine Morgan as the first National Suicide Prevention Advisor, reporting to the Prime Minister, sends an important signal about the importance of a whole-of-government approach to suicide prevention.

We agree with the Commission that the specific needs of consumers from particular communities or backgrounds are likely to be better met with initiatives and services that are

³ Spark L, Robinson S, Dickinson H (2019) *Collaborative Pairs Australia National Demonstration Trial: Review of existing evidence*: <https://www.chf.org.au/sites/default/files/20191212-cpadt-literary-review.pdf>, accessed 8 January 2020.

⁴ Brown A, Dickinson H, Robinson S (2019) *An independent evaluation of the Collaborative Pairs Australia National Demonstration Trial – Final Evaluation Report Executive Summary*: https://www.chf.org.au/sites/default/files/20191216-cpadt_final_evaluation_exec-summary.pdf, accessed 8 January 2020.

sensitive to their experiences, culture and the specific issues they face. CHF believes Aboriginal and Torres Strait Islander organisations should be the preferred providers of mental health, suicide prevention and social and emotional wellbeing programs in their communities.

CHF supports **Draft Recommendation 21.2** – a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan to be developed through COAG. Aboriginal and Torres Strait Islander people should be included at the table during the development of the strategy, and the strategy should include an explicit provision that Indigenous organisations are the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. All organisations providing programs or activities into Indigenous communities should be required to demonstrate they meet cultural competency standards.

CHF also supports **Draft Recommendation 21.3**, which calls for a clear articulation of the roles and responsibilities of different levels and parts of government in relation to suicide prevention. Due to the wide range of factors associated with suicidal behaviour and the need for approaches to be tailored to the local context, a place-based approach that draws on the expertise of local communities and coordinates with services outside of the health system is likely to be most effective. Accompanying approaches with outcome-based evaluation and reporting is critical to building a strong evidence base.

Follow-up after a suicide attempt

There is a significant evidence base demonstrating the increased risk of future suicide attempts for people who have made a previous suicide attempt, and that the immediate days, weeks and months following a suicide attempt are a particularly high-risk time for the individual.

Aftercare support for people who have attempted suicide can prevent future suicide deaths and attempts, as well as reducing the associated social, emotional and economic costs of suicide. We therefore strongly support further investment in effective aftercare initiatives to achieve universal access for anyone presenting to a health or government service following a suicide attempt, as outlined in **Draft Recommendation 21.1**. Comprehensive, outcomes-based evaluations must be included in any program roll out to demonstrate the effectiveness of each initiative.

Consumer and carer experience of the mental health system

CHF believes Australians have a right to a universal mental health care system that integrates seamlessly with other parts of the health and social care system to give access to essential services in the right place, at the right time, and in the right way. In 2014 the NMHC found that this is not being achieved due to a range of factors, including the concentration of resources in costly acute and crisis care; fragmentation of services and poor coordination between them; services designed with a focus on the needs of providers rather than consumers and carers; and inequitable access to care especially for people in regional and remote areas and

for disadvantaged groups. Based on consumer feedback and the Draft Report it is apparent that the NMHC's findings are still relevant today.

CHF believes that mental health services need to be more integrated and that policy needs to be equally integrated to create a funding and implementation environment where comprehensive, multi-disciplinary and coordinated service delivery by a team of providers is the outcome, both within a service as well as across services settings.

At the point of care consumers need stepped models that give them options for accessing the level of care that meets their needs, ranging from low intensity supports to crisis services that are person-centred and provide wrap-around support. Targeted services for people in rural and remote areas, Aboriginal and Torres Strait Islander people, young people, the LGBTIQ+ community and other groups with specific needs are critical to reaching vulnerable individuals.

Access to services

CHF supports the vision articulated in **Draft Recommendation 5.9** that all Australians should have access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), that is timely and culturally appropriate. We agree that the mental health system needs to be reconfigured to achieve this vision and that it will require a coordinated approach across Commonwealth and state and territory governments.

The Commission's characterisation of a mental health system severely hampered by funding and workforce shortages, that is not responsive to individual needs, where many people cannot access services and fall through the gaps, aligns with CHF's view as informed by consumer experience. This situation can be rectified if there is a commitment to long-term investment and reform.

Stepped care model

CHF strongly endorses the implementation of a stepped care approach in Australia as well as the NMHC's recommendation that the fundamental elements of the stepped care approach lie in prioritising delivery of care through general practice and the primary health care sector. CHF's view is that PHNs have a fundamental role to play in introducing a stepped care approach that is tailored to the needs of local communities. In our previous submission we called for the accelerated implementation of stepped care approaches to integrated mental health service delivery on a regional basis led by PHNs. To enable regional stepped care models, while we note that some PHNs and LHNs have already done so, all should be required to take a "one system" mindset and work together to produce, implement and monitor joint regional mental health plans.

We recognise the potential for more consumers to be accessing lower cost and lower intensity services that meet their needs. We strongly agree that any approach must be developed in partnership with the consumer in order to have high acceptability for consumers and therefore be effective. This is consistent with a person-centred approach and is an important component of identifying the "right" treatment for any individual.

CHF supports **Draft Recommendation 5.2**, where commissioning agencies promote best-practice assessment and referral to match people with the level of care that best meets their needs. However, any best practice model must include a requirement for consumer engagement and the flexibility to adjust the approach based on the acceptability of the approach to the consumer. We also support the long-term monitoring of assessment and referral practices to identify any barriers to engaging with lower intensity services.

In relation to **Information request 5.1** regarding the gains from having a greater share of treatment provided by low intensity therapy coaches, CHF is broadly supportive of this approach in light of the expensive nature of the Better Access Program and the NMHC's recommendations about the need to shift the cost curve towards lower intensity services. Evaluation is critical and we support the expansion of these kinds of roles where program efficacy can be demonstrated.

While low intensity therapy coaches have the potential to be beneficial for a wide range of consumer cohorts, the acceptability of the service to the consumer will be critical to its effectiveness. Consumers need to be provided with clear information about the service and why it would be beneficial for them. If the service is perceived by consumers to be a lower quality option consumer uptake is likely to be low and effectiveness will be limited.

Rural and remote services

In late 2019 CHF undertook a qualitative survey of rural and remote consumers focusing on their access to primary care and prevention services and mental health was identified as a particular area of need for rural and remote communities. Many consumers are concerned about the ageing profile of the health workforce, particularly GPs, and many communities have difficulty attracting younger health professionals to work in rural and remote areas.

Consumers in our survey valued the skills of a range of health professionals including nurse practitioners and allied health professionals and see potential for them to have a wider scope of practice in some settings. Consumers are prepared to look at different models of care and service delivery, but most still value face-to-face visits over the alternatives. And while they might not describe it as such, consumers clearly value bio-psychosocial oriented services that are geared around the interconnection between biology, psychology and socio-environmental factors. With mental health becoming an increasingly major issue in rural and remote communities, the integration across physical and mental health needs to be improved.

While technology will inevitably play an increasingly role in service delivery to rural and remote communities, for the sake of quality and continuity of care, consumers continue to value being able to access face-to-face interactions with their healthcare provider. Noting these findings, CHF strongly supports **Draft Recommendation 11.7** that Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave.

Crisis support

We have already argued the need for a shift towards primary care and prevention, and one benefit of this approach is that it provides more resources to invest in high quality acute care

for those who need it. Improving upstream mental health services will help to prevent deterioration and is part of the answer, but appropriate acute services are also an essential element of the system.

The feedback from consumers is consistent with the Australian College of Emergency Medicine's comment that emergency rooms are an inappropriate setting for most mental health interventions, and so alternatives need to be available that provide a calm, private and safe environment. Consumer-led models like the Safe Haven Café in Melbourne are an important part of the service mix and funding should be expanded to allow them to open after hours and during peak times.

CHF supports **Draft Recommendation 8.1**, including the need for better alternatives to emergency departments, support for paramedics and improvements to the emergency department experience for mental health patients.

In our previous submission, CHF also noted that the number of inpatient beds is too low to meet the needs of those in crisis or requiring longer term care. We support investment in early intervention and primary care so that fewer people require acute admissions, but for those that still need acute care it must be provided in an appropriate environment.

We agree with the Commission that no child or adolescent should be placed in an adult mental health ward and that dedicated, separate child and adolescent mental health beds should be available in every jurisdiction (as per **Draft Recommendation 8.2**). These facilities should also allow flexibility for young people aged 18-25 to be treated separately from adults if they choose and if appropriate. It is also important that young people with lived experience are given the opportunity to contribute to service planning and design so that services and supports meet their needs.

Using technology to expand access to care

Effective digital transformation has a significant role to play in the reform of the mental health care system, but simply adding on digital touchpoints to current processes will be ineffective.

While consumers continue to value face-to-face consultations, they are also willing to engage with different models of care including telehealth, video conferencing and supported online treatment, if the necessary systems and infrastructure are in place to make it user friendly. Technical improvements like secure messaging and interoperability, as well as changes to clinical workflows and funding arrangements are needed so that we can deliver high quality, integrated, team-based care. As the NMHC noted, e-mental health will not replace the need for face-to-face care, but it can reduce the need for expensive services where self-management is possible.

CHF supports **Draft Recommendations 6.1 and 6.2** to expand access to supported online mental health treatment and increase awareness of these programs in the community to encourage greater uptake. Funded programs must have a strong evidence base for their efficacy and systems must have the capability to securely forward outcomes and reports both to the consumer and to their nominated primary care provider so that care is integrated and coordinated.

CHF also supports the expansion of eligibility for both psychology and psychiatry consultations via videoconference to include metropolitan, regional and large rural areas (**Draft Recommendations 5.7 and 7.2**). Distance is just one of the reasons consumers may choose to access treatment via videoconference and access to care should not be restricted if the consumers chooses to engage in that way. Additionally, as we expand the role of e-mental health and videoconferencing in health care, it is essential that unreliable and slow internet connections in parts of rural and remote Australia are rectified as a matter of urgency so that there is equitable access to these services.

Person-centred care

The current mental health care system puts the needs of providers and funders in front of the needs of consumers, resulting in a mental health care system that is difficult to navigate, lacks integration and requires significant work by consumers and carers to coordinate their own care.

CHF supports the NMHC's vision where people with lived experience, families and support people encounter a system that involves them in decisions, is easily navigable and provides continuity of care. A key component of this is for consumers to be informed about their right to choose their provider, including a different specialist or allied health provider to the one listed in their referral. CHF strongly supports **Draft Recommendation 5.8** and we call for this relatively simple change to become a requirement under MBS regulations as soon as possible.

The principle of person-centred care extends beyond clinical services and should also apply to psychosocial support. As outlined in **Draft Recommendation 12.2**, CHF calls for access to psychosocial support to be expanded to allow care to be provided while a person is applying for the NDIS or if a person chooses not to apply for the NDIS. Psychosocial support should be provided based on the person's need for it, not based on the category the system has placed that person in. This is also critical for continuity of care as we know that many people experience long waits while their NDIS application is being processed.

It is also important that person-centred care extends beyond the individuals and is inclusive of families and carers in the process. CHF supports **Draft Recommendation 13.3** which requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers.

Self-help and self-management

CHF welcomes the Commission's recognition of the importance of self-help and self-management as part of the stepped care continuum. With access to the right information and the right support structures in place, some people with mental illness are able to manage their own mental health without formal clinical intervention.

The challenge for many consumers is not that they are unable to self-manage, but rather being able to identify which information and sources are evidence-based, given the abundance of information available online and the variable quality and accuracy of the advice. Options to help people, their families and communities to support themselves and each other and improve ease of navigation for stepping through the mental health system should be built into

all service design processes. Consumers who choose not to self-manage or who are unable to do so should still be empowered to play an active role in their care through measures like shared decision making and social prescribing.

Coordination and integration

CHF applauds the Commission for broadening the reach of this inquiry and the recommendations beyond the mental health system and also beyond clinical services. How we support people with mental health issues in primary care, aged care and other areas is critical, as is the ability for people to move easily between parts of the health and social care systems.

The Commission has made a significant number of recommendations to support better coordination and integration across the mental health system. This must occur across the service continuum, across the public-private service mix, and with psychosocial and community supports. CHF would like to highlight our support for the following recommendations in particular:

- **Draft Recommendation 5.1** – introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues. This would ideally provide GPs with greater confidence and support to manage patients in primary care and avoid referrals into specialist services if not required. Managing their condition through a single clinician is easier for the consumer and reduces the time and cost burden of attending additional appointments.
- **Draft Recommendation 10.1** – assistance phone lines should facilitate better exchanges of information between service providers. When consumers seek support through an assistance phone line, that provider should have the capacity to send relevant information about outcomes and referrals to another health provider with the consumer's consent. This should minimise the need for consumers to repeat information, which can be traumatic for some individuals.
- **Draft Recommendation 10.2** – online navigation platforms with information on pathways in the mental health system should be accessible to service providers, including those outside the health system (e.g. schools and psychosocial support services). This is a critical mechanism to ensure that providers are aware of the range of services available and can easily refer consumers to those services. Social and community programs that are beneficial for self-management and addressing social determinants (i.e. those used in social prescribing) could also be included in these platforms.
- **Draft Recommendation 10.3** – single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers. CHF supports this concept but suggests additional work is required to determine who has responsibility for, and control over, the care plan. Where the consumer or carer chooses to be the coordinator of their own care their role needs to be recognised and respected.

Additionally, the capacity to share information through an electronic health record needs to be improved and the limitations of the My Health Record system need to be addressed.

- **Draft Recommendation 10.4** – access to care coordination is provided for all people with severe and persistent mental illness who require these services due to their complex health and social needs. CHF supports this recommendation, but further work is required to determine what the care coordination role involves, how consumers and carers can be engaged in defining that role and how services would differ between NDIS and non-NDIS participants.

Options for short-term care coordination may also be required, particularly for people with episodic mental illness who can normally self-manage but may require periods of assistance.

Primary care treatment options

While there is good evidence for individual psychological therapy as an effective treatment option, the MBS Review's Mental Health Reference Group found that the current system is not working for consumers. Feedback from some patients shows they are unable to access as much care as they need through the Better Access program, and at the same time, MBS data shows that many patients with a Mental Health Treatment Plan do not use all of their allocated sessions.

CHF supports the call to increase the number of MBS-rebated psychological therapy sessions available under the Better Access program (**Draft Recommendation 5.4**) and increase the flexibility of the program to cater to different levels of need. CHF calls for the Commission's final recommendations to be adjusted to be consistent with those of the Mental Health Reference Group to give the Government a clear path forward on this issue. The recommendation should include the following:

- expand the Better Access program to patients who are considered at-risk of developing a mental health disorder in the next 12 months;
- increase the maximum number of Better Access sessions in any one referral from 6 to 10 sessions (with 10 as a maximum but flexibility if less is required); and
- introduce a 3-tiered system for Better Access sessions with up to 10, 20 or 40 sessions available in a 12-month period depending on the level of need

In line with our calls for a shift towards providing more mental health care in primary and preventive settings, we support the move to upskill GPs and other medical practitioners with additional mental health training (**Draft Recommendation 11.5**). In particular, the issue of medication management and side effects is a key safety and quality issue and is becoming more common with increasing rates of multimorbidity.

CHF also supports consideration of an advanced specialist mental health pathway for GPs: this would be consistent with the rationale underpinning recent work by the National Rural Health Commissioner on a national rural generalists pathways for GPs wishing to specialise in areas such as emergency care or obstetrics in order to better serve rural communities, Registration in this specialty would allow consumers to identify GPs with advanced skills and an interest in mental health.

Peer workers

Mental health consumers place significant value on the role of peer workers and see them as a great asset to understand the situation a person is in and help navigate their way through relevant services. CHF supports efforts to grow the peer support workforce and integrate them more commonly into existing care models, including the work progressing through the NMHC at the moment.

We strongly support **Draft Recommendation 11.4** and would like to see the strengthening of the peer workforce taken up as an immediate priority by governments. We also support the Commission's call for education and engagement with health professionals on the role and value of peer workers as this is a significant barrier to peer workers being integrated into existing services.

Looking beyond the health system

Social determinants of mental health

It is well known that socio-economic factors in people's lives can affect their health and wellbeing and can often be the reason people reach out to healthcare services. And while the health system can provide a clinical response, efforts to address the underlying causes of mental ill-health are likely to be more effective at improving health and wellbeing outcomes in the long-term.

CHF recognises that for Aboriginal and Torres Strait Islander people the concept of health involves overlapping and connecting concepts of physical, mental, emotional, cultural and spiritual health, and that the health of the individual is intrinsically linked to the wellbeing of the whole community. Additionally, discrimination and disadvantage have had a detrimental effect on the health and wellbeing of many Aboriginal and Torres Strait Islander people.

CHF supports **Draft Recommendation 20.3**, recognising the role of traditional healers in improving social and emotional wellbeing for Aboriginal and Torres Strait Islander people and calling for an evaluation of how partnerships between traditional healers and mainstream mental health services can work best to deliver holistic, integrated care for Aboriginal and Torres Strait Islander people.

Housing

Unstable or inadequate housing is a key risk factor for poor health and can both cause mental distress and exacerbate an already existing mental illness. Having access to stable and suitable housing is critical for preventing poor mental health and promoting recovery.

CHF strongly supports **Draft Recommendations 15.1 and 15.2** to prevent people with mental illness from experiencing housing issues or losing their home, and to support people with severe mental illness to find and maintain housing in the community. In particular, early efforts to connect tenants to mental health services and ready access to tenancy support for those with mental illness is important for an early intervention approach.

We strongly support a nationally consistent policy of no exits into homelessness for people discharged from institutional care, integration with community supports on discharge and increasing the number of supported accommodation places for individuals with severe mental illness to provide long-term housing solutions for these individuals.

We also strongly support **Draft Recommendation 24.3**, calling for a significant increase in the quantum of funding provided to state and territories for housing and homelessness services under the National Housing and Homelessness Agreement. Current funding is not sufficient and leaves people with mental illness in unstable and distressing situations that exacerbate poor mental health and place increasing pressure on acute mental health services.

With the current Agreement not due to expire until 2023, we call on all governments to start negotiations now and consider options for a variation to the current agreement to get more funding into the system which is urgently needed.

Justice and corrections

People with mental illness are over-represented at all stages of the criminal justice system, from police custody to the courts and correctional facilities. The criminal justice system is neither an appropriate nor cost-effective place to treat mental illness and so strategies to divert people away from the criminal justice system are needed. Those people who do enter the criminal justice system are entitled to receive the same standard and quality of care as you would receive in the community, and there must be transparency around the provision of those services.

While considering this issue, it is important to reiterate that the majority of people with mental ill-health never make contact with the criminal justice system, and that the association between mental illness and criminal behaviour, particularly violence, contributes to stigma. We must continue to challenge and break down these associations to reduce stigma for people with mental ill-health.

Alongside our support for better alternatives to emergency departments, CHF supports **Draft Recommendation 16.1** to better enable police to respond to mental health crisis situations. The co-location of police, ambulance and mental health workers is being used in a number of jurisdictions and shows promise as a way to deescalate situations effectively and avoid both arrest and emergency department attendances. Continued investment in these sorts of approaches is needed.

CHF is also pleased to see a strong set of recommendations in the report calling for high quality care for people in correctional facilities to identify, assess and treat mental illness. CHF highlights our support for the following recommendations:

- **Draft Recommendation 16.2** – the national mental health service standards should apply to services in correctional facilities to the same level as in the community. Access to healthcare is a human right and should not be restricted due to incarceration.
- **Draft Recommendation 16.3** – mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release. Coordination with services in the community on release (with consent of the

individual) is important as people often fall through the gaps when leaving an institutional setting.

- **Draft Recommendation 16.4** – Aboriginal and Torres Strait Islander people in correctional facilities should have access to mental health supports and services that are culturally appropriate. CHF encourages all governments to work with the Aboriginal Community Controlled Health sector to identify opportunities for these services to provide care within correctional facilities, particularly given the over-representation of Aboriginal and Torres Strait Islander people in correctional facilities across Australia.

CHF is also a strong supporter of health justice partnerships and the work of Health Justice Australia to embed legal help into healthcare settings and support populations who are likely to experience legal problems which impact on their physical and mental health. These are important initiatives at the prevention and early intervention stage that can reduce engagement with the criminal justice system later down the line.

Social isolation

CHF is pleased to see the Commission highlight the issues of social isolation and social exclusion in **Finding 20.1**. The interaction between social exclusion and poor mental health is cyclical and an individual is likely to deteriorate without engagement and support.

In November 2019 CHF, in partnership with the Royal Australian College of General Practitioners and the NHMRC Partnership Centre for Health System Sustainability, held a thought leadership roundtable on the emerging practice of social prescribing. We see social prescribing as an important tool to help increase consumer enablement and self-management, decrease social isolation and loneliness and build stronger communities. The final report from the roundtable, including a set of recommendations to progress social prescribing in Australia, will be published in late January 2020. We call for the Commission to include a specific recommendation for governments to invest in approaches like social prescribing to address social isolation and the associated impacts on poor mental health.

Climate change

The fires and drought engulfing Australia have confronted Australians with the dire health consequences of climate change and the imperative for an urgent and credible response. The health impacts of climate change have long been discussed, but the mental health impacts are often overlooked as they are more difficult to quantify.

In their 2018 report on health and climate change, the Lancet found that climate change will lead to an increasing number of people being exposed to extreme weather events and the resulting psychological problems. They also found that there is strong evidence linking heat waves to increases in population distress, hospital psychiatric admissions and suicides.⁵ In 2017 the American Psychological Association released a report titled *Mental Health and Our*

⁵ Watts N et al. (2018) 'The 2018 report of the Lancet Countdown on health and climate change: shaping the health of nations for centuries to come' *The Lancet* 329: 2491.

*Changing Climate: Impacts, Implications and Guidance*⁶ which raises awareness and provides tools to respond to the mental health impacts of climate change.

CHF is a member of the Climate and Health Alliance because we recognise how profound the health and mental health effects of climate change will be for consumers. This inquiry is a once in a generation opportunity to address the key issues in our mental health system and we feel it is vital that the mental health impacts of climate change are recognised in the final report. We call for the inclusion of a recommendation to invest in additional mental health services for communities impacted by extreme weather events. We also call for the development of evidence-based climate and mental health communication materials, particularly to inform conversations with children and young people who are deeply concerned about this issue.

Education and employment

Schools as places to support mental health and wellbeing

In their 2019 submission to the Commission the CHF Youth Health Forum identified the need for more resources for improving education and training for teachers, support staff and students about mental health. They called for an emphasis on mental health literacy and open discussion about mental health issues in early secondary school curricula. This would improve understanding and assist with destigmatising mental ill-health, encourage young people to seek help and for school staff to be able to offer appropriate support and referral to other services.

In line with these comments, CHF supports **Draft Recommendation 17.3**, calling for a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum. CHF believes that mental health and well-being in schools should not only focus on the identification and education of risks and early symptoms of mental ill health but should also include creating and promoting mental wellness, such as through the use of mindfulness and other techniques.

We also support **Draft Recommendation 17.4** to review the support offered to children with mental illness in the education system and make necessary improvements, including through information sharing between treating health professionals and teachers. This is an important part of a coordinated and integrated care pathway that includes both public and private service providers as well as to services outside the health system

Opportunity to live a contributing life

CHF believes the primary purpose of accessing mental health services and supports is to enable a person to live a contributing life, and that will look different for each individual. Engagement in education, training and employment will be a goal for some people.

⁶ Clayton S, Manning CM, Krygsman K, Speiser M (2017) *Mental Health and Our Changing Climate: Impacts, Implications, and Guidance*. Washington, D.C.: American Psychological Association, and ecoAmerica.

Recognising that young people aged 18-24 are at an important transition point which can bring stress and potentially experiences of mental ill-health, it is important to have targeted and appropriate supports for that age group through a range of different avenues.

Providing options that people feel comfortable with is critical and the best way to understand the preferences of young people is to engage with them directly. CHF's Youth Health Forum is one example of young people who are engaged and want to have input into the design and delivery of health policies and services.

Others who are less engaged may still seek support through family, friends, their school, university or employer. These institutions need to be prepared to encourage people to seek support and have the right responses in place when they do. CHF supports **Draft Recommendation 18.1** to require training on student mental health and wellbeing and guidance on supports for all staff at tertiary education providers, as well as in vocational education and training.

Income support

As the Youth Health Forum outlined in their earlier submission, the current Targeted Compliance Framework for income support recipients is punitive and lacks appropriate measures for individuals to challenge incorrectly applied penalties.

We strongly support **Draft Recommendation 14.4** to implement a more flexible approach to targeted compliance and more assistance with personalised job plans. We also would like to see a change in the culture and approach to income support compliance to be more person-centred and considerate of the needs of mental health consumers. CHF also reiterates the Youth Health Forum's call for the timely implementation of all recommendations from the *Jobactive: failing those it is intended to serve*⁷ report from the Senate's Education and Employment References Committee, which would contribute to this.

CHF also calls for an additional recommendation to support an increase to Newstart, Youth Allowance and related payment by \$95 per week and to ensure it is indexed in the future in line with wages. CHF is a supporter of the Raise the Rate campaign and we believe this is one of the most important measures that can be taken to promote social and economic participation and improve mental health and wellbeing.

Behind the scenes arrangements

In order to effectively implement the range of policy and service delivery changes discussed in previous sections, the structures, systems and funding arrangements at the back end need to support a more holistic and coordinated approach to mental health. At the moment blurred lines of responsibility and accountability between stakeholders in the system from

⁷ The Senate Education and Employment References Committee (2019) *Jobactive: failing those it is intended to serve*:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/JobActive2018/Report, accessed 13 January 2020.

governance, funding and service delivery perspectives leave some people to fall through the cracks and make the system harder to navigate for consumers.

Australians have a right to a universal mental health care system that integrates seamlessly to give access to essential services in the right place, at the right time, and in the right way. Without a widespread, easily understood and shared vision for a person-centred mental health system with commensurate obligations for governments to act, making that right a reality may remain out of reach.

Consumer and carer involvement in programs and policies

We know that the attributes of high performing health systems include patient enablement and the patient-team partnership, including recognising the expertise that patients, their families and carers bring to the encounter. We also know that when consumers are equipped and supported to be partners in care, better health outcomes are generally delivered.

As was outlined in CHF's 2018 White Paper *Shifting Gears*, CHF supports transformational shifts at the system level to enable consumers to be involved in all levels of decision making, to feel trusted and respected by service providers, managers and funders and to be engaged in collaborative and partnership approaches to service planning and improvement. These shifts must occur across policies, attitudes, behaviours and practices.

Consumer capacity building and leadership

CHF strongly supports **Draft Recommendation 22.3**, that consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives. However, it is vital to recognise that not all consumers and carers have the system literacy, confidence and skills needed to engage in the codesign of services and policies.

Building consumer and carer capability and capacity to be partners in planning and decision-making is an obligation on government and health providers, not just so consumers can have a voice in policy planning and co-designing service delivery, but so they can be effective partners in their own health, support and treatment decisions. There is a particular need to not just better include those that can already speak up and contribute, but to also actively work to include those who can bring new perspectives to the table. These people would, without effort, remain marginalised, unheard, and underserved by the health care system.

CHF also believes this recommendation should go further and move beyond consumer participation to recognise the need for consumer leadership. This includes driving a culture shift from typically seeing consumers as 'users and choosers', to being valued as 'makers and shapers' of health services.⁸ In our previous submission to this inquiry, CHF called for the establishment of an independent national mental health consumer and carer organisation to

⁸ Spark L, Robinson S, Dickinson H (2019) *Collaborative Pairs Australia National Demonstration Trial: Review of existing evidence*: <https://www.chf.org.au/sites/default/files/20191212-cpadt-literary-review.pdf>, accessed 13 January 2020.

strengthen person-centred policy setting and program design as well as investment in consumer leadership development.

As this Draft Report was being published there was an announcement of the formation of a National Peak Consumer Alliance, bringing together mental health consumer peak bodies from across six states and territories to increase mental health consumer influence on national policy. CHF strongly supports the Alliance and would like to see a recommendation in the final report calling for governments to support it in order to give it the necessary resources and level of influence.

Governance and service delivery

CHF agrees with the Commission's finding that there are currently unclear responsibilities between tiers of government and that is preventing the mental health system from operating effectively for the benefit of the community. We agree that major reforms are needed to inject genuine accountability for system outcomes and clarify responsibilities for program funding and delivery. Consumers want a system where care is seamlessly integrated, both within the mental health system and across other systems, to enable access to essential services.

Roles and responsibilities

CHF strongly supports **Draft Recommendation 22.1**, calling for the development of a National Mental Health and Suicide Prevention Agreement between Australian, State and Territory Governments. This agreement must enable consumers and the community to know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services.

While we recognise that there is significant and positive work already happening under the *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan), we agree with the Commission's assessment that a key shortcoming of the Fifth Plan is the lack of formal mechanisms to link with services and systems outside of the health system. This therefore limits the ability to implement a whole-of-government approach to mental health.

In our previous submission, CHF called for a COAG-led whole-of-government policy and implementation roadmap for mental health reform, and we believe a new national agreement can deliver this. However, we are concerned about the call for the separation of funding and governance arrangements for mental health from physical health. While this may be necessary in some cases, we are concerned that siloing mental health from the broader health system will lead to fragmented care for consumers, particularly for the increasing number of people with multimorbidity. We appreciate the need for clear accountability but believe this can be done through measuring against outcome measures rather than separating funding allocations.

We strongly support the call for an integrated approach to the delivery of services and supports across the health and non-health sectors in **Draft Recommendation 22.2**. CHF believes that in order to achieve a truly integrated approach across mental health, primary care and human services, governments, including PHNs as the regional commissioning

agencies, need to have access to appropriate levels of flexible funds, rather than siloing and segregating funding to one system or another.

CHF supports the call for the development of a new whole-of-government National Mental Health Strategy, with a requirement to collaborate with consumers and carers to ensure that the vision and ambition in the Strategy aligns with community views. The engagement of non-health sectors such as housing, justice, social services, education and employment is also critical. The Strategy must include clear links to other related strategies and policies to avoid duplicating or confusing actions already underway.

To lead and inform this work, CHF supports an expanded role for the NMHC as an interjurisdictional statutory agency. The NMHC has a core role to play in independently reporting on the state of the mental health care system. Currently, a lack of resources and difficulty accessing data have hindered their efforts and any new arrangements should strengthen both of these areas.

In response to **Information Request 22.1**, CHF would like to see the NMHC given clear and unambiguous support through COAG. Building on this, the NMHC must have the powers to effectively compel federal, state and territory departments to share information to allow the NMHC to report on their indicators. The NMHC should have sufficient independence to enable it to initiate reports or inquiries where necessary, and to have the power to publish its findings as it sees fit.

Commissioning arrangements

The fundamental measure for determining commissioning and funding arrangements should always be whether it leads to the overall improvement of the lives of consumers and carers. Linked to this is whether proposed commissioning arrangements contribute to a universal system of coordinated and integrated mental health care, rather than fragmenting care and making it difficult to navigate for the people receiving it.

CHF supports the Commission's approach to have clear lines of responsibility and remove areas of duplication where both state and federal governments currently provide certain services. There we support **Draft Recommendation 23.2** for psychosocial and mental health carer support services outside the NDIS to be commissioned solely by state and territory governments.

However, it will be important to be mindful of the pathway for individuals moving between NDIS and non-NDIS psychosocial supports. As noted in recommendation 12.2, anyone who requires psychosocial supports should be able access them and this includes people waiting for an NDIS application to be assessed.

On the broader question of the architecture of the mental health system (**Draft Recommendation 23.3**), CHF agrees that it is necessary to allocate clearer roles and responsibilities and that greater regional control and responsibility for mental health funding is needed. CHF supports the role of PHNs as the regional infrastructure to translate and implement national policy by serving stewardship, regional integrator, innovation accelerator and commissioning roles in mental health services.

It is noteworthy that, as conveyed in the 2018 Report of the PHN Advisory Panel on Mental Health co-chaired by the NMHC and Mental Health Australia, there is variation in the maturity of PHNs as organisations and hence their commissioning, leadership and stewardship capabilities but nonetheless there remains a longstanding commitment that their integral role in mental health should be strengthened, not diluted. Therefore, CHF believes PHNs should be given the authority and mandate to serve as stewards of integrated mental health, primary care and human services, and to commission services at scale.

In order to achieve this, PHNs will need to have access to appropriate levels of flexible funds and to operate under highly transparent performance and accountability arrangements, which are currently not in place. Investment is also required to ensure all PHNs develop the necessary capabilities, including commissioning maturity and skills, to be effective stewards of integrated care at the regional level.

While we have considered the merits of the Rebuild model, our preference is for the Renovate option for the following reasons:

- While the Rebuild model may achieve integration within mental health, CHF is concerned about the fragmentation between mental and physical health services and the impact this will have for consumers with multimorbidity. Physical and mental health are intrinsically linked, and we believe a model that facilitates integration across the two through primary health care is necessary to achieve improved health outcomes for consumers.
- PHNs are still a relatively new reform and any declarative assessment of their effectiveness is likely premature. As noted earlier, each of the 31 PHNs have achieved varying levels of maturity and there remain opportunities to share learnings and devolve funding to enable all PHNs to implement localised stepped models of mental health care.
- The health sector has been through multiple cycles of reform and reconfiguration of regional commissioning arrangements over the past decade. The Commission's report outlines the urgent need for mental health investment, and we are concerned that the time required to establish a significant new governance arrangement – RCAs – would mean that the focus and momentum generated through this inquiry may be lost.

We believe that improvements to integration can be achieved by formalising relationships and arrangements between PHNs and LHNs under the proposed new National Mental Health and Suicide Prevention Agreement, at significantly less time and expense than would be required under the Rebuild proposal.

Monitoring and reporting

As a general principle, CHF advocates for maximum transparency in measuring and tracking the performance of the health system overall. While there is a significant focus in the health sector on collecting and reporting data, too much of that is focussed on measuring service delivery and activity rather than consumer outcomes and experience. The focus of any data collection must be to drive reform, improve safety and quality or improve the patient experience in other ways.

CHF strongly agrees with the Commission that a robust evidence base is necessary to ensure that the mental health system is improving outcomes for consumers and carers and using taxpayers' money effectively and efficiently. At the same time, social licence is crucial for any

data collection and so measures must be taken to preserve and improve the trust that consumers place in government to manage their data safely and use it well to enhance the public good.

CHF is broadly supportive of the range of recommendations the Commission has made to improve monitoring and reporting practices in mental health, and we particularly highlight our support for the following recommendations:

- **Draft Recommendation 22.4** – accountability for mental health outcomes should include measurement against predetermined performance targets. We agree with the Commission’s analysis about the benefits and potential pitfalls of setting targets for mental health and suicide prevention. If targets are well designed and implemented, they can lead to a strong focus and effort to improve outcomes and the risk of not meeting them is not reason enough not to try.
- **Draft Recommendation 22.5** – a robust culture of program evaluation should inform the allocation of public funds across the mental health system. CHF supports an expanded role for the NMHC as a statutory authority with power to lead evaluations of any government funded mental health programs. CHF strongly supports the inclusion of consultation with consumers and carers about the NMHC’s future schedule of program evaluations.
- **Draft Recommendation 25.2** – the Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years. CHF commends the Australian Government for re-establishing the ABS *National Survey of Mental Health and Wellbeing* and agrees that this survey should be conducted routinely to provide meaningful data on changes to prevalence rates, service usage and outcomes. The survey must include representation of sub-groups that experience high rates of mental ill-health including young people, Aboriginal and Torres Strait Islander people and LGBTIQ+ Australians.
- **Draft Recommendation 25.3** – high-quality and fit-for-purpose data should be collected to drive improved outcomes for consumers and carers. An update to the National Mental Health Information Priorities is a good first step with longer term planning needed to fill existing data gaps. CHF strongly supports a shift towards services only being funded if their effectiveness can be evaluated and having relevant outcomes data is necessary to inform that process. Service level data should also be available publicly so consumers can make informed decisions about which provider they use.
- **Draft Recommendation 25.4** – monitoring and reporting should be more focused on outcomes for consumers and carers and broadened beyond health portfolios. Meaningful outcomes indicators should be developed in consultation with consumers and carers and should include measurement of relevant social determinants on mental health outcomes.

CHF supports the use of the Contributing Life Framework to identify outcome areas for monitoring and reporting. Additionally, in response to **Information request 25.2**, consumer surveys and feedback consistently highlight the need for data and agreed measures in relation to the following areas:

- Affordability of mental health care
- Consumer and carer experiences of services
- Stigma and discrimination experienced by people with mental health issues
- Mental health service usage

Furthermore, with regard to patient reported outcome and experience measures, the work of the NSW Agency of Clinical Innovation in reports like, 'Patient Experience and Consumer Engagement: A Framework for Action' and Safer Care Victoria's approaches are instructive starting points in this area.

Funding

CHF has long argued that financing reform – particularly in the primary health care sector – is overdue. We support the modernisation of Medicare through the introduction of patient and family centred health care homes that would feature voluntary enrolment, blended and bundled payments for general practices to configure teams of health care professionals to provide coordinated, convenient, multidisciplinary care, including the scope to more actively use non face to face modes for care delivery.

The introduction of these types of models is already occurring and primary mental health care is a prime candidate for this kind of care. While we believe widespread roll out of this sort of model would be beneficial for consumers in the longer-term, we also recognise the need for intermediate changes to funding mechanisms to improve the system in the interim.

As an important first step, CHF strongly supports **Draft Recommendation 12.1**, to extend the funding cycle for psychosocial supports to five-year terms at a minimum. We agree that continuity for the sector helps promote stability, enables the retention of a skilled workforce and leads to greater continuity of care for consumers. This change should be implemented as soon as possible.

Additionally, CHF supports a shift towards locally planned and commissioned mental health services through Primary Health Networks. While there are some services best delivered at a national level (e.g. online resources, helplines etc.), effective place-based commissioning is central to delivering services that meet the varying needs of local communities. CHF's view is that the current directive from the Department of Health for PHNs to fund specific services undermines the role of PHNs as system integrators and stewards. Therefore, we support **Draft Recommendation 24.2** for there to be no requirements that commissioning agencies have to fund particular service providers, and instead allow them access to a flexible funding pool to be used to best meet the needs of their region.

As noted in our previous submission, while we support more flexibility for PHNs to manage their funding pools, there are also clear areas where improvement is needed in relation to PHN commissioning practices. We suggest the following areas for consideration:

- Improved coordination mechanisms and tools between PHNs, such as:
 - digital marketplaces for procurement
 - shared resourcing and contracting arrangements, including pooled funding for regions

- Improved methods of analysing and disseminating ‘what works’
- Better coordinated reporting on performance, and implementing performance indicators that support better coordination between PHNs
- Consideration of tying funding to performance
- Ensuring integration of actions with the Federal Department of Social Services and state level equivalents.

It is also important that there are mechanisms within the system to support innovative service models and funding arrangements. CHF agrees with the Commission that trialling and evaluating new approaches can be seen as risky and costly, which is a disincentive for PHNs to lead in this space. Therefore, CHF supports the call for a Mental Health Innovation Fund to be established (**Draft Recommendation 24.4**) to support commissioning agencies to trial new models and have them independently evaluated. Social prescribing is one example of the kind of care that doesn't fit neatly into an MBS fee-for-service model and could therefore be trialled using this type of funding.

Pooled funding arrangements

CHF supports arrangements that encourage hybrid or pooled funding arrangements where it will improve access to care and/or system navigation for consumers. In particular, models where after-hours primary care services can be incentivised to provide an alternative to emergency departments can be of significant value, both to consumers and to the system. Breaking down the silos between MBS-funded allied mental health services and similar regionally commissioned services would support better system planning and reduce duplication at the regional level.

While CHF is not best placed to comment on the specific mechanism for distributing the funding, we support **Draft Recommendation 24.1** which calls for a single funding pool for MBS-rebated and regionally commissioned allied mental healthcare. In particular, the change to allow State and Territory governments to co-fund MBS out-of-hours primary care services is an important mechanism for shifting funding and service delivery away from the acute setting.

We're pleased to see the Commission recommend a 2-5 year transition period for the move to link MBS-funded allied mental health services to PHN budgets, and we'd encourage PHNs and the Department to work closely with the mental health sector and consumers and carers to determine how this new arrangement can lead to a seamless, integrated care experience. We note that services outside of the health sector that address the social determinants of mental health will remain outside of PHN funding pools and that efforts to integrate arrangements across these services, as well as across the public and private systems, will be required.

Private Health Insurance

CHF agrees with the Commission that consideration of substantial changes to the scope of private health insurance is beyond the scope of this inquiry. CHF reiterates our call for a separate comprehensive, independent review of all issues related to private health insurance to look at what should be covered, how it should be structured and the best way to fund it.

While CHF is open to considering how private health insurance arrangements can support moving hospital-based services into the community in line with consumer preferences, we are concerned about the potential for the development of inequitable access and a two-tiered system in primary care if private health insurance were to be extended to items like GP care.

We do not want to see a repeat in primary care of what now occurs too frequently in public hospitals where privately insured patients get precedence over public patients. Australians in most cases can still expect to receive GP care regardless of their means, and it is worth noting that a disproportionate number of people with mental illness live on low incomes, cannot afford co-payments and do not hold private health insurance.⁹

However, we recognise the need to consider how private health insurance products can be made more innovative in order to be more appealing and of better value to consumers. Consideration should be given to how the list of designated 'hospital substitutes' can be broadened to include relevant mental health services, as well as what mental health services can be included under a chronic disease management program. Therefore, CHF supports a review of current private health insurance regulations as proposed in **Draft Recommendation 24.5**. However, we believe such a review should not include extending private health insurance to cover GP mental health services as this would undermine universal access to primary health care.

Other issues

Out of pocket costs

Out of pocket costs are a significant and growing concern in the Australian health care system that diminish positive health outcomes and put at risk the fundamental principles of a universal health system. A universal health care system isn't universal if you can't afford to access it.

In April 2018 CHF released two reports – *Out of Pocket Pain: Research Report*¹⁰ and *Hear Our Pain: Consumers in their own words*.¹¹ The sample was not specific to mental health but the following key findings from the research report are relevant to mental health consumers who experience out of pocket costs through specialist appointments, allied health and primary care, as well as gaps in private health insurance coverage. We provide these findings in response to **Information request 3.2**:

- Private patients routinely face bills running into thousands of dollars, in a system characterised by high cost, complexity and confusion

⁹ Australian Council of Social Services (2006) *Submission to the Senate Select Committee on Mental Health*:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c12, accessed 14 January 2020.

¹⁰ Consumers Health Forum of Australia (2018) *Out of Pocket Pain: Research Report*:

https://chf.org.au/sites/default/files/20180404_oop_report.pdf, accessed 14 January 2020.

¹¹ Consumers Health Forum of Australia (2018) *Hear Our Pain: Consumers in their own words*:

https://chf.org.au/sites/default/files/20180404_hear_our_pain.pdf, accessed 14 January 2020.

- One in six survey respondents reported that costs had a significant impact on their lives, with some having to draw down on their superannuation
- Well over one third of respondents said that no-one had discussed the possibility that they may face significant out of pocket costs with them and that they had the right to 'shop around'
- Out of hospital care for those with chronic illness requiring frequent specialist consultations posed difficulty for many because of the difference between fees and the Medicare benefit available. As a result of their condition, these patients are often unable to work and/or earn a reasonable income.
- Of Australians aged over 45 who needed to see a specialist, nearly half (45%) did not because of cost
- For patients from rural and regional Australia, costs of travel, accommodation and hospital parking present daunting cost issues on top of the out of pocket medical costs.
- 32% of respondents with a chronic illness had incurred between \$5,000-\$10,000 in out of pocket costs in the past two years
- Out of pocket costs for GP consultations were an area of concern for 12% of respondents. Those particularly affected were consumers in rural areas who are unable to access bulk billing services and those with chronic or ongoing illnesses

The following are personal stories that consumers shared through the survey and give examples of how out of pocket costs impact on their lives:

"Living in rural and remote community in Queensland, the cost to travel as well as out of gap payment for a specialist is extraordinary. To travel to the closest specialist appointment from my home town of Charlesville to Brisbane is 10 hours trip. Accommodation is another burden as well as feed ourselves along the way. PTSS [The Patient Travel Subsidy Scheme] only pays for \$66 per night accommodation and will only reimburse travel (fuel) on our return which does not help if you don't have money up front to travel a couple of days before the specialist appointment." Maleeta, remote area, Queensland

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"I have Bipolar disorder and see my psychiatrist once per week at a cost of \$450. I can claim back \$154 from Medicare each visit until we reach the safety net (I have spent \$2080 out of pocket). Once our family has reached the Safety Net we can claim \$396.00 back from Medicare each visit. I also see a Neurologist every 3 months as I have an autoimmune disease, which costs around \$80 out of pocket. Plus of course GP visits for both my husband and myself. This puts enormous strain on our family especially in the first few months of the year." Tina, major city, Queensland

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"As a patient with a chronic and complex condition (including several autoimmune diseases and mental health issues) I have found that despite access to care plans, my out of pocket expenses have been unmanageable. I've often had to go without allied health and psychological treatment because I could not afford it working part time (and have been working part time due to my health concerns). I have lost time at work due to chronic pain and fatigue and this the income I

need to get treatment. It's unsustainable for people who have to have regular and consistent care to manage their pain and wellbeing." Abbie, major city, Victoria

★★

"I have three children with ADHD requiring regular medication, psychologist appointments. My eldest son also has Juvenile arthritis and at times requires him to go to Sydney children's hospital for out patient clinic appointments this is a very expensive appointment. The appointment is free it's the three days of work to get him there. Three meals for two of us, parking, petrol and night accommodation and two days off work. If my son sees an ophthalmologist locally it costs \$250 dollars. He needs to get his eye checked every six months sometimes we just cannot afford this so we do not get it done." Sally, major city, Western Australia

★★

In addition to the direct costs of mental health care these stories highlight how mental health out of pocket costs cannot be separated from other health expenses for many consumers. With many consumers having multiple conditions and seeing multiple health professionals, the cumulative effect of small costs over time (e.g. gap fees for medications, GP co-payments) can be prohibitive and becomes a barrier to accessing care for some consumers.

CHF supports the following reforms to address this issue:

- An independent investigation into all aspects of private health, including out of pocket costs
- Better integrated arrangements between tiers of government to improve access to travel reimbursement schemes
- Develop a process for a single quote for any episode of treatment that includes all health professional costs
- Informed financial consent procedures to be strengthened and insurers to work with consumers and providers to ensure this happens
- Move to a system of unnamed referrals so consumers can better exercise their right to choose a provider
- Further investigation to be conducted into the impact of 'no gap' or 'known gap' arrangements on the quality, choice and availability of healthcare
- Health professionals should make their fees publicly available on an independent website which will allow consumers to be better informed and compare their costs prior to accessing any treatment.