CATHOLIC HEALTH
Australia

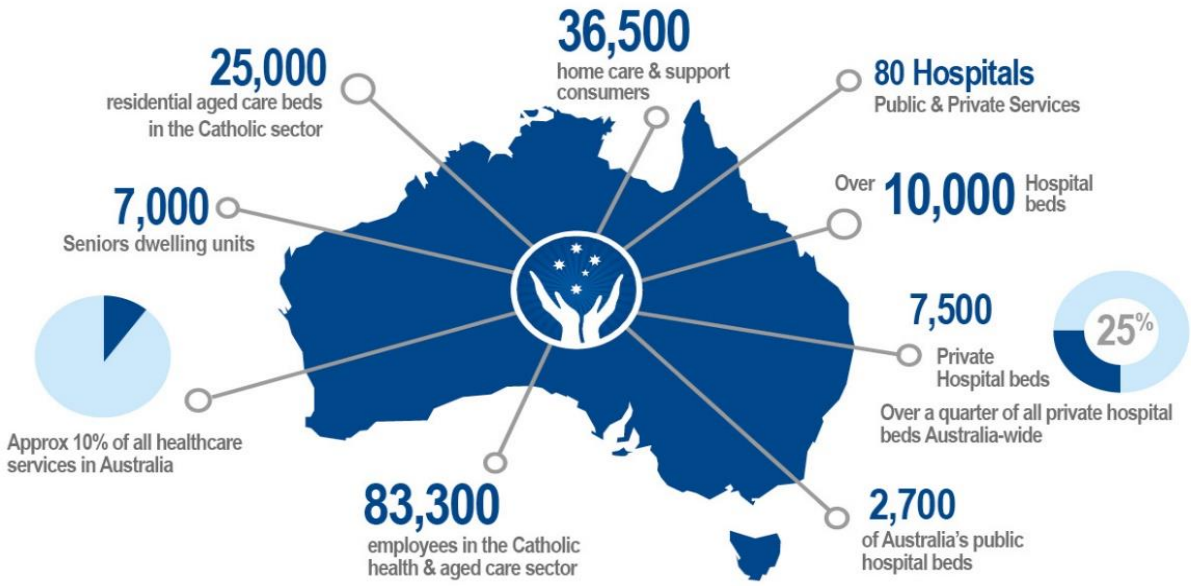
18 April, 2019

Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Dear Productivity Commission,

Response to the Productivity Commission's Inquiry into Mental Health in Australia

CHA appreciates the opportunity to provide input into the Productivity Commission's Inquiry into Mental Health in Australia. CHA is Australia's largest non-government grouping of health, community, and aged care services accounting for approximately 10% of hospital-based healthcare in Australia. Our members also provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly. CHA mental health services are offered in acute and sub-acute public and private hospital facilities, including specialised child, youth and adolescent services such as those provided by the Mater Young Adult Health Centre Brisbane and USpace St Vincent's Health Sydney, outpatient services, aged care and some community care.



Every Australian, regardless of their state of wellbeing, should have access to appropriate and timely mental health care that supports their economic and social participation. Economic and social participation amongst those vulnerable to mental ill-health is vital to maintaining a person's wellbeing. For some, this requires little to no support and for others, this may require significant, complex and intensive supports from multiple sectors including health and social services.

However, in Australia, the most vulnerable populations remain those most poorly served by our mental health system, including Aboriginal and Torres Strait Islander people and asylum seekers. We are experiencing unprecedented increasing demand for mental health services, particularly crisis services, in a system whose design prohibits the delivery of the best care.

Equity in access and integration of care is fragmented by the structure of the system and by funding models. There are fragmentation points between age groups, between geographic areas, between levels of need and between sources of funding. There are clear areas for improvement.

Please find attached our submission, which focuses on areas of mental health care relevant to the CHA membership, including public and private hospitals. We aim to highlight areas of need but also innovative models of care, which if adopted more widely could greatly enhance the mental wellbeing of Australians. If CHA can be of any further assistance during this inquiry process, please do not hesitate to contact us.

Yours sincerely,

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Summary of CHA Recommendations

1. Continue to shift the focus of the system from crisis and acute care to community-based services, primary health care, prevention and early intervention, including:

    - Increased access to community-based supports following discharge from hospital, particularly for those at high risk of suicide.

2. Continue to move towards a single source of funding for all Mental Health services, thereby removing existing barriers (multiple systems with little integration) to efficient service delivery, including:

    - Private hospital patients accessing funded allied health services and community-based support;
    - Improvements to the National Disability Insurance Scheme (NDIS) planning and approval process to increase timeliness, particularly for those leaving hospital. Pricing and the adequacy of supports also requires immediate action.
    - Improving the transition from child/adolescent mental health to adult mental health services.

3. Improve the capability and capacity of Primary Health Network (PHN) commissioning processes for the delivery of local mental health services, including:

    - Joint commissioning of services between PHNs, Local Health Districts/Areas (LHDs/LHAs) and Private Hospitals, where appropriate.

4. Improve funding and access to mental health services to meet the needs of asylum seekers.

5. Adopt innovative evidence-based models of integrated care such as Open Dialogue and emergency department diversions.

Removing Barriers in a Sector with Multiple Systems and Little Integration

All mental health care in Australia aims to be holistic and patient-centred at all levels, but the reality of the situation is far from this. The mental health system in Australia is under such extreme demand in an environment that is structurally fragmented and which has been chronically under-resourced for decades. The result is costly, inefficient care and a bizarre interface between systems that keeps people in acute care for longer than is needed.

There are at least four vastly different mental health systems operating in parallel, rarely in concert. These are the public and private hospital system, community and primary mental health systems and the NDIS. At each level of care patients and carers experience deep frustration at the lack of interface between services; for example, between the public and private tertiary hospital system, between the tertiary system and community care and between the NDIS and all other forms of support.

Fragmentation of the mental health system is fundamentally driven by siloed funding models and is particularly marked between the public and private sectors. Further fragmentation is introduced by the establishment of PHNs as commissioning bodies, with variable readiness and lack of joint commissioning approaches particularly with local health districts (LHDs) or private hospitals and continued inadequate funding across the sector. This is compounded as there has been a limited federal response as action has primarily occurred on a state-by-state basis. A single source of funding for all mental health services will remove many of these barriers to efficient service delivery and can provide long term stability to the sector.

Private health insurance (PHI) should pay for the most efficient model of care, which is the right care in the right place. In some circumstances, those in the private system are unable to access publicly funded supports and are limited by what private health insurers are willing to fund outside of hospital. Removing barriers for private sector patients, including funding for physical health comorbidities and specialised treatments, would enable inclusive and comprehensive care.

There are numerous examples of where PHI efficiencies can be improved in mental health. These result from divisions in what will be funded by PHI and a lack of community services that cover the gap outside of what PHI covers. For example, transcranial magnetic stimulation (TMS) is a treatment available for those admitted to a private hospital for the treatment of depression, however, this is not available anywhere else in the community. Therefore, any individual wanting to access TMS must be admitted to a private hospital to access the treatment at a disproportionate cost to the system. Similarly, individuals with eating disorders are rarely able to access acute public mental health care and therefore default to the private system, although care in the community is possible, although not readily available. Of note, CHA does not support PHI funders directly providing community care for those requiring mental health treatment as it is inappropriate for insurers to decide what is the clinically most appropriate care. CHA supports the delivery of health services that are provided in the most appropriate setting for the patients according to best clinical evidence and patient preference, not restricted by PHI funders.

Fragmentation continues to put pressure on crisis and acute care rather than promoting a shift towards community-based services and the impacts of fragmentation are significant. For example, there is evidence to suggest that 45 per cent of people aged 16-25 years old, those with the highest rate of suicide and the highest prevalence of mental illness, accessing care as adolescents drift out of

care at 18 years of age. This is largely due to the existence of very different models of care between child/adolescent mental health and adult care. For this group there are limited private offerings that are developmentally informed, they often don't meet the threshold to access acute public services, they may or may not be covered under their parent's private health insurance and primary care responses struggle to offer psychiatry or an experienced workforce. The outcome of not responding well to this group is significant in all aspects of economic and social participation, as well as health outcomes.

CASE STUDY: YOUTH TRANSITION TO ADULT MENTAL HEALTH
JAMES' STORY

The Mater Young Adult Health Centre based in Brisbane is a specialised service providing adolescents and young adults with high quality care, as well as uniquely tailored programs that address their emotional, social and developmental needs. The centre delivers support across a wide range of specialities in inpatient, outpatient, and community settings, and can respond to the complex healthcare needs of young people aged 16-25.

James is an 18 year old with Asperger's syndrome, significant social anxiety and episodes of severe depression. He is well supported by public Child and Adolescent Mental Health Services with regular outpatient and inpatient care and a focus on both his developmental and mental health needs.

At age 18 he is referred to adult public mental health services where he is deemed not acute enough for service. He gets a referral for psychology through his GP, however the psychologist feels he will require more than the allocated number of sessions and cannot see him at home.

James is effectively lost to care, withdraws from education and social activities and becomes increasingly dependent on his parents.

In general, there is a lack of step-up and step-down services. For those leaving a public hospital, state-run community mental health (CMH) services operate follow-up support, however, the adequacy of these supports is questionable, particularly for those who are well enough to leave hospital, but not well enough to be managed by community mental health teams. Similarly, there is little available in the way of escalating support beyond the treatment available in the community or primary health which does not require hospitalisation.

The Fifth National Mental Health Plan Key Performance Indicators detail that discharge from psychiatric facilities is to be followed by a recorded community contact within 7 days. Although variable between states and territories, CMH follow-up is a CMH service contact, in which the consumer participated, that was recorded in the 7 days following that separation. This KPI presents a

number of issues; firstly that the level of contact is inadequate. In 2015-16, follow-up rates within the first 7 days of discharge from an acute psychiatric inpatient admission nationally were just 68.2%[1]. Secondly, this KPI fails to acknowledge that the period of risk of suicide and readmission extends beyond the first 7 days, to the first 30 days, and requires higher levels of support than a single contact. This has been demonstrated by several successful programs aimed at improving patient care following discharge, whereby more intensive support is able to improve clinical outcomes as well as reduce readmissions and suicides[2,3].

Another area of concern which is causing great instability is the NDIS. Although the Commission has placed the NDIS largely out of scope of this Inquiry, and the NDIS has great potential, the NDIS represents one of the most disruptive reforms the mental health sector has experienced to date. There has been little acknowledgement of the impact of this process on those who are living with a severe mental illness.

The demand for NDIS services that is not being met, due to slower than predicted transition to the scheme and eligibility and engagement issues, is being redirected towards the acute care sector. The poor agility of the scheme creates an impasse in the sector, where people cannot be discharged as NDIS supports are not available and those community programs that were once available have been defunded.

Furthermore, the deskilling of the community mental health workforce, driven by pricing changes under the NDIS, poses real concerns for the quality and safety of both workers and those they support. The disruption to people's normal support, advocacy and community networks is likely to have a significant impact. The "simple" act of a change in a long-term, trusted support worker as a result of redundancies in the sector, can have profound effects on an individual's mental health.

CHA supports more effective partnerships between the public and private sectors including improved mechanisms for collaboration. Implementation of greater coordination and collaboration would require the involvement of health funding bodies and the health insurance industry. A revised system could incorporate mechanisms to fund private hospital mental health service providers to become more involved in crisis response and initial care and to facilitate greater consultation with primary care practitioners.

[1] The Australian Institute of Health and Welfare (AIHW) 2018. Mental Health Services in Australia- 2018. Accessed 20/3/2019 at https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-indicators/key-performance-indicators-for-australian-public-mental-health-services

[2] Ernst & Young (2016). The Way Back Support Service Northern Territory - Final Evaluation Report for beyondblue. Accessed 20/03/2019 at https://www.beyondblue.org.au/docs/default-source/default-document-library/the-way-back-nt-final-evaluation-report-2016.pdf

[3] Scanlan JN, Hancock N, Honey A. (2017). Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalisation. BMC Psychiatry, 17:307

CASE STUDY - ST VINCENT'S HOSPITAL SYDNEY (SVHS)

PATIENTS DON'T ALWAYS FIT WITHIN OUR SILOS OF CARE AND FUNDING – STORIES FROM THE COALFACE

An issue that has been frequently written about is "stepped care" where hospital care is at the end of many algorithms for community based care, but with the idea that hospitals provide emergency urgent acute and high risk care. The reality is that hospitals for mental health provide a lot of long term disability support as well as emergency care and exist as one of the only services that are open and responsive all the time to community needs within a very inefficient patchwork of many different services that are slow to respond, unavailable after hours, have multiple exclusion criteria, and are different across geographical areas, so that negotiating those services is too hard for most people and they are sent to the emergency department.

The illustration of this point can be found in the following example provided by a senior clinician from SVHS.

"A few weeks ago, during the Mardi Gras weekend- one of the weekends when SVHS would need to have beds available and an ED ready to respond to potentially high numbers of presentations, our six bed HDU- the area of the mental health unit with the highest nursing ratio for the most acute patients- was full of people with very chronic illnesses, some with very long lengths of stay, with multiple disabilities, who could ideally have ben cared for in a properly supported and resourced community setting if one existed or the system was more efficient. This is not an uncommon occurrence – re having an ICU filled with people with very chronic illnesses who could be cared for in a nursing home, so that when the next person arrives with a life threatening acute condition, they may not be able to be admitted immediately.

Two people in the HDU that day were: a 42 year old man with a history of treatment resistant schizophrenia since the age of 17, who has had multiple lengthy hospital admissions, had a poor response to medication, is homeless, has issues of violence and drug use and who has been an inpatient in this unit and other local units for about two years continuously at this point. He has NDIS funding approved for 24 hour care but no appropriate organisation as yet ready to care for him in the community due to risks. There is an organisation that may work with him in future and we have been meeting with them and the local coordinators since November last year to negotiate his ongoing care.

Another was a 50 year old man with chronic schizophrenia, a brain injury, drug use problems and a forensic history who is homeless. He had an eight year admission to another hospital before absconding last year and living on the streets in the inner city. He has a public guardian and NDIS funding but has been rejected for care from most facilities due to his history and high risk behaviour.

Both these people required care and ostensibly had funding to provide care, but the process of arranging and organising care in appropriate community based services is extremely time consuming and often pushed aside by the need for hospital staff to attend to the next emergency case arriving at the ward or to deal with bed flow pressures 24 hours a day through the ED.

Most community organisations have exclusion criteria that exclude these kind of people (high risk behaviours such as drug use and violence). Hospital care provides safety, but there is very little stimulation in an area that is designed for a length of stay measured in days. People like this end up living in an acute ward."

Other Areas of Acute Need: Asylum Seekers

The mental health of asylum seekers is highly politicised and generally inadequately assessed and managed. CHA has serious concerns about the effects of long-term restrictive and community detention on and off-shore. Prolonged processing times of applications results in many people living in uncertainty for years with the constant threat of deportation to the country they have fled. Concurrent poor access to health care, legal services and income support have a significant impact on the mental and physical health of asylum seekers.

Asylum seekers and refugees are amongst those most vulnerable to poor mental health due to the experience of torture, trauma and stigma. The prevalence of mental illness amongst this population is estimated to be at least twice as high as those migrants who have entered Australia on economic grounds, with at least half of this group experiencing post-traumatic stress disorder (PTSD)[4]. For many, lack of safety and fear create substantial barriers to engaging in effective health care to address the trauma. The nature of Australia's current immigration legislative framework causes further moral injury. Lack of access to specialised services, difficulties in engaging in therapy due to the sustained periods of uncertainty and long term separation from family members exacerbates their vulnerability.

The complexity of mental illness amongst this population requires specialist trauma-informed interventions and resources that are either not available or have significant barriers to access. For those in community detention, access to medical services provided by Medicare, or disability services through the NDIS, are restricted and state funded services may be all the support that is available in some areas. This has a significant impact on the ability of asylum seekers to participate economically and socially in Australian life.

[4] Young P & Gordon MS. (2016). Mental health screening in immigration detention: a fresh look at Australian government data. Australasian Psychiatry, 24(1):19–2.

CHA recommends the following changes to improve the way mental health needs for asylum seekers are addressed:

- Implement a screening program across all points of initial contact between asylum seekers and social, health, welfare or legal services to identify previously unrecognised cases of mental disorders in asylum seekers and those at imminent risk of developing such problems.
- Support the development of specialised mental health services for asylum seekers that can provide a holistic, trauma informed model of care that incorporates psychosocial and psychiatric treatment.
- Provide language interpreting services and bicultural worker support to assist asylum seekers to navigate service systems.

Please see the attached Cabrini Outreach submission for more information regarding CHA's position on asylum seeker mental health.

Innovations in Mental Health Care

Open Dialogue

Open Dialogue is a model of care, which originates from Finland, which uses a person-oriented approach which aims at mobilising an individual's psychosocial resources during a crisis by engaging the person, the family, and the individual's social network in a series of meetings.

The program is based on the following seven main principles of treatment:

1. Immediate help.
2. A social network perspective.
3. Flexibility and mobility.
4. Responsibility.
5. Psychological continuity.
6. Tolerance of uncertainty.
7. Dialogism - which aims to increase the capacity of the individual and his/her family and extended network to take action in their own lives.

The program has been adopted by St. Vincent's Hospital Sydney and has been well received. Evaluations of the effects of Open Dialogue are compelling: improved clinical and functional outcomes, fewer days of hospitalisation (an average of 36 days) than the comparison group receiving treatment as usual (an average of 117 days) and improved employment status (83% compared to 30% in the comparison group)[5,6].

Emergency Department (ED) Diversions- The Safe Haven Cafe

[5] Seikkula, J., Aaltonen, J., Alakare, B., & Haarakangas, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue model. Psychotherapy Research, 16(2), 214-228.
[6] Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The comprehensive open-dialogue approach(II). Long-term stability of acute psychosis outcomes in advanced community care: The Western Lapland Project. Psychosis, 3, 1–13.

The number of mental health related ED presentations is increasing rapidly across Australia, at approximately 2.7% per year[7]. In 2016–17, there were 276,954 mental health-related presentations to hospital emergency departments. Concerningly, the greatest increases in ED presentations are seen amongst adolescents and young people.

While most in the sector would agree that mental health is best cared for outside of the ED system, ED provides an important function of crisis care. For example, to fill the gap created by a lack of out of hours community services, because someone is experiencing a mental health crisis that can only be dealt with by emergency services, or simply because a carer recognises a window of opportunity to intervene in someone's illness that cannot be missed.

ED providers work hard to provide a safe and welcoming environment for those in a mental health crisis, however, the nature of an ED means that they are often busy, crowded and can be noisy and distressing for someone who is in a mental health crisis. Many organisations have created safe, quiet spaces in EDs for people in need, are working to improve rapid triage, or use direct admission to mental health units. However, people with a mental health crisis wait longer than those with a physical health problem, with many experiencing further deterioration whilst waiting or leave ED without receiving treatment [8].

Another approach is ED diversion, such as mental health cafes which are being trialled with impressive success. The mental health café model originates from Hampshire, U.K. and has been shown to reduce social isolation for vulnerable people and to help them to maintain their mental health on an ongoing basis as well as reduce ED costs. It also serves a de-escalating function, avoiding the need for people to present to mainstream services, thereby releasing capacity[9]. St. Vincent's Hospital Melbourne has implemented such a model.

[7] The Australian Institute of Health and Welfare (AIHW) (2018). Mental Health Services in Australia- 2018. Accessed 20/3/2019 at https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-indicators/key-performance-indicators-for-australian-public-mental-health-services

[8] Australasian College for Emergency Medicine (2018). The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments. Accessed 05/04/2019 at https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

[9] The North East Hampshire and Farnham Clinical Commissioning Group (2014). Safe Haven Evaluation Report. Accessed 20/03/2019 at https://acem.org.au/getmedia/d955dbb0-86c6-4ca2-b25c-ac367b949bb8/Hampshire-Crisis-Cafe-Evaluation-ReportUK

CASE STUDY: ALTERNATIVE TO ED FOR PEOPLE SEEKING MENTAL HEALTH HELP AFTER HOURS

St Vincent's Hospital Melbourne (SVHM) Safe Haven Café

Every day dozens of people present to St Vincent's Emergency Department (ED) experiencing mental health issues. These people may also be homeless, isolated, and lacking established support networks. Navigating the mental health system in times of crisis is a real challenge for consumers and their loved-ones. People often don't know where to go, and can end up in the wrong places. As well, outside of Emergency Departments, there is currently no safe therapeutic space for mental health consumers.

The Safe Haven Café provides an alternative access point for support for people experiencing loneliness, isolation and/or personal difficulties. Designed by consumers, for consumers, the Safe Haven Café offers a compassionate alternative to attending the ED.

The Safe Haven Café, established in 2018, is an investment in an alternative means of supporting people with mental health issues, and empowering them to have more control over their wellbeing.

Located in the St Vincent's Art Gallery, it offers respite in a warm, caring and respectful environment with an emphasis on peer support to empower people looking for assistance, but not needing acute care.

The Safe Haven Café has peer support workers and volunteers with a lived experience of mental health issues, who work alongside mental health professionals to provide a safe, therapeutic space for people needing it. The Café doesn't replace clinical mental health interventions, but enables people to explore what options may be available to support them, and identify relevant local services.

The Café ensures that consumers do not end up in the ED unnecessarily and encourages them to develop self-management skills to help maintain their mental health on an ongoing basis. Some 40% of attendees use the Café to feel safe and supported and to access support in an open and welcoming space.

The objective of the initiative is to create a sustainable model of care for mental health consumers who would otherwise present to the emergency department seeking safety and respite.

The Safe Haven Café is open Friday 6-8pm, and 2-8pm Saturday and Sunday.