National Health and Hospital Networks, COAG and Mental Health Reform

Position Statements

Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

This paper summarises the positions taken by the MHCA and its members in relation to the proposed NHHN Reforms as they pertain to the Australian mental health sector. These issues or principles are proposed to underpin a whole of sector advocacy position.

The Reform Package

Position: The NHHN Agreement and the reform process has failed to take account of the urgency for direct action outlined in the NHHRC Final Report in relation to mental health, dental health, indigenous health and rural and remote health.

- The NHHN Agreement and the commitment made by the Federal Government in 2010 to mental health are woefully inadequate and continue to marginalise Australians experiencing mental illness.
- The decision to defer consideration by COAG on arrangements for mental health services to mid 2011, after the commencement of all LHNs and a large number of Medicare Locals, reinforces the marginalisation of mental health services and clients. The decision fails to recognise that good health is dependent on good mental health.
- The NHHN Agreement fails to take account of the massive shortfall in funding for mental health services – now at just 6.5% of all health care spending and falling for the first time since the 1990s.

Position: The reform process must be underpinned by independent and transparent accountability.

- The reforms are complex and involve major changes to structures over the next 4-5 years. It is imperative that an independent and appropriately resourced organisation can report to the community on progress.
- There are significant risks to 'patient' safety and well being in the transition period.

Position: The boundaries for Medicare Locals, Local Hospital Networks and Local Government Areas should align to the maximum extent possible.

- Boundaries for Medicare Locals and Local Hospital Networks should align. They should also align with Local Government Areas and other state or regional boundaries to the maximum extent possible to assist in planning and reporting.
- From a preliminary analysis of the boundaries released late on 23 December 2010, there appear to be anomalies; most notable are the boundaries in the Brisbane South/Ipswich area.
- Any realignment should seek to avoid significant realignment of boundaries that will have significance for bed flow arrangements and may result in inter-Local Hospital Networks negotiations about services.

Position: ***There must be significant new investment in community mental health services. By 2013-14, 15% of all mental health funding must be directed to the community-managed mental health sector, 30% by 2020.***

- The evidence to support increased investment in community mental health services, (both clinical, and recovery and support services) is compelling while the evidence to support greater investment in acute inpatient care is weak.
- Unmet demand for services for people with moderate to severe mental illness continues to be massive. In New Zealand, funding to the community managed mental health sector is now over 30%. These services provide community-based recovery and support. The most recent National Mental Health Report shows the Australian average is just 8.3% and most of the increase since 1992 has occurred in the last four years.
- By 2020 30% of all mental health expenditure in Australia should be directed to the community managed mental health sector as is the case in New Zealand. This will require a balanced process of purposive investment of both new and existing resources.
- While increased investment in community mental health services will likely lead to decreased pressure on acute and continuing care provided by the specialist mental health system, this investment in community managed mental health services must not happen at the expense of specialist mental health services.

Position: ***There must be significant new investment in prevention and early intervention mental health services. By 2015, 10% of all mental health funding must be directed to prevention and early intervention services.***

- The evidence to support investment in early intervention is strong. The evidence to support investment in prevention is growing.
- Australia needs to build a 21st century mental health care system based on early identification and early intervention for the 1 million younger Australians who need access to services and the 20,000 people who develop or show signs of developing psychosis each year.
- Investment in early intervention and prevention initiatives must address the needs of all Australians across their lifespan, from children through to the elderly.
- The economics to underpin this investment in future working generations is compelling.
- The Government must commit to the full implementation of a national youth primary care service (*headspace* or similar), a national network of EPPIC programs and other evidence based prevention and early intervention mental health services. This can be achieved by 2015.

Priorities outside the NHHN reforms

Position: ***Consumer and carer engagement, participation and representation must be integrated into the design, implementation and evaluation of all relevant programs and reforms that may impact on them.***

- Australia continues to have inadequate structures and supports to enable genuine and meaningful consumer and carer engagement, participation and representation. Resources must be committed to support both a national mental health consumer peak body and a national mental health carer peak body.

- Appropriate benchmarks must be set for both performance and monitoring of consumer and carer participation in mental health from the service level to the national policy development level.
- There must be appropriate funding and effective monitoring of initiatives outlined in the Fourth National Mental Health Plan, including:
    - the establishment of an effective peer workforce and expansion of opportunities for meaningful involvement of consumers and carers[1]
    - increased consumer and carer employment in clinical and community support settings[2]
    - accountability of service delivery including public reporting[3]
    - establishment of a culture of continuous quality improvement within service delivery systems that revolve around benchmarking and consumer and carer involvement.[4]
- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

Position: Cross-sector[5] service systems must be integrated, collaborative and flexible in order to address the unique needs of mental health consumers within a social determinants of health framework.

- Working collaboratively to improve the social, economic and environmental determinants of poor health at both the systemic and individual levels will lead to greater equity in mental health outcomes amongst Australians.
- Data collection standards need to be introduced at all levels of Government and service delivery in order to inform and support targeted and innovative service delivery models that will meet the needs of disadvantaged and marginalised mental health consumers and carers.
- More research and monitoring of the nature and scale of mental health inequity and its relationship with social determinants is urgently required at all levels of Government and service delivery.
- Service funding formulas that mix performance based and activity based incentives are likely to support responsiveness to service demand and the development of innovative service models that target hard-to-reach client groups.

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[1] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

[2] Ibid p51.

[3] Ibid p61.

[4] Ibid.

[5] Including, but not limited to, the mental health, aged care, disability, AOD, housing, employment and education sectors.

Position: Systemic issues relating to housing, including housing affordability, housing insecurity and homelessness must be addressed in conjunction with mental health reforms.

- Thirty percent of public housing stock must be set aside for people living with a mental illness.
- Properly resourced and monitored discharge planning must be implemented across Australia, with zero tolerance for discharge from hospitals to homelessness or unstable housing. This goal must be independently monitored and publicly reported.
- Home and community must become the preferred treatment sites with the number and scope of peer, carer, allied health and community options being significantly increased.
- A whole-of-government homelessness strategy that includes appropriate recognition of the relationship between mental health and homelessness should be developed in consultation with stakeholders, and then appropriately resourced.
- More research and monitoring of the nature and scale of homelessness and housing insecurity amongst people living with a mental illness is urgently required.

Position: Systemic issues relating to employment of mental health consumers and carers, including unemployment, underemployment, and inappropriate support services must be addressed in conjunction with mental health reforms.

- The employment rate for people with a mental illness needs to be increased from 29% to 53% — this is the rate for people with other forms of disability (physical and intellectual) and comparable to the rate of employment reported by the OECD in other developed economies for people with mental illness.
- Australian Government employment of people with a disability needs to increase from its current level of 3%[6] to at least the 1986 level of 6.6% of the of the total public service workforce.
- Support for innovative models of employment assistance for people with a mental illness including psychiatric-specialist employment service providers.
- There must be appropriate funding and effective monitoring of initiatives outlined in the Fourth National Mental Health Plan, including:
    - The establishment of an effective peer workforce and expansion of opportunities for meaningful involvement of consumers and carers[7]
    - A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

[6] In 2009, the number of employees in the APS was 4,566 or just 3% of total ongoing employees - the lowest recorded. Employment statistics of people with disability in the Australian Public Service can be found at http://www.apsc.gov.au/mac/disability6.htm#f61 and http://www.apsc.gov.au/stateoftheservice/0809/ataglance.html)

[7] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

Position: A life-course approach that recognises and addresses the social determinants of health must be employed across all early intervention mental health programs.

- The Australian mental health system is overwhelmingly skewed towards providing acute and continuing psychiatric care to adult Australians, and is ill-equipped to provide the targeted early intervention and support needed to improve the mental health outcomes of Australians outside the 26 – 64 age bracket, including children, youth and adolescence, and older people.
- Children's mental health outcomes, for example, are fundamentally influenced by their relationships with caregivers, other significant adults and their peers.[8] As a consequence of this, effective early intervention programs targeting children often employ a family and community focus, incorporating broad intersectoral partnerships between mental health, health, AOD, education, child care, child protection and judicial sectors. This model of service delivery is mostly unsupported within Australia's current mental health system.
- Early intervention programs must go beyond solely clinical interventions and address the full gamut of social and environmental factors that may negatively impact on the mental health of Australians.

Position: A national mental health promotion and anti-stigma campaign that addresses issues like stigma and discrimination, mental health illiteracy and help seeking behaviours must be undertaken as a matter of priority.

- State, territory and federal governments commit millions of dollars in highly visible campaigns promoting physical illnesses and injuries associated with smoking, alcohol consumption, obesity and road accidents, but have so far neglected to address mental health in such a comprehensive and systematic way.
- Anxiety and depression are the leading cause of burden of disease and injury in Australian women and the third cause for Australian men. Suicide and self-injury amongst Australian men ranks 8th in the leading cause of burden of disease and injury.[9]

Position: A national mental health workforce strategy must define roles for clinical and non-clinical service providers and enhance opportunities to expand services in areas of need

- A National Mental Health Workforce Strategy will address workforce issues experienced by both clinical and non-clinical service providers working with Australians experiencing mental illness. It will also outline mechanisms for attracting mental health personnel to rural, remote and other areas of geographic and other need.
- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

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[8] Further information in relation to the mental health needs of infants, children and adolescence can be accessed in the Australian Infant, Child, Adolescent and Family Mental Health Association's 2011 Position Paper entitled *Improving the mental health of infants, children and adolescents in Australia.* See http://www.aicafmha.net.au/resources/files/AICAFMHA_pos_paper_final.pdf

[9] Australian Institute of Health and Welfare (2007). *The burden of disease and injury in Australia 2003*, Cat No. PHE 82. AIHW, Canberra.

Local Hospital Networks

Position: The integrity of funding streams needs to be retained

- LHN governance models need to retain control and quarantining of funding.
- Mental health funding needs to be controlled by mental health. This would ensure mental health core and project funding is not blocked or diverted to non-mental health expenditure.
- Further dividing up components of care will make the system vulnerable to agencies "cherry picking" mental health clients putting undue stress/cost on other parts of the system.

Position: Services need to be integrated

- There is a need to retain and build integration of hospital and community services. Any realignment should not separate community mental health or alcohol and other drug inpatient structures – one integrated 'whole' service: specialist services covering the continuum of care for appropriate management of patients/clients.

Position: Disruption to client flow must be avoided

- There is concern about the maintenance of existing acute referral pathways and how control of governance and funding can be maintained to ensure an organised patient flow.
- Cross border arrangements for best care need to be considered, e.g. networking Albury/Wodonga, Dareton with Mildura etc., for acute care conditions.

Medicare Locals

Position: There is a need for clarity in relation to what is covered by 'primary health'

- Primary health care is more than general practice.
- Primary health in the COAG Agreement is focussed on high prevalence disorders; it does not address the higher order more serious physical and medical conditions and the lower prevalence serious mental illnesses. This is problematic and simplistic. People with severe mental illness have multiple physical health needs which, in many cases, can best be addressed through integrated primary care that is effectively supported by specialist mental health services.
- It would be helpful to identify the scale of under-provision of service and funding for moderate and severe mental illness.

Position: Services need to be integrated

- Separation of clients by illness is not helpful. Primary care, specialist community care and hospital care need to be seamless for all clients across the lifespan.
- Mental health services, both clinical and non-clinical, must also be integrated with other relevant services such as employment, housing, education, training etc.

Position: Community mental health services must have adequate representation in the governance structures, if they are not fully independent.

- Governance arrangements for the new Medicare Locals are critical. In line with contemporary governance practice, they should be fully independent and professional.
- Governance structures should ensure adequate representation of service providers, consumers, carers and community mental health organisations.

Sub-acute Care Initiative

Position: ***Providing funds for beds alone is inappropriate to support and promote recovery-oriented mental health service delivery. Packages of care that address both clinical and non-clinical needs of individuals moving into sub-acute care 'beds' must be available in both hospital and community settings.***

- Multiple evaluations in Australia, and some overseas, show the value of investing in this type of packaged care. Stable and secure housing, access to timely and appropriate care based on need, and access to employment support can dramatically improve the health, social and economic outcomes for people with severe and persistent mental illness.
- Such approaches are cost effective when compared with either acute or sub-acute hospital based services.

Position: ***No less than 25% of the $1.6 billion allocation under the sub-acute initiative must be allocated to mental health and the total number of 'beds' allocated to mental health must not be less than 25% of the total 1,316 beds made available.***

- It has been estimated that over the past two decades, the number of non-acute beds available for mental health consumers has declined by nearly 2,000. If the 1,316 beds allocated under this initiative were directed specifically to mental health alone,[10] this would only restore 80% of the 1993 capacity of non-acute beds.[11]
- The reduction in non-acute beds in mental health has increased pressure on acute services, significantly diminished service options, and negatively impacted on the quality of care and the ability of people with severe and persistent mental illness to recover.

Position: ***Models of care for the sub-acute 'beds' allocated to mental health should be based on evidence and agreed to with the mental health sector.***

- A significant allocation of beds under this initiative has already been announced by the Federal Government. This has occurred with little scrutiny or consultation with the mental health sector.
- A number of the announcements, indeed all of those in NSW and Queensland, appear to place the sub-acute beds within the campuses of hospitals. The evidence to support the building of sub-acute beds for mental health within institutional settings does not exist.
- Both the international and Australian evidence is strong to support investment in supported accommodation for the prevention of acute care admission and recovery following acute care stays.
- More research is required into varying models of sub-acute mental health care to demonstrate good practice.
- Flexible care packages with both transitional and stable accommodation would represent a best buy in mental health for the sub-acute bed initiative. On the available

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[10] See http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/ImplementationPlan-Stream1

[11] Department of Health and Ageing (2010). *National Mental Health Report 2010: Summary of 15 years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008.* Canberra: Commonwealth of Australia. p6.

evidence from existing programs in several Australian states, an allocation of $400 million would provide between 5,000-6,000 places. This is a compelling case for Government to consider.

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