

Submission to the Productivity Commission Mental Health Draft Report

This submission to the Productivity Commission on its draft report on Mental Health is made by the following organisations:

- Metro North HHS
- Brisbane North PHN
- Metro South HHS
- Brisbane South PHN

Our organisations welcome the opportunity to provide feedback to the Commission on its report. As regionally based health organisations, we have a particular interest in the issues and recommendations in chapter 23 (Federal roles and responsibilities) and chapter 24 (Funding arrangements) and these will be the focus of our comments.

This submission is made jointly by our organisations, building on our strong partnerships as health system managers, commissioners and providers in our regions. We work together to jointly assess the needs of our communities and plan, commission and deliver health services. Through the development of joint mental health and suicide prevention regional plans and shared governance arrangements we have further developed a strong understanding of the needs of our local communities and the priorities for action.

Overall, we are supportive of the direction of recommendations in the report around: re-orienting healthcare services to consumers (including primary care, online treatment, specialist community mental health services, emergency and inpatient services); re-orienting surrounding services to consumers (including psychosocial support, carers and families, income, employment, housing and justice) and early intervention and prevention (including early childhood and school education, youth participation, workplaces, social inclusion and suicide prevention).

We support the recommendation (23.3) for the Australian Government and State and Territory Governments work together to reform the architecture of Australia's mental health system to clarify roles and responsibilities and bring greater regional control and responsibility for mental health funding. Currently it is unclear and inconsistent across the country as to what state and federal governments should fund or deliver, leading to gaps, duplication and fragmentation. We also recommend the development of a national mental health treatment and recovery framework which would set out the minimum expectations of service availability in each region across the acute, primary and community sectors (based on the architecture of the National Mental Health Services Planning Framework - NMHSPF). Regional Commissioning Functions (see below) would then use this framework to plan and commission local services.

Regarding the architecture of the future mental health system (23.1), our preferred approach is a variation to the 'Renovate' and 'Rebuild' models, which builds on the cooperation between PHNs and HHSs. PHNs and HHSs should jointly establish a Regional Commissioning Function (RCF). While these could take the form of separate entities, a more efficient model would leverage the existing infrastructure and expertise in place between the PHNs and HHSs, with the RCF function being jointly governed by the PHN and HHS (along with people with a lived experience and potentially involving other

stakeholders e.g. NDIA or housing). Please see at appendix one an example of a PHN and HHS establishing a new entity to undertake complex joint regional activity.

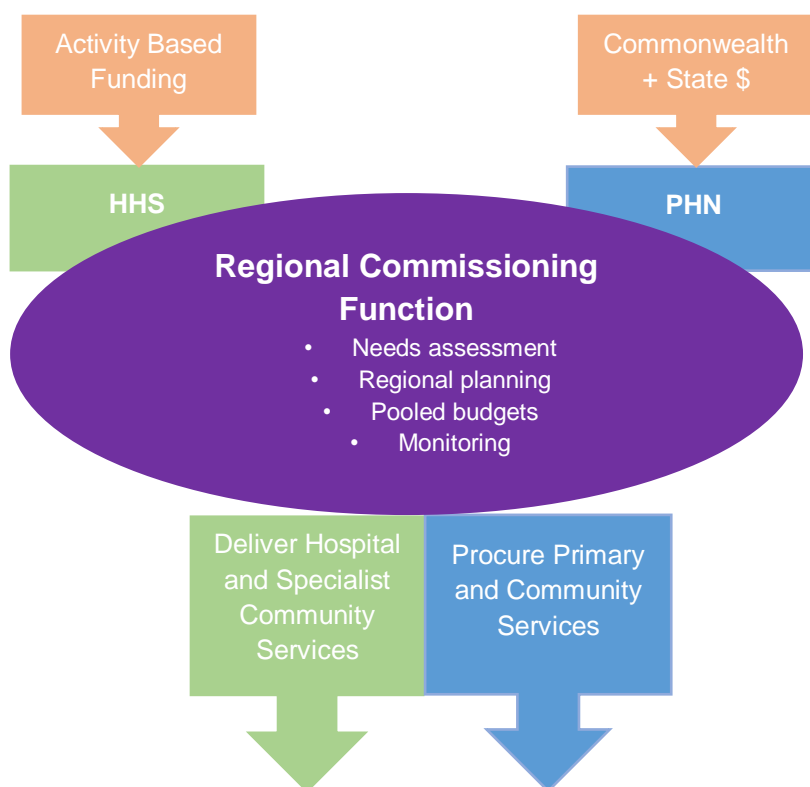
RCF responsibilities would include:

- assessing the needs of local populations;
- mapping existing service capacity;
- undertaking a gap analysis of services against projections from the NMHSPF;
- developing a joint regional plan for mental health and suicide prevention, including investment decisions, quality improvements and system reform, consistent with the national treatment and recovery framework
- brokering the development and implementation of the regional plan with local stakeholders, including people with a lived experience;
- using the plan to guide service delivery and procurement approaches; and
- monitoring and evaluating the implementation of the regional plan.

The funding mechanism for public hospital services would continue as is, with decisions as to how to best apply the funding being agreed by the RCF governance function through the regional plan (e.g. number and type of beds, specialist community mental health services, subacute/non-acute bed-based services). The HHS would then be responsible for delivering hospital services as per the regional plan.

Funding for MBS services would largely remain the same, subject to the proposed changes in MBS co-payments and a review of Better Access. Current funding for mental health services in the community/NGO services, via State and Commonwealth governments, would be commissioned through the PHN. The PHN would be responsible for procuring primary and community care services as per the regional plan agreed by the RCF. Clinical and psychosocial services should be integrated wherever possible.

As both parties would be responsible for planning and commissioning decisions within a defined budget through the RCF, there would be an incentive to commission services which meet the quadruple aim of: improved health outcomes; better patient experience; sustainable costs and improved clinician experience.



It should be noted that on the basis of initial local gap analysis against the National Mental Health Services Planning Framework, there is a significant gap in current funding levels, especially for community based mental health services. Any future changes to the architecture of the mental health system must be accompanied by an increase in funds available at the regional level.

We do not support the creation of separate, stand-alone, mental health specific Regional Commissioning Authorities under the 'Rebuild model'. PHNs and HHSs have built effective working relationships over the past five years and it would be a duplication of resources and effort to create a third entity (i.e. health data analysis, engagement, planning, procurement, contract management, system management). Given the disparity in mortality due to physical health concerns of people with a mental illness, planning and commissioning for mental health should not be separated from primary, community and acute care.

Appropriate measures would need to be put in place to ensure that all PHNs and HHSs (or equivalents) work together in the way outlined above. This could involve writing it into the funding agreements between the State government and HHSs and the Commonwealth government and PHNs. This could then translate into KPIs for Boards, CEOs and operational units. The expanded and strengthened National Mental Health Commission would then be responsible for monitoring the development, implementation and review of the RCF and their regional plans.

We support the recommendation (24.1) to allow the flexible funding pool to co-fund MBS-rebated allied mental health professionals. This would for example free up headspace centres to attract MBS providers especially in underserviced areas. It would also allow for a more efficient use of the PHN budget for psychological services for underserviced population groups (i.e. PHN would pay a gap fee and the MBS pay the rebate for psychological services, rather than the PHN paying the total cost).

Given both HHSs and PHNs have already integrated alcohol and other drug treatment with mental health, we believe alcohol and drug treatment services should be included in the authority of the RCF.

We support the recommendation (24.4) to establish a Mental Health Innovation Fund to which Regional Commissioning Agencies could apply for additional funding to trial new system organisation and payment models. For people with severe mental illness and other life complexities, this could involve the cashing-out of MBS rebates to move from a reactive fee-for-service based model, to a more proactive package of care.

We do not support the recommendation (23.1) to review activity-based funding classification for mental healthcare. The Independent Hospital Pricing Authority (IHPA) covers the types of clinical rating tools used in Community Mental Health Teams (HoNOS, LSP etc.) across several phases of care (POC - assessment, acute, functional gain, intensive extended, consolidating gain). The Australian Mental Health Care Classification is the culmination of a significant national program of work led by the IHPA and is structured around the key concepts of setting, episode and phase. The MH POC identifies the "primary goal of treatment and care". These concepts are underpinned by a range of establishment (e.g. facility, setting, team) activity (e.g. episodes) and consumer (e.g. diagnosis, clinical outcomes, phase of care) information. This data combined creates a number of categories called 'End Classes'. POC is determined prospectively at the commencement of, and at intervals during, an episode of care. When there is significant change in a consumer's symptoms, functioning or other relevant factors, the POC is reviewed and changed to reflect amendments to the consumers care plan.

A change in POC triggers additional data-entry requirements (completion of a HONOS, LSP etc.). This has the potential to deter clinicians from regularly updating the POC as it creates a data entry burden. To exemplify, for community mental health teams, it is not unusual for consumers to have recorded only

one POC (Functional Gain), which is reviewed at 3-month intervals. This approach may not reflect the acuity and/or change of treatment plan necessary to support wellness but is necessary to balance the priority of delivering clinical services, rather than data collection. Additionally, the POC does not support new ways of providing mental health care, such as home-based acute care and step-up step-down facilities. These approaches offer an alternative to admitting consumers into an acute MH inpatient ward, however POC does not adequately describe these activities and are consequently under-rated. Finally, specialist services including Consultation Liaison Psychiatry and state-wide teams (e.g. Queensland Forensic Mental Health Services, Queensland Eating Disorder Service etc.) do not have a POC which appropriately corresponds with the uniqueness of what these teams deliver.

Currently the clinical information systems for community mental health teams collect service contact across two separate KPI's:

- Service contact duration – captures consumer activity from the consumer perspective (direct contact with the consumer/family).
- Average community clinician duration per active day – captures consumer activity from the clinician's perspective (covers any contact with / for the consumer).

In both these indicators, the specifications under-report the overall time clinicians spend managing a consumer's case based on their exclusions – e.g. travel time, supervision, time put aside for an appointment which was not kept by the consumer, time spent compiling various documents/reports/KPI reporting are all not included. As these indicators do not collect the full spectrum of a clinician's workload, the reported data does not reflect an accurate picture.

Modifying the clinical information systems to accept the broad and varied array of activities would be very complex and would add to the data entry burden placed upon clinicians – which ultimately takes them away from consumer contact.

We support the recommendation (8.1) to improve the experience of people with mental illness in emergency situations. Metro North HHS is trialling several programs aimed at improving consumer's experience of care in an emergency mental health context. These include:

- Establishing a state-wide Mental Health Liaison Service within the Queensland Police Service, who provide information to their officers
- Establishing a state-wide Mental Health Liaison Service within the Queensland Ambulance, who provide information and advice to paramedics
- Trial of a co-responder (mental health and QPS) at Caboolture
- Establishing ED-based mental health nurse practitioners at TPCH and Redcliffe and a further trial at Caboolture Hospital.
- Trial of a Clinical Nurse Consultant within the Emergency Department at TPCH
- Establishment of a Step Up Step Down facility servicing RBWH and TPCH catchments
- Establishment of a Youth Step Up Step Down facility at Caboolture
- Establishment of a Psychiatric Emergency Centre for people presenting to the RBWH and establishing a Mental Health Short-Stay Unit at Caboolture Hospital
- Trial of a mental health peer support worker based in the Emergency Department at TPCH
- Establishment of Operational Liaison Committees across the three MNMH sites, involving QAS, QPS, the Emergency Departments and relevant mental health staff
- Trial of Safe Spaces at TPCH to commence in July 2020 – project being worked up at the moment

The HHS would like to trial:

- Health staff (these are usually ED staff with MH experience) based in watch houses
- Expand the co-responder model across the HHS

We support the recommendation (10.3) to develop a single care plan for consumers with moderate to severe mental illness receiving services across multiple providers. At the Nundah House step-up/step-down facility, Metro North HHS is trialling an approach using CIMHA with the NGO provider, so that the clinical team (employed by the HHS) and the psychosocial team (employed by the NGO) are both accessing and writing to a single care plan.

We support recommendations (17.1, 17.2, 17.3, 17.4, 17.5) regarding the importance of prevention, screening, treatment and capacity building with infants, children and young people, including through school programs at both primary and secondary schools. Prevention and early detection of mental health issues at a young age will result in improved health and wellbeing for the child and their families and less cost to the health system in later years.

We support the recommendation (16.1) regarding improved responses for people in the justice system. As the report states, Queensland has had some success with mental health services working more closely with police and ambulance services, and this could be expanded. We also support recommendations (16.2, 16.3) regarding the health of people in correctional facilities and on release and the need for these services to meet national mental health service standards.

Appendix One: Case Study - Health Alliance

December 2019

The Health Alliance

The Health Alliance has been created by the Boards of Metro North Hospital and Health Service (MNHHS) and Brisbane North Primary Health Network (PHN) to support a “neutral space” in the region where parts of the health sector and other sectors related to health can come together to work on health challenges in the region that cannot be addressed by the organisations operating in isolation. This process will in future become an element of regional commissioning, where planning is better connected to purchasing and implementation, taking account of the local context.

The Joint Board Committee

The Joint Board Committee is a governance mechanism for Brisbane North PHN and MNHHS to progress their strategic intent through partnership between the organisations. It provides governance of the activities of the Health Alliance and the Joint Operations Group (described below). The Joint Board Committee is made up of the two Board Chairs, two other members from each Board, and the two Chief Executives. The Chair of the Committee rotates annually between the organisations.

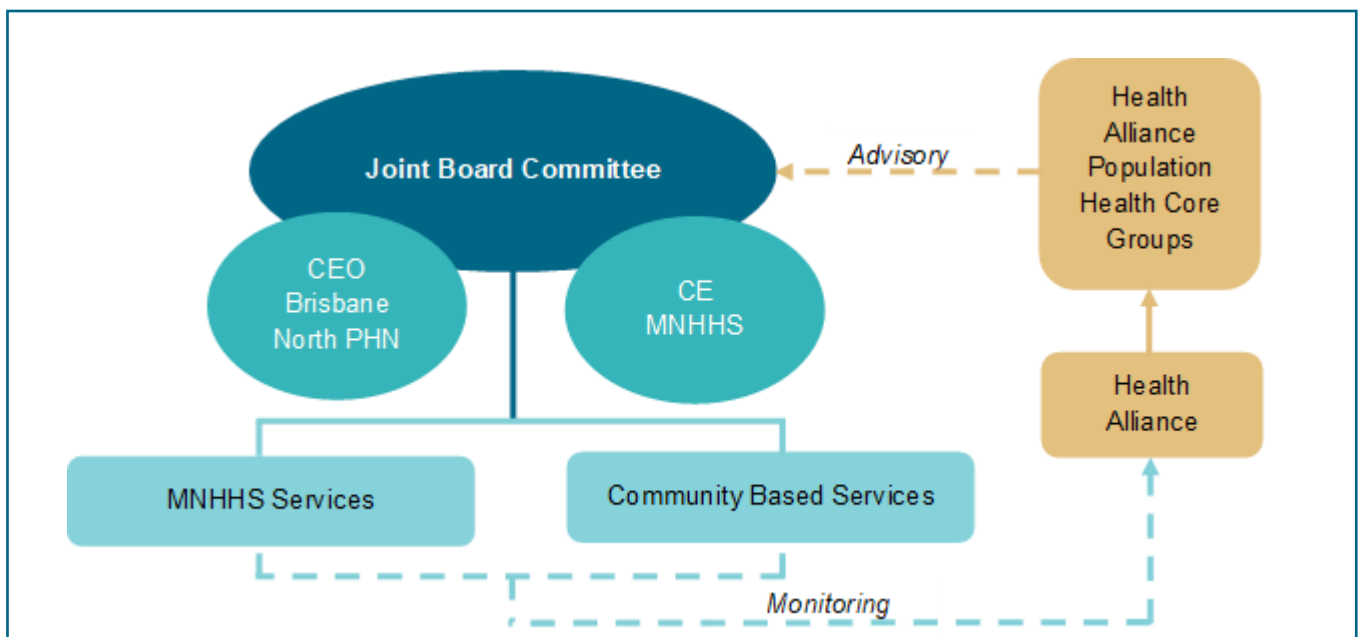


Figure 1. Health Alliance governance

Population Health Core Groups

The Health Alliance activities currently focus on three population groups: older people, children in the Caboolture area, and people with complex health and social needs who frequently attend emergency departments (ED). For each of these populations a ‘Core Group’ has been formed, consisting of the relevant stakeholders in the region. For example, the Core Group focused on older people includes non-government service providers, GPs, Residential Aged Care Facilities (RACFs), consumers and carer representatives, Indigenous service providers, Brisbane North PHN, MNHHS, Geriatricians, and the Queensland Ambulance Service.

The Core Groups empower people and the sector to design a system response not limited by existing program or institutional boundaries. The Alliance holds an objective and open-minded view, with a focus on solutions that benefit both patients and the health system.



Figure 2. The Health Alliance process

Core groups also play a monitoring role, reviewing system performance and designing quality improvements. They have each developed an outcome statement and outcome indicators to focus their activities and provide advice to the Joint Board Committee.

Joint planning and funding at the local level: Regional commissioning

In addition to the governance structures described above, the two organisations are developing mechanisms in preparation for a regional commissioning role; a regional commissioning strategy which describes how outcome-focused prioritisation and purchasing decisions would be made at the regional level, and a North Brisbane Population Health Advancement Fund. This fund would be governed by the Joint Board Committee, but would remain virtual in nature with specific resources identified within each of the two organisations.