Mental Health Australia

Submission in response to Productivity Commission Inquiry on Mental Health

Global Evidence Review

JULY 2019

Contents

Executive Summary

The Productivity Commission Inquiry into Mental Health is a once in a generation opportunity for significant, but incremental mental health reform. Mental Health Australia's original submission to the Inquiry provided preliminary advice to the Productivity Commission about how to target its Inquiry both in relation to the suite and mix of mental health services needed and the structures which underpin those services.

Mental illness is shaped to a great extent by the social, economic and physical environments in which people live. The risk factors for many common mental illnesses are strongly related to social inequalities. Thus, in responding to the Productivity Commission's Issues Paper, Mental Health Australia believes there are two key areas for consideration which we will address in depth in two supplementary submissions.

This first supplementary submission is a targeted global evidence review of innovative and best practice service delivery models in mental health. It highlights the need for development of a mental health system that reinforces integrated flexible support and treatment services. This paper discusses how coordinated services and supports must recognise the social determinants of health related to the diversity of people, their culture, individual circumstances and location.

The second supplementary submission will take a more detailed look at intergovernmental governance and finance arrangements. It will highlight key levers and controls to be considered in the pursuit of constructing a sustainable system that continually builds upon capacity and capability. The second supplementary submission will also discuss how a strong governance framework is required to address the structural shortcomings of Australia's current system and ensure sustainability and success of a newly designed mental health system. Further, it will reinforce the need for strong feedback and monitoring models to ensure continuous quality improvement and change to assist in overcoming the constraints that underpin the mental health system.

Findings from this global evidence review are highlighted as 'key considerations for the Productivity Commission' and categorised into three overarching themes:

- the suite and mix of mental health services;
- enabling systems and structures; and
- addressing the social determinants of mental health.

A summary of these findings is below with more detailed information provided in the section 'Systems in Place Internationally'.

The suite and mix of mental health services

- Focussing on early intervention and crisis care can help address access and outcome inequalities.

- The Improving Access to Psychological Therapy (IAPT) program in the United Kingdom reinforces the benefits of a stepped care approach to mental health.

- Suicide prevention must be implemented as part of a society-wide effort, as suicide is much more than an individual problem.

- Transition from a biomedical approach to a community mental health approach could lead to significant reductions in suicides.

Enabling systems and structures

- Funding models should reward service providers for exceeding outcome based targets to encourage quality service delivery.

- The Delivery System Reform Incentive Payment and The Medicaid Accelerated Exchange Series in the United States of America have improved service integration and successfully tailored services to reduce hospitalisation.

- The Value Based Payment system in the United States of America improves consumer outcomes.

- The Value Based Payments system in the United States of America potentially delivers sustainable system integration through care coordination across physical and mental health and rewarding high value care delivery.

- Mental health support needs can be embedded with physical healthcare, suicide prevention and workplace and employment wellbeing and support.

- A comprehensive suicide prevention strategy, based in legislation can assist in the development of suicide prevention policies.

- The development of the Japanese Suicide Prevention Act and Policy was done in phases, which allowed for laws to be enacted and revised to further support people at high risk throughout the process.

- Maximising opportunities for individuals to voluntarily agree to treatment, requires a supplementary education piece for society on the best approaches, i.e. how, where and why.

- To effectively implement community based care, resources and funding allocation needs to be based on the level of need and demand for the service.

Addressing the social determinants of mental health

- Mental health should not be measured on health outcomes alone and should encompass outcomes related to functional dimensions of health and recovery.
- Increasing funding and activities for suicide prevention in Japan led to a comprehensive, multi-sector approach with attention to the social factors underlying suicide including medical, financial and other factors.

It will be important for the Productivity Commission to consider international examples of models of care described in this submission (and beyond) as it undertakes its Inquiry into Mental Health to ensure that Australians have access to world leading mental health care into the future.

Introduction

Articulation of national mental health policy in Australia (through the National Mental Health Strategy, National Mental Health Policy and National Mental Health Suicide Prevention Plan) is world leading. High quality implementation has unfortunately not followed. The Productivity Commission has an opportunity through its Inquiry into Mental Health to make recommendations about the design of an Australian mental health system, which would enable the national policy vision for a system which enables recovery, prevents and detects mental illness early and enables access to appropriate care to be fulfilled.

Mental Health Australia's original submission to the Productivity Commission Inquiry into Mental Health provided preliminary advice about how to target the Inquiry both in relation to the suite and mix of mental health services needed and the structures which underpin those services. However, it is also important for the Productivity Commission to draw on international examples of good practice to ensure the recommendations it makes represent world class care. This first supplementary submission provides a targeted global evidence review of innovative and best practice service delivery models, emphasising key learnings in relation to the following three themes.

- the suite and mix of mental health services;
- enabling systems and structures; and
- addressing the social determinants of mental health.

This submission first summarises the current state of Australia's mental health system, including the key factors influencing the system. An overview of key mental health system requirements, beyond the biomedical model is then discussed, followed by a review of international examples of models of care from the United States of America, the United Kingdom, Japan and Italy. Finally, the paper makes preliminary suggestions about key considerations the Productivity Commission could draw on in applying some aspects of international models in the Australian context.

Current State

Overview of the current mental health system

The Australian healthcare system is recognised as one of the best in the Organisation for Economic Co-operation and Development (OECD). However, the system has come under intense pressure due to an ageing population, changes in healthcare needs, social inequities, and complex health conditions, resulting in increased demand and healthcare costs.

Australia's mental health system is supported through a variety of services, providers and settings, including:

- primary mental health care that is delivered by general practitioners and funded by consumers who receive Medicare rebates for a percentage of the cost and must pay the rest of the fee themselves

- community based mental health care that is provided by medical and allied health professionals and funded by:
    o consumers who receive Medicare rebates for a percentage of the cost; and
    o private health insurers' contributions.

- hospital based mental health services that are funded through:
    o activity and block grants from federal and state governments;
    o private health insurers' contributions, and
    o consumer contributions.

- community based psychosocial support that is predominately provided by community mental health organisations and funded through:
    o individualised fee-for-service funding provided through the National Disability Insurance Scheme (NDIS);
    o short-term grants provided by Primary Health Networks, Local Health Networks and some Commonwealth programs (noting all Commonwealth and some state programs will expire as a result of transition to NDIS); and
    o philanthropic donations.

State and territory governments are responsible for funding and delivering public specialised mental health care services, including admitted in-patient services and services delivered in

community settings. They may also fund programs and support services delivered by non-government agencies. A significant proportion of specialised mental health care is also provided by private hospitals and health practitioners working in private practice, such as psychiatry and psychology.
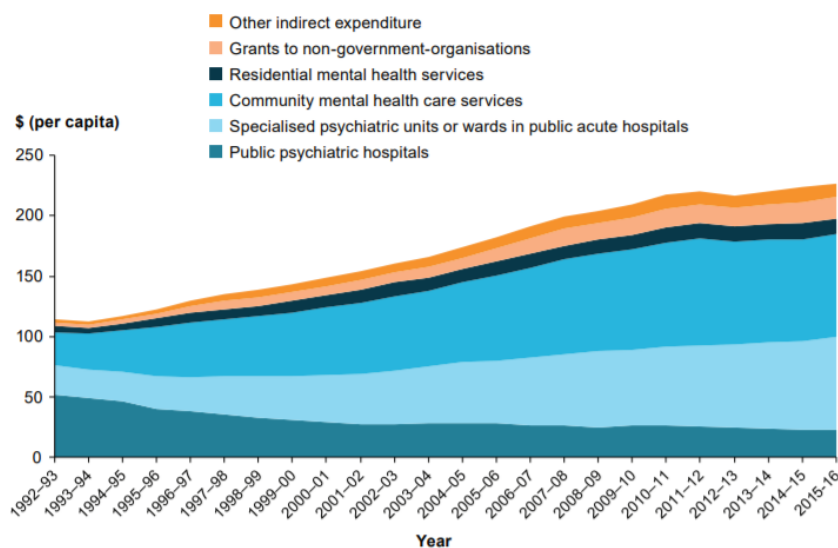
Currently, there are very few subsidised services available for people with a moderate mental illness who require more support than what is subsidised through Medicare GP Mental Health Treatment Plans, but who are not experiencing symptoms severe enough to warrant hospital admission. This leaves those who are unable to afford, or who have been refused private health insurance because they have a mental illness, without a service. This could potentially lead to a costly hospital admission. This is a consequence of a mental health system that lacks coordination, is under resourced, and the distribution of resources continues to be ineffective across the service components.

Gaps in service delivery, particularly in rural and remote areas, and a lack of continuity in care across the range of mental health service providers, mean that many people needing mental health services are still not getting the support they need to maintain good mental health or recover.

Key factors influencing the mental health system

In 2016-17, $9 billion was spent on mental health in Australia.[1] Figure 1 below illustrates the expenditure per capita on state and territory mental health services, 1992-93 to 2015-16.[2] These figures include, but do not separate, community based funding to psychosocial support services, which are very limited and an important element of care for those with severe mental illness.

Figure 1 expenditure per capita on state and territory mental health services[3]

[1] Australian Institute of Health and Welfare (2018) *Health expenditure Australia 2016-17*, retrieved from:
https://www.aihw.gov.au/reports/hwe/073-1/health-expenditure-australia-2016-17/contents/table-of-contents
[22] Australian Institute of Health and Welfare (2018) *Health expenditure Australia 2016-17,* retrieved from:
https://www.aihw.gov.au/reports/hwe/073-1/health-expenditure-australia-2016-17/contents/table-of-contents
[3] Australian Institute of Health and Welfare (2018) *Health expenditure Australia 2016-17*, retrieved from:
https://www.aihw.gov.au/reports/hwe/073-1/health-expenditure-australia-2016-17/contents/table-of-contents

Using the National Mental Health Services Planning Framework it is estimated each year approximately 290,000 persons with a severe mental illness require some form of community support (individual support, group support or non-acute residential) including 180,000 adults who require individual community support. In addition, there are 153,600 mental health consumers whose *carers* require some form of support.[4]

It is estimated that 20% Australians have experienced a mental illness in the last 12 months.[5] Despite this, in 2016-17 only 7.4% of government health expenditure was spent on mental health-related services.[6] It is also important to note the mental health burden of disease has increased by 13.5% since 2010.[7]

It is clear the level of expenditure on mental health services is insufficient in light of the mental health burden of disease significantly increasing each year since 2010. This is likely to result in under treatment, increased avoidable disability and mortality, decreased national economic output and increased household-level health spending.[8]

The need to rebalance funding

In 2017, mental illness and suicide accounted for $33.6 billion of the aggregate cost of burden of disease in Australia.[9] Furthermore, in 2017-18 there were an estimated 286,985 mental health related Emergency Department (ED) presentations (3.6% of all ED occasions of service).[10] In 2017-18 just under 58.1% of these individuals were *not* admitted as patients.[11] The number of mental health related ED presentations per 10,000 population continues to increase, highlighting not enough is being done in the community, particularly in prevention and early intervention.

The balance of funding between acute care in public hospitals, primary care, and community-managed mental health should be weighted based on need, demand and disease burden, as opposed to competition between sectors and specific mental illnesses. Poor access to community care delays discharge or leads to people being discharged from hospital without appropriate out of hospital care. Inadequate funding for community services mean prevention, support services and early interventions are difficult to access or coordinate.[12,13]

[4] Mental Health Australia (2017) *The implementation and operation of the psychiatric disability elements of the National Disability Insurance Scheme: A recommended set of approaches*

[5] Australian Institute of Health and Welfare (2018) *Mental health services in Australia*, retrieved from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies

[6] Australian Institute of Health and Welfare (2018) *Health expenditure Australia 2016-17* retrieved from: https://www.aihw.gov.au/reports/hwe/073-1/health-expenditure-australia-2016-17/contents/table-of-contents

[7] Mindgardens Neuroscience Network (2019) *Review of the burden of disease for neurological, mental health and substance use disorders in Australia*, retrieved from: https://www.mindgardens.org.au/white-paper/.

[8] Vigo, D., Kestel, D., Pendakur, K., Thornicroft, G., Atun, R. (2018) *Disease burden and government spending on mental, neurological and subatsance use disorders, and self-harm: cross-sectional, ecological study of health system response in the Americas*, Lancet Public Health 4:e89-96.

[9] Mindgardens Neuroscience Network (2019) *Review of the burden of disease for neurological, mental health and substance use disorders in Australia*, retrieved from: https://www.mindgardens.org.au/white-paper/

[10] Australian Institute of Health and Welfare (2019) *Mental Health Services in Australia: Hospital emergency services*, retrieved from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services

[11] Australian Institute of Health and Welfare (2019) *Mental Health Services in Australia: Services provided in public hospital emergency departments. Table ED. 11*, retrieved from, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services

[12] Australian Medical Association (2018) *Mental health 2018*, retrieved from: https://ama.com.au/position-statement/mental-health-2018

The need for broader system integration

The diversity and fractured coordination of service systems beyond the mental health sector can hinder the ability of individuals to access services they need. Consumers and carers are left to navigate a system that is complex, uncoordinated and not tailored to meet their respective needs. For example, a person experiencing a psychotic episode admitted to hospital is often discharged without adequate post-discharge community care, leaving them at particularly high risk of suicide.

Improving the mental health of Australians requires consideration of systems and supports including housing, social services and measures provided through workplaces, education providers and justice systems. In developing a comprehensive integrated model of mental health the interplay between these components should be considered with respect to the individual consumer, their carers and the wider community.

It is of great concern the issues identified within the 2014 National Mental Health Commission Review of Programmes and Services are still very relevant today, including:

- stigma still persisting for many individuals with a lived experience of mental illness/ill-health;

- people with lived experience, families and support people have a poor experience of care, limited choice, not enough specialist services;

- the current mental health system does not prioritise needs

- the system responds too late, with many people never receiving the support they require;

- the system is fragmented resulting in duplication, overlap and gaps in services;

- the system does not see the whole person, demonstrated by continuing poor physical health, high rates of unemployment and people being discharged from hospital without adequate discharge planning; and

- the system uses resources poorly with the greatest level of funding still going into high cost areas, such as acute care.

An integrated and responsive care model

The World Health Organisation (WHO) recognises the urgent need for action in reducing the burden of mental illness worldwide. The world's leading public health agency developed a Mental Health Global Action Programme that provides clear and coherent strategy for closing the gap between what is urgently needed worldwide and what is currently available to reduce the burden of mental illnesses.[14] The WHO Mental Health Action Plan highlights the need for integrated and responsive care that focuses on meeting both the mental and physical needs of individuals across general health and social services.[15]

The WHO report concludes the current global mental health crisis is firmly rooted within a biomedical model which has failed to proactively address mental illness at both a national and global level. The WHO argues the mental health field continues to be over-medicalised and the biomedical model, driven by parts of the pharmaceutical industry, continues to dominate global clinical practice, research agendas and medical education.[16] Australia, for example, has the second highest rate of anti-depressant use in the world, with nearly one in 10 Australians taking them.[17] This rate has more than doubled since 2000, despite accumulating evidence anti-depressants are not as effective as previously thought. While antidepressants undoubtedly have their place in treating certain mental illnesses, emerging evidence supports that combining treatments, such as medicine with psychotherapy, might provide the best outcomes for people living with a mental illness.[18] Over reliance, or over emphasis on the biomedical model provides limited opportunities to optimise health outcomes. On the other hand systems that promote holistic approaches empower people living with a mental illness and improve their overall health and wellbeing.[19] A shift to holistic consumer centred care has been shown to enhance individual adherence to treatment plans,[20] improve health outcomes and increase consumer service satisfaction.[21]

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[14] World Health Organisation (2008) *mhGAP Mental Health Gap Action Programme*, retrieved from: https://www.who.int/mental_health/mhgap/en/

[15] World Health Organisation (2013) *Mental health action plan 2013-2020*, retrieved from: https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=B1A70B680D755D290B864D7435B1FD97?sequence=1

[16] United Nations Human Rights Council (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*

[17] OECD (2015) *Health at a glance 2015*, retrieved from, https://www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf.

[18] Davey, C., Chanen, A. (2016) *The unfulfilled promise of the antidepressant medications*, The Medical Journal of Australia, 204(9): 348-350.

[19] Delaney, L. (2018) *Patient-centred care as an approach to improving health care in Australia*, The Australian Journal of Nursing Practice, Scholarship and Research, 25:1:119-123.

[20] Thompson, L., McCabe, R. (2012) *The effect of the clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review*, BMC Psychiatry, 12:87.

Mental health cannot be seen in isolation from wider societal influences, such as experiences in utero and early childhood, social disadvantage, marginalisation, and unemployment. People born into areas of social disadvantage are more likely to develop behavioural issues, not complete school, engage with risk taking behaviour and make unhealthy lifestyle choices.[22] These factors have been directly shown to correlate with the development of a mental illness.[23] The under-resourcing of mental health programs often prevents the least able and most vulnerable people from overcoming adverse health determinants and early childhood experiences.[24] The balance between funding acute care in public hospitals, primary care, and community-managed mental health needs to be correctly weighted and should be allocated on the basis of need, demand and disease burden, not a competition between sectors and specific mental illnesses.

For any mental health system to comply with the WHO's "right to health" agenda, biomedical and psychosocial models of mental health care must be appropriately balanced. A global shift away from the assumption biomedical interventions alone are the most effective form of treatment is vital in overcoming core system challenges and advancing universal mental health.[25] A well designed mental health system facilitates integration and coordination of promotion, prevention, treatment, rehabilitation, care and recovery services. By integrating mental health services with primary and general health care, the focus is shifted to early intervention and identification while addressing the underlying social determinants of health. The significant burden of mental ill-health, for individuals, societies and economies, has seen the development of progressive mental health systems and practices across Europe, the United States of America and Australasia.

[21] Ekman, I., Wolf, A., Olsson, L., Taft, C., Dudas, K., Schaufelberger, M., Swedberg, K. (2012) *Effects of person-centred care in patients with chronic heart failure: The PCC-HF study*, European Heart Journal, 33:1112–1119.

[22] McLaughlin, K. A., Costello, E. J., Leblanc, W., Sampson, N. A., & Kessler, R. C. (2012) *Socioeconomic status and adolescent mental disorders.* American journal of public health, 102(9), 1742–1750. doi:10.2105/AJPH.2011.300477.

[23] McLaughlin, K. A., Costello, E. J., Leblanc, W., Sampson, N. A., & Kessler, R. C. (2012) *Socioeconomic status and adolescent mental disorders. American journal of public health*, 102(9), 1742–1750. doi:10.2105/AJPH.2011.300477.

[24] Australian Medical Association (2018) *Mental health 2018*, retrieved from: https://ama.com.au/position-statement/mental-health-2018

[25] United Nations Human Rights Council (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*

Systems in place internationally

This submission is informed by a brief global evidence review and analysis of innovative and best practice service delivery models. Below are four international examples of innovative and unique approaches to mental health system design the Productivity Commission should further investigate.

New York State, United States of America - Delivery System Incentive Payment (Value Based Payments)

Prior to 2014, New York State had some of the worst healthcare outcomes in the United States. In response, the State Department of Health implemented a state-wide Delivery System Reform Incentive Payment (DSRIP). The DSRIP Program is a 5-year reform initiative targeting the creation of integrated delivery networks of care and significantly improving health outcomes for the six million beneficiaries of the state-sponsored Medicaid insurance scheme. The program promotes integration of mental and social services into community care locations, building up primary care capacity, setting up cross-provider evidence-based protocols, and real-time sharing of data within and between integrated delivery networks, known as Performing Provider Systems.

The DSRIP system reinforces that mental health should not be measured on health outcomes alone and should encompass outcomes related to functional dimensions of health and recovery. As such, the pillars against which transformation is measured are the level to which it is person-centred, recovery-oriented, integrated, data-driven and evidence based. To date, the DSRIP program has hit all of its measurement targets, with a primary objective of reducing avoidable emergency department presentations by 25%. The program has also improved access to appropriate care and shifted the focus of care to communities and away from costly acute inpatient and emergency department services.[26]

The Medicaid Accelerated Exchange (MAX) Series is an innovative initiative deployed as part of the DSRIP program. It involved running workshops for multidisciplinary teams to redesign patient care pathways with a focus on patients with high service utilisation, particularly those who disproportionately use emergency department and inpatient services. Through MAX, participating teams restructured care for high service users by embedding the participating teams into community resources and services. The deployment of

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[26] New York State (2014-2018) *NYS DSRIP Quarterly Reports*, retrieved from:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports.htm

community based initiatives and care pathways has seen a 13% decrease in hospital utilisation by high users and a reduction in readmissions to hospital.[27]

The State Department of Health also launched a concurrent state-wide value-based payment (VBP) reform to transition the current fee-for-service model into managed care structures with a set menu of value-based options. Value Based Payments are set up between health care providers and payers, the contractual agreement sets out specific performance expectations for quality measures which encourages performance around health care outcomes and costs related to service utilisation.[28] Accountability of health care providers and systems to provide high quality services across the continuum of care is accentuated through these arrangements. Two fundamental variables that underpin the incentivisation of performance include:

- quality: a proportion of a health care provider's payment is tied to achieving or exceeding quality standard measures.

- efficiency: providers may earn shared savings or risk financial penalties based on the actual health care costs of assigned populations over time compared to the expected cost.[29]

Evidence has shown VBP programs lead to better consumer outcomes. These outcomes were paralleled by shorter timeframes to translate treatment into clinically significant improvements in symptoms.[30] Converting to VBP arrangements has also developed a sustainable system, which incentivises value over volume. More than 42% of Medicare health plans are now value-based.[31] Delivery system reform incentive payment has fundamentally restructured New York's health care delivery system to improve the financial sustainability for those who do not quality for other public assistance programs.

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[27] 27 New York State (2014-2018) *NYS DSRIP Quarterly Reports*, retrieved from:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports.htm

[28] 28 Greater New York Hospital Association (2018) *Value-Base Payment Fundamentals*, retrieved from: https://www.gnyha.org/tool/value-based-payment-fundamentals-a-guide-to-new-york-state-medicaid-vbp/

[29] Greater New York Hospital Association (2018) *Value-Base Payment Fundamentals*, retrieved from: https://www.gnyha.org/tool/value-based-payment-fundamentals-a-guide-to-new-york-state-medicaid-vbp/

[30] Bao, Y., et al. (2017) *Value-Based Payment in Implementing Evidence-Based Care: The Mental Health Integration Program in Washington State*, The American Journal of Managed Care, vol. 23:1, 48-53.

[31] 31 New York State. (2014-2018) *NYS DSRIP Quarterly Reports*, retrieved from:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports.htm

Greater Manchester, United Kingdom – Whole of System Strategy

Inconsistency in service provision and outcomes, combined with a lack of integration in Greater Manchester, led to the deployment of a whole of system strategy in 2016 by the Greater Manchester Combined Authority that involved both independent and third sectors.[32] The system improvements aimed to improve the mental health and wellbeing of individuals and their families through building resilient communities, inclusive employers and holistic services that maximise autonomy and informed decision making. To eliminate variability of services and outcomes, the strategy embeds mental health supports into physical healthcare and focuses on suicide prevention and workplace and employment wellbeing and support.

The strategy addresses access and outcome inequalities by promoting pathways to early intervention and crisis care. The strategy recognises employment as a crucial health outcome and ensures there is consistent support available across Greater Manchester for people currently unemployed and seeking employment, including access to CV clinics, coaching and mentoring.

The strategy focuses on directing all primary care referrals for consumers with mild to moderate common mental health problems directly to evidenced based Improving Access to Psychological Therapy (IAPT) clinical teams, rather than via the unintegrated single point of contact model. IAPT is a program underpinned by individualised patient wants and needs. It is integrated with physical healthcare pathways, with the patient matched directly with a

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[32] The third sector comprises the part of an economy which is non-government and not for profit.

suitable health care provider based on the intensity of their mental illness and required duration of treatment.[33] This redesign has resulted in the reduction of steps in the referral process and delivered a more streamlined service for service users and referrers. To date, a 13% reduction in waiting times and a 24% increase in recovery rates has been seen in individuals receiving IAPT services.[34]

The creation of single shared services for acute hospital and specialist services are utilised to deliver improvements in patient outcomes and productivity through the establishment of consistent best practice. Single shared services align hospitals with similar skill sets to centralise specialist services, standardise care pathways and fill service gaps.[35] The implementation of Rapid Access Interface Discharge as part of the strategy allows comprehensive assessments of a person's physical and psychological well-being in a general hospital or community setting to be conducted. The program has supported timely discharge and has proven to reduce bed days and as a result drive efficiencies.[36]

Taking a local approach to developing workplace mental health programs is also included as part of the Greater Manchester Strategy providing bespoke, proactive support that is reflective of different staff needs, local support available and service demands.[37] Benchmarking assessments commissioned by the Health and Wellbeing Board continually assess areas of best practice, the development of working and efficiency partnerships, and continuous improvement in the workplace. To date, results have been highly favourable.[38]

The Greater Manchester Strategy highlights the opportunity of promoting behavioural change in communities to build independence and support consumer autonomy.

[33] NHS England (2016) *Adult Improving Access to Psychological Therapies programme*, retrieved from: https://www.england.nhs.uk/mental-health/adults/iapt/

[34] NHS Greater Manchester Mental Health (2019) *Transformation plans*, retrieved from: https://www.gmmh.nhs.uk/transformation-plans

[35] NHS The Pennine Acute Hospitals NHS Trust. (2019) *Manchester Single Hospital Service Programme*, retrieved from: https://www.pat.nhs.uk/about-us/manchester-single-hospital-service-programme.htm

[36] Greater Manchester Combined Authority (2016) *Greater Manchester Mental Health and Wellbeing Strategy*, retrieved from: http://www.gmhsc.org.uk/wp-content/uploads/2018/04/GM-Mental-Health-Summary-Strategy.pdf

[37] Greater Manchester Mental Health (2018) *Annual Report and Accounts 2017/2018*, retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765451/Greater_Manchester_Mental_Health_NHS_Foundation_Trust_Annual_Report_and_Accounts_2017-18.PDF

[38] Greater Manchester Mental Health (2018) *Annual Report and Accounts 2017/2018*, retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765451/Greater_Manchester_Mental_Health_NHS_Foundation_Trust_Annual_Report_and_Accounts_2017-18.PDF

Japan – Basic Act for Suicide Prevention

Suicide rates in Japan are one of the highest in the developed world. For decades suicide in Japan was taboo, leaving surviving families with little to no support.[39] In 2006, however, major reform occurred when Japan began to look at suicide as a social problem, instigating organised action across government and NGO systems. The Basic Act for Suicide Prevention was introduced and in 2007 it was further supported by the General Principles of Suicide Prevention Policy. In addition, a Special Fund program for local governments was developed, which alongside the Basic Act and General Principles led to the development of a comprehensive and multi-sector approach to suicide prevention.[40]

The purpose of the Basic Act was to prevent suicide and provide support to survivors of suicide, thus helping to create a more stable society where people could lead healthy and meaningful lives. The Basic Act takes a whole of society approach outlining the responsibilities of government, local authorities, employees and citizens in the reduction of suicide.[41] The Basic Act also mandated the Government of Japan to establish a set of immediate objectives as part of the General Principles of Suicide Prevention Policy. The Policy takes a holistic approach to continually reviewing and addressing the medical, financial and other factors driving suicide. The funding model directs funds toward early intervention and prevention. Furthermore, taking a local approach to developing prevention and public awareness campaigns has meant tailored, demographically aligned support has been successfully delivered.[42]

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[39] World Health Organisation (2015) *Japan turning a corner in suicide prevention*, retrieved from, https://www.who.int/mental_health/suicide-prevention/japan_story/en/

[40] Takeshima, T., et al. (2015) *Suicide prevention strategies in Japan: A 15-year review (1998-2013)*, Journal of Public Health Policy, vol. 36:1, 52-66.

[41] Nakanishi, M., Takashi, Y., Takeshima, T. (2015) *National strategy for suicide prevention in Japan: Impact of a national fund on progress of developing systems for suicide prevention and implementing initiatives among local authorities*, 69: 55-64.

[42] World Health Organisation (2015) *Japan turning a corner in suicide prevention*, retrieved from: https://www.who.int/mental_health/suicide-prevention/japan_story/en/

Face to face counselling and trauma informed programs were implemented alongside the Basic Act. The face to face counselling program is used simultaneously as a method to screen the level of need within the community and ensure appropriate referrals are being administered. Trauma informed policies and practices are applied flexibly, local authorities administer services based on the suicide specific issues in the area e.g. railway suicides.[43]

After 2009, the suicide rate declined, bringing the annual number of suicides in 2012 to below 30,000, for the first time since 1998. Suicide rates have continued to dramatically decrease among men aged 45-64.[44] Declines in suicide rates have also been observed for the elderly and individuals across a large geographical spread.[45,46]Evidence has also illustrated an increase in local adoption of early-intervention programs, face to face counselling and community based support uptake, demonstrating the effect the reform has had on the broader community.[47]

Productivity Commission Key Considerations

The suite and mix of mental health services
- Suicide prevention must be implemented as part of a society-wide effort, as suicide is much more than an individual problem.

Enabling structures and systems
- A comprehensive suicide prevention strategy, based in legislation can assist in the development of suicide prevention policies.

- The development of the Act and Policy was done in phases, which allowed for laws to be enacted and revised to further support people at high risk throughout the process.

Addressing the social determinants of health
- Increasing funding and activities led to a comprehensive, multi-sector approach with attention to the social factors underlying suicide including medical, financial and other factors.

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[43] Nakanishi, M., Takashi, Y., Takeshima, T. (2015) *National strategy for suicide prevention in Japan: Impact of a national fund on progress of developing systems for suicide prevention and implementing initiatives among local authorities*, 69: 55-64.

[44] [44] Takeshima, T., et al. (2015) *Suicide prevention strategies in Japan: A 15-year review (1998-2013)*, Journal of Public Health Policy, vol. 36:1, 52-66.

[45] World Health Organisation (2015) *Japan turning a corner in suicide prevention*, retrieved from: https://www.who.int/mental_health/suicide-prevention/japan_story/en/

[46] World Health Organisation (2015) *Japan turning a corner in suicide prevention*, retrieved from: https://www.who.int/mental_health/suicide-prevention/japan_story/en/

[47] Nakanishi, M., Takashi, Y., Takeshima, T. (2015) *National strategy for suicide prevention in Japan: Impact of a national fund on progress of developing systems for suicide prevention and implementing initiatives among local authorities*, 69: 55-64.

Italy – Community mental health care model

The mental health system redesign in Italy began in 1978. Reform saw the transition away from hospital based care delivery toward community mental health care. By 2000, all psychiatric hospitals were closed. Psychiatric beds were moved to community residential facilities. The community mental health care model acknowledges that individuals with a mental illness have the right to be treated equally to people with a physical illness. As such, treatment is provided on a voluntary basis, with compulsory admissions reserved for emergency interventions, or when alternative community treatment cannot be arranged.[48] Between 2000 and 2011, Italy's suicide rate fell by 13.4%, while the OECD average reduction was 7% over the same period.[49] Italy has also seen a drop in unplanned readmission rates for patients with bipolar and schizophrenia. This demonstrates the quality and continuity of care being delivered in the community.[50]

Notably the community mental health model presents several limitations. The focus of community residential services is on rehabilitation, however, average time spent in community facilities has increased suggesting that, instead, inpatient care and long stay services are being provided.[51] Both quality of life indicators among individuals engaging with community mental health and the burden placed on families is high. The large variability of accessibility and quality of services across Italy has left a proportion of people without adequate access to treatment.[52] The noted weakness of the community mental health care model it that it is are underpinned by a lack of resource and funding allocation.[53] Increased investment in the model could result in an innovative opportunity to redesign the patient treatment experience.

Productivity Commission Key Considerations

The suite and mix of mental health services
- Transition from a biomedical approach to a community mental health approach could lead to significant reductions in suicides.

Enabling structures and systems
- Maximising opportunities for individuals to voluntarily agree to treatment, requires a supplementary education piece for society on the best approaches, i.e. how, where and why.

- To effectively implement community based care, resources and funding allocation needs to be based on the level of need and demand for the service.

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[48] Barbui, C., Papola, D., Saraceno, B. (2018). *Forty years without mental hospital in Italy*, International journal of mental health systems, 12:43.
[49] OECD (2013) *Italy led the way in deinstitutionalisation, but regional disparities remain a Concern*, retrieved from: https://www.oecd.org/els/health-systems/MMHC-Country-Press-Note-Italy.pdf
[50] OECD (2013) *Italy led the way in deinstitutionalisation, but regional disparities remain a Concern*, retrieved from: https://www.oecd.org/els/health-systems/MMHC-Country-Press-Note-Italy.pdf
[51] Barbui, C., Papola, D., Saraceno, B. (2018) *Forty years without mental hospital in Italy*, International journal of mental health systems, 12:43.
[52] Barbui, C., Papola, D., Saraceno, B. (2018) *Forty years without mental hospital in Italy*, International journal of mental health systems, 12:43.
[53] Barbui, C., Papola, D., Saraceno, B. (2018) *Forty years without mental hospital in Italy*, International journal of mental health systems, 12:43.

A future Australian system

Australia's mental health system needs to be re-designed to focus on the needs of service users, rather than providers. This involves shifting beyond the traditional biomedical model to deliver a suite of mental health services and programs, developing systems with robust enabling structures to support the delivery of these services, with a focus on addressing the social determinants of health. The targeted global evidence review outlined in this submission has also highlighted innovative and good practice service delivery models, emphasising key considerations in relation to service delivery and integration of mental health within broader health systems.

The suite and mix of mental health services

An integral component to the Productivity Commission's final report will be recommendations about the suite of mental health services required to address anticipated need. The international examples described in this submission demonstrate the importance of adequately funded, community based support to match need. They demonstrate the importance of early intervention and crisis care (including suicide prevention) in addressing outcome inequalities. They reinforce the benefits of a stepped care social model of health, integrated with primary care, designed in collaboration with people with a lived experience of mental illness. In general, they support Mental Health Australia's and the WHO's calls to expand Australia's approach to mental health well beyond the biomedical approach to treating mental illness.

Enabling systems and structures

None of the many previous reports, inquiries, reviews and evaluations of Australia's mental health system have resulted in comprehensive lasting reform. This suggests the enabling systems and structures underpinning Australian mental health reform are not robust enough to implement recommended reforms. To improve mental health outcomes in the long term, all levels of government need to agree on, and commit to, the many structural features and system enablers which underpin a sustainable mental health sector. Through this Global Evidence Review, Mental Health Australia sought to identify international examples of discrete enabling system and structure reform.

International examples described in this submission emphasise the importance of funding models which reward service providers for exceeding outcome based targets to encourage quality service delivery. For example, Value Based Payment structures tailored to an Australian context could potentially deliver sustainable system integration through care coordination across physical and mental health. New South Wales has already launched a

large scale Value Based Healthcare program across a range of physical health conditions but not mental health.[54] The Productivity Commission may wish to draw on lessons learnt through value based healthcare for physical health in Australia to consider its application to mental health.

In addition, the above described international case studies, provide examples of effective integration of physical and mental health care. It will be important for the Productivity Commission to consider practical solutions to the lack of integration of mental health services in Australia and between mental health and other services. NSW has been working on integrated care models to tailor care to individuals' needs. This initiative focusses on people with chronic conditions.[55] The Productivity Commission could use the lessons learnt through this initiative alongside the above-mentioned case studies to consider what practical underpinning structures are required to achieve integrated mental health care in Australia.

Finally, one international example demonstrated the importance of ensuring transition to community based care is supported by adequate funding to match need for community services. In Australia, this will require building a sound understanding of the need for community and clinical care and ensuring both are adequately funded. A necessary pre-requisite for such an outcome, is the establishment of sound intergovernmental arrangements in mental health that outline clear lines of responsibility while enabling cross portfolio benefits to be realised. Mental Health Australia's third submission to the inquiry will cover this issue in detail.

Addressing the social determinants of mental health

Mental health is affected by social, economic and physical environments. Many risk factors for mental illness are associated with social inequalities. Mental Health Australia therefore supports the Productivity Commission's consideration of strategies to address the social determinants of mental health.

The international examples outlined in this submission demonstrate the importance of integrating mental health services with other services and physical health services in particular. They show mental health support needs can be embedded with physical healthcare, suicide prevention and workplace and employment wellbeing and support.

In addition they indicate mental health should not be measured on mental health outcomes alone and encompass outcomes related to functional dimensions of health and recovery. The examples considered in this submission show that multi-sector approaches with attention to the social factors underlying suicide in particular, including medical, financial and other factors, has been shown to reduce suicides.

There is a need to invest in services outside the health sector, with a focus on the social determinants of health to improve population mental health. Investing in services delivered outside the health sector will improve population mental health of Australians and achieve higher social and economic participation and contribution benefits over the long term.

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[54] NSW Government (2019) *Value based healthcare,* retrieved from: https://www.health.nsw.gov.au/Value/Pages/default.aspx
[55] NSW Government (2019) *Integrated care for patients with chronic conditions,* retrieved from: https://www.health.nsw.gov.au/integratedcare/Pages/chronic-conditions.aspx

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Conclusion

The National Mental Health Strategy was endorsed in April 1992 as a framework to guide mental health reform. The Strategy includes the National Mental Health Policy, National Mental Health and Suicide Prevention Plan and the Mental Health Statement of Rights and Responsibilities. The National Mental Health Policy was revised in 2008 which set out a vision for a mental health system that:

- enables recovery;

- prevents and detects mental illness early; and

- ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) identified eight priority areas, which were intended to set the direction for change and provide a foundation for longer-term system reform. Despite the comprehensive nature of the National Mental Health Policy providing a strategic framework to guide coordinated government efforts in mental health reform and service delivery, significant challenges and limitations still exist within the current mental health system.

Articulation of national mental health policy in Australia has been world leading. High quality implementation has unfortunately not followed. The promise of the Fifth Plan still has not been realised. The failure to implement and monitor reform has prevented significant progress being made in ensuring people are getting the support they need to maintain good mental health.

This submission has described examples of reforms implemented in other countries, which go some way to improving mental health outcomes through: improving the suite and mix of mental health services, improving enabling systems and structures, and demonstrating innovative approaches to integrate services across the social determinants of health. Through examination of the key considerations highlighted throughout this submission the Productivity Commission will come closer to offering recommendations which enable the National Mental Health Policy vision to be fulfilled.

Mental Health Australia

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Mental Health Australia

**Mentally healthy people,
mentally healthy communities**