Response to the Draft Report of the Productivity Commission Inquiry on Mental Health

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Abbreviations

Abbreviation	Definition
COAG	Council of Australian Governments
DESDE-LTC	Description and Evaluation of Services and Directories in Europe for long-term care
DoH	Department of Health
GP	General Practitioner
HCH	Health Care Homes
LGA	Local Government Areas
LHD	Local Health District
MBS	Medicare Benefits Schedule
MHC NSW	Mental Health Commission of NSW
NGO	Non-government organisation
NMHC	National Mental Health Commission
PHN	Primary Health Network
SDH or SDOH	Social Determinants of Health
WSPHN	Western Sydney PHN

Introduction

The Western Sydney Primary Health Network (WentWest) is pleased to present this response to the Draft Report of the Productivity Commission Inquiry on Mental Health (the Inquiry) into the role of improving mental health to support economic participation, enhancing productivity and economic growth.

Firstly, we wish to commend the Commission for the comprehensive analysis and scale of the task undertaken in compiling the Draft Report. We welcome the Commission's recognition that "a generational change" is required and that past reform efforts have not enabled 'the mental health care system to keep pace with needs and expectations in relation to how individual wellbeing and productive capacity should be supported'.

While a 'generational change' is needed, future reform must not be a mirror image of the past generation of reform. As we state in our submission (Submission 445), in contrast to many areas of health where Australia has achieved very significant reductions in prevalence rates and the burdens of death and disability, twenty-five years of national efforts in relation to mental illness have yielded **almost no change**.

From prevalence rates to life expectancy, the health status and outcomes for those with mental illnesses remain stubbornly stuck, or in many areas have worsened. This points to a failure to provide access to **quality** mental health care across the lifespan and a growth in demand for services.

As the Commission notes, in the time since national mental health reform commenced in 1992, there has been a wealth of information, reports, policy documents and action plans, but there has been **too little focus on sustained capacity building** to enable effective implementation.

We would emphasise that in light of the Draft Report and the recommendations presented by the Commission, changes to **governance and accountability** are central to achieving improved personal, social and economic outcomes. However, WentWest disagrees strongly with the separation of accountability for physical and mental health given the well accepted - and strongly evidenced interplay between a person's general health and their mental health. This inter-relationship lies at the heart of general practitioners' pivotal role in integrating responses at the point of care.

In light of this, Wentwest notes that the Commission proposes two options to improve clarity over funding and responsibilities in the mental health system: Option 1 Renovate model and Option 2 Rebuild model. The Commission has indicated that Option 2 is its preferred model. WentWest's strong view would be to neither 'renovate' nor 'rebuild', but instead to 'reinforce' the current approach to capitalise on the gains achieved over the past decade of reforms – most notably over the four short years since the establishment of PHNs. Our position is explained in this response.

In this response we provide a number of key points, some additional perspectives on strengthening governance and accountability, and examples of existing regional collaborative health planning and program delivery. A constant feature of such successful examples is their commitment to building high quality Primary Care foundations – well connected across services and sectors, that is essential to whole person mental health care and an integrated, effective and equitable regional health system.

Key Points

- Western Sydney PHN (WentWest) welcomes the Productivity Commission's Draft Report as it provides clarity, scope and detailed descriptions which enables constructive dialogue and responses to contribute to the Final Report.

- We note that the role of PHNs is referenced in over 25 percent of all submissions made to the Commission, demonstrating the key place PHNs have in supporting, commissioning and locally integrating mental health services.

- The Draft Report maps out the extent of the community impact of mental illness, and for the first time in our nation's mental health reform efforts, seeks to quantify the economic impact.

- The Draft Report clearly recognises the interplay of the social and economic context such as education, justice, employment and housing in people's development and experience of, and recovery from mental ill health. PHNs understand this well and seek to underline the key interplay between a person's environment, general health and mental health. This interplay lies at the heart of general practitioners' pivotal role in integrating responses at the point of care; a point recognised in the Draft Report. In this response we will directly address the recommendations in the Commission's Draft Report.

- WentWest strongly supports the Commission's recognition of the need for a whole of government approach to addressing non-health areas impacting on the mental health of individuals and community. It is suggested that substantially stronger whole-of-government mechanisms and processes are needed to ensure that *all* government policy contributes to the mental health and wellbeing of the community and addresses some of the major drivers of mental illness.

- We also note that the environmental context is only broadly referenced in the Draft Report with no discussion on current and future impacts of climate change. The most recent Lancet Countdown report[1] provides this stark warning: *"Left unabated, climate change will define the health profile of current and future generations, will challenge already overwhelmed health systems."* Already this summer, western Sydney has experienced record-breaking heatwaves and over 21 days of hazardous air quality due to climate change induced events.[2] We would request the Commission to fully examine the evidence on climate change and mental health as a priority for the Final Report.

- The Commission's findings resonate with WentWest's experience of planning, re-designing and commissioning mental health services in diverse western Sydney primary care settings, and we are keen to engage with the Commission - particularly on how prevention, early intervention and team based service delivery can be enhanced in community and home based settings in regions – particularly those with fewer private healthcare practitioners.

- The recommendation relating to improved coherence in planning, funding, governance and delivery of mental health services across Commonwealth and state/territory government jurisdictions is also supported. However, the solutions proposed - either a 'renovate' model (increasing the capacity of PHNs to plan and respond to local need) or a 'rebuild' model (based on an entirely new governance model replacing both PHNs and LHDs) are not supported.

- Rather, WentWest advocates that – instead of potentially undoing the collaborative gains of the last four years, a third option (reinforce) is adopted: to build on, and accelerate current reform directions enhancing the substantial progress already made through regional PHN-LHD partnerships and wider collaborations, including increasing co-design with affected communities. The National Healthcare Agreement - currently under review, provides the opportunity to rapidly progress these directions.

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[1] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32596-6/fulltext
[2] https://blogs.scientificamerican.com/observations/australias-angry-summer-this-is-what-climate-change-looks-like/

Collaborative Governance and Accountability

Funding and Institutional Reform

…clinical transformation must infuse mental health care into every part of the health system. It must be rooted in an idealistic view of how things should work, but rather in how patients actually seek care.

Institute for Healthcare Improvement, Health Affairs Blog, 14 February 2019

Options 1 and 2

The Commission has proposed two options to improve clarity over funding and responsibilities in the mental health system: *Option 1 Renovate model* and *Option 2 Rebuild model.* The Commission has indicated the Option 2 is its preferred model.

WentWest welcomes the plan to strengthen place-based planning and governance and we are already well established and demonstrating this capacity. Rather than replacing existing structures and process with a new entity, with the usual 2-3-year transition period and potential loss of gains to date, we believe the better and more sustainable option is to '**reinforce' what has already been built upon**.

WentWest is already the most significant point of integration in local planning and delivery of integrated health and social care in western Sydney, in partnership with Western Sydney Local Health District (LHD) and broader government clusters (including education, families and communities, police, etc.). Joint regional mental health planning is an existing active pathway for collaborative commissioning including pooling funding for improved efficiency and effectiveness of services across jurisdictional levels with both state LHD partners and the private healthcare sector.

Governance mechanisms are already in place in Western Sydney with documented agreements between Boards and the Executives across health and social care partners as to how to jointly govern these activities. These arrangements, in place since 2014 and continually being strengthened, provides a bridge for collaboration with the social care, local government and business communities. It has also provided the mechanisms by which funding is pooled and services commissioned around the individual based on local need.

It is our strong belief that the critical aim of locally integrating care across all health domains within the social, economic and environmental context should be a central focus of WentWest's endeavours. This approach has a strong and strengthening evidence base internationally. Splitting mental health planning and funding from general health services across primary, secondary and tertiary care is not supported by WentWest and is not supported in the literature. While PHNs are a relatively new entity and receive only a small proportion of a region's total mental health funding (between 5-10%)[3], PHNs are actively leading integration across the health and social service domains in local areas to deliver better outcomes the most vulnerable in the community.

WentWest's view would not be to 'renovate' or 'rebuild' but rather to 'reinforce' and build upon the current reform approaches to capitalise on the gains achieved over the past decade of reforms – and particularly gains made since the advent of PHNs some five years ago. Building on the momentum in community, achieved integration in several areas between primary, community and acute care and capitalising on state and territory governments support for PHNs as regional commissioners can more quickly, cost effectively and appropriately achieve value for consumers.

This integration and the achievements of the past decade, in fact, are not unsubstantiated. They can be evidenced through the processes, technologies and agreements/contracts in place which govern collaboration (legally binding or otherwise). This was recognised Lucinda Brogden, the National Mental Health Commissioner, who commented that "PHNs were well placed to address mental health problems, which were so often driven by social determinants".[4]

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[3] Total funding for mental health services in every PHN region consists of three key elements: funding provided to LHDs for public mental health services and NGOs; funding for Medicare subsided primary and specialist services and funding provided to PHNs for commissioning services. The latter is the smallest component and varies between 5-10% pf total funding with rural and remote PHN regions receiving more than urban PHNs.

[4] *https://www.smh.com.au/national/1-45-billion-for-mental-health-removes-uncertainty-for-local-services-20190115-p50rhs.html*

We have also collectively made huge strides forward in western Sydney in data sharing and the availability of evidence of outcomes in line with the Quadruple Aim. Although isolated to specific interventions using evaluations, the fruits of our efforts to link data and monitor outcomes to continually enhance services around patients are beginning to show the measurable difference regional partnerships are making.

WentWest has undertaken extensive **needs analysis and service mapping** to better understand local needs and commission targeted services. We are the only region in Australia to have systematically mapped services over a five-year period. The Integrated Atlas of Mental Health undertaken in 2019, shows an almost threefold increase in the availability of psychosocial care services across the region and even greater increases for most special population groups since 2015. This has directly resulted from local planning and commissioning of WentWest with our partner agencies for the benefit of the community. Figure 1 shows the differences in relation to self-help, information, accessibility, social and health outpatient and day care between 2014 and 2019.[5]

We have, through the work of our Health Intelligence Unit, also developed a range of enhanced outcome measures for aligning commissioned services with the priorities of government and local needs.
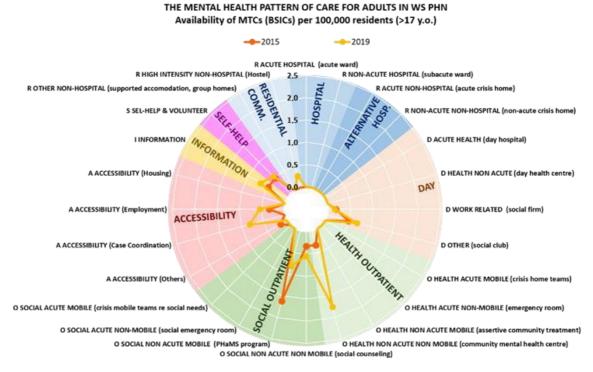

FIGURE 1 THE MENTAL HEALTH PATTERN OF CARE FOR ADULTS IN WSPHN, 2014 & 2019

The Commission recognises the importance of clear and seamless care pathways with single care plans for people with complex needs. Global evidence supports that position and that the creation and sustaining of these pathways is best achieve at a local health level.

We again reiterate that strong local planning and governance is necessary for improved and sustained integrated care. PHNs need to be provided strategic guidance and support so they are able to consistently apply systems thinking and context analysis and engage experiential perspectives to build and strengthen 'evidence-informed health care'. This means applying a combination of:

- **Evidence based medicine** – or Experimental knowledge developed through Random Controlled Trials, systematic reviews and the like
- **Observational cohort studies** – providing richer understandings of interventions and target audience impacts

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[5] Furst M, Salinas-Perez JA, Hopman K, Bagheri N, Campos W, Gillespie J, Mendoza J, Salvador-Carulla L. (2019). *The Integrated Atlas of Psychosocial Care in the Western Sydney Primary Health Network Region*. Centre for Mental Health Research, Australian National University

- **Context Analysis –** demographics and geo-spatial analysis
- 'Evidence-based health care' or '**evidence-informed policy**' - through the addition of routine big data and local context information
- **'Knowledge- guided policy'** - through the incorporation of domain experts, both within and beyond the western Sydney region, to the data analysis process
- **Experiential knowledge** – the incorporation of the expertise from those with lived experience – consumers and carers

Evidence-informed, rather than merely evidence-based, healthcare policy and practice acknowledges that policymaking is an inherently political process in which research evidence is only one factor that influences decision-making.[6]

By recognising PHNs as the arm's length, independent Regional Commissioning Authorities (RCA) for both Commonwealth and State the reforms proposed by the Productivity Commission can be accelerated for the benefit of patients, families and carers. In fact, although the term RCA is not used at present this is the role Western Sydney PHN is already starting to play across a range of funders including NSW Health through Collaborative Commission.

To achieve the vision the Productivity Commission has set out for mental health services (and other related and complementary services) this would mean movement of state and territory community mental health services[7] to a collaborative commissioning approach – jointly governed by both the LHD and the PHN. PHNs as the deemed RCA would then act upon decisions made by the joint governing body and commission services as an independent entity (not a service provider). PHNs already have a diverse set of programs and experience in combining these programs, effectively wrapping them around a patient for an outcome, and therefore can act as the fundholder to integrate service and streamline contracts for providers.

There is strong rationale for not moving all community mental health services to a commissioning model. In a range of service types, for example outpatients, there will be strong logic to maintain the current approach. In other service types, like outreach and mobile assessment and treatment services, the value services provide against the quadruple aim and the integration with other community services and with primary care could be significantly enhanced.

Wentwest is progressively overcoming the barriers to collaboration in partnership with WSLHD and the NSW Ministry of Health. What the Productivity Commission states as 'practical difficulties' (Volume 1, pg 44) can be overcome in a regional commissioning model like the one we have at present. Bringing state services under the same governance arrangement in a consistent and deliberate way would 're-reinforce' and build upon our successes while at the same time adding sophistication in a measured way so that capacity and capability can continue to grow with the market.

The model outlined above, if collaboratively governed, has the potential to deliver significant value for patients through transparency and joint system management while recognising each organisation unique value proposition (strengths and capabilities).

Activity Based Funding

We also note the Commission supports the use of Activity-Based Funding (ABF) for both hospital-based and community mental health services. We question this in the light of international experience and evidence and suggest further analysis of the evidence is undertaken prior to the Final Report.

ABF has two key components. The first component is the classification system. In itself, establishing a classification system is a positive development enabling more robust comparisons of costs for like services. To be of value, the classification has to properly mirror the real world of service delivery in a range of service settings.

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[6] Adapted from Salvador Carulla et al. (2017). From the EBM pyramid to the Greek temple: A new conceptual approach to Guidelines as implementation tools in mental health. *Epidemiology and Psychiatric Sciences*, 26(2), 105-114.

[7] **Community mental health care services** *include hospital outpatient clinics and non-hospital community mental health care services, such as crisis or mobile assessment and treatment services, day programs, outreach services, and consultation/liaison services.*

The second element is often the most problematic in ABF which is of course deciding how to fund a specific service/procedure/intervention. Here extensive costing studies are required to determine the relative cost of different classified services and then provide the funding incentives to drive desired patterns of service and change.

There are few examples of ABF being used to effectively incentive desired person centred, outcome based behaviours and certainly none, to the best of our knowledge, in mental health. The experience of ABF in mental health has tended to incentivise hospital-based care over community based care – which is in contrast to the strongest evidence for consumer outcomes.

Co-designed, person centred and outcome focussed services are required to meet people's needs in community. Implementing ABF in community mental health services may setback the system which is currently focussed on commissioning for outcomes and value. However, focussing on enhancing and properly funding data sharing and data linkage to enable timely measurement and monitoring of outcomes is needed to deliver on the quadruple aim for patients. This is already well advanced in NSW in relation to physical health under the 'Lumos Program' but does not yet include mental health activity and outcomes data.

Mental Health in All Policy

We note the Commission's reference to a range of actions to enable successful reform including:

- A new whole of government National Mental Health Strategy to "align the collective efforts of health and non-health sectors to improve mental health outcomes".
- A call for COAG to agree "on a set of targets and specific mental health and suicide prevention outcomes over a defined period".
- The "development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023", and
- "The National Mental Health Commission should have statutory authority to lead the evaluation of mental health and suicide prevention programs" (p. 881).

We wish to make several points in relation to these priority actions.

First, we fully support the strengthening of the NMHC as a statutory authority. Its current status as an executive office within the Department of Health is both unstable and inappropriate for a 'commission'. The legislation of the new entity must be informed by successful statutory authorities operating at the Commonwealth level that are tasked with complex and sometimes 'wicked' policy issues.

On the other three points, we would ask how will these be different to what has occurred in the past? All have either been incorporated in past National Mental Health Plans or agreed by COAG.

For guidance, we again refer the Commission to the discussion paper of the National Advisory Council on Mental Health and the National Health and Hospital Reform Commission (2009), setting out a broader vision and direction for mental health policy in Australia; one focussed on creating and protecting 'mental wealth' across the lifespan. [8] It had wide stakeholder endorsement at the time.

It stated:

A mentally healthy Australia is fundamental to our sustainability – economically, culturally and socially. Being mentally healthy means being in a state of complete mental, emotional and social wellbeing and this involves much more than merely 'the absence of a mental illness'. Being mentally healthy is more than having access to a first rate person-centred health care service where and when we need it.

…. To be successful, investment in a mentally healthy Australia needs to be embedded across a whole-of- government national policy framework. This means that we need to reflect a focus on mental health across the board – in our approach to education, social services, housing, employment, Indigenous affairs and so on – not just in our health or mental health services

Our vision is that all Australians can live a mentally healthy life and be able to access quality mental health services and support when and where they need it.

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[8] National Advisory Council on Mental Health (2009). *A Mentally Healthy Future for all Australians. A Discussion Paper.* November 2009. Canberra

As we have known for a long time, health outcomes, including mental health outcomes, are determined by social and environmental factors more than other factors. Policies on human rights, taxation, employment and income, transport, housing, education, parenting and early childhood, aged care, public infrastructure and the built environment, social security and immigration – all beyond the responsibility of health Ministers and their agencies – impact positively and negatively on individual's and community's mental health and wellbeing.

The intergovernmental arrangements ensuring that consideration, at the very least, is given to policies in these areas, before they are implemented and active monitoring is operating, must be given priority at the highest level of all Australian governments. Cross-portfolio and intergovernmental governance arrangements must be strengthened with greater community leadership and engagement and greater transparency.

One option, developed by previous Secretary of Treasury, Dr Ken Henry, was the establishment of a Social Impact Unit within that department. The Departments of Treasury, Finance and/or Prime Minister and Cabinet are the appropriate central agencies at the Commonwealth level to ensure there is a capacity to apply **mental health to all government policy** and funding decisions. A similar arrangement existed in the South Australian Government under Premier John Bannon through the Human Services Sub-Committee of Cabinet.

To continue to not build health and mental health policy into all policy, will simply contribute to the challenges now so evident in the mental health and wellbeing of the Australian community.

Accountability

A point acknowledged by the Commission in the Draft Report is the absence of accountability in mental health at all levels.

We would emphasise that a critical related issue is the **lack of access to data.** De-identified service utilisation and outcomes data must be available to program planners, researchers and most importantly the Australian community to enable informed decisions – from new investments and closing services to making an informed choice of a provider.

As we made clear in the WentWest submission, there has been a constant cycle of reports emanating from statutory authorities over the past 20 years on aspects of the mental health system often with the same recommendations repeated. This is costly and may undermine reform efforts. Governments need to consider how agencies can be held accountable if they fail to implement the changes recommended by auditors and statutory authorities.

Further, we need to develop formal processes by which the findings of independent audits are reviewed systematically, and the outcomes made available in an accessible form to the Australian Health Ministers' Advisory Council (AHMAC) and/or the Council of Australian Governments (CoAG) and to consumers and carers and those who represent them.

Examples of Collaboration in Healthcare in Western Sydney

Collaborative Commissioning

WentWest and Western Sydney Local Health District have been successful in gaining funding for a joint commissioning program of works, over several years. This program builds on previous collaborations and applies the 'reinforce' approach described previous at scale (increasing pooled funds over the next three years by more than 30 times). It is focused on translating the collective ambitions of our Boards and Executives to reframe past paradigms and reform the western Sydney health system.

The aims of the project are to:

1. Collectively deliver 'one western Sydney health system' which is value based and patient centred.
2. Deliver the right care, at the right time and the right place – in community and primary care wherever possible.
3. Improve equity in health, reducing health risk, promote healthy lifestyle and respond to social determinants.

Key features of the work that is being developed includes:

- Moving from input and activity to outcome-based commissioning - Reforming western Sydney 'joint commissioning' of service models and funding of inputs/activities to collaborative commissioning of activity and incentivising outcomes and value across providers.

- Consolidating and enhancing governance to enable an enhanced governance model for broader western Sydney collaboration. Collaborations with our Sydney service Deliver Reform, which includes significant other departments such as Treasury and the Police and Education clusters, will help address the social determinants of health.
- Scaling collaboration to realise system wide impacts by thinking as 'one system, one team' and working accordingly.
- Considering macro, meso and micro reforms required to realise short, medium- and longer-term impacts, with a specific focus on change management, 'changing hearts and minds' and orienting the system to a new way of operating.
- Embedding a co design approach with consumers and clinical councils.

In addition to the above the objective is to reduce the number of people with low acuity conditions who would otherwise have gone to a western Sydney emergency department, while increasing the quality of the patient experience through the provision of patient centred care at the right time in the right place.

Western Sydney Service Delivery Reform

Looking beyond physical and mental health services and acknowledging the importance of the social determinants of health, in 2014 the Western Sydney Service Delivery Reform initiative was established giving those on the front line across health and human services the mandate to work across agency boundaries. SDR focussed on innovation and delivering what is needed at the local level to achieve the collective vision for *all children, young people, families and communities in western Sydney to be healthy, resilient and thriving*.

Western Sydney Service Delivery Reform (SDR) is being driven by Western Sydney Local Health District, WentWest (WSPHN), NSW Department of Communities and Justice (including Police and Youth Justice), NSW Department of Education (DoE), Sydney Children's Hospital Network (SCHN) and Aboriginal Housing Office (AHO). The coalition is supported by Western Sydney University (WSU), Their Futures Matter (TFM), NSW Treasury and the NSW Department of Premier and Cabinet (DPC).

We work in partnership with stakeholders, communities and families in western Sydney to:

- Deliver and commission cohesive and integrated service pathways and models of care.
- Build protective factors and strengthen the capacity and resilience of children, young people, their parents and families.
- Develop nurturing and inclusive communities with strong collective capacity, networks and relationships.
- Increase awareness of the impact of childhood adversity on health and wellbeing outcomes.

The five current projects are:

1) MaSH - Making a Safe Home

Making a Safe Home works with vulnerable families whose children are either at high or imminent risk of entering the out of home care system. The initiative also aims to assist in the restoration of children to their parents, where it is deemed to be in their best interests to do so. It was developed through a multi-agency co-design process and provides practical home support for as long as the client needs it.

Agencies involved:

The MaSH program is offered to families by the Department of Communities and Justice (DCJ) (Western Sydney/Nepean Blue Mountains Districts, in partnership with Western Sydney and Nepean Blue Mountains Local Health Districts.

Project outcomes:

To date over 105 families have been supported by the program with 70% of those cases being closed after being assessed by DCJ as demonstrating ongoing safe parenting for their children. As at the end of 2019, there were 43 families comprising 114 children being supported in the program.

2) Vulnerable Families

The Vulnerable Families program provides a central point of contact for families living in western Sydney with identified health care needs. Access to public health services is arranged, or private services sought where needed, utilising DCJ brokerage funding.

The initiative led to the establishment of a Vulnerable Families Coordinator, sitting in WSLHD who looks at the holistic health care needs of the whole family and provides a central point of contact for DCJ caseworkers to consult with and refer to. Where the public health system cannot meet the families' needs in a timely manner, private health services are facilitated utilising DCJ brokerage funding.

Agencies involved:

Department of Communities and Justice (DCJ) and Western Sydney Local Health District (WSLHD).

Project outcomes:

Implementation of the project has led to caseworkers having a greater focus on meeting the health-related needs of the children and families that they work with. It has contributed to improved and more timely access to health services for vulnerable children, young people and their families as well as early identification, better coordination and a more holistic approach to care for vulnerable families. It has also led to better value for money, significantly improved relationships between DCJ caseworkers and WSLHD staff and has provided for the development of a continuum of care model with a range of other projects being implemented under or linked to the Vulnerable Families Project.

As at October 2019 415 families with 769 children had been referred to the Vulnerable Families Coordinator for access to health services.

3) Middle Years Project

The Middle Years Project is a multi-agency transition project for students in Years 5 – 8. The middle years are a critical period for students as they experience changes physically, cognitively, socially and emotionally. Many vulnerable students disengage with school during this period and may have increased contact with mental health and correctional services.

The Middle Years project provides assistance for students requiring additional support with their social, emotional and learning needs and behaviour regulation. The project commenced in February 2017 with a focus on two Primary schools in western Sydney and one high school. The aim is to minimise vulnerability by increasing attendance and engagement at school and connectedness with the community and their culture.

Agencies involved:

Education, Department of Community and Justice, NSW Health, Police, Wentwest.

Project outcomes:

- The identification of the language needs of this cohort of students and the subsequent recruitment by NSW Health of a Speech Pathologist who works across the three schools. The Speech Pathologist provides screening and assessment of the students and professional development for the staff.
- NSW Health provide health screening and referrals for the students identified in the cohort.
- NSW Police and the High school are collaborating to offer a Deadly Truths program for the ATSI students.
- The recent recruitment by Education of a Community Liaison officer will strengthen the connections across the schools and with the families.

4) Thriving Families NSW – Their Futures Matter

Thriving Families NSW is a strengths-based model to wrap services around vulnerable young parents by ensuring they have access to appropriate services that meet the needs of their whole family. The approach includes pregnancy and post-pregnancy support meetings, outreach services provided by a multidisciplinary health team, and a dedicated care coordinator to help the family navigate the service system and build a network of supports to empower vulnerable young families and help them thrive.

Agencies involved:

Thriving Families NSW is delivered as a partnership between Western Sydney Local Health District, Department of Education Department of Communities and Justice and WentWest (WSPHN) and funded by the NSW Stronger Communities Investment Unit – Their Futures Matter. It also works with a range of other government and non-government agencies.

Project outcomes:

As at November 2019, the program has had 110 families referred. Many of these families are quite transient and move out of area or escalate to Risk of Significant Harm and / or have had children removed rendering them ineligible for the program.

To date 42 families have consented and engaged in the program, and 27 families remain actively engaged.

5) Pregnancy Family Meetings

Pregnancy Family Meetings (PFM) provides pregnant women an opportunity to address identified child protection concerns prior to the birth of her baby. The PFM process is voluntary and is offered to women as one of the options available to them when working with DCJ. The overarching aim of PFM is to support parents with identified child protection concerns in being able to reduce the risks for their unborn baby in the antenatal period, and to be able to care for their baby at home in a safe and nurturing environment.

The model facilitates multi-agency collaboration to improve longer term outcomes for vulnerable families. The process aims to increase safety and reduce risk for children of clients who have been allocated to a DCJ caseworker during the antenatal period and who are attending a WSLHD hospital for antenatal and/or birthing care. The caseworker will be tasked with completing the safety assessments, offering PFM as a tool to address the identified concerns and provide the ongoing casework services to the client to manage the risks prior to the birth of the baby.

The PFM will offer the woman and her family an opportunity to participate in open and transparent discussions with Health and DCJ, regarding the risks and strengths within the family, whilst identifying changes that need to be made to reduce the risk of harm to the unborn child. The meetings focus on engaging the family in problem solving and utilise independent facilitators to guide the discussion.

Agencies involved:

Pregnancy Family Meetings (PFM) have been implemented in WSLHD from 2015 as a partnership between WSLHD and Department of Communities & Justice (DCJ).

Project outcomes:

Since commencement of the PFM in April 2015 to 31 December 2018, 77% families retained the care of their infant at birth. The majority of families participating in the PFM were dealing with a combination of stressors. 63% were current or previous victims of domestic/family violence. 63% women reported experiencing mental health difficulties. 77% women reported had past or current problematic drug/alcohol use.

Mental Health Youth Navigator Project

As a leading cause of death for young people aged between 15-24 years, suicide and suicidal behaviour continues to have a significant impact on communities in NSW. In 2017, 106 young people aged 15-24 lost their lives to suicide in NSW. And for every attempted suicide, it is estimated that a further 30 people make an attempt (Mental Health Commission of NSW, 2018).

In Victoria, between 2008-09 and 2014-15, the number of mental health ED presentations increased by 6.5% per year among children and young people aged between (0-19) years. (Hiscock, Neely, Lei & Freed, 2018). In NSW, a remarkable increase in children and adolescents ED presentation related to mental health concerns has been flagged. The preliminary data suggests that young people are not receiving a follow-up service after presentation. It is estimated that approximately 20% of suicide attempts could be reduced by providing effective aftercare, assertive follow up and crisis care (see Figure 1) (Blackdog Institute, 2016). A range of after-care models have been trialled across NSW however, there is currently no consistent model of aftercare offered to people following an ED presentation and no aftercare model has been tailored to address the needs of children and adolescents.
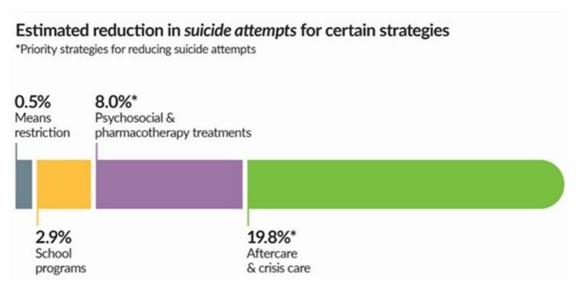
Estimated reduction in *suicide attempts* for certain strategies
*Priority strategies for reducing suicide attempts

0.5%
Means
restriction

8.0%*
Psychosocial &
pharmacotherapy treatments

2.9%
School
programs

19.8%*
Aftercare
& crisis care

FIGURE 2 : Sourced from the Black Dog Institute, 2016

As a response, WentWest and Western Sydney LHD Perinatal, Child and Youth Mental Health Services (WSLHD PCYMHS) have collaboratively co-designed and developed the Child and Youth Mental Health Navigator project to address the gaps and as a part of implementing the priorities which have been identified in the Strategic Framework for Suicide Prevention in NSW 2018-2023 and based on the WSPHN Needs' Assessment Reports (November 2017 and December 2018).

In 2018, the pilot project Child & Youth Mental Health ED Navigator model of care was founded on the principles of patient centred and continuity of care, service integration and collaboration. The main activities for this project was to provide two Mental Health Clinical Nurse Consultants (Grade 1) to support children and adolescents who frequently presenting to the three major sites receiving presentations in the target group, being Blacktown, Mount Druitt and Westmead Emergency Departments for Mental Health concerns that do not meet the threshold for in-patient admission.

The CNCs roles were to utilise the agreed service maps to assist the child, young person and their family to navigate the system and find the right mental health care, at the right time, in the right place and work closely with General Practice and community based services.

General Practice

Since 2002, WentWest has maintained an unwavering commitment to General Practice and primary health care development. Our submission set out a range of initiatives that are transforming primary health care in western Sydney. This work is informed by the world's leading primary care systems in the US, UK and NZ. We recommend that the Commission examine these models and the evidence in preparing the Final Report.

> *A strong primary care system is essential to the equity, efficiency and effectiveness of the health system and improvements in health outcomes*
>
> Russell and Dawda, Menzies Centre for Health Policy, Feb 2019.

The view expressed in the quote from this recent review of PHNs, is one that has been documented many times by many of the world's leading health organisations – WHO, Institute of Medicine, Institute of Healthcare Improvement and others.

In the Australian context, primary health care is supported through the Medical Benefits Scheme or Medicare. Approved providers receive payments for a schedule of over 5,000 services or items. The fee-for-service or occasions of service funding model supports the overwhelming majority of primary care practice in Australia. It does not readily support the exemplary primary care practices documented by Bodenheimer et al or the Institute of Healthcare Improvement[9], and others around the world.

Russell and Dawda (2019), Duckett[10] (2015) and many other Australian researchers have pointed to the Medicare fee-for-service models hindering the adoption of collaborative and integrated care.
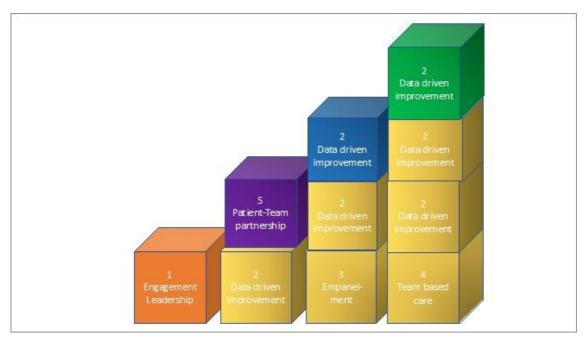
Exemplar primary care has the **Ten Building Blocks** shown below and presented in our Submission. The four foundational elements – engaged leadership, data-driven improvement, 'empanelment' or the linking of each patient to a care team and a primary care clinician, and team based care – assist the implementation of the remaining six building blocks.

Primary care models such as the Patient Centred Health Care or Medical Home do embody these elements. In Australia, the closest model to these is the DVA 'White' and 'Gold' Health Care schemes. Nonetheless, the DVA model lacks a number of the elements described by Bodenheimer.

Fundamental reform to Medicare, and associated primary care funded programs, is required if Australia is to be able to meet the challenges of an aging and more diverse population, address the growing inequality of access to MBS-subsidised services and address the **mental health needs** of the population in 21st Century. **Mental health reform requires health reform** – without broader system reforms, mental health reform will remain at the margins of health care. That reform should be driven by aligning our major funding programs to the Ten Building Blocks framework.

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[9] Institute for Healthcare Improvement. (2015)

[10] Duckett S, Beaumont M, Bell G, Gunn J, Murphy A, Wilson R & Crowley T (2015). *Leading Change in Primary Care: Boards of Primary Health Networks can help improve the Australian health care system.*

FIGURE 3 THE TEN BUILDING BLOCKS OF HIGH PERFORMING PRIMARY CARE[11]

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[11] Bodenheimer T, et al (2014). The 10 Building Blocks of High Performing Primary Care. *Annals of Family Med.* 12(2); 166-171

Social Determinants

The Draft Report acknowledges the importance of addressing social determinants of mental health and identifies housing, employment, justice and income support in the discussion. Education is also extensively discussed in other sections of the report, but not in the context of social determinants.

There is no dispute that social, environmental and economic factors play a significant role in shaping the health and wellbeing of individuals and populations. The links between social determinants of health and the development of diseases and conditions, including mental illnesses, are usually associated with access to opportunities and resources such as family support, quality education, adequate and meaningful employment, safe and affordable housing, accessible transport, nutritious food, safe local environments and accessible health services. Income also plays a critical role as it provides flexibility and options.

Evidence dating back to the 1950s shows the impact of social determinants (childhood circumstances, education, housing, occupation and income) on an individual or community's mental health and suicidal behaviour.[12] It is increasingly clear that levels of mental distress among communities need to be understood less in terms of individual pathology and **more as a response to relative deprivation and social injustice**, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing.[13][14] Disadvantage starts before birth and accumulates throughout life.

We wish to reemphasise the importance of this evidence in our Response to the Draft Report.

The more recent research emphasises it is not poverty per se, but **relative disadvantage** that impacts adversely on the mental wellbeing of individuals, families and small communities that have fewer economic, social and environmental resources.[15] A review of the evidence in 2016 found the main **individual factors** shown to have a significant independent association with worse mental health were low income, not living with a partner, lack of social support, female gender, low level of education, low socio-economic status, unemployment, financial strain and perceived discrimination. The **area level** factors associated with mental health were neighbourhood socioeconomic conditions, social capital, geographical distribution and built environment, neighbourhood problems and ethnic composition (i.e. a lack of diversity and a high Indigenous proportion of the population).[16]

The Commission's Draft Report makes few recommendations on addressing either these individual or area level factors. If Australia is to see a sustainable reduction in the levels of psychological distress and mental illness then actions to address these social determinants is essential, particularly in regions such as western Sydney and LGAs such as Blacktown.

We note and welcome the Commission's focus on early childhood and the expansion of health checks to include social and emotional development and the expansion of parent education and support. We believe this goes only some way to addressing the complex needs of vulnerable infants and children. Programs such as The First 2,000 Days and Maternal Early Childhood Sustained Home-visiting (MESCH)[17] are examples of integrated prevention programs and should be available nationally.

MESCH was developed as an effective intervention for vulnerable and at-risk mothers living in areas of socio-economic disadvantage. The MECSH program draws together the best available evidence on the importance of the early years, children's health and development, the types of support parents need, parent-infant interaction and holistic, ecological approaches to supporting families to establish the foundations of a positive life trajectory for their children. The MECSH program requires organisations, and practitioners to work differently with families, to truly act on the rhetoric of prevention and early intervention to improve outcomes for some of the most vulnerable families.

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[12] Hollingshead AB & Redlich FC. (1958). *Social class and mental illness: Community study.* Hoboken, NJ, John Wiley.

[13] Pickett KE, et al. (2006). Income inequality and the prevalence of mental illness: a preliminary international analysis. *Journal of Epidemiology & Community Health* 60(7): 646-647.

[14] World Health Organisation Europe. (2009). *Mental Health, Resilience and Inequalities*. Copenhagen, Denmark, WHO

[15] World Health Organization & Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health.* Geneva.

[16] Silva M, Loureiro A & Cardoso G (2016). Social determinants of mental health: a review of the evidence. *Eur J Psychiat;* 30(4): 259-292.

[17] https://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/about-mecsh

The MECSH program is delivered as part of a comprehensive, integrated approach to services for young children and their families. The program is delivered by child and family health nurses who are embedded within universal child and family health nursing services. The program is managed by universal child and family nursing services and embedded within the broader child and family health services system. The MECSH program uses a tiered service model, which encompasses the primary health care and more specialised services that families may need.

Tier	Key Program provider	Other providers	Function	
Tier 1 Primary level of care	Child and family health nurse	• Midwives • General practitioners • School teachers	• Provide primary level of care • Identify problems early in their development • Offer general advice • Health promotion and prevention	
Tier 2 A service provided by professionals relating to workers in primary care	Social Care Practitioner/s*	• Cultural health workers • Paediatricians (especially community) • Perinatal psychiatrist/ psychologist • Allied health workers • Mental health workers • Drug and alcohol health workers • Housing workers • Community Service workers	• Training and support of professionals within Tier 1 • Consultation with Tier 1 professionals to support their delivery of prevention and early intervention programs with families • The social care practitioner can provide psychosocial support and brief intervention for families	Extended Program team
Tier 3 A specialised service for more severe, complex or persistent issues		• Paediatricians • Perinatal psychiatrist • Allied health teams • Mental health teams • Drug health teams • Psychologist • Housing (including refuges) • Child Protection Services • Family support workers	• Assessment and treatment • Assessment for referrals to Tier 4	Specialist referral services
Tier 4 Tertiary level services such as day units, highly specialised out-patient teams and in-patient units			• Inpatient and residential care • Specialist teams (eg. for developmental delay, child abuse) • Specialist provision of treatment services	

* Social Care Practitioner/s in this context are defined as a professionals who work to provide direction for individual development and control over life situations and to alleviate personal pain and distress. These roles include instrumental support (e.g. assistance with housing, child care and community service issues) and psychosocial support (e.g. brief counselling sessions).

FIGURE 4 MESCH PROGRAM ARCHITECTURE