



Integrated Mental Health Care

The extent to which the Productivity Commission “Shifting the Dial Supporting Paper No. 5” (The Paper) provides a useful information for advancing integrated mental health care in Australia.

Overview

Various initiatives to support the development of integrated mental health care in Australia have been explored over the past decade. Despite this, service delivery for the individual, taking into account the multiple providers that mental health consumers with complex needs have contact with, remains fragmented.

Much of what is covered in the Paper can usefully be applied to mental health services (MHS). However mental health service examples are rarely referenced. There is only one reference in 28 pages of references, one mention in the general text and no mentions in Appendix A which refers to examples of Integrated Care in Australia. Given therefore mental health care involves the person, their families, intimate relationships and communities as core foci of assessment and service delivery the paper inevitably falls short in terms of its value for integrating care for mental health consumers.

Critically the paper has a regional focus for integration whereas equally if not more important for mental health consumers are the interorganisational and individual aspects of the service delivery system including the part that they themselves may play in it. For the paper to be more useful for MHS, the issues and challenges of integrating mental health services with each other and within mainstream services needs more attention. If this had been the case then it is proposed, not only would there been added value for mental health services but also the general health services that receive the greater proportion of attention. The maxim “no health without mental health” being a case in point.

This said, much of what applies to integrating general health services also applies to mental health services and in this respect the Paper is quite useful especially in it’s early sections in specifying general areas for attention and improvement.

Key points relevant to the integration of MHS in the Paper

Section 1 of the Paper makes clear that a key future direction for the Australian Healthcare system is that should be well integrated. This is particularly important for mental health services.

There is reference to the “quadruple” aim and the need to be thinking across all levels of the health care system (ie the macro, meso and micro levels) from Government and State policy through to enter agency collaboration and finally the coordination of patient care in terms of prevention, treatment planning and care coordination. In terms of the latter the reference made to providing GPS with a discharge summary is particularly relevant to improved mental health services delivery. The section also refers to the fact that “lean thinking”, new funding and governance arrangements, consumer power, good communication and performance metrics are essential patient centred, integrated care.

Sections 2 & 3 of the paper focus in on patient centred care. Arguably this has been a key concern of mental health services for at least the last two decades, to the extent that it is embedded in national policy and practice, in terms of mental-health “consumer recovery” and in advance of its more widespread presence in the general health literature. The mental health literature is therefore much more nuanced than the Paper and could have added value to it in terms of what patient centred care means in practice and how to achieve it.

Notwithstanding this however, the comments made about patient centred care not being the dominant model in Australia would still in many respects, apply to mental health care as much as general health care. Comments made about the expense all waiting times would also be relevant to mental health services.

Section 3 cites a number of initiatives that could or have been undertaken to make care more patient-centred, including upholding the legitimacy of the concept, improving health literacy and role that might be taken by the use of the “My Health Record”.

These are all useful however fall well short of what mental health services have come to expect as far as an emphasis on empathy, dignity, identity, culture, self-determination and autonomy are concerned. Moreover, while there is certainly value in referring to the “My Health Record” MHS consumers in particular tend to be wary of how information is conveyed and utilised by professionals. Much more personal means of communication are sought in the first instance. Section 4 stresses regional approaches to integration referring to the development of LHNs and PHNs and collaboration between them and reinforce the point that “relationships matter”.

Local is not defined other than by reference to LHN and PHN areas and efforts that have been made to align them as far as possible.

Reference is made to other providers such as NGOs and Local Government Agencies (LGAs) such as Justice, Housing, Education and Family/Community, but the emphasis is on LHNs and PHNs. In MHS NGOs, including consumer and carer advocacy organisations, and LGAs form an increasingly important aspect of the MHS delivery systems.

This is not to say however that Regional Integration is not important as far as MHS are concerned. However, given their importance in patient centred care and MH recovery, Family and Community Services (or their equivalent in States other than NSW) and Housing, Police and Ambulance should be included at the Regional Level in any initiatives to integrate MH care on a regional basis.

There is also a critical need for the Paper to elucidate and strengthen initiatives to integrate care at a meso (interorganisational) and micro (clinical) levels for MH Consumers. Experience in NZ indicates that “good will” and contracts with individual providers does not guarantee integrated care. In fact, there is much to be said for local providers contracting with each other (perhaps as ACOs) to ensure that services and professionals work in the best interests of consumers.

Section 5 & 6 refer to the insufficient financial incentives for a system wide approach to integrated care. It focuses on examining the incentives “suppliers should have to direct people to the most suitable and cost-effective services and where possible, prevent the

onset of chronic conditions". The main mechanisms described include ABF, fee for service and how Private Insurers are limited by their claim frameworks.

These are all important in any consideration of how efficiencies are found vis a vis people with "high prevalence" MH disorders (anxiety, depression and addictions) but are limited when taking into account people with low prevalence, "high cost" disorders such as schizophrenia. The Paper makes the point that the integration of hospital-based care stands to be improved and costs lowered with ABF but as things stand community based initiatives and integration restricted. If this is the case for General Health for MHS ABF could be disastrous as far as the implementation of national MHS policies relating to community based integrated care are concerned, by preferencing the funding of inpatient care.

This said, it is possible that commissioning of community MHS by PHNs could redress the situation, at least to some extent. However, as the Paper points out PHNs are underfunded to adequately perform their functions let alone beginning to meet the requirements of ensuring that gaps in community MHS are sufficiently funded and integrated.

For low prevalence disorders, "block funding" remains an important mechanism. However, this needs to allow for sub-contracting of services by LHNs for funding MHS are still being worked out. Mechanisms for providers to pool funding and/or to be able to bid for joint contracts to cover populations with high and complex needs are still not available in a form that would draw MHS providers together.

It is important to note however that a number of options are cited in Section 6 the Paper, including those which could cover ABF interventions outside a hospital setting, blended PHN payments the establishment of a "Prevention and Chronic Condition Management Fund" (PCCMF) which could be explored for application to the needs of the chronically mentally ill.

There is also reference to Health Care Homes (MH equivalents are Community Respite and Home Based Treatment) and "managed competition" which deserve consideration. Sections 7 describe the funding of quality care in an integrated system and Section 8 the role of patient incentives. No reference is made to MHS examples despite high incident rates in MHS and the section focuses on physical interventions that have low cost effectiveness or no value. Reference to Practice Standards and Training is noted but of little value as described to integrating MHS.

Given that the treatment rate in high prevalence disorders such as anxiety is around 40% the best patient incentives are likely to be a more realistic funding of their treatment rather than a "10 session" programme with an 8 session extension.

Section 9 refers to information collection and management. It is a useful chapter for MHS, but it says nothing about on-line treatment programmes and the apps that are now available to encourage patients to take medication, record symptom intensity and progress or survey potential providers among the range of apps becoming available for MH consumers.

Section 10 gives a very high-level view of implementing new systems of integrated care. The paper focuses, in line with regional focus favoured by the Commission, on initiatives that can be taken at this level and in particular by primary healthcare networks and practitioners, saying very little about inter-provider collaboration or care coordination so critical in the care and lives of MH consumers. Taken in combination with Appendix A which refers to

Integrated Care in Australia the paper and makes no reference to MH examples apart from the use of the K10 (Kessler) to identify depression, this section is disappointing in terms of its relevance to MHS.

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