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Member Briefing

1 November 2019

Mental Health Productivity Commission Draft Report

Introduction

The Productivity Commission (the Commission) has published the draft report of its inquiry into the mental health system. The report sets out a compelling case for reform to Australia's mental health system, proposing reforms across many domains of the community and economy.

The Report offers a significant number of reform recommendations. The VHA has selectively summarised those most relevant to the architecture of the mental health system, and those that would apply to acute hospital and community-based settings. The Report goes into great detail across a number of non-health domains, however, these recommendations have not been included in this briefing. The full draft report can be viewed here: https://www.pc.gov.au/inquiries/current/mental-health/draft

Commentary

The scope and ambition outlined in the Report is vast and encompasses findings and recommendations across all parts of the Australian community and economy, including health, justice, housing, addiction services, workplaces, schools and education settings, and importantly, the roles and responsibilities of governments.

The potential reforms to the delivery of acute and community-based mental health services are significant. The Report proposes a major change to the system architecture, led by the development of a National Mental Health and Suicide Prevention Agreement through COAG, with new governance and funding arrangements for mental health supports and suicide prevention activities.

This Agreement would be a separate from the existing National Health Reform Agreement, and would codify government responsibilities across all tiers, and facilitate transfers of funds from the Commonwealth Government to the state and territory governments in return for a new monitoring, reporting and evaluation framework.

The Commission sets out two options for achieving its proposed reforms.

The first is the 'renovate' model, which would see a continuation of the current governance and funding approach, with some changes to improve the flexibility of PHNs and enabling them to contract with Medicare-funded clinicians. Mental health services in public hospitals and in the community would remain the responsibility of state and territory governments. Community mental health services would have their funding changed from block allocations to an activity-based model.

The Commission's preferred approach is the 'rebuild' model, which would see most mental health funding held in regional funding pools controlled by each state and territory government and administered by regional commissioning authorities (RCAs). RCAs are intended to create a seamless system offering continuity of service provision and a material means of addressing gaps between the existing services run by the various tiers of government.

The Commission proposes the following funding lines to be administered by RCAs:

- Payments by state and territory governments for mental healthcare under the National Health Reform Agreement
- Funding for PHN-commissioned mental healthcare (under the 'rebuild' model, PHNs would lose their commissioning role for mental health services)
- Additional payments proposed for psychosocial and carer supports.

Relevant recommendations of the Productivity Commission

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- The National Mental Health Commission should be afforded statutory authority to support its role evaluating mental health and suicide prevention programs.
- State, territory and commonwealth government funding for mental health supports should be pooled to improve care continuity and incentivise innovation.
- A National Mental Health and Suicide Prevention Agreement should be developed through COAG that includes:
  - Specific responsibilities for each tier of government to fund and deliver mental health services and supports, and suicide prevention activities
  - New funding and governance arrangements between states and Commonwealth for mental health services and supports, including the mechanism for establishing funding allocations
  - Recognition of the importance of separating funding and governance arrangements of mental health from those of physical health
  - Governance arrangements for RCAs.
- State and territory governments should be enabled to provide additional funding to MBS-rebated out-of-hours GP services with the agreement of PHNs, as a means of reducing mental health-related ED presentations.
- PHNs should cease to be directed to fund headspace centres and instead allocate funding according to regional needs, which could include headspace centres or other more appropriate providers.
- New models of funding and mental health care could be trialled by regional commissioning bodies (RCAs or PHNs) using cashed out MBS rebates for allied mental health professionals, then administered through means of their choosing.
- The regulations that prevent private health insurers from funding community-based mental health services should be reviewed with the aim of increasing the scope for insurers to fund programs that prevent avoidable hospital admissions.
- MBS-rebated psychological therapy should be evaluated and additional sessions trialled, increasing the number of available sessions from 10 to 20 in a 12-month period.
- State and territory governments should assess the number of public acute mental health beds, specialist mental health community treatment services, and sub-acute bed-based services to meet the needs of each region, then undertake to provide these on an ongoing basis.
- State and territory governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness. In addition, hospitals should improve the emergency department experience, including through separate spaces, or otherwise creating an environment suitable to the needs of people with an acute mental illness.
- Child and adolescent mental health beds should be separate from adult mental health wards. Where this is not possible, state and territory governments should contract with private providers or provide care as Hospital in the Home.
- Aftercare should be offered to anyone who has presented to a hospital, GP or other government service following a suicide attempt. Aftercare should be provided directly or referred, and include support prior to discharge, as well as proactive follow-up support within the first day, week and three months of discharge.

Next steps

The Commission is seeking submissions on its Report, its recommendations and on a number of specific questions outlined in the report.

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