Submission to Royal Commission into Victoria's Mental Health System

Introduction

Healthscope appreciates the opportunity to provide a submission to the Royal Commission into Victoria's Mental Health System, as we note that reviews of the mental health sector, including the National Mental Health Strategy rarely, if ever involve the private mental health sector.

This omission does not accurately reflect the pivotal role of private providers in the provision of mental health services within Australia, where over 34,000 patients per annum are treated in inpatient facilities, with many more participating in outpatient programs, or in private psychiatry consultations.

And whilst the Victorian Government is to be commended for recognising the high level of stress being experienced by the public mental health sector and more importantly by its consumers, with over 45% of Victorians holding private health coverage, this Royal Commission should not limit itself to an examination of public mental health system in isolation. To complete such a process would not only exclude important voices but may also lose the opportunity for synergised solutions; ignoring a private sector ready to partner with and support, the provision of public mental health

Many of these insured patients are being needlessly directed into public mental health units, often to leverage private health insurers as an alternate finding source for public health, but for some patients, simply because the disconnect between private and public mental health services is too difficult to navigate, especially in times of crisis.

Healthscope believes that to provide the required scale and standard of mental health care to all Victorians, we must look at a whole-of-sector solution. There are more similarities than differences between the private and public mental health systems and to view these two halves as separate, loses the opportunity for an integrated partnership approach to the mental health of Victorians. Both systems seek to provide timely access to the highest standard of evidence-based care and to accompany Victorian's on their journey to mental health.

In recent years, there has been an increasing recognition of mental health issues across the spectrum of severity. In concert with this has been the acknowledgement that all degrees of mental illness are deserving of attention, and that early intervention in a person's mental duress can play a key role in preventing an escalation to more serious forms of mental illness. With the public system struggling to meet the demands of even the sickest patients, those patient with moderate but escalating mental illness have become the "missing middle"; unable to access timely treatment until they are in crisis.

The stigma in seeking mental health treatment continues to be weakened and whilst this must be viewed as a positive development it has led to an increasing number of people seeking community-based and inpatient mental health treatment across both the public and private mental health systems.

Healthscope's private mental health facilities are seeing approximately 30% of referrals originating from consumers or their families directly contacting our inpatient hospitals rather than through medical practitioners. These people have often been turned away from public mental health facilities . This level of self-referral is unique to mental health services, and reflects a level of difficulty and in some cases desperation, in attempting to navigate the mental health sector as a mentally unwell individual.

In addition, up to 30% of mental health patients in public hospitals and emergency departments throughout Victoria hold private insurance however are remaining within the public system for their care. This not only places an unnecessary burden on a system already under duress, but inevitably, displaces public patients back to the community placing them at risk.

It is becoming increasingly obvious that one cannot examine the public mental health system in isolation, as it forms part of a private-public-community mental health ecosystem which must work synergistically to provide access and excellence in mental health care to Victorians.

It is Healthscope's position that the private mental health sector should be a key pillar in mental health provision in Victoria, and must play a pivotal role in conversations regarding the future of the mental health sector. Healthscope seeks to lead the private sectors engagement in such conversations.

There is abundant opportunity to create partnerships between public, private and others within the mental health sector, both on an individual service/ microscopic level but also at a wider macroscopic sector and policy level. Healthscope believes that such partnerships hold the key to a truly integrated and functional mental health system in Victoria.

Healthscope

Healthscope is Australia's second largest private healthcare provider operating 43 acute, subacute and mental health facilities across Australia. Healthscope currently services 630 inpatient mental health beds across Australia, supported by a diverse suite of comprehensive outpatient and outreach community treatment programs. Healthscope partners with thousands of private psychiatrists, nurses, psychologists and other allied mental health practitioners to provide multidisciplinary and evidence-based mental health care.

Healthscope provides treatment for healthcare consumers across the continuum of care and seeks to partner with clinicians and patients to provide access to both community and facility-based care.

As in the public mental health sector there has been an increase in recent years in private health consumers seeking to access mental health care. Accompanying this has been an increase in acuity of mental illness as well as in the number and complexity of comorbid conditions, both mental and physical. This has placed a demand on private mental health services and an inevitable shift in the acuity of the inpatient cohort.

Healthscope's private mental health facilities are seeing approximately 30% of referrals coming from consumers or their families directly to our inpatient facilities rather than to individual medical practitioners. These patients are then triaged by Healthscope mental health practitioners and referred appropriately either to inpatient or outpatient services as required.

This level of self-referral is unique to mental health services, and reflects a level of difficulty and in some cases desperation, in attempting to navigate the mental health sector as a mentally unwell individual.

Private mental health sector and private health insurers

Healthscope welcomes the Minister for Health, Hon Greg Hunt MP's, announcement of the private health insurance reforms that allow for the immediate upgrade for people requiring admission to a private psychiatric hospital where their health insurance product does not fully cover the costs of treatment.

There are still however potential restrictions that may be placed on policies by way of the Hospital Purchaser Provider Agreements between health insurers and hospital operators. In differentiation to acute medical or surgical patients, mental health consumers may require more frequent readmission during acute illness stabilisation, and there is significant opportunity for partnership with private health insurers to address how to address this and other challenges, through innovative models of care and funding.

This will protect the public mental health system from unnecessarily absorbing privately insured patients based on funding and administrative reasons.

Partnerships and whole of sector strategy

There is great opportunity for partnerships between private health providers and government, NGOs, community, private health insurers and public hospitals. Innovation and evidence base should cluster conversations based on patient centred pathways rather than arbitrary delineations in funding models.

In addition, a whole-of-sector approach to a needs analysis of current and future growth areas in mental health is essential to an integrated approach. Demand for clinical subspecialties such as anxiety, post-traumatic stress disorder, addiction medicine, youth mental health and old age psychiatry is increasing. Understanding the Victorian demographic in these and other areas will aid in informed service planning across public and private domains.

This public-private approach could be facilitated through the formation of communities of practice in areas of mental health such as youth, or old age psychiatry and would allow for creation of patient pathways across the system which exploit synergies and remove the burden of navigation from mental health patients.

The private health sector can also provide capacity and capability for outreach to regional and remote communities, either through telehealth or technology driven solutions or through more concrete partnership models with rural public organisations.

Recommendations:

Formation of mental health communities of practice which involve public, private and community providers of mental health services focusing on high growth subspecialty areas and designed around patient pathways across the system; both metropolitan and rural.

Partnering with the public mental health system

Private patients in public hospitals

The discordance of treating privately insured patients in our public hospital system has never been starker than in the area of mental health, where for funding reasons and to offset state government costs, there is an expectation that a certain number of privately insured patients are treated in public hospitals. This despite public units being so overwhelmed by demand, that they struggle to accommodate mental health patients from their emergency departments.

A significant percentage of patients remaining in emergency departments around Victoria for more than 24 hours are mental health patients awaiting admission. This not only affects efficiency and flow through public emergency departments but delays access to treatment for our very sickest mental health patients. This is particularly true for involuntary mental health patients who regardless of insurance status are mandated to remain in the public health system or are transferred there from private mental health facilities once they become involuntary patients under the *Mental Health Act 2014.*

The conversation about treatment of private patients in public hospitals is a much larger one, however it is critical in the meantime that mental health patients are excluded by directive from government from any such quotas and that pathways and mechanisms are established to facilitate the flow of privately insured patients into the private mental health sector, relieving the public system of unnecessary burden.

Recommendation:

Immediate exclusion of mental health patients from Government private-in-public expectations. Establishment of streamlined pathways for privately insured patients to access private mental health care from public emergency departments and mental health units.

Managing patient access

Currently the utilisation of beds in the private sector to assist in public sector patient overflow and capacity shortfalls is ad hoc, often done either in times of crisis, using bed broking agencies or through a lengthy tender process.

A more strategic partnership with private providers would allow for relationships to be established between hospitals whereby real-time private provider operational data could be shared with public hospitals to facilitate short- or medium-term management of patient access and time to treatment; especially within emergency departments.

Recommendation:

In the short to medium term, enhancement of partnership and relationships between public and private providers, to facilitate meaningful use of private beds by the public mental health sector including the provision of real-time private hospital data to public hospitals to allow for ad hoc management of patient flow across the sector.

This public-private partnership should also encompass the establishment of a private consultant liaison model, with the possible deployment of private mental health practitioners to public emergency departments to assist in the identification and admission of suitable mental health patients to private mental health facilities. This would not only assist the management of public emergency department access and public mental health services but would also provide timely and quality care to mental health patients when they need it most.

Recommendation:

Establishment of a private mental health consultant liaison service within large public emergency departments to assist with identification and admission of suitable patients to private mental health facilities.

Workforce recruitment and training

The foundation to any high-quality mental health service is in recruitment, training and retention of the highest quality clinical workforce. Many health practitioners, whether from medical, nursing or allied health sectors seek to work in both public and private practice which presents many opportunities for workforce synergy between the public and private mental health sector.

With the cornerstone of mental health care lying in a multi-disciplinary model of care, it is critical that both capacity and capability are assessed, and any shortfalls prioritised across the sector, rather than competing for scare resource.

Sharing of expertise and also the creation of that expertise through access to training and sub-specialisation is critical to growing capability and leadership within the mental health workforce. The private sector provides access to clinical areas and treatments that may not be as widely available in public mental health services, and visa versa, often due to differences in case mix and acuity.

This potential collaboration extends to common areas of interest in research and innovative models of care. It is an unfortunate reality of public health that innovative models of care often struggle for sustainability based on fiscal constraints despite many demonstrating significant operational efficiencies and possible treatment benefits for mental health patients.

There is therefore great opportunity for productive partnership in the areas of innovation and translational research potentially underwritten by private infrastructure.

Recommendation:

Partnerships are established between public and private providers to look for opportunities in shared workforce recruitment, training and education, research and clinical innovation.

Involuntary patients in private mental health facilities

In Victoria, under section 3 of the *Mental Health Act 2014* (Act) it is states that to admit involuntary patients the facility needs to be a 'designated mental health service' listed in Schedule 1 of the Regulations

The Act defines a designated mental health service as meaning, amongst other things:

a) a prescribed privately-operated hospital within the meaning of section 3(1) of the *Health Services Act 1988* (Vic) (s 3(1)(c)); and

b) a prescribed private hospital within the meaning of section 3(1) of the *Health Services Act 1988* (Vic) that is registered as a health service establishment under Part 4 of that Act (s 3(1)(d)).

So, whilst nominally, under the Act a private mental health facility is eligible to be a designated mental health service, in a list of designated mental health services provided in schedule 1 of the *Mental Health Regulations 2014*, only public hospitals are listed.

The historical context of omitting private health services from this list of designated mental health services is unclear, however in practice this precludes private mental health facilities from treating privately insured involuntary mental health patients.

This has a number of flow-on effects:

- Inpatients within private mental health facilities who experience deterioration in their clinical condition requiring them to become an involuntary patient under the Act, must be transferred immediately to a public mental health service.

This disrupts the continuity of patient's treatment at a time when they are at their most unwell and most vulnerable. It is extremely detrimental to remove a patient in crisis from a familiar environment and treatment team and to place them into the public health system, and undoubtedly places them at unnecessary risk.

This has the additional effect of creating increased and unnecessary burden to the public health system for the resource intensive treatment of high acuity mental health patients.

Once a patient's status reverts to voluntary, they are transferred back to their private mental health facility where the private treatment team attempt to re-establish stability in the treatment plan.

- Privately insured patients who present to public facilities and emergency departments who are required to become involuntary patients on admission are mandated to remain in the public health system, where otherwise they could be transferred to a private mental health facility.

These patients are generally not transferred to private facilities once they become voluntary patients to maintain continuity of care in a fragile cohort.

This provides an unnecessary burden to an already overloaded public mental health system.

It is proposed that private mental health facilities are given a clear pathway and criteria to obtain designated mental health service status so that they may provide privately insured involuntary patients with the continuity of care they require. It is understood that private mental health facilities would be subject to the same governance requirements and regulations around treatment of involuntary patients as designated public mental health services and as set out in the Act.

Recommendation:

Private mental health facilities are given the opportunity to apply for status as a designated mental health service to enable treatment of involuntary mental health patients within their facilities in accordance with The Act. Healthscope would support a pilot initiative.

Youth

Healthscope mental health services are seeing a rapidly increasing demand for youth mental health services with 75% of mental illness presenting for the first time below the age of 25 years. These patients are frequently covered under family private health insurance policies, however access to youth mental health facilities and programs is limited by availability of age-appropriate programs.

This is particularly true for early intervention models, where the evidence suggests a significant positive impact on medium to long-term recovery where an integrated approach to treatment is undertaken through youth-targeted programs such as those run by Headspace and Orygen.

There is great potential in synergising youth workforce training and deployment across both public and private, capturing consistent expertise and treatment models. This will facilitate continuity in care of youth mental health patients if required across the public and private sector, reducing variation and increasing access to treatment.

Increasing comorbidities are also being seen within the youth space, both in the areas of physical health and primary prevention of disease, but also in areas such as autism spectrum disorder (ASD) which often presents with comorbid mental health concerns.

Funding to more complex patients with potentially chronic disease concerns is fragmented and multifaceted and involves state and Commonwealth government funding, the National Disability Insurance Scheme (NDIS) and private health insurers. Parents and carers of such children can struggle to create a comprehensive treatment plan in private particularly, and therefore may be forced to default to public mental health and paediatric services.

Strategic partnerships with public and non-government organisations hold the key to creating a comprehensive youth mental health strategy across the sector.

Recommendation:

Development of a statewide youth mental health strategy which incorporates private mental health services and integrates aspects such as physical health prevention and promotion as well as comorbidities such as autism spectrum disorder.

Evidence Based Design of mental health facilities

Since the mid-1980s, there has been growing evidence of link between the built hospital environment and clinical outcomes. Organisations such as the Center for Healthcare Design have created a large research repository and community of practice around translating patients' holistic health care requirements into mindful and efficient building design.

Whilst the evidence in mental health facility design is less prominent, there is abundant research linking the creation of healing physical environments with significant improvements in care, such as clinical outcomes, length of stay, patient safety and the requirement for medication. In particular in mental health facilities, the design should not be of an impersonal clinical landscape but rather of a soothing and therapeutic environment.

The private sector has the advantage of resource and agility in the creation of mental health infrastructure, and in doing so seeks to deliver innovative models of care and healing. This ambition however, is significantly hampered by the current Department of Health and Human Services interpretation and regulation of design guidelines for hospitals which are based on the Australian Health Facility Guidelines.

And while safety is paramount, it cannot and does not, have to be delivered at the expense of basic dignity and human rights. For example, having to toilet or shower with restricted rights to privacy and dignity, or a proposed move to ban carpet in bedrooms, despite little evidence of reduction in infective or other risk.

With an evidence-based approach to thoughtful facility design, Victoria has the chance to elevate mental health care provision through delivery of world's best mental health infrastructure.

We must strive to deliver mental health facilities which support excellence in care, healing and reflect our patients' requirements for safety but also their requests for, and rights to, dignity, autonomy and respect for cultural safety and individuality.

Recommendation:

The design guidelines for hospitals be comprehensively reviewed with widespread sector consultation and review of current design evidence base as well as the current consumer expectations around safety, cultural awareness and patient rights.

Conclusion

The public and private mental health systems should be seen as parts of a greater whole; the systems are co-dependent and to provide timely and equitable access for all Victorians to high-quality and evidence-based mental health care, both the public and private mental health sectors must be working synergistically.

Government must therefore recognise and effectively leverage the interdependencies of the public and private mental health systems and must work to collaborate with the private sector through strategic partnerships.

This will allow us all to deliver something greater for all Victorians.

Summary of Recommendations:

1. Government recognise and effectively leverage the interdependencies of the public and private mental health systems and work to collaborate with the private sector through strategic partnerships.
2. Formation of mental health communities of practice which involve public, private and community providers of mental health services focusing on high growth subspecialty clinical areas and designed around patient pathways across the system; both metropolitan and rural.
3. Immediate exclusion of mental health patients from Government private-in-public arrangements with public health services. Establishment of streamlined pathways for privately insured patients to access private mental health care from public emergency departments and mental health units.
4. In the short to medium term, enhancement of partnership and relationships between public and private providers, to facilitate meaningful use of private beds by the public mental health sector including the provision of real-time private hospital data to public hospitals to allow for ad hoc management of patient flow across the sector
5. Establishment of a private mental health consultant liaison service within large public emergency departments to assist with identification and admission of suitable patients to private mental health facilities.
6. Partnerships are established between public and private providers to look for opportunities in shared workforce recruitment, training and education, research and clinical innovation.
7. Private mental health facilities are given the opportunity to apply for status as a designated mental health service to enable treatment of involuntary mental health patients within their facilities in accordance with the *Mental Health Act 2014*. Healthscope would support a pilot initiative.
8. Development of a statewide youth mental health strategy which incorporates private mental health services and integrates aspects such as physical health prevention and promotion as well as comorbidities such as autism spectrum disorder.
9. The design guidelines for hospitals be comprehensively reviewed with widespread sector consultation and review of current design evidence base as well as the current consumer expectations around safety, cultural awareness and patient rights.

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