REGIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN

CONSULTATION PAPER 1

OVERVIEW PAPER

Characteristics of the ACT Mental Health System

phn ACT
An Australian Government Initiative

Capital Health Network
ACT's primary health network

ACT Government
Health

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Introduction

Capital Health Network (CHN) and ACT Health are working together to develop the ACT Regional Mental Health and Suicide Prevention Plan (The Regional Plan) to align with Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). The development of The Regional Plan is intended be a process that is collaborative across the spectrum of the mental health service sector in the ACT and as such will involve contributions from all parts of the sector including Primary through to Tertiary health care, Community care, Non-Government Organisations, Consumer and Carer experience.

The Regional Plan will be developed in a staged approach – ensuring that it is responsive to the needs and experiences of the ACT region. The focus of the first stage of development of The Regional Plan is a Consultation Forum centred on consumer and carer experiences of the mental health sector in the ACT. These consumer and carer journey's will be explored through the forum to gain a greater breadth of understanding of the current state of the service system and to identify opportunities for reform in relation to these journeys, to make them easier and better for consumers, families and people working in the system.

The new Regional Plan will 'start here' as it seeks to drive positive and practical change in mental health, working in conjunction with the new ACT Office for Mental Health and Wellbeing and others.

Two papers have been prepared for this Consultation Forum.

1. **Consumer and Carer Journeys**
   The Consumer and Carer Journey paper describes six consumer and carer case studies. These studies represent typical journeys of people experiencing mental illness in the ACT and the people trying to help them. The journeys are intended to represent high prevalence presentations in the service system and are not intended to cover every possible presentation. The journeys form a basis for discussion and provide an opportunity to explore how the system is working through the consultation process.

2. **Overview Paper**
   This has been prepared to help Consultation Forum participants understand the broader outlines of mental health and mental illness in the ACT. It is not intended that this second paper be a focus for discussion at the Forum. It is not intended to be a complete picture of mental health care in the ACT. It merely aims to offer some useful background material in relation demography, epidemiology and service characteristics.

The Context for a Regional Plan

A Regional Mental Health and Suicide Prevention Plan for the ACT will guide the further development of integrated mental health services over the next decade, led by Capital Health Network (CHN) as the ACT Primary Health Network (ACT PHN), and ACT Health Directorate (ACT Health). These organisations are committed to the joint development of a Regional Plan and working toward the implementation of the Fifth Plan at the local level.

CHN and ACT Health have been working on the development of new plans for mental health in 2018.

ACT Health has been developing a territory wide services framework to be supported by a range of Service Specialty Plans (SSPs). The SSPs will sit underneath a broader strategic framework and address different areas of health, including mental health, explaining how each service intends to meet the needs identified in the broader framework. ACT Health has also been working on the ACT Health Strategic Framework for Mental Health and Suicide Prevention (2018-2023) which provides information about the service landscape, a gap analysis, and ACT Health priorities and activities identified against the Fifth Plan.

This kind of planning is in some ways mirrored by CHN through the lens of the Primary Care setting and its integration across the tertiary and community care sector. CHN undertakes an annual needs assessment process which reviews local area needs, key gaps around service delivery and access and emerging vulnerable populations and issues. This process informs CHN's commissioning activities.

A Regional Mental Health and Suicide Prevention Plan provides an opportunity for CHN and ACT Health to work in partnership to identify and respond to areas of need in the ACT, in a coordinated and integrated way. CHN and ACT Health share responsibility for the great majority of mental health care provided in the ACT. Recent mental health reforms at the Federal level, including the Fifth Plan, emphasise the need to develop regional or local approaches to mental health service design, working closely with service users and providers. In most cases, this arrangement relies on cooperation between Primary Health Networks (PHNs) working with potentially multiple local health districts.

Canberra offers a unique and potentially powerful opportunity because of the direct alignment between CHN, the ACT government, and the local health district as key funders and service providers.

ACT Mental Health Planning Environment

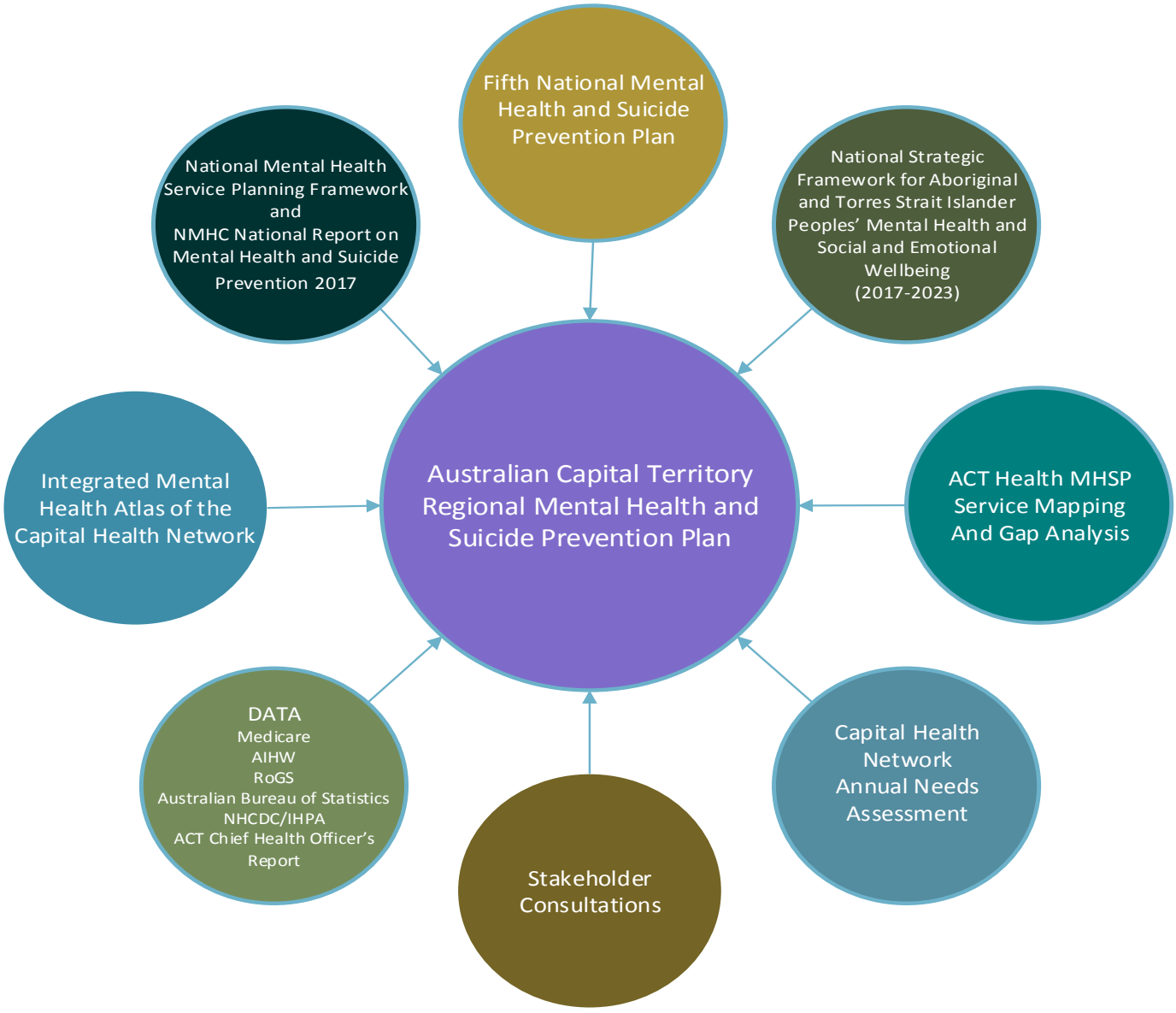


Figure 1. Diagrammatic representation of the ACT Mental Health Planning Environment

About this Paper

This paper has been designed to provide a snapshot of prevalence, service access and identified needs in the ACT.

CHN and ACT Health already have considerable data at their disposal. This paper does not seek to replicate the totality of this information. Rather, the aim here is to sort through the plethora of available data to present some baseline information and set a context for the Plan.

Within the Regional Plan development process a number of questions are being considered to guide thinking and ensure that all bases are covered. These questions are:

- What does the ACT mental health system look like now?
- What does demand and supply look like?
- What issues does this contextual presentation then throw up for the development of the Plan?
- Are there clear priority issues or areas?
- Is it obvious where to start and how to proceed?
- What is already being project-managed for future implementation?

In order to address these questions, it has been possible to bring together data from a variety of sources, including:

- Information supplied by ACT Health
- The Annual Needs Assessment prepared by CHN
- Medicare data supplied by CHN
- The Australian Institute of Health and Welfare's Mental Health Services in Australia series AIHW 2018 Report on MH Services.
- The 2013 National Mental Health Report
- The Productivity Commission's Report on Government Services 2018 (and earlier versions)
- The National Hospital Cost Data Collection
- The Integrated Mental Health Atlas of the Capital Health Network
- Australian Bureau of Statistics
- The People Living with Psychotic Illness 2010 (SHIP) Survey

What does Mental Illness and Suicide look like in the ACT?

A summary from the 2016 ACT Chief Health Officer's Report [1] indicates that:

- 1 in 5 people reported receiving a mental health disorder diagnosis in the preceding 12 months;
- 17% of adults surveyed for the ACT General Health Survey reported having been diagnosed with a mental health disorder in the preceding 12 months;
- of those reporting a mental health diagnosis with ongoing symptoms, 78% reported seeking treatment for the condition;
- ACT residents (16%) were more likely to report being diagnosed with a Mental or Behavioural Disorder than their national counterparts (14%);
- about 30 deaths are registered as suicides in the ACT each year;
- men accounted for about 70-75% of all deaths by suicide;
- Aboriginal and Torres Strait Islander peoples were around twice as likely to die by suicide;
- people who reported having a mental health diagnosis were significantly more likely to indicate other co-morbidities such as chronic disease and other lifestyle risk factors;
- the proportion of respondents reporting a diagnosis of anxiety in the ACT increased from 7% in 2007–2008 to 10% in 2013–2014, making it the most frequently reported mental health diagnosis;
- about 4100 ACT residents are living with dementia, and the number of dementia-related hospitalisations more than doubled between 2004-05 (637) and 2013-14 (1404).

Epidemiology

Mental illness affects around one in five Australians every year, equating to around 76,000 ACT residents. Of this population, around 11,000 ACT residents are likely to have anxiety disorder, 5000 an affective disorder and 4000 a substance use disorder (noting people may have more than one illness in a 12-month period) [2]. In addition, it is estimated that the ACT population would include around 4000 people with psychotic illness [3].

Current data suggest 33 Canberrans die by suicide each year [4]. Lifeline suggest as many as 65,300 suicide attempts in Australia each year. On a pro-rata basis, in the ACT this would equate to three suicide attempts occurring each day [5].

In the ACT, mental health disorders were responsible for 15% of the total burden of disease, higher than the national figure of 13.3% [6].

The level of psychological distress in the ACT is shown in Table 1.

Table 1 – Adults with very high levels of psychological distress 2014-15 [7]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Males	2.9	3.8	3.2	2.7	3.8	3.3	1.5*	-	3.1
Females	4.5	4.2	4.1	3.4	5.5	4.7	6.4	-	4.3
Total	3.8	4.1	3.8	2.9	4.9	4.3	3.7	2.0	3.7

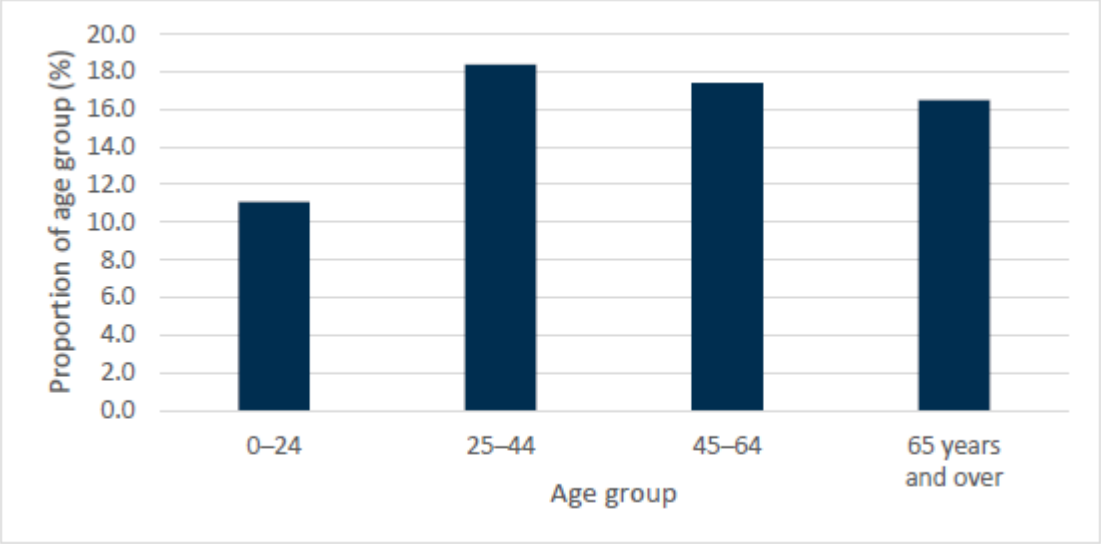
** There is some unreliability associated with the male figure provided in Table 1.*

The level of distress affecting the Aboriginal and Torres Strait Islander population of the ACT presents a different profile to the general community. Almost one third of Aboriginal and Torres Strait Islander people over 18 years reported having high/very high levels of psychological distress (30.9%), and are nearly three times as likely to experience these levels as non-Indigenous people [6]. The ACT rate of hospitalisation for mental health is 23 per 1000 population. This is 2.3 times higher than the non-Indigenous population. The Aboriginal and Torres Strait Islander access community mental health services at a rate of 1711 contacts per 1000 population. This is 2.6 times higher than the non-Indigenous community [8].

Every year thousands of young Australians aged 15-19 years participate in Mission Australia's Youth Survey. In 2016, over three in ten (31.6%) Aboriginal and Torres Strait Islander respondents met the criteria for a probable serious mental illness, compared to 22.2% of non-Aboriginal or Torres Strait Islander respondents. Across the five-year period reported, the likelihood of probable serious mental illness was found to be consistently and significantly higher among Aboriginal and Torres Strait Islander young people compared to non-Aboriginal or Torres Strait Islander young people [9].

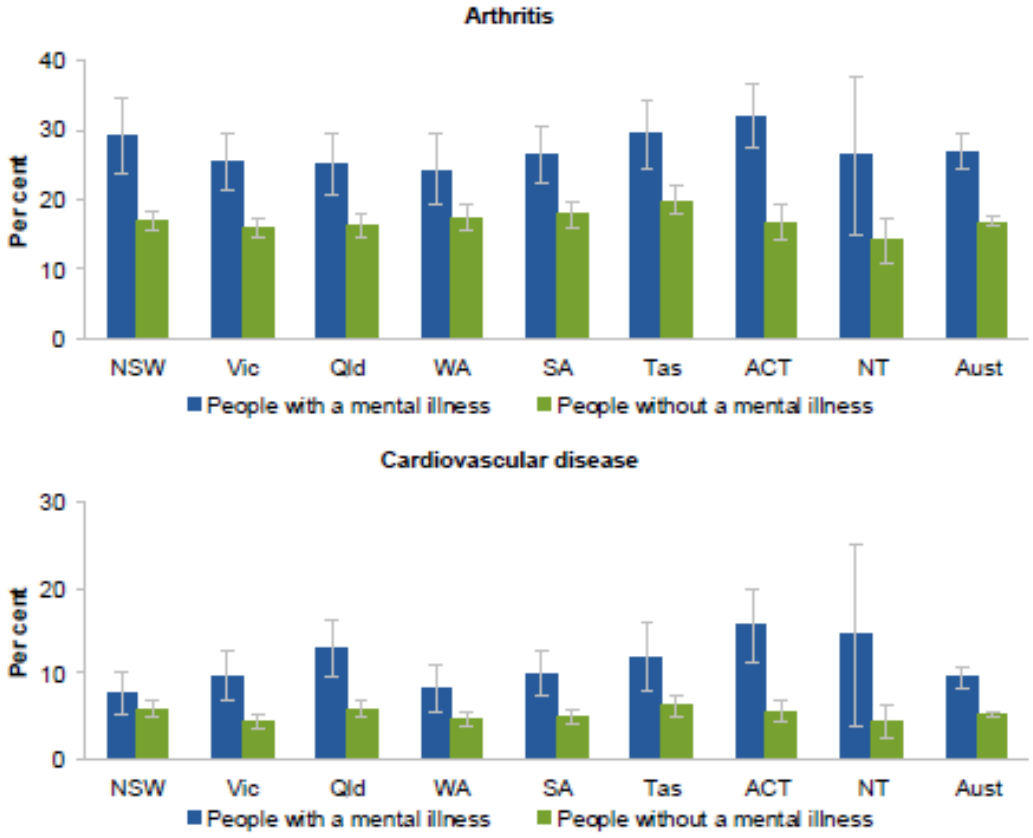
75% of all mental illness manifests before the age of 25 years. The figure below shows the prevalence of illness by age in the ACT [10].

Figure 2 – Prevalence of mental illness in the ACT by age [10]



It is worth noting that the ACT has the highest rates of co-occurrence of some key chronic illnesses among people with a mental illness. This is shown in Figure 3.

Figure 3 – Rates of Co-morbidity for Key Chronic Illnesses [11]



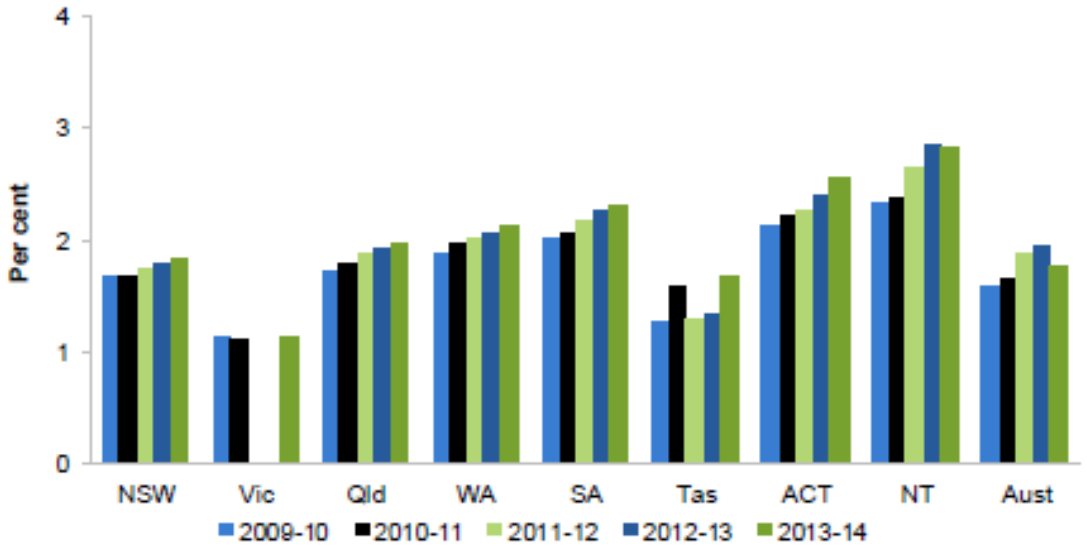
The ACT has a suicide rate just below the national average while the reported rate of the use of seclusion in ACT mental health services is the lowest in Australia.

Services and Spending

As at April 2017, ACT Health, Mental Health Justice Health, Alcohol and Drug Service (MHJHADS) was providing services to clients, across the following service areas: Adult Acute, Adult Community, Child and Adolescent, Justice Health, Rehabilitation and Specialty services. Calvary Public Hospital Bruce also provide public mental health services as contracted by ACT Health.

The rate of access by the ACT population to specialist mental health services has lifted slightly over recent years, as shown below. ACT Health estimates that new clients represent around 40% of total clients each year into ACT Mental Health Services. This is about the same as other jurisdictions.

Figure 4 – Population using State and Territory specialised mental health services Trend Data 2009-14 [12]



State and Territory governments' specialised mental health services (covering the three service types of: admitted patient, community-based ambulatory and community-based residential) tend to treat people with the lower prevalence, but severe mental illnesses. Figure 4 indicates that the proportion of the population accessing specialised mental health services provided by ACT Health has remained reasonably stable over this five-year period, noting that the ACT's population grew by about 40,000 people over this time. The proportion of the total Australian population treated in these public services remained below 2 per cent between 2007-08 and 2013-14. Lifting the rate of access to mental health care remains a challenge across Australia.

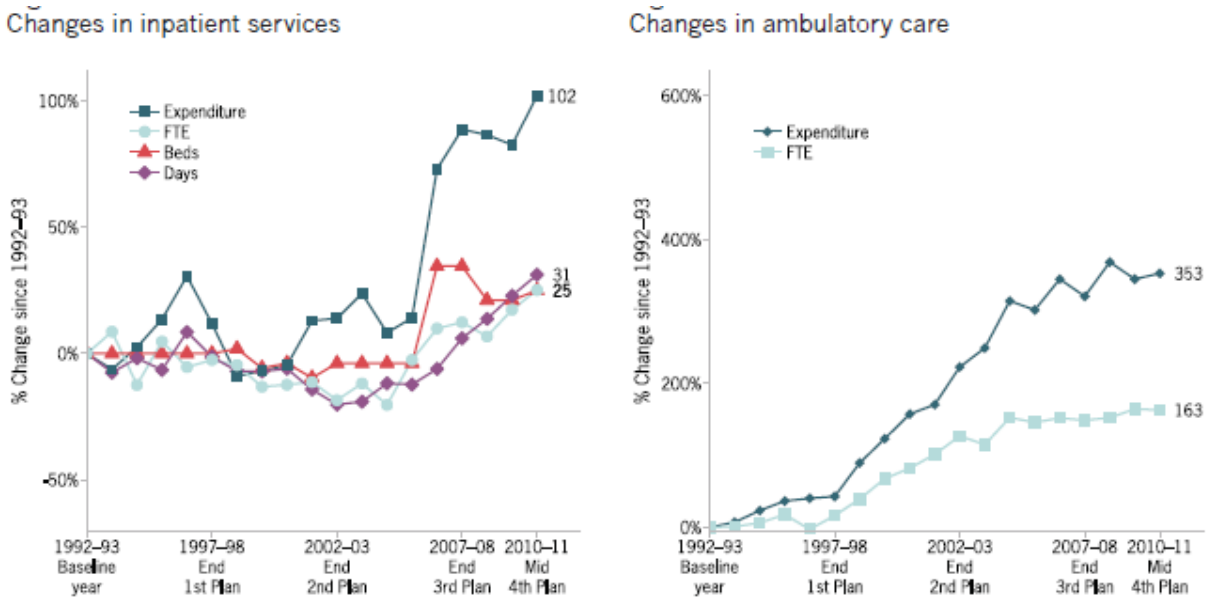
It is possible to break this information down further to understand which professionals are providing the services used in the ACT. This is shown in Table 5 below, which indicates some differences between this jurisdiction and others, particularly in regard to access to psychiatry services.

Table 5 - Proportion (%) of people receiving clinical mental health services by service type [12]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Psychiatrist	1.6	1.7	1.8	1.3	1.7	1.6	1.0	0.4	1.6
Clinical Psychologist	1.8	2.1	1.8	1.8	2.7	2.8	2.1	0.5	1.9
GP	8.0	8.8	8.1	6.3	7.5	7.4	6.7	3.8	7.9
Other Allied Health	3.0	3.7	3.4	1.7	2.2	2.5	2.3	1.0	3.0

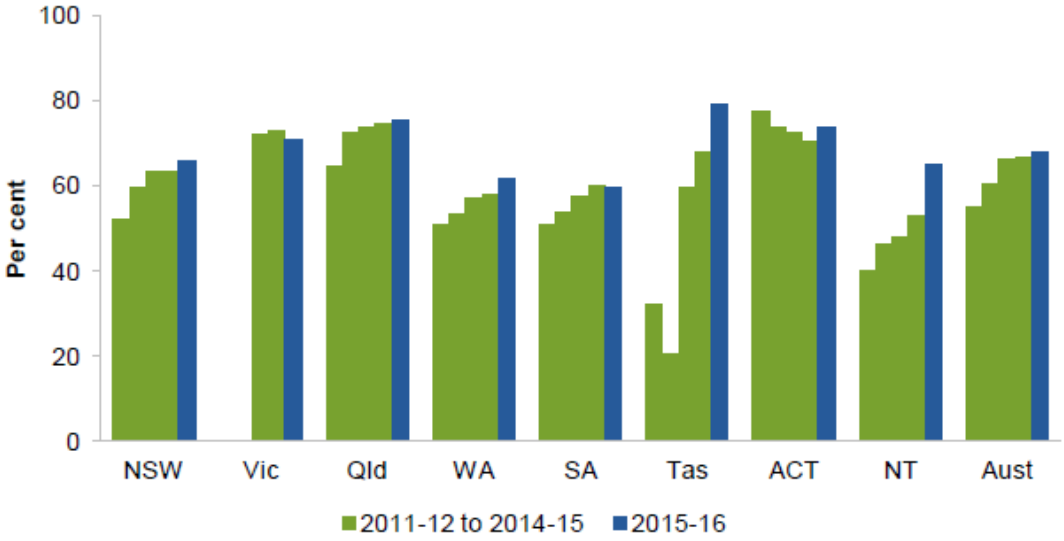
The graphs below, although only showing data from 1992-2011, show the impact of changes to mental health services in the ACT over time. Significant increases in expenditure are shown, with modest increases in services, which could reflect better payment structures, credentialed health professionals, lack of psychiatrists residing in the ACT, or more reliance on psychiatrists as a result of increased GP awareness of mental health issues and services.

Figures 5 and 6 – FTE and Expenditure Changes 1992-93 to 2010-11 [12]



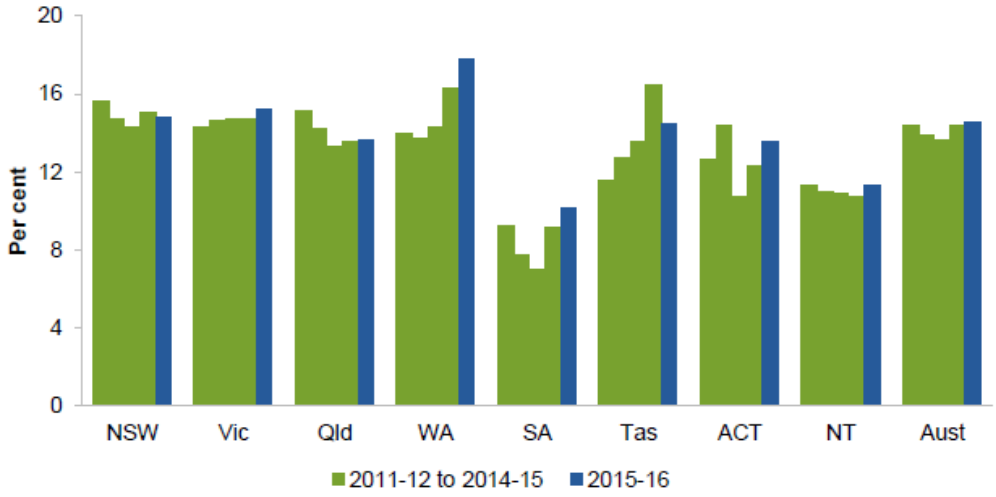
'Community follow-up after psychiatric admission/hospitalisation' is an indicator of governments' objective to provide services that are coordinated and provide continuity of care. The ACT's inpatient mental health service appears more connected to services outside the hospital than other jurisdictions, as shown in Figure 7.

Figure 7– Community Follow-up with 7 days of discharge from Inpatient MH Units, ROGS 2018 [7]



Readmission rates to hospital care within 28 days of discharge from the mental health unit are slightly better than the national average. A person in the ACT is less likely to be readmitted here than in most other jurisdictions though it should be noted that this rate has increased from around 4% to 11% since 2009-10, as shown in Figure 8.

Figure 8 – Readmissions to hospital acute psychiatric units within 28 days [7]



Expenditure

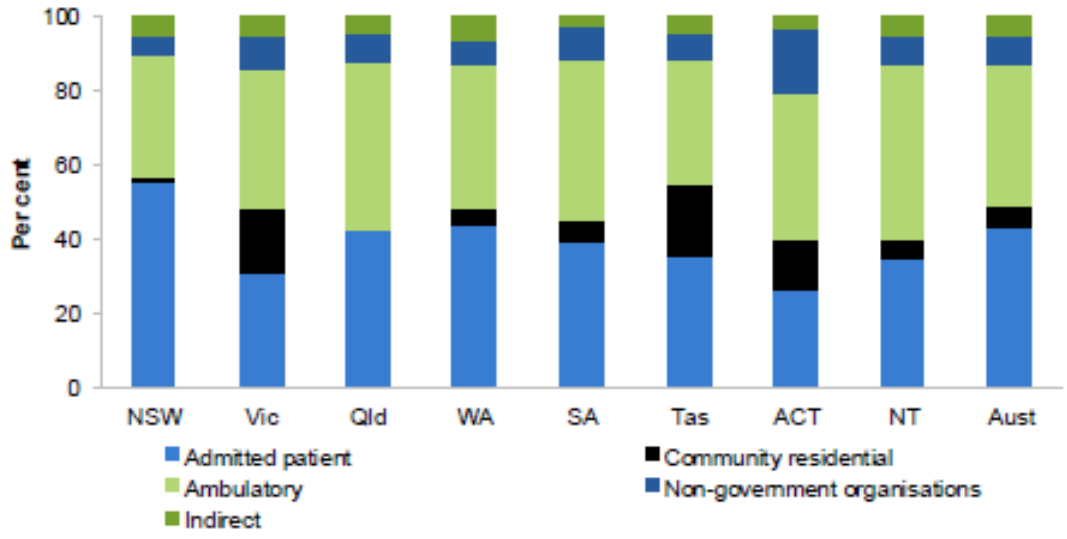
Table 6 shows how the ACT compares with other jurisdictions in terms of spending on mental health. It shows total spending per capita, spending on non-government organisations in particular, and how the ACT ranks overall. The investment in NGO services is the standout feature, suggesting opportunities for greater service diversification and also challenges for systemic integration.

Table 6 - Per Capita Spending 2015-16 [13]

	$ Total	Rank	$ NGO	Rank
Nat Avg	226.52	n/a	17.26	n/a
NSW	224.19	5	12.83	8
Vic	197.30	8	18.18	6
Qld	213.70	7	17.00	7
WA	298.75	1	21.60	3
SA	257.65	4	18.29	4
Tas	222.96	6	21.95	2
ACT	263.22	2	52.73	1
NT	260.43	3	18.27	5

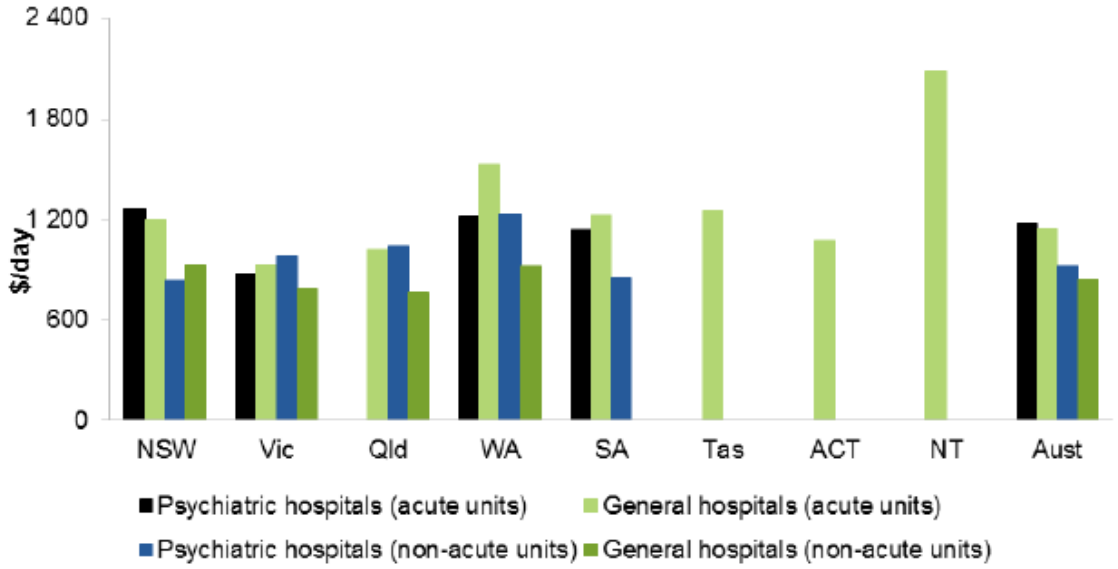
The shape of ACT spending is a little different to other jurisdictions, as shown in the Figure 9.

Figure 9 – Pattern of Recurrent MH Expenditure 2013-14 [12]



The National Hospital Cost Data Collection has traditionally suggested the ACT has the highest cost per inpatient episode in Australia. The 2013-14 data (Round 18) indicated the average cost to the ACT was $2363 per inpatient day, again the highest in Australia [14]. The situation in mental health appears different, as shown in Figure 10 which demonstrates that the per bed day cost attributed to inpatient mental health care in the ACT is around $1000 and not the highest in Australia.

Figure 10 – Jurisdictional Cost Per Inpatient Day 2015-16 [7]



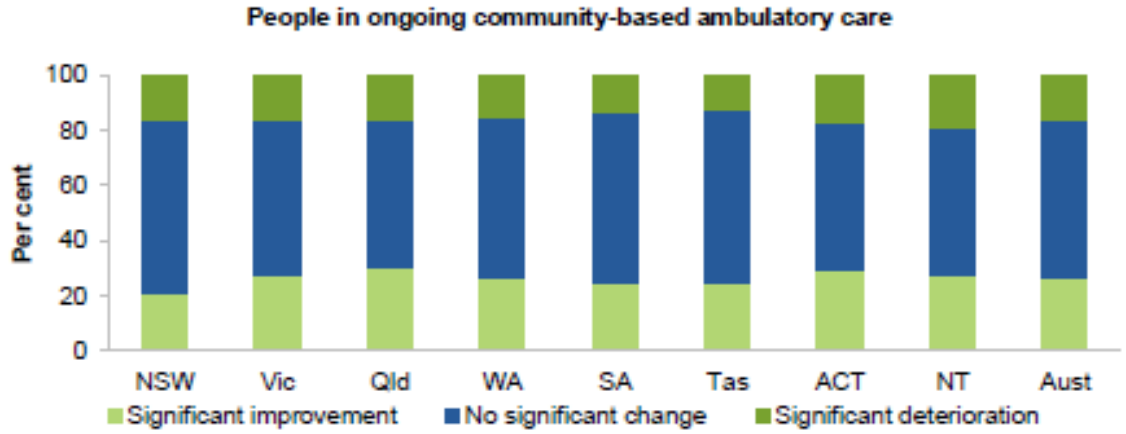
A key difference between the ACT and other jurisdictions is clearly the investment in community mental health services provided by MHJHADS. The ACT has the second highest number of treatment days per episode of ambulatory care in Australia, well above the national average.

Figure 11 – Jurisdictional Ambulatory Treatment Days [7]

	NSW (d)	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*
Average treatment days per episode of ambulatory care									
2006-07	6.8	7.7	5.2	4.5	5.0	4.1	8.0	4.0	6.1
2007-08	8.0	7.7	5.4	4.6	5.2	5.9	8.0	3.9	6.5
2008-09	7.2	7.6	4.5	4.8	5.3	6.0	8.0	3.9	6.1
2009-10	7.6	7.6	4.9	4.9	5.3	5.2	8.2	3.5	6.3
2010-11	7.5	7.7	5.2	5.0	5.5	5.5	8.2	3.6	6.4
2011-12	8.0	na	5.8	5.0	5.4	4.5	8.6	3.6	6.4
2012-13	7.8	na	6.4	4.8	5.4	3.9	8.4	4.0	6.5
2013-14	8.2	7.1	6.5	4.9	5.4	6.0	8.4	4.4	6.8
2014-15	8.6	7.0	6.8	4.9	5.2	5.5	8.6	4.4	6.9
2015-16	8.9	6.6	7.0	4.9	5.4	5.4	8.4	4.4	7.0

Data on the outcomes of this difference are few. The ACT contributes to the national collection and reporting of the Health of the Nation Outcomes Scores (HONOS). These are shown in Figure 12. It is important to remember the data presented here only reflects the ACT MH Services which contribute to HONOS. The ACT's NGO sector and services funded through CHN do not contribute data. Figure 12 shows little difference between the ACT and other jurisdictions in relation to outcomes for people in ongoing community-based ambulatory care.

Figure 12 – ACT Mental Health Outcomes 2015-16 [7]



The ACT average length of hospital stay is slightly less than in other jurisdictions, as shown in Figure 12 below.

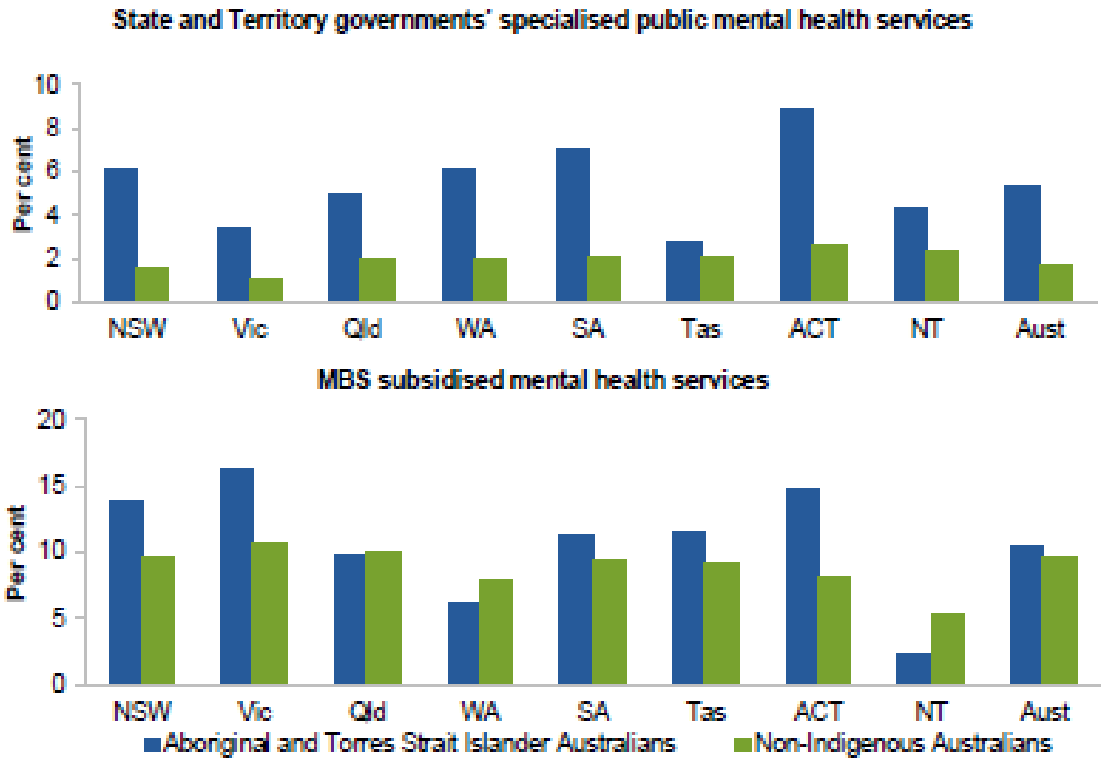
Figure 13 – Average Length of Stay 2015-16 [7]

	NSW (c)	*Vic* (d)	*Qld* (d)	*WA* (d)	*SA*	*Tas* (e)	*ACT* (e)	*NT* (d),(e)	*Aust*
General mental health services	13.7	12.5	10.6	12.1	9.3	10.8	12.6	11.3	12.1
Child and adolescent mental health services	16.8	7.9	10.0	8.2	3.4	..	..	..	9.9
Older persons mental health services	42.6	29.1	20.9	40.5	29.8	..	36.4	..	33.5

Use of Territory and Medicare Services

Another key characteristic of the ACT is the relatively low take-up of Medicare-subsided mental health services, as shown below. While the ACT provides greater access to specialised public mental health services than most other jurisdictions, access to Medicare-subsidised mental health services is lower than other places. The ACT looks more successful than other jurisdictions in providing access to Aboriginal and Torres Strait Islander residents.

Figure 14 – Percentage of the population using mental health services 2015-16 [11]



Again, it is possible to discern some variation between the ACT and other jurisdictions in terms of workforce. Table 7 shows how many mental health related items were processed by Medicare by provider. The ACT's per capita MBS access rates are lower than the national average for general practice, psychiatry, (registered) psychology and allied health services.

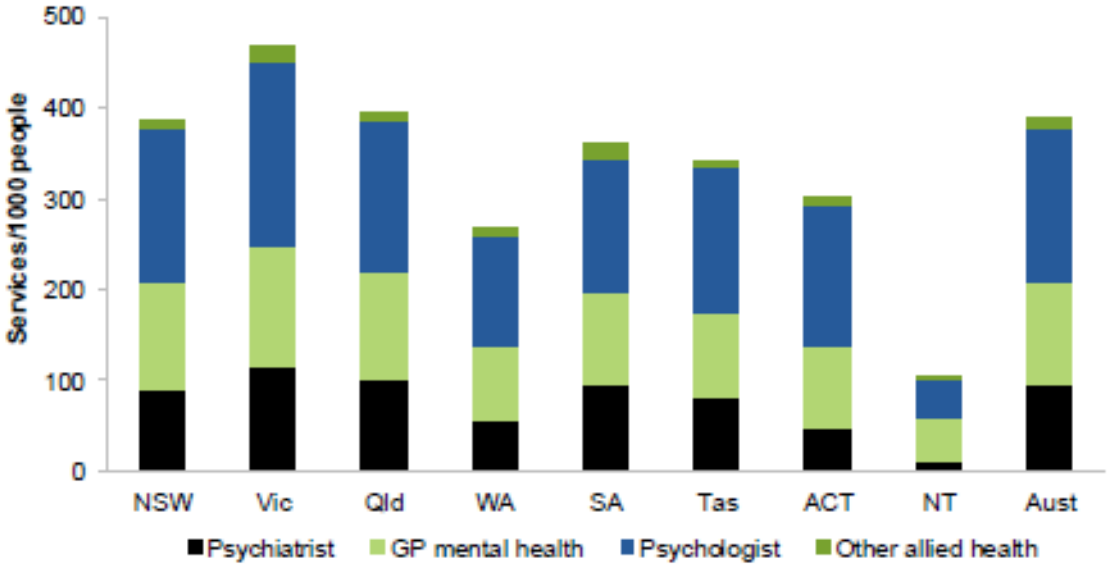
Table 7 - Mental health care specific MBS Items processed per 1000 people 2015-16 [7]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Psychiatrist services	94.1	116.6	111.9	61.5	97.0	94.0	46.9	15.8	98.4
GP services	137.0	156.1	137.9	105.6	121.2	106.5	110.1	61.3	135.5
Clinical Psychologist services	78.5	93.7	76.9	82.1	111.5	113.8	94.9	18.0	85.1
Other Psychologist services	110.6	137.6	122.9	62.6	68.1	82.6	86.7	34.9	109.8

Other Allied Health services	12.1	21.4	14.9	8.2	17.9	9.6	7.4	2.3	14.7

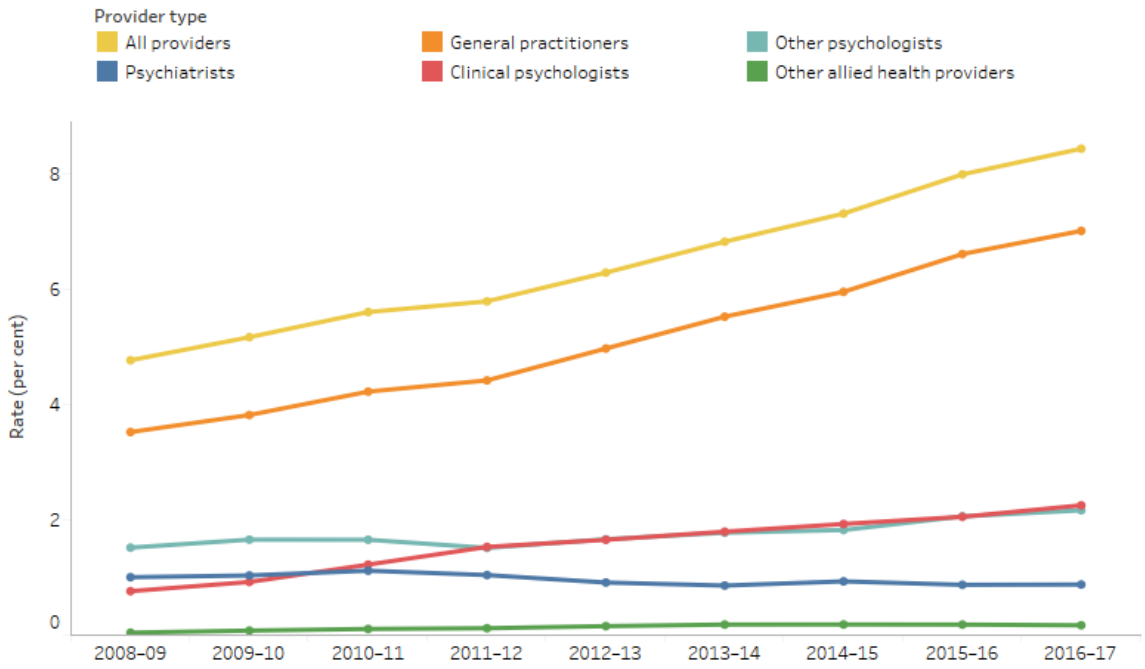
The difference in Medicare access is also shown in Figure 15 below.

Figure 15 – Medicare Services by Provider Type 2013-14 [12]



This is demonstrated further in Figure 16, which shows that across all Medicare-subsidised mental health services, those provided by General Practitioners, clinical psychologists and to a lesser extent other psychologists have increased their rate of public access to care.

Figure 16 - Rate (% of the population) of people receiving Medicare-subsidised mental health-specific services, by provider type, ACT, 2008–09 to 2016–17 [14]



Overall in relation to Medicare-subsidised mental health services, in 2016-17 in the ACT 146,414 services were provided by psychiatrists, psychologists, GPs and some allied health professionals to almost 34,000 people at a cost of $15.8m to Medicare. Almost two-thirds of all clients seen were female, one-third male.

Table 8 - Growth in Medicare-subsidised Mental Health Services in the ACT

Year	No. Services	MBS Benefits Paid	No. Patients
2011-12	98,620	$11.1m	21,269
2012-13	107,081	$11.9m	23,435
2013-14	113,877	$12.6m	26,009
2014-15	123,459	$13.7m	28,314
2015-16	134,437	$14.5m	31,627
2016-17	146,414	$15.8m	33,929

This data has been derived from MBS online.

As is the situation across Australia, access to mental health services under Medicare in the ACT has grown strongly over recent years, by around 7% each year since 2011-12. Despite this growth, the ACT appears one of the lower-ranking jurisdictions in relation to access to Medicare-subsidised mental health services.

This needs further investigation given additional data suggests that the rate of access to Medicare-funded psychology services is higher than other jurisdictions. This is shown, for both registered and clinical psychologists in Figures 17 and 18.

Figure 17 - People receiving Medicare-subsidised mental health-specific services, by jurisdiction 2016–17; Registered Psychologists [14]

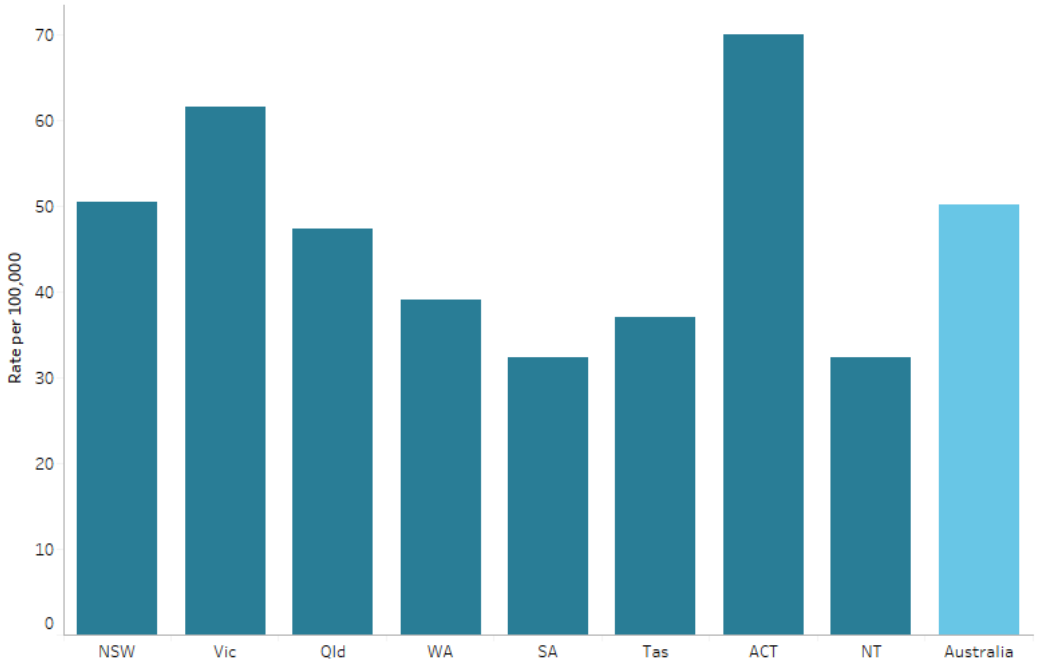
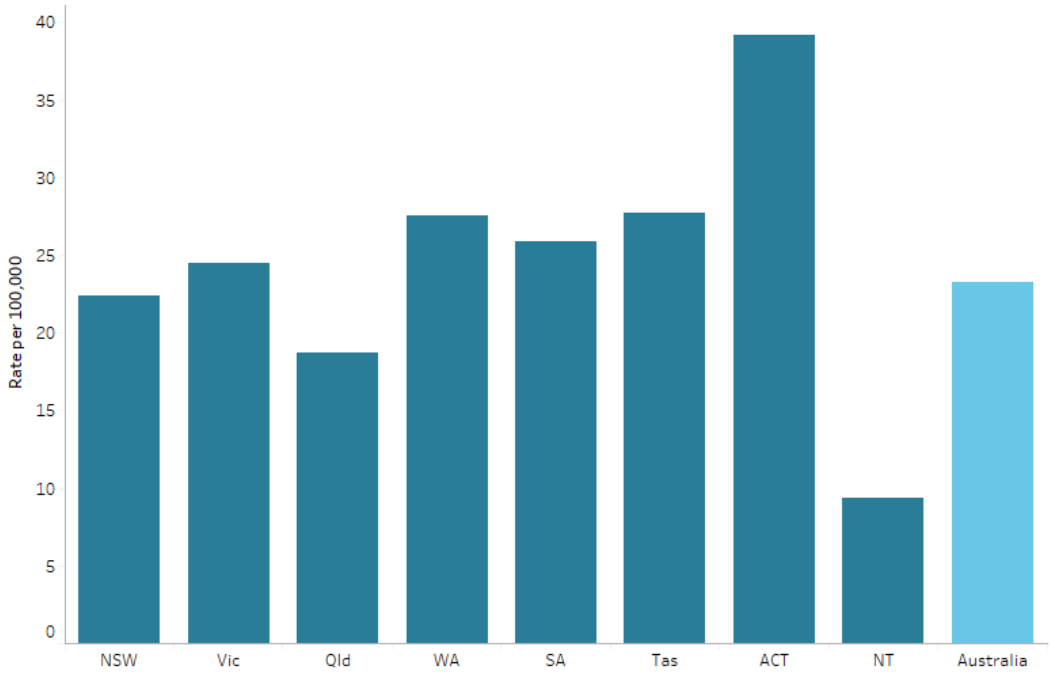
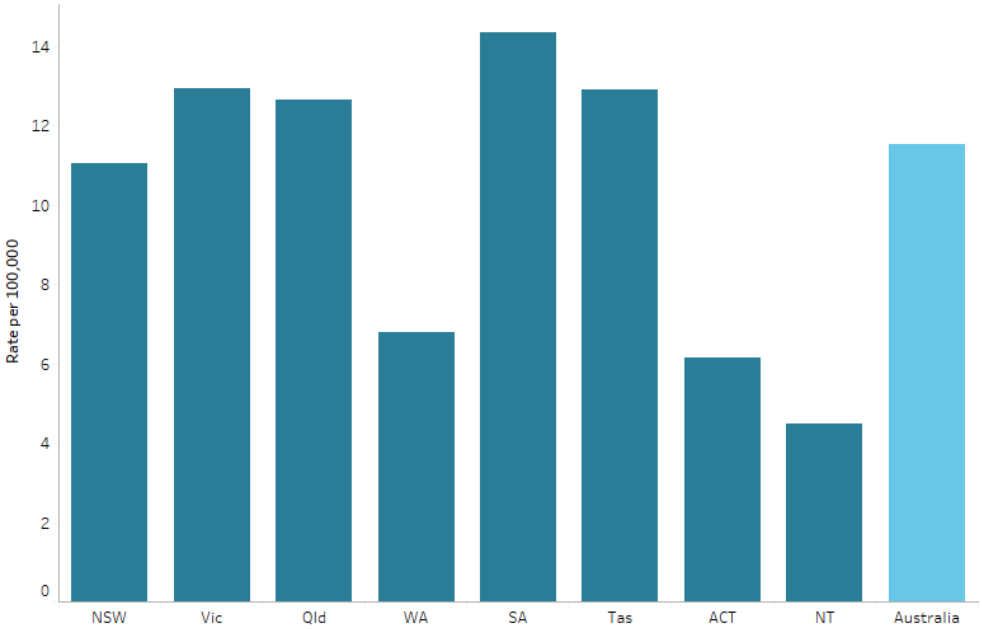


Figure 18 - People receiving Medicare-subsidised mental health-specific services, by jurisdiction 2016–17; Clinical Psychologists [14]



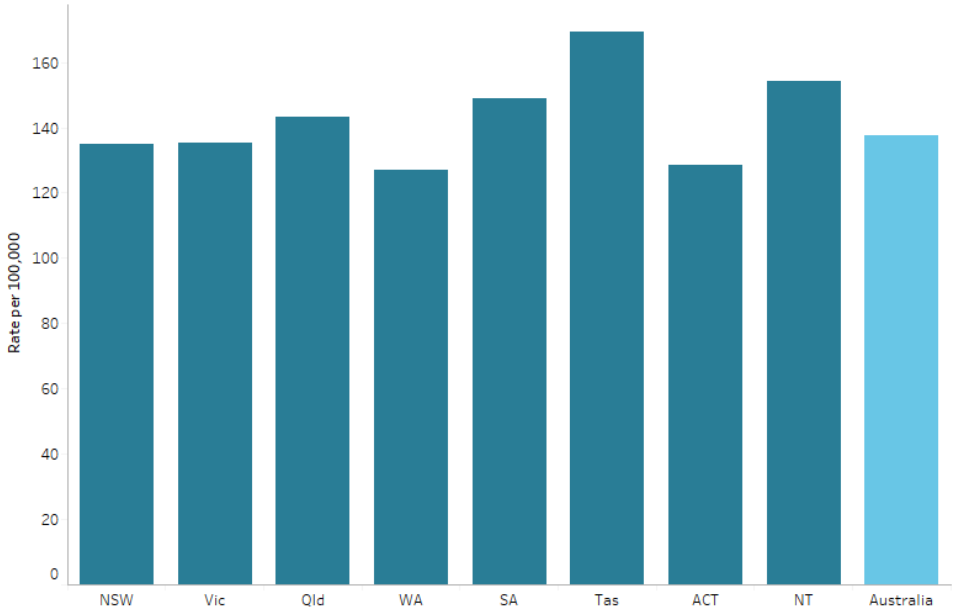
By contrast, ACT access to Medicare-funded psychiatry services is the second lowest in Australia, behind only the NT. This is shown in Figure 19.

Figure 19 - People receiving Medicare-subsidised mental health-specific services, by jurisdiction 2016–17; Psychiatrists [14]



This is also the case with GPs whereby the ACT is the second lowest provider of Medicare-subsidised mental health services in Australia, as shown in Figure 20.

Figure 20 - People receiving Medicare-subsidised mental health-specific services, by jurisdiction 2016–17; General Practitioners [13]



Discussion

While the shape of the ACT's mental health services is certainly a little different from other jurisdictions, it is difficult to ascertain the impact this has on outcomes for consumers and carers. Data on outcomes is sparse. Data from NGOs relating to client outcomes is not collected. Health of the Nation Outcomes Scale (HONOS) is not the only way to measure outcomes of a service system. Our view is therefore partial.

It is possible to summarise some key service gaps already identified. For example, the ACT Integrated Mental Health Atlas suggested the key ACT gaps were:

- Acute and sub-acute residential care
- Day care
- Employment related services; and
- Services for culturally and linguistically diverse groups.

The Needs Assessment (2017) completed by CHN identified the following as key gaps:

- Early intervention in life; illness; and episode
- Management of comorbidities, particularly physical health comorbidities in the community
- Psychological services for people with moderate to severe presentations

- Integration between primary and tertiary services, and with the NDIS
- Multidisciplinary services for some key demographic groups, including transgender population, homeless people and the Aboriginal and Torres Strait Islander population.
- Need to build workforce skills in relation to trauma informed care
- Need for follow-up community support after discharge following a suicide attempt, including better GP support
- Need to build network of peer support services

In the context of the Fifth National Mental Health and Suicide Prevention Plan, it is not clear which of the regional 'gaps' listed above should have priority or the comparative benefit of remedial action across the list. Fixing which areas would make the most benefit?

While there are some specific gaps or potential actions for the primary and acute ends of the service spectrum, clearly one of the larger 'gaps' is in relation to the range of secondary, largely community-based services which can operate as the glue between these sectors.

The ACT is clearly investing in many contracts with NGOs and can call on a valuable repository of psycho-social rehabilitation skills across these organisations. The impact of the NDIS rollout on those eligible and not eligible for support is critical to understand.

It would be useful to build greater understanding about the range of services and people currently receiving care in this sector, with a view to identifying opportunities for greater integration.

Similarly, the ACT is clearly investing in community mental health services provided by ACT Health Mental Health services. It would be useful to better understand the model of care and service design which underpins these services, again to drive integration with services provided by NGOs and in the primary and tertiary sectors.

Better understanding of secondary mental health services in the ACT would give the Regional Plan increased opportunity to design services which can respond as mental illness escalates to prevent unnecessary hospitalisation. It would also permit improved transition from hospital to independent community living for people with severe mental illness on their discharge from tertiary care.

Priority Areas and Tracking Progress

A key priority for the development of a Regional Plan should be the early articulation of a set of key priority areas for improvement or focus and an Outcomes Framework, with associated performance indicators, by which to track the progress of reform. An Outcomes Framework would need to focus on system level improvement and consider health and social determinants related indicators.

Conclusion

This paper has been prepared to set a context for discussion at the Consultation Forum. It does not provide a complete picture, however some important features of the ACT system emerge.

The ACT is unique compared to other jurisdictions, with variations in service models and funding. Not all these differences are fully understood, particularly in relation to the community sector. Additionally there is no clear evidence that these differences result in fundamentally better or worse outcomes for people in Canberra compared to those receiving mental health care in other jurisdictions. This is important given the current level of investment in mental health in the ACT.

A clearer understanding of the ACT's large community sector would then set the scene for proper consideration and prioritisation of the gaps already identified. It would permit a system-wide perspective, establishing all the iterations necessary to effectively deploy a stepped care approach to mental health care. Such a stepped approach would see the continuation of early intervention, primary care and community-based approaches with the tertiary sector providing the critical back-up, not the front door.

The ACT has most of the key components to make this stepped approach a reality. The Consultation Forum can consider this further in relation to typical consumer journeys. The implementation of a robust, achievable set of mental health indicators would then permit effective tracking of reform.

While the ACT already provides considerable funding for mental health, it is important to realise that change is not free. Realignment and restructuring of services and responsibilities takes resources. The Regional Plan will provide an important opportunity to optimise the advantages and advances already made in the ACT.

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