GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

☐ I do not want my submission published

☐ I would like my submission to be published but remain anonymous

Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

Mental Health Matters 2 is a community systemic advocacy group of volunteers whose aim is to improve outcomes for its members. These include people who experience mental distress, alcohol and other drug use and possibly contact with police, courts or prison; and their families and supporters. This group is often seen as 'complex' and they fall into the gaps between the siloed health (H), mental health (MH), alcohol and other drug (AOD) and allied sectors. They report experiences of stigma and discrimination within services and consistently report finding it difficult to access effective, non-judgmental, competent, person-centred, holistic treatment services where their voices are respectfully listened to.
What is needed to develop a more sustainable, patient-centred health system in WA?

* See the person, not the problem / label.
  With a purely bio- medical approach to mental health, the focus is on reducing 'symptoms' rather than adopting a more holistic view of wellness. For example, discharging people from Emergency Departments to homelessness is likely just to leave people coming back into the acute part of the health system.
  (Refer: The Homelessness Health Project at Royal Perth Hospital by Dr Amanda Stafford and team is an example of innovative and effective practice in this area).
* Greater care and attention needs to be given to the social determinants of good physical and mental health health - with particular attention to the availability of safe and secure housing. (Refer: Flatau, P, Wood, L, MacKenzie, D, Spinney, A, Zaretzky, K, Valentine, K & Habibis, D (2015) The Inquiry into the funding of homelessness services in Australia, AHURI Inquiry Discussion Paper, Melbourne: Australian Housing and Urban Research Institute Limited. Available from: http://www.ahuri.edu.au/about/nhrp/epi82090.) This study found that health savings of between $5,000 and $13,000 per person could be made by providing public housing for people who are homeless or at risk of homelessness.
* Adoption of evidence-based innovations such as Housing First reduce the individual's contact with acute health services such as Emergency Departments.
* Trauma-informed policies and practices would help to increase individuals' confidence in the health system and minimise the harm that can happen through coercive mental health practices, including seclusion and restraint. Health consumers are reluctant to attend at a health service they experience as unsafe. Often this then means the person will wait until the situation is at crisis point, requiring ambulance service and Emergency Department admission.
* Culturally secure services need to be provided for Aboriginal and ethnic minority communities.
* More holistic assessments which would include physical health assessment is carried out when a person presents for mental health treatment/support.
  (Refer: 2010 Clinical Guidelines for the Physical Health Care of Mental Health Consumers pg 2 : "The Duty to Care report on preventable physical illness in mental health consumers (Lawrence,Holman & Jablensky, 2001) demonstrated markedly elevated rates of a range of physical disorders. As a consequence, people with a severe mental illness are 2.5 times more likely to die from preventable physical illness than people in the general population".
* A broader view of 'treatment' needs to be adopted and resourced, particularly

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in public mental health services. In the mental health system, 'treatment' is often limited to hospitalisation and medication, whose adverse effects contribute to significant physical health issues including Metabolic X Syndrome and tardive dyskensia. Evidence based approaches such as Open Dialogue (Finland) should be investigated for their applicability to WA.

* A broader view - even in the narrow context of a mental health ward - can yield better results in consumer engagement and empowerment. Initiatives such as SafeWards are well researched and have broad applicability.
* Individuals and families must be informed in their treatment choices and in particular about the adverse effects of medication being prescribed. (Refer to the 2017 Critical Literature Review on the direct, adverse effects of neuroleptics (anti-psychotics) - Curtin University and the National Mental Health Consumer and Carer Forum).
* Improved system navigation and articulation is required both within the various parts of the health systems well as between H, MH and AOD. The possibility of developing a peer consumer and family/carer workforce to act as System Navigators particularly for those individuals and families who traverse a range of sectors would be beneficial and likely lead to earlier engagement with the most appropriate services, rather than an over-reliance on after-hours services and Emergency Departments.
* Greater attention needs to be paid to the amount of money which is wasted by consumers not having greater access to responsive and resourced community mental health services and as a result, ending up in hospital or an Emergency Department.
* Clinical staff need training and development in working effectively in partnership with consumers and families/carers. Refer: Adversity to Advocacy: The Lives and Hopes of Mental Health Carers 2009 in which the no. 1 key issue raised is the importance of being listened to and respected. This issue is raised repeatedly in other reports including the Stokes Review 2010.
  A sustainable health system can only be maintained when the health consumer and their family/support network are empowered to learn and be partners-in-their-care, with the service taking a 'on tap, not on top' approach.
* Treatment and discharge planning for people with mental health exiting hospital continues to be lacking with families continuing to report that they have not been included in discharge planning and consumers often only having cursory input. This issue is consistent since the 1994 Burdekin Report. Often due to demand for beds, mental health consumers are discharged while still unwell with their main support as family or friends (for those consumers who do have this support). When there has been no input into discharge planning, these support people are left with little knowledge of how best to support the person to wellness.
* The Carers Recognition Acts 2004 needs to be reviewed and more robust accountability of services' adherence to it needs to be developed.
* Clear referral pathways need to be developed and resourced for people transitioning to and from AOD detox, rehab and detention. The 'No Wrong Door' seems to be firmly shut at 4.30pm on Fridays and quite difficult to find even during services'

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regular opening hours.

* Health services in prisons need to be governed by Health, not Department of Justice whose focus is on detention and security. There is much evidence of the over-representation of people with diagnoses of mental illness and people with intellectual disability in prisons, including WA's shameful record of high level of imprisonment of Aboriginal people. When people are in prison, particularly on medium to long sentences it provides an opportunity to provide health interventions which might be difficult to deliver in the community but which could improve chronic conditions by employing specific interventions such as Hepatitis C treatment. By taking a more robust health focus for prisoners, other health interventions such as needle exchanges could be implemented which result in significant long-term health savings. Prisoners are still citizens and both part of our community - albeit it in a removed capacity. Most are likely to return to the broader community at some stage. Improving their health can only have a positive impact for them, their families and their communities.
* Mental health services in prisons are inadequate. This is often referred to in reports by the Office of the Inspector of Custodial Services. Given WA's burgeoning prison population (nearly 7,000), it is counter-intuitive that the number of forensic beds (30 at the Frankland Centre) remains the same as when the prison population was 3,000. Forensic mental health services are often working with individuals and families who have fallen through many of the cracks in the systems and who have multiple, unmet needs, sometimes as a result of inadequate or ineffective service provision. It is therefore, important that this area is resourced to meet the needs, rather than operating at levels well below demand as it currently does.
* The transition from prison is a key gap into which prisoners with health needs can fall. Delays in accessing community services can result in lack of medication, which then results in individuals acute services such as Emergency Departments. Developing seamless transfers of care - particularly for those individuals with multiple health issues - would save money in the longer term by ensuring easy access to community-based health services and reducing reliance on acute services.
* Community based options for mental health need to be developed which will take the pressure off more expensive hospital beds.
* More holistic options such as Social Prescribing could be used (walking, rather than medication). These also encourage people's engagement in actively taking care of their health.
* In mental health, the Recovery approach needs to be more clearly supported in practice (it is embedded in WA, national and international policy). An inherent part of this approach is empowering the person with the skills, knowledge and capacities to manage their health which is a more sustainable approach.
* The development of a supported and qualified peer workforce in mental health and drug and alcohol would support many of the initiatives mentioned above. Peers help to bring lived expertise into practice.

Thank you for the opportunity to make this submission.