Royal Commission into
Victoria's Mental Health System

# Formal submission cover sheet

**Make a formal submission to the Royal Commission into Victoria's mental health system**

The terms of reference for the Royal Commission ask us to consider some important themes relating to Victoria's mental health system. In line with this, please consider the questions below. Your responses, including the insights, views and suggestions you share, will help us to prepare our reports.

**For organisations**

Written submissions made online or by post, may be published on the Commission's website or referred to in the Commission's reports, at the discretion of the Commission. However that is subject to any request for anonymity or confidentiality that you make. That said, we strongly encourage you to allow your submission to be public - this will help to ensure the Commission's work is transparent and that the community is fully informed.'

Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commission's reports.

Because of the importance of transparency and openness for the Commission's work, organisations will need to show compelling reasons for their submissions to remain confidential.

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them. If you would like to contribute and require assistance to be able to do so, please contact the Royal Commission on 1800 00 11 34.

| Your information | |
|---|---|
| Title | Ms |
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| | |
|---|---|
| Please indicate which of the following best represents you or the organisation/body you represent. Please select all that apply | ☐ Person living with mental illness<br>☐ Engagement with mental health services in the past five years<br>☐ Carer / family member / friend of someone living with mental illness<br>☐ Support worker<br>☐ Individual service provider<br>☐ Individual advocate<br>☒ Service provider organisation;<br>Please specify type of provider: Health Insurer & Aged Care Provider<br>☐ Peak body or advocacy group<br>☐ Researcher, academic, commentator<br>☐ Government agency<br>☐ Interested member of the public<br>☐ Other; Please specify: |

**Your contribution**

***Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.***

1. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
2. What is already working well and what can be done better to prevent suicide?

**Nature of the problem**

The Australian Institute of Health and Welfare's latest findings indicate Australia spends $28 billion per annum on mental health services. This report also highlights that most of this funding reaches less than 50% of people - often late in their illness, delivers expensive care, and shows little evidence of effectiveness or how many people are able to return to work after a diagnosis. High level care costs are due to the inability to access the right care, at the right time with the right service provider. KPMG research (National Mental Health Commission Report 2014) shows that the number of equivalent healthy years lost over a nine-year period for sever bipolar disorder, depression, anorexia and schizophrenia under current traditional services was 3.4, 3.8, 4.0 and 6.6 years respectively. Improvements from optimal care are significant – they range from 16% for PTSD to 34% for bipolar disorder.

Bupa's own consultations with people and families with a lived experience in mental health highlight significant difficulties in navigating the health system and accessing the right high-quality care at the right time across their lives – from early childhood to healthy ageing.

**What Victoria does well**

Victoria has made a significant investment in its infrastructure and is uniquely positioned as a State to drive mental health reform in partnership across industry, academia, government, the NGO and philanthropic sectors in two areas:

1. Promotion and prevention - emphasising the social determinants of health to drive mentally fit, healthy and resilient communities.
2. Early intervention and treatment - person-centred care, ensuring that people are supported in their local communities to access care and support early in their mental health journey with a significant opportunity to explore how the public and private health care systems might integrate care through wrap-around shared case management for low-prevalence, highly complex disorders across multiple agencies.

This approach supports a highly co-ordinated service model with an emphasis on collaboration, rather than competition, and a leadership, across sectors, focused on innovation and system reform. Some examples of such work include:

- VicHealth: is a world class leader in understanding the social determinants of mental health, and driving practical community based mental health promotion campaigns and socially innovative interventions that support wellbeing and promote good mental health;
- Social Ventures Australia, Donkey Wheel, Social Traders, Second Muse, The Foundation for Young Australians and the university sector are driving partnerships with industry and philanthropy to reduce social inequity (homelessness and community violence);
- Victoria is home to Australia's leading teaching and research institutes (i.e. Murdoch Children's Research Institute, Orygen Centre for Excellence, Phoenix Centre for PTSD etc) producing cutting-edge

R&D, prolific and respected international experts in mental health, with the potential to translate this research to practice and policy; and
- A private health care and hospital system reaching a significant portion of the Victorian population focused on partnerships, and keeping people fit, healthy and well and engaged in education, employment and community life.

**Leveraging Victoria's capability for the future**

Bupa believes that working collectively, industry, government, NGOs and the university sector in Victoria could drive the following:

- Address and provide guidance for the navigation of the mental health system where most people initially start to engage with mental health issues, such as in our schools, universities and workplaces;
- Develop person-centred models of care that aim to keep people out of inpatient facilities and supported in the communities in which they work and live;
- Identify bundled care packages tailored to an individual's needs, supported by multidisciplinary teams focusing on the right care, at the right time, delivered in the right way – and targeting functional impairment rather than just treatment. In practice this includes a focus on keeping people in education and employment, navigating access to financial support and providing a broader remit of care than just GP or psychologist delivered cognitive behaviour therapy
- Investigate and test opportunities for private and public health sectors to work together to bundle, and coordinate care, focussed on local communities and the best outcomes for Victorians
- Implement outcome measurements focused on the 'Three C's', namely:
    - Capability (the frequency or degree to which you can do the things that matter to you: go to work, walk up the stairs, lift your child, see well enough to read);
    - Comfort addresses physical and emotional pain – whether your pain is getting better or worse; and,
    - Calm addresses the interruption to your life as you pursue health care: is your life being overtaken by appointments, side effects and the chaos of fragmented services.

**Specific recommendations**

Bupa recommends that the Royal Commission consider:

- Provision of bundles of health care focused on mental health support and treatment that is more responsive to individuals' needs and preferences across both the public and private system;
- A choice about where services are provided, with an emphasis placed on the person's preference to receive high quality care in the community, across both the public and private health care systems;
- An emphasis on quality of treatment outcomes with a shift from fee for service, towards fee for outcomes;
  An emphasis on mental health that looks at the continuum of care – with a focus on strength and capacity to build mental fitness and wellbeing (diet, exercise, sleep, social connection, meaningful participation, management of life stress) to high quality evidence based 21st Century Systems of Care that are designed as integrated models of care, with an emphasis on shared management and partnership between people and the clinical and community teams that support them.

3. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
4. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

**Summary**

People consider their health in the context of their lives. If people are physically and mentally well they have a greater chance of engaging in the community, succeeding in education and employment, and over the lifespan, contributing and flourishing.

From a consumer's point of view, a health event either has a beginning an end or it is an ongoing issue that requires management over time.

This is not always the case with mental health, which can be relapsing and remitting. A fundamental structural flaw within our health system is that it does not respond to health events in an integrated manner, but sees them, and the care required to manage them, as episodic. Events are categorised as either hospital or out-patient episodes, with funding following these classifications rather than the consumer 'journey'. Further complicating this distinction are systems and records that are siloed and inhibit the flow of relevant information between healthcare providers – however, that said My Health Record, should see an integration in health information that is driven by, and owned by the consumer.

**Background**

The World Health Organisation defines mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community. The positive dimension of mental health is stressed, as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

This definition is particularly relevant to Victoria, given the role that VicHealth, and key Victorians such as Professor Helen Herman and Professor Rob Moodie from the University of Melbourne, played in its definition, and in defining the social determinants of health. Bupa is committed to taking a lifespan approach to mental health and wellbeing with an emphasis in reducing disparities in access to high quality healthcare, while at the same time working to create 21st century systems of health care that position the consumer at the centre of that health system, able to make informed and deliberate choices about health care.

The World Health Organisation has collated evidence that shows that many common mental disorders are shaped by the social, economic, and physical environments, or settings, in which people live, work and play. Social inequity is associated with an increased risk of many common mental disorders, and a decade ago the UK in a ground breaking and seminal piece argued that the 'wealth of a nation' reflects its mental capital, the aggregated cognitive, emotional, and behavioural resources of its citizens, measured through active participation in education, employment and community life (Beddington et al., 2008). It is therefore clear that improving the conditions of daily life across the lifespan provides opportunities both to improve population mental health and to reduce the risk of those mental disorders that are associated with social inequalities.

The World Health Organization has identified 10 social determinants of health:

- the social gradient

- stress
- early life
- social exclusion
- work
- unemployment
- social support
- addiction
- food
- transport

**The mental health structural problem**

In Australia we have a universal healthcare system supported by comprehensive private health care, however our model of health care in mental health has been focused on 'treatment' and responding to patients when they become acutely unwell, often late in the progression of illness.

In other areas of health care, such as cardio-vascular disease and cancer care, significant advances have been made in the promotion of lifestyle factors that prevent onset (i.e. diet, exercise, smoking cessation), or earlier identification – while at the same time significant scientific advances in treatment. This has not been the case in mental health care – despite Victoria being well positioned to showcase world class mental health promotion and systems of integrated clinical care.

Victorians are now living longer and making different lifestyle choices, this coupled with significant advances in science, has seen the greatest burden of disease shifting from infectious disease and acute injuries to chronic long-term conditions that require self-management and shared management, and yet the system has largely stayed the same – that is a medical model, with top down, rather than bottom up person centric care.

In both our public system and our private system suppliers of health care services, that is GPs, psychologists, psychiatrists, mental health nurses, occupational therapists and allied health professionals are paid according to the services they provide rather than the quality of the outcome achieved for the patient in their care. This is the most significant structural flaw within the current healthcare system. It means there are few incentives to provide the right care, in the right setting, at the right time. Because the consumer is not at the centre of the care journey, social determinants are not addressed, and care is neither coordinated nor well connected.

This is particularly problematic for mental health care which requires a unique approach due to:

1. its onset in childhood, adolescence and young adulthood – 75% of mental illness has its onset before the age of 25;
2. the lack of help seeking due to structural stigma, self-stigma and the help negation effect – this is particularly evident in men, with research showing they take between 5 and 15 years to seek support for mental health problems, and in our young people indicating that less than 70% seek help, preferring to manage on their own;
3. the differential burden and complexity of low prevalence but extremely debilitating disorders such as complex mood disorder, addiction and eating disorders versus high prevalence disorders such as anxiety and depression, which can be debilitating, but do respond well to simple interventions if treated early in the course of the illness (i.e. online cognitive behaviour therapy is just as effective as face to face cognitive behaviour therapy);
4. significant comorbidities, between disorders such as anxiety, depression and substance use, but also comorbid mental and physical health problems; and,
5. limited advances in the treatment of complex disorders, treatment resistance to complex disorders such as PTSD, and a 'one size fits all' mentality which argues for 'sessions' of CBT rather than case management identifying the complexity of needs that should be met (i.e. employment, homelessness, poverty) before treatment is even viable.

**Recommendation for an Integrated Model of Care**

An integrated model of health care would position consumers in both self-management and shared management, with an emphasis on promotion, prevention and early intervention. In addition to this is the concept of bundled care and person centred care, that sees the integration of care across the community, in home and focused on the functional impairment of the person, and how that might be addressed with appropriate and evidence based treatment. Historic funding models have stifled innovation, and continuing the categorisation of services as either in or out-patient has not served the consumers' best interest as it limits choice.

A best practice mental health system would see funding, across the public and private system, repurposed and integrated in a way that followed the patient, their needs, and their preferences, along the continuum of care. This would be aided by the measurement of health outcomes which provides evidence of where and when the best care should be provided.

Compounding current issues in consumers accessing care in the right care, in the right setting at the right time is the shortage of publicly funded community-based mental health services which means Australians who may require care have suboptimal access to services that would enable them to live well in their community. Those experiencing a mental health issue often have limited options other than to pay significant out-of-pocket costs, continue to deteriorate and/or be (re)admitted to hospital. This 'revolving door' perpetuates the worst inefficiencies of the system; that is, a lack of funded community mental health services increases demand for expensive in-patient mental health care.

As outlined in our response to questions 1 and 2, there is opportunity to investigate and test opportunities for private and public health sectors to work together to bundle, and coordinate care, focussed on local communities and the best outcomes for Victorians.

Bupa is well positioned to build, in partnership, a settings-based approach to holistic models of health care, that explore the social determinants of health and 21st century systems of care that include self-management and shared management. Across the lifespan, Bupa has touchpoints with its customers through the provision of insurance, but also increasingly across settings where whole population and community approaches and ecosystems of wellbeing and care could be explored, for example:

1. **Clinical Services and Innovative Care Models:** From July 1st, Bupa will be providing services to 100,000 employees across the Army, Navy and Airforce, and currently supports the Australian Government by providing medical assessments for 250,000 onshore applicants and 160,000 complex offshore cases. Bupa also currently funds in-patient mental health care supporting 1,200 complex cases of people diagnosed with depression, anxiety, drug and alcohol problems and eating disorders.
2. **Mentally Fit Communities and 21st Century Models of Wellbeing:** Bupa has a customer base of 4.7 million people that we can reach.
3. **Mentally Fit Universities:** Bupa currently partners with eleven Australian universities supporting a student population of international students, with an opportunity to conduct cutting edge research exploring how we might support mentally fit universities. Partners in Victoria include La Trobe University with an emphasis on digital health solutions.
4. **Mentally Fit Workforce:** Bupa, as an employee could position itself as a mentally fit workplace, customising mental health promotion and prevention activities to its 17,000 employees.
5. **Healthy Aging:** Bupa is Australia's largest private provider of aged care, supporting around 6,700 residents across 72 Nursing Homes – where 70% of the clientele live with dementia, other cognitive impairments and increasingly complex mental health conditions.

Bupa fully supports mental health services that are person centred, are underpinned by a co-ordinated system that supports partnerships to enable self-management focused on wellbeing with clear pathways of stepped care, with a focus on shared management and the interface with clinical care.

5. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Productivity loss due to poor mental health currently costs the Australian economy an estimated $60 billion[1]. Early indicators of mental stress such as sleep disturbance, increased alcohol consumption, relationship breakdown, bullying and victimisation and avoidance of social situations are a significant reason employee's seek mental health care. This care is usually provided by employee assistance programs, often operating in isolation from broader workplace or community-based initiatives aimed to promote good mental health (i.e. WorkSafe WorkWell, the DHHS mental health and wellbeing program or, the National program or the Heads Up initiative launched by beyondblue in partnership with the Mentally Healthy Workplace Alliance).

In addition to employing or sub-contracting a multi-disciplinary mental health workforce that includes psychologists, mental health nurses, occupational therapists, psychiatrists, general practitioners, dieticians and exercise physiologists each delivering services across a variety of settings including in our aged care homes, eleven universities and Joint Health Command[2], Bupa has also prioritised a mental health workforce focused on keeping people mentally fit, healthy and well and currently provides life coaching and counselling services to our 4.7 million insured customers.

**Mentally healthy workplaces**

Bupa Australia is considered an international leader in the promotion of 'mental health at work' supporting the mental health and wellbeing of its 17,000 employees. Bupa is well positioned to drive mentally healthy workplaces in Australia, that move beyond just a focus on mental health first aid and mindfulness programs.

Evidence clearly shows that keeping people in role, and engaged in work, results in better mental health outcomes. Bupa believes that amendments should be made to workplace health and safety legislation and regulations to explicitly incorporate the identification of psychosocial risks and appropriate control measures.

The greater accountability that flows from this will encourage quicker uptake and implementations of measures that mitigate the risk of psychological injury in workplaces.

**Bupa's workplace mental health approach**

Bupa's experience in workplace mental health involves our global Smile program as well as Mental First Aid training.

Smile

Smile, Bupa's global employee health and wellbeing program was launched in Australia in May 2016 to 400 site locations and 15,000 people. The focus is to engage our people and assess their health and wellbeing.

The Smile program varies within each country, but at local level businesses across Bupa use employee insights to deliver tailored products and services centered on four quadrants — healthier bodies, healthier minds, healthier cultures and healthier places.

At the heart of Smile is Performance Energy. Designed in partnership with a clinical psychologist this leader-led program gives insights, tips and ideas on ways in which our people can better manage their energy to be at their best mentally and physically, at work and at home.
Performance Energy focuses on three core building blocks: physiology, choices and mindset to help our people to prioritise what is most important to them.

[1] https://www.mentalhealthcommission.gov.au/media-centre/news/economics-of-mental-health-in-australia.aspx

[2] Bupa delivers Australian Defence Force Health Services, which offers a range of health services directly to ADF personnel

Given the diverse nature of our employee population we have developed multiple delivery channels to suit different needs, ranging from three-hour face-to-face sessions run by a network of specially trained Performance Energy Coaches in partnership with leaders, through to a self-paced digital version for our call centre and retail employees.

### Mental Health First Aid

The Mental Health First Aid (MHFA) program certifies participants as mental health first aiders in the workplace. Participants do not become qualified to diagnose and treat mental illness, but learn practical information about key mental illnesses so they can identify risks in the workplace, and provide assistance if someone is experiencing a mental health issue.

The MHFA program provides a first aid process for non-crisis intervention, which can be applied to someone experiencing depression, anxiety, psychosis and the effects of an alcohol or substance disorder.

This program also provides a process for dealing with crisis situations for suicidal thoughts, feelings or behaviours, panic attack, severe psychotic episodes, and high levels of intoxication (sometimes with aggressive behaviour). MHFA is a highly interactive course and the key outcomes are:

- Improved confidence and skill when dealing with a mental health problem in the workplace
- A greater awareness of mental health, and reduced stigma about mental illness
- Better promotion of good mental health and wellbeing in the workplace
- Early intervention techniques which lead to faster recovery for people experiencing mental health problems

Bupa has seen advantages of both of these programs in the workplace through employees having better control over their job demands which leads to job satisfaction and retention; greater awareness, understanding and confidence to appropriately recognise and support mental health conditions; and prompt support and early intervention for employees to reduce severity and impact of any mental health condition.

6. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Victorians with a mental health need require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care. Mental health services should be funded and delivered according to a continuum of care model and a range of specialist treatment and support services should be available.

**Current mental health service model**

Evidence clearly supports holistic models of health care that consider the social determinants of health, and the importance of both social and economic participation, in the mental wealth of communities. Service provision that is person-centred would strongly advocate that better outcomes in health care are achieved when people are given a choice about how they access support, the convenience of accessing care, the cost effectiveness of that care and the speed at which people receive care. Community based health care and wraparound support, provided in the settings in which people are active in their communities (i.e. school, university, workplaces, sporting and social clubs and community centres) clearly supports social and economic participation.

The current service model tends to favour care, late in the mental health journey often when symptoms have become acute, and often at the expense of either the public or the private health care system. Waiting lists and a 'revolving door' perpetuates the worst inefficiencies of the system; that is, a lack of integrated community mental health services, which ultimately increases the demand for expensive in-patient mental health care as people have progressively become so unwell that they can no longer function in the community and with their own support networks, of family and friends.

The National Mental Health Commission Report clearly highlighted a major failing in our mental health system, with a system that is fragmented, difficult to navigate for the person and their families and littered with duplication and wastage, poor quality clinical care and often resulting in long waiting lists, limited options that result in significant out-of-pocket costs, continued deteriorate in symptoms and increasing functional impairment and/or a revolving door which increasingly sees people re/admitted to hospital.

**Health insurer impediments to delivery**

Bupa, together with the insurance industry have a meaningful role to play in reducing the financial burden on both consumers and the sector as a whole by funding out of hospital mental health services for their customers. This could include community-based care options. Victoria would have a valuable role to play in advocating to the Commonwealth for more flexibility for delivery of community based services, which would benefit Victorians and provide more options for mental health care.

Unfortunately, the Commonwealth rules that dictate what health insurers can and cannot fund for customers do not enable delivery of such services. Victoria could be a valuable advocate at COAG in working to remove some of the barriers in mental health community delivery. In an environment where integrated, outcomes focussed care is the objective, such rules no longer make sense. We recommend an overhaul of such rules. Currently, mental health services for private health insurance customers can only be provided 'in hospital' or 'in patient admitted'. In self-management and shared management models, with an emphasis on multi-disciplinary teams providing community care, this model is archaic in its approach, and perpetuates a reliance on clinical services rather than a recovery focused model that aims to keep people socially and economically engaged in their community.

Bupa has sought to navigate these structural deficiencies by developing alternative models of care at the moderate to severe end of the care continuum with hospital substitution models (General Treatment when the care is provided by a non-hospital provider) being a key focus. These demonstration models are examples of customer-centred care delivered by different providers and funders. We have included at Appendix 1 six case studies of such demonstration models:

- Mind Care Choices (case study 1)
- This Way Up (case study 2)
- Kids Helpline (case study 3)
- Mobile Recovery Support (case study 4)

These models allow customers the choice of receiving care in their community, rather than in hospital, if that is their preference and it is clinically appropriate. Trying to offer this seemingly simple choice to the 45% of Australians who choose to insure themselves through illness and injury reveals a material structural weakness – health insurers are unnecessarily hamstrung by funding rules that can obstruct care that will provide the best health outcomes.

A large structural weakness inherent in the current system relates to the classification of what constitutes admitted and non-admitted hospital services. Certain programs, and how they are defined within legislation, have specific funding rules that determine what health insurers can fund as an alternative to in-hospital care.

Bupa knows that our customers find these distinctions meaningless, and when they come to us to claim for a mental health condition, they are wanting a solution to their current health need rather than added complication in choosing care based on the fund rules of what constitutes "in-hospital" or

"admitted" patient care.

People with a mental health need require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care. Mental health services should be funded and delivered according to a continuum of care model and a range of specialist treatment and support services should be available.

It would increase social and economic participation if people living with mental illness were able to exercise more options in their care. Numerous studies have shown that being part the community can have a positive effect on mental health and emotional wellbeing. Community involvement provides a sense of belonging and social connectedness. It can also offer extra meaning and purpose to everyday life. Allowing Victorians to exercise choice to have mental health treatment in the community would provide greater connectedness and social participation.

Bupa recommends that Victoria advocate to the Commonwealth for changes to what is classified as admitted and non-admitted hospital services. These rules in federal legislation determine what Bupa may be able to fund for its customers along a continuum of mental health services.

7. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Bupa, as a partner in supporting the mental health and wellbeing of all Victorians, is committed to the following approach:

1. Consumer led health care with an emphasis on self-management and shared management to deliver right care, right time in the environments that empower consumers to make informed choices regarding health care;
2. Values-based healthcare, where fee for service models are replaced with an outcomes-based model defined by customised care based on complexity of the disorder and functional impairment.

Victoria has an opportunity to undertake reform that delivers support, care, treatment and follow-up in the most appropriate setting, and which aligns to consumer preferences.

The Royal Commission should work with stakeholders across the public and private sector, with people with a lived experience and their families, and the professionals who provide care to identify why low value care is a problem in Victoria and to discourage it by shifting funding towards value (where value equals health outcomes that matter to patients divided by cost) rather than volume of services.

Specifically;

<u>Elimination of Low Value Care</u>

Low value care is care that lacks an evidence-base, fails to improve health outcomes and is high cost without a corresponding increase in function. In general, low value care can perpetuate a patient's reliance on services without an emphasis on recovery.

Under Commonwealth legislation, health insurers are often obligated to fund low value care. Examples include in-patient care without a treatment plan, measurement of outcomes or goals linked to functional improvement and pathways of support back to the community (i.e. return to work). Day programs currently on offer include mindfulness colouring and photography, but without links to the community and social inclusion, they provide at best a means of keeping patients occupied.

Victoria could be a powerful advocate to the Commonwealth on working to eliminate programs and funding models which enable low value care in the mental health space.

In both public and private health systems, and particularly with an emphasis on integration of services, greater resource utility would be achieved through an investment in an evidenced-based, tailored care plans that follow a treatment path with progress tracked and measured over time. This allows for patients' treatment progress to be monitored and changes made to their care plan if required. It allows for a person's care to move and adapt to their changing social and economic circumstances, with an emphasis on promoting recovery and functional improvement.

Bupa's auditing process reveal many private psychiatric providers may offer low value mental health care to our customers. Many factors combine to create the environment where these examples of low value care can continue. From a customer point of view, they often feel they are receiving value from these day programs as they do not encounter an out of pocket cost for the psychiatrists they see that day, they receive free meals, and activities are arranged for them. The issue from a system and productivity perspective is that this is a high expense and inefficient use of funds. Health insurers could better use the funding expended on such services in more targeted mental health interventions.

8. Is there anything else you would like to share with the Royal Commission?

Bupa has attached an appendix to this document outlining our attempt to navigate current structural deficiencies in provision by developing alternative models of care at the moderate to severe end of the care continuum with hospital substitution models (General Treatment when the care is provided by a non-hospital provider) being a key focus. These demonstration models are examples of customer-centred care delivered by different providers and funders.

[redacted]

[redacted]

## A community mental health program in Victoria – case study 1

**Recommendation**

**Based on the results from our pilot, considering ways to encourage community care over in-patient care makes sense from an outcomes, experience and affordability standpoint.**

As part of Bupa's Mind Care Choices suite of services, we partnered with an organisation to provide a community mental health program for eligible customers in Victoria. This program is made available at **no additional cost to the customer**. The program means customers can choose to receive mental health care in their community, rather than in hospital. The service commenced on 1 September 2017 and is a pilot program approved by the Department of Health for two years. During the first year of the program, **almost 100 customers accessed the program**.

### Results

At 12 months post launch we assessed preliminary results. The Patient Health Questionnaire 9 (PHQ-9) was employed to measure depression scores and the Generalised Anxiety Disorder 7 (GAD 7) to measure anxiety scores. Full results below. Importantly, **clinical outcomes measurably improved for most groups of customers in the program**. Some customers' score improved to the point they are **clinically regarded as in "recovery"*.**

In addition to outcome improvements for customers, the rate of psychiatry claims reduced for all admission types. Particularly noteworthy, **the rate of outpatient psychiatry claims for program participants halved** since starting the program. Further, the **average cost of mental health admissions per customer has reduced two-thirds** compared to costs when the program commenced.

While these preliminary results are indicative only (as the pilot continues further results continue to come in and averages are continually adjusted), they are incredibly promising.

Importantly, the Net Promotor Score (NPS) of the program is +82. Thus patients did not see the change of setting as deleterious. NPS is the patient reported experience measure we are using to evaluate the program, it is a widely used metric to measure customer satisfaction and loyalty. An NPS result of over +50 is generally considered excellent.

**Patient Health Questionnaire 9-(PHQ-9)***

| Length of Treatment | Average Baseline Score | Average Score as of 31 August 18 | Clinical change |
|---|---|---|---|
| 10-12 months | 17.7 | 9.3 | Recovery |
| 7-9 months | 13.8 | 10.5 | Improved |
| 4-6 months | 13.3 | 11.5 | Improved |
| 0-3 months | 14 | 9.5 | Recovery |
| All Active | 14.6 | 9.3 | Recovery |

**Generalised Anxiety Disorder- 7(GAD-7)***

| Length of Treatment | Average Baseline Score | Average Score as of 31 August 18 | Clinical change |
|---|---|---|---|
| 10-12 months | 13.7 | 9.3 | Improved |
| 7-9 months | 10 | 10.3 | On-going treatment |
| 4-6 months | 7.4 | 9 | On-going treatment |
| 0-3 months | 13.1 | 7.2 | Recovery |
| All Active | 11.7 | 9.3 | On-going treatment |

*Definitions of scores: **Clinical case** (person needing intervention/ongoing intervention) defined as: PHQ-9 score of 10 or higher and/or GAD-7 score: 8 or higher. **Improvement** is a reduction in end of intervention scores compared with baseline: PHQ-9: -5.2 points or more and/or GAD-7: -3.5 points or more. **Recovery** defined as: PHQ-9 score: <10; GAD-7 score: <8; proportion of participants whose end of intervention scores have decreased. A participant will be considered as recovered if their PHQ-9 and/or GAD-7 score meets the definition of recovery at any point in their intervention.



Appendix

## 'This Way Up'– case study 2

### Recommendation

**Based on the results from our pilot, considering ways that iCBT could be offered to the wider population is something the Productivity Commission should consider.**

A review of the mental health programs available to our customers demonstrated that the level of support available for those *at risk* or living with *mild* mental illness was low. We also knew through consumer research that 84% of customers would prefer home or community treatment for mental health care (where clinically appropriate). We realised then there was a gap in our mental health offering and therefore an opportunity to fill this gap for our customers.

After much research on the best way to proceed, we decided to pilot full-fee rebate-able internet-based cognitive behavioural therapy (iCBT) to customers who are at risk of or are living with mild mental illness.

### Further context

Cognitive behavioural therapy (CBT) is one of the most effective treatments available for depression[1] and for all types of anxiety[2]. CBT has traditionally been delivered face to face, in individual or group settings[1,2], however it can also be delivered digitally, making treatment accessible to a broader population in a cost-effective way.

This Way Up (TWP) offers a series of confidential iCBT programs that cover a range of mental and emotional health issues, including depression and anxiety among many others. The programs are delivered over a 3-month period.

iCBT delivered via TWU is effective for most people – clinical trials have shown that 80% of people who complete their iCBT courses respond well to treatment, with 50% improving to the point of no longer being troubled by their anxiety or depression[3]. Treatment outcomes are equivalent to traditional CBT, and longer lasting than medication[3].

Our pilot was implemented to primarily investigate the customer appetite and uptake for a Bupa funded iCBT program delivered by TWU. The pilot sought to explore the following questions:

1. What is the uptake for iCBT?
2. What level of adherence is observed?
3. What impact does course participation have on mental health outcomes?

### Method

A representative sample of over 100,000 customers who had not previously claimed a private hospital admission (inpatient or outpatient) nor extras services related to a mental health condition, was identified. They were then sent an email to participate in one of nine paid courses focussed on anxiety or depression related disorders offered by TWU. Three free wellbeing courses focussed on stress management, introduction to mindfulness, and insomnia were also available. Customers were required to pay the $59 course fee directly to TWU at the time of registration and were eligible to claim the full fee rebate upon completion of the course.

The TWU pilot achieved a click rate of 5.8%, with 4.5% (114) of these customers registering for a course. The rate of uptake (0.1%) was lower than expected when compared to other Bupa marketing campaigns (1%). The courses were attractive to members of all ages (ranging from 18 to 73 years). The average age was 42 and 70% of those who registered were female. Members from across Australia participated, including 25% from regional, remote and very remote areas. Almost two-thirds registered for a paid course. While most emails were sent to the policyholder, the program offering was passed on to other members on the same policy as well as friends and family not included in the email, indicating that this offering for mental health support is appealing to customers.

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## Continued

### Clinical results

Results show TWU paid courses are successful at reducing symptoms of psychological distress. For customers who completed a 6-lesson paid course, only 1 in 5 were considered likely to be well at baseline, rising to 3 in 5 after completing all 6 lessons. More than half were considered to have a moderate or severe mental disorder at baseline, but this figure reduced to less than 1 in 10 (8.6%) after completing all 6 lessons.

Importantly, there is a dose-response relationship with greater improvement in distress symptoms achieved when more lessons are completed. There was an average reduction of 6.9 points for members completing 4 or more lessons compared to a reduction of 2.6 points for those only completing 3 or fewer lessons. Free courses also result in greater improvement in distress symptoms when more lessons are completed, although to a lesser degree than for paid courses.

### Wider results

The level of psychological distress of participants was higher than expected. The pilot originally intended to target members with mild mental illness. It was assumed that people suffering from moderate or severe mental disorders would have previously made claims for hospital or ancillary treatment related to their illness, and so would have been excluded from the sample population. The results of this pilot indicate that this is not the case.

Results indicate that members reporting more severe distress symptoms are more likely to participate in a disorder specific paid course than a free wellbeing course. At baseline, 48.5% were considered likely to have moderate or severe mental disorders, three quarters of whom elected to participate in a paid course. A further 26.7% were considered likely to have a mild mental disorder, two-thirds of whom elected to participate in a paid course. The remaining 24.8% were considered likely to be well and of these, only half elected to participate in a paid course.

To date, the completion rate for paid courses is 54% and for free courses is 27%. This is more than double the completion rate expected by TWU based on completion rates for the broader population (25%). Incentivising course completion to receive a full fee rebate increased the rate of completion.

### Next steps

As a result of these findings, we are exploring ways to make iCBT available for our customers aged over 18. We are also starting to look at iCBT options for customers aged under 18 years.

[1] Jorm, A., et al. 2013. *A guide to what works for depression: 2nd Edition.* Beyondblue, Melbourne. Available here
[2] Reavley, N., et al. 2013. *A guide to what works for anxiety: 2nd Edition*. Beyondblue, Melbourne. Available here
[3] This Way Up. (n.d.). Internet-delivered Cognitive Behavioural Therapy (iCBT). Available here

## Bupa and Kids Helpline – case study 3

***To build and support a generation of emotionally well and resilient, young Australians.***

### Recommendation

**Based on our experience and learnings from this partnership, early and barrier free access for young people to mental health support can increase resilience and improve their mental health more generally. As such, investment in this area makes sense from economic, outcome and customer experience perspectives.**

Underpinned by a commitment to improve the mental health and wellbeing of young people in Australia, in 2017 Bupa entered into a partnership with Kids Helpline (KHL). KHL is Australia's only free, private and confidential 24/7 phone and online counselling service for young people aged 5 to 25. Working together, KHL and Bupa aim to enable every young person/student in Australia to have access to the tools and resources necessary for mental wellbeing.

At any given time, 1 in 4 young Australians experience mental health challenges. To meet this growing demand and better target children's needs, KHL developed Kids Helpline @ School (KAS), an early intervention program focused on issues impacting children's mental health and wellbeing. The program offers free primary school classroom sessions with a counsellor via conferencing technology to talk openly about issues and break down barriers for children who are afraid or anxious to reach out for help.

**In its first year, KAS reached more than 13,000 students across 70 schools**. Bupa and KHL have a joint desire to grow the program to support more schools and students.

The shared objectives of the Bupa and KHL partnership include:

- Increasing the resilience and mental wellbeing of young people in Australia;
- Driving and meeting demand for help-seeking behaviours across the community; and
- Providing support and guidance on the mental wellbeing of young people, particularly to parents.

### Results so far

The program far exceeded its targets achieving close to quadruple its schools target (276%) and more than doubling its student reach (154%). Of the 163 teachers who responded to the teacher's survey, 96% believed the KAS Wellbeing session was likely to positively influence students' future choices and decision-making.

## Mobile Recovery Support Service – case study 4

### Recommendation

**Based on results from this pilot, considering ways to encourage community care makes sense from an outcomes, experience and affordability standpoint.**

The Mobile Recovery Support Service (the Service) has been provided through a partnership between Bupa and Toowong hospital since April 2017. The Service is for eligible customers living with a mental illness, who are at risk of admission to hospital and require support in relation to self-management of their wellbeing. The Service is aimed at supporting customers in their community to prevent further hospitalisations and, additionally, to reduce the length of stay if they are admitted for an in-patient service. The service builds strength and resilience by teaching customers skills and providing them with support to enable them to achieve maximum wellness in their community without undue reliance on professional support.

### Method

The Service is delivered by Registered Nurses and Allied Health Professionals who work collaboratively with the customer, treating psychiatrist, and any other health professionals, carers and/or significant others that the customer identifies and consents to having involved in their care. This helps to develop and deliver an **integrated care and treatment plan**. The service is delivered either face to face in the form of outpatient clinic reviews or in the community as home visits or via telephone consultations.

41% of customers participating in the Service were aged 45-64 years, 21% aged 35-44 and 18% aged 25-34. Each of the remaining 10 year age bracket groups had about ~5%. 84.5% of all participants were female. 70% of participants had Major Depressive Disorder.

### Results

To date a total 99 patients have accessed the service since its inception. Of these 65 have been discharged during this period with 34 continuing with the program. A range of outcome measures were employed to monitor customers' symptoms, both at entry and discharge and during the course of the Service. Many customers (65) have been discharged from the program with 37 (57%) noting that their mental health had improved to the point of *'no longer requiring service'*. These outcome measures were demonstrated by moderate to large effect sizes.

Ongoing patients are reviewed every ninety days and there are clear trends of mental health improvement during participation in the program, across a range of mental health outcome measures (overall mental health (HoNOS, MHQ-14 Mental Health, K10), social functioning (LSP16 Withdrawal, LSP16 Antisocial) and reduction in symptoms of depression, anxiety and stress (DASS Depression, Anxiety, Stress)).

In 2018 The Bupa Health Foundation announced their Foundation Grants Program will be investing $1 million dollars in research on improving mental health models of care in Australia. More than 150 expressions of interests were received from the health and medical research community. Following a two-stage evaluation process The Bupa Health Foundation awarded $500,000 to two research projects which each demonstrated innovative research that ultimately aims to improve the mental health and wellbeing of the Australia population.

## Bupa Health Foundation – case study 5

### *Follow my journey: a data-linkage project to establish effectiveness, efficiency and sustainability of a stepped care model*

This research project involves a Queensland consortium of primary health providers and hospital services within a large regional and rural population to evaluate an innovative stepped care approach for mental health. The stepped care model for mental health is an evidence-based, staged system comprising of multiple levels of interventions, from the least to the most intensive, matched to the individual's needs. While stepped care is central to guiding mental health activity by Primary Health Networks (PHNs), little is known about an individual's movement through the various stepped services or the effect on their emotional and physical wellbeing.

After introducing an innovative centralised intake and triage system for stepped care in their region, the Central Queensland Wide Bay Sunshine Coast PHN will **use data linkage and consumer feedback to assess patterns of service usage** across the system and also the experiences of patients as they access care. This will be **the first time that health outcome data and health administrative data have been linked for stepped care research**.

The data captured over the two-year research project will provide evidence of the impact of the new model of care on patients and health services in the region, which will **inform future system design to alleviate pressure points, improve access to and quality of care**.

## Bupa Health Foundation – case study 6

### *Best Care, First Time: can digitally-supported care pathways deliver better care for young people with emerging mood or psychotic disorders?*

This project **brings together organisations from the health research and care communities** who are committed to ensuring young Australians get the right mental health care they need, at the right time, by using innovative digital technologies.

These organisations include health research organisations, The Brain and Mind Centre at the University of Sydney and The Sax Institute (a national leader in promoting the use of research evidence in health policy), with several mental health service providers in Sydney representing the multiple care pathways for an individual including primary care, specialist care, outpatient and hospital settings.

The **project aims to address the current siloed approach to providing mental health care for young Australians.** This siloing leads to situations where young people find it difficult to find the right mental health care matched to their unique needs. It also creates care that is episodic rather than continuous with transfers needing to happen between health services. This impacts young people's health and wellbeing now and also into the future.

The project will test whether implementing a digitally supported care protocol with linked IT system across multiple service settings will **better coordinate care for young people with emerging mood or psychotic disorders**. The digital platform will be managed by the young person, and will support them to access the right care for their needs at the right time. A component of the project will also focus on supporting health organisations and their partners in a geographic area make decisions on **what combinations of services and interventions at the local level will result in the most optimal health outcomes** for young people.

After two years, the research will provide evidence on the impact of introducing digitally-directed coordinated care on clinical safety and service quality for each participating service, as well as the improved health outcomes of young people with mental illness and overall experience of young people, their families and their health professionals.