

Submission to the Productivity Commission on the Draft Mental Health Inquiry Report

Mental Health Carers NSW Inc. Submission

22/01/2020



MHCN
mental health carers

www.mentalhealthcarersnsw.org
www.twitter.com/MHCARERSNSW
www.facebook.com/mentalhealthcarers
carer connections helpline 1300 554 660
suite 501, 80 William St, Woolloomooloo, 2011
funded by the Mental Health Commission of NSW

Mental Health Carers NSW Inc.

Mental Health Carers NSW Mental Health Carers NSW (MHCN) is the peak body for mental health carers in NSW. MHCN is a community based, non-government organisation that provides systemic advocacy and education for carers, family and friends of those experiencing mental illness across NSW. MHCN works to ensure that the voices of mental health carers in NSW are represented and heard in policy and service provision reform processes to ensure that they are recognised and that their rights are upheld. We endeavour to empower mental health carers across the state to engage with mental health reform and advocacy.

A Vision for a Relational System

The Productivity Commission is in the privileged position to make a substantial contribution which builds upon several decades of reform that have already produced a momentous cultural change in the mental health system. Merely a few decades ago the concept of recovery from severe mental illness was considered radical or misinformed. The cultural change that has been forged is so significant that recovery is now integral to daily business. Although the way that we provide treatment to individuals has fundamentally changed, care for the relationships which are so integral for mental wellbeing remains a missing piece.

Recent developments in mental health have presented overwhelming evidence that recovery from mental illness is relational. There is an undeniable link between mental ill health, family breakdown, intergenerational trauma and social isolation. Recovery from mental health occurs in the context of meaningful relationships with family, friends and community. Relational recovery has evolved as a term which describes this new paradigm. Relational recovery does not imply sacrificing access to individual care. In fact, relational recovery encompasses holistic care to both individuals, families and communities that seeks to address the biological, psychological and social factors that contribute to poor mental health. A relational system also recognises and intervenes to mitigate the considerable impact of mental ill health on families and communities. Just as additional investment in community care prevents expensive hospitalisations in the long term, investment in relationships within families and communities can end cycles of mental ill health, family breakdown and trauma or prevent that cycle in the first place.

Australia's services and systems have not caught up to our rapidly evolving understanding of mental health as relational. While there are areas of excellence, the relationships integral people's to experiences of mental illness and recovery are far too often side-lined in treatment or considered as optional add-ons, rather than comprehensively integrated into a therapeutic program that addresses the causes of mental illness such a social isolation and trauma. Although it is incomprehensible to most people that a happy and fulfilling life could be devoid of healthy relationships with friends, family and community, too often people who seek help receive medication for their symptoms, strategies to address unhelpful patterns of thinking and yet no practical support to build healthy connections with others. Family and carer engagement is poorly implemented across the system and family members and carers often have limited or no options to access relevant supports for themselves or to help them support their loved one's recovery, or otherwise are not informed that such possibilities exist. Community mental health supports, which enable people living with severe mental illness to participate in the community are chronically underfunded, in spite of being repeatedly and persistently identified as being hopelessly inadequate to meet the needs of Australia's current (much

less rapidly growing) population. On the national stage, the bulk of mental health funding is devoted to MBS funded counselling services and the Disability Support Pension. Whereas, programs which enable social or employment participation or intervene to address loneliness have very limited funding. However, the aspirations of vulnerable Australian's are just as worthy of support as those of the healthy and well-off, but with a far greater moral obligation for Australia's governments.

The Productivity Commission's draft report identifies significant gaps in many areas of the mental health system which primarily focus on delivering relational care and outlines opportunities to;

- Deliver a competent, comprehensive and universally accessible mental health system which is a safe partner in recovery for consumers and partner in care for carers;
- Address social isolation and enable improved connectedness within the community
- Improve options for social and economic participation through employment and education and;
- Supports critical relationships with family and carers.

If the above recommendations are implemented in collaboration with consumers and carers, individuals and families will have more options to access holistic care which is considerate to the link between quality relationships and mental wellbeing.

However, the Productivity Commission's draft report has missed the opportunity to outline an overarching vision for mental health reform which would firmly orient the sector towards a system which is relational, comprehensive, trauma informed and recovery oriented. As a body primarily concerned with economics, the Productivity Commission's focus on structural reforms which are likely to produce improved efficiency and increase the impact of investment in mental health is understandable. However, it is simply inescapable that this system needs more and new resources allocated to it to make it effective. Further, the culture of the mental health sector, and the relationship clinicians have with consumers and their carers is critical to drive effective implementation of any reform agenda. While the Productivity Commission's draft report has successfully presented many of the building blocks necessary for reform to the mental health sector the final report should also provide a blueprint that articulates exactly what sort of mental health sector the Productivity Commission's recommended reforms are intended to build and how it will consistently deliver the kind of care required. Rather than piecemeal programs and initiatives which seek to improve access to relational care in specific areas, a cohesive cultural change which drives the system towards consistently providing relational recovery by nurturing relationships is required and the Productivity Commission can take a leading role by articulating an overall vision for the mental health sector within the final report.

Relational recovery provides an overarching framework and a vocabulary to describe a vision for a system which places the person *and their carers, family members and communities* at the centre of service delivery. It presents a vision where mental wellbeing is understood as relational, where people's mental health is not siloed from their social and economic wellbeing, treated as separate to their past experiences of trauma and disconnected from their relationships with families, friends and communities. A system where aspirations, hopes and dreams are met with practical, holistic support that seeks solutions for all barriers to a meaningful life whether they be biological, psychological or social. A system where professionals recognise trauma and intergenerational trauma are common to the experience of mental illness in families and recognise that a relational approach is central to healing across family and community networks. A system that understands that community connectedness is heart and centre to mental wellbeing and seeks to build this from the ground up. A

system which builds and strengthens whole communities as networks of supports for mental health for all, wherein family and carers are engaged and supported. A system which puts consumers, carers, families and kinship groups in positions of power to drive mental health reform.

The Evidence for Relational Recovery

There is now overwhelming evidence that mental ill health is interlinked with experiences of trauma.¹ Layered experiences of multiple adverse events have a cumulative impact which is referred to as 'complex trauma'. The effects of adversity, trauma and mental illness are multidirectional. Mental distress is a natural response to trauma and adversity which can lead to chronic mental ill health in people's lives. Likewise, mental ill health can interfere with individuals' capacity to engage in healthy relationships and pursue life goals leading to stigma, isolation, loneliness and disempowerment, factors that combine to render people vulnerable to further adverse life events.² This forms a powerful cycle in individuals' lives of immense gravity that is formidable to escape.

Both mental ill health and experiences of trauma are intergenerationally transmitted biologically (through genetics and epigenetics) and through adverse familial and/or caregiver interactions (which are often compromised by trauma and mental distress).³ The intergenerational nature of trauma and mental illness shapes a cycle of mental ill health, trauma, distress, family breakdown, disadvantage and lost life potential within families and communities.

Recovery occurs in the context of supportive relationships with professionals, family, friends and community.⁴ This is unsurprising given the strong link between family breakdown, social isolation and mental ill health. There is some evidence to suggest that the quality of therapeutic relationships, as opposed to the clinical model used, is the most important factor in determining long term outcomes.⁵ While professionals and services are critical as expert guides, they are not meant a substitute for informal relationships. Family, friends and community ultimately provide a sense of connectedness, self-esteem and purpose that cannot be substituted. Social interactions prevent loneliness and enable people to live a socially and intellectually enriching life. The interactions that people have with close family and friends are critical to shaping identity. Family, friends and community remain in people's lives long after professionals complete an episode of care. Untimely professionals should seek to build supportive relationships as an integral part of recovery and as a protective factor to maintain recovery in the long term.

Relational recovery has evolved as a model in recognition of the fact that mental health is irreducibly relational.⁶ Within a relational model of recovery individual needs are still stressed, but these needs are viewed as situated in and emerging from the persons' social context.⁷ Relational recovery is a broad term which encompasses more than just carer engagement or family therapy, although this is

¹ Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society

² *ibid.*

³ *ibid.*

⁴ Price-Robertson, R., Obradovic, A. & Morgan, B. (2017) Relational recovery: beyond individualism in the recovery approach, *Advances in Mental Health*, 15:2, 108-120

⁵ Swift, J. K. and J. L. Callahan (2010) 'A comparison of client preferences for intervention empirical support versus common therapy variables', *Journal of Clinical Psychology* 66(12): 1217-1231.

⁶ Price-Robertson, R., Obradovic, A. & Morgan, B. (2017) Relational recovery: beyond individualism in the recovery approach, *Advances in Mental Health*, 15:2, 108-120

⁷ *ibid.*

often a critical part of relational care. Rather, relational recovery is driven from a position of genuine curiosity about the important relationships in a person’s life and about how these relationships shape their sense of self and impact upon wellbeing. In a relational model the importance of relationships is recognised and is integrated throughout therapeutic care and service provision even where family and carer involvement is not appropriate or impossible.

Recommendation:

The Productivity Commission should consider emphasising the importance of social and caring relationships to mental wellbeing throughout the report and outline relational recovery as an important model for service provision which should be integrated throughout the mental health sector.

Elements of a Relational System

The Productivity Commission’s draft report makes numerous recommendations which have the potential to contribute to a relational mental health system. The key elements for a relational mental health system identified within the Productivity Commissions report include;

- Mental Health Services which utilise models of care that are holistic and address the biological, psychological and social factors which contribute to mental illness.
- Community mental health services and psychosocial supports for people experiencing mental illness which address loneliness and enable social and economic participation.
- Mental Health services which consistently implement best practice standards in family and carer engagement.
- Specialised services which specifically support family members and carers of people living with mental illness.
- Specialised services which specifically support families affected by mental illness as a whole unit.
- A reliable system of governance that is driven by and is accountable to consumers, carers, families and communities.

Family and Carer Engagement at Mental Health Services

Benefits of family and carer engagement

Family and carer engagement refers to identifying and engaging appropriately with the relationships that consumers have with families and friends that have significant impact on their mental wellbeing to achieve the best outcome. Given that quality relationships are critical to mental wellbeing, this should occur at all mental health services for every individual who receives care.

The Productivity Commission has rightly identified that family and carer engagement has numerous positive outcomes. The benefits of family and carer engagement are listed in the following table;

Benefits for the Individual Receiving Care

- | |
|---|
| <ul style="list-style-type: none">• Family members and carers can provide health workers with significant insight into consumer based on their experiences in a long-term relationship with the person. |
|---|

- Quality relationships are critical to recovery from mental illness and are likely to be a source of long term support for consumers which continues after the completion of a single episode of care. Family and carer engagement can help to support and improve the quality of informal relationships.
- Family and carer engagement can improve the quality of support provided by informal relationships by equipping family and carers with the information they need to be effective in their caring role.
- Family and carer engagement is critical to patient safety.⁸ In particular, involving family and carers in discharge planning and providing appropriate information to family and carers prior to discharge can reduce suicide risk, especially when the family are expected to be involved in the persons care subsequent to discharge. Family members are often the first people to notice when the person they care for starts to deteriorate. Carers often play a critical role in implementing a safety plan by identifying when the person needs additional support and accessing relevant services. Carers should receive the information that they need to be effective in this role.

Benefits to family members and carers

- Family members and carers often experience substantial stress and anxiety around the wellbeing of the person they care for and appropriate engagement can help to ameliorate this stress.
- Moderate to severe mental illness can also have an impact on family members and carers wellbeing. Carers and family members (including children) should have access to information and support which enables them to look after themselves. Family and carer engagement often encourages family members and carers to identify their own unique needs and facilitates access to carer services and family supports.

Benefits to families

- There is a link between mental ill health, poor quality of social relationships and family breakdown. Family and carer engagement can help to improve the quality of family relationships.

The Productivity Commission’s final report should further emphasise the importance of family and carer inclusive practice, particularly with regards to patient safety. It is essential that policy makers and service providers are aware of the significant consequences of poor family and carer engagement.

Recommendation:

To further emphasise the importance of family and carer inclusive practice, the Productivity Commission should identify that family and carer engagement is often critical to patient safety especially following discharge. The Productivity Commission should include this information in the final report under the heading “A partnership model between carers and mental health services.” (pages 495-500 of the draft report).

⁸ For further evidence the Productivity Commission could seek to access Root Cause Analysis data on critical incidents within public mental health services. This data is typically held by state and territory governments and is not publically available.

Family and Carer Engagement in Australia

According to the draft report participants to the inquiry expressed concerns that carers and families' role, views and needs are not being recognised and respected by mental health services (see page 495-496 of the draft report). The feedback which Mental Health Carers NSW has received from carers and other stakeholders matches the feedback to the Productivity Commission outlined in box 13.3 of the draft report. The Productivity Commission has rightly identified that reform to the mental health system should seek to drive quality improvement in family and carer engagement within the mental health sector.

Common misconceptions around carer inclusive practice

MHCN is pleased that the Productivity Commission has devoted an entire section of the report to outline the need for quality improvement in family and carer inclusive practices throughout the mental health system. However, the section of the report which addresses family and carer inclusive practices within public mental health services has an overwhelming emphasis on information sharing reflected by the title of the section "Supporting information sharing between services and carers." With the exception of information sharing and carer involvement, the draft report is missing a brief description of what carer inclusive practice involves. Key elements of family and carer inclusive practice, such as identification of family members, referrals to carer supports and support for consumers and families to improve their relationships with each other are not outlined in this section of the report. The report does not clearly differentiate between family and carer inclusion in care decisions and family and carer inclusive practice. While family and carer inclusion in care decisions entails involving family and carers input in making decisions about an individual's care, family and carer inclusive practice is a more expansive term which encompasses appropriate engagement with all people who have significant relationships the consumer.

A common misconception shared by many health practitioners and policy makers is that there is a dichotomy between family and carer inclusive practice and the needs of the person with a mental illness. The misconception that 'family and carer inclusive practice' is not always in the best interests of the individual has evolved because activities which are perceived as 'family and carer inclusive practice', such as information sharing, are not appropriate in every circumstance. Family and carer inclusive practice does not necessitate that family members should always have access to confidential information or be involved in every aspect of the person's care. Rather, family and carer inclusive practice requires services to appropriately navigate the complexities in relationships with families and friends to negotiate outcomes that support wellbeing.

Circumstances where the consumers' needs are opposed to the needs of a family member are often cited as a reason that family and carer engagement may not be appropriate for all consumers. Unlike family and carer support, family and carer inclusive practice prioritises the relational needs of the consumer. Often the needs of family members and carers are mostly aligned with the needs of the individual receiving care, however, in situations where the needs of family members, carers and consumers are diametrically opposed, family and carer inclusive practice involves appropriately navigating the complex situation to achieve the best possible outcome for the consumer. Within this framework, the practitioner should pursue all opportunities to support carers and family members without compromising the needs of the consumer, such as through a referral to independent services.

The overwhelming focus on issues related to information sharing and confidentiality in the Productivity Commissions report inadvertently portrays family and carer inclusive practice as potentially problematic. The delicate balance which needs to be struck between the independence and confidentiality of the individual with the benefits of family and carer involvement will always present ‘problems’ to service providers regardless of their stance on family and carer inclusive practice. Best practice in family and carer inclusive care is not a contributor to these issues but rather the solution. Best practice standards in family and carer inclusive care should be used to inform the way in which services navigate decisions which require them to negotiate carer involvement and consumer confidentiality.

The draft report should seek to present a clear definition of family and carer inclusive practice which clarifies the common misconceptions outlined above. Although it is critical that any discussion on family and carer inclusive practice addresses issues related to information sharing and confidentiality, other important elements of carer inclusive practice should also be outlined in the report. The Productivity Commission’s draft report identifies several guidelines based on best practice evidence which describe family and carer inclusive care. These include; “A Practical Guide for Working with People with a Mental Illness” developed by Mind Australia and Helping Minds and the Victorian Chief Psychiatrists Guideline for Working with Family and Carers. The Productivity Commission should refer to the guidelines for detailed description of the key elements involved in family and carer inclusive practice. The following table summarises key elements involved in family and carer inclusive practice as they are described within the two guidelines;

Identification of Family Members and Carers

Mental health services should seek to identify all of the key informal relationships to the consumer. Although this may seem obvious, feedback from stakeholders indicates that services often do not identify carers and family members in a timely fashion. In particular, young carers and non-nuclear family relationships are often overlooked by services. Services should always ask consumers about the relationships that are important to them and the support that they receive from both friends and family. This should be revisited from time to time as consumers may share different information depending on the level of trust in the therapeutic relationship and the impact of the symptoms of mental ill health on their insight and decision making capacity.

Information Sharing

As identified by the Productivity Commission information sharing is critical to ensure that carers are able to collaborate with services in caring for their loved ones. Information sharing ensures that carers, services and consumers are on the same page with regards to care plans, medication and safety plans. Information sharing by the service with carers equips carers with knowledge that they need to be effective in their caring role. Services should also actively seek information from carers to inform care planning, care provision, medication and diagnosis.

Family and carer inclusive practice involves exercising sound clinical judgement to determine whether information should be shared with family and carers and how this information should be shared. Decisions to share or withhold information with family members should take into account;

- Legal responsibilities under mental health and privacy legislation;
- The consumers wishes with regards to how their private information is shared;
- The relevance of the information to family and carers and;
- The clinical judgment of the practitioner.

Strategies which ensure that information is shared appropriately without breaching confidentiality include;

- Identifying information which can be shared without breaching confidentiality. Services can seek information from carers which is relevant to care planning without breaching confidentiality. Services can share information with carers which is in the public domain without breaching confidentiality, such as general information on mental illnesses or carer on carer supports.
- Upholding rights to carer confidentiality and consumer confidentiality. Services should consistently seek consent from carers and consumers before sharing their personal information with other family members or services.
- Seeking consent from carers to include them in a care plan or safety plan for an individual who will be discharged from an inpatient facility and informing them about the care plan or safety plan.
- Professionals can employ strategies which encourage consumers to consider sharing relevant information with supportive family members and carers and to involve them in their care. Most consumers will indicate that they want their family members and carers to be involved in their recovery and will agree to share information with them if asked at an appropriate time in an appropriate manner.
- For individuals with fluctuating decision making capacity due to mental ill health, services should support them to prepare an advance care directive which outlines their wishes regarding how personal information should be shared when they are very unwell.
- Services should have clear guidelines for staff regarding confidentiality and information sharing which are in line with legal obligations under mental health and privacy acts.

Involvement of Family Members and Carers as Partners Care

Family members and carers often provide substantial care to the consumer and have significant involvement in consumer's recovery. Whenever this is the case, family members and carers should be considered to be critical partners in care and services should interact with family and carers accordingly. There are a wide array of strategies which practitioners can employ to facilitate a partnership between carers and services. These include;

- Sharing information with family and carers within the boundaries of confidentiality.
- With the consumers consent, inviting family members and carers to attend therapy sessions and to be involved in care plan meetings.
- Checking family members' perception of their role in caring for their loved one and their willingness to be involved in this role. This is especially relevant when services expect that family members will provide care or housing to the consumer.
- Providing family members with information and psychoeducation to build their capacity to be effective in their caring role.

- In situations when it may be beneficial for family and carers to step back from their caring role to allow greater independence for the consumer, services should work with the carer and consumer to respectfully encourage and safely facilitate this transition.

Support for Family Members and Carers Own Needs

The wellbeing of family members and carers is often impacted by the experience of caring for someone who is very unwell. Family and carer inclusive practice requires services to be aware of and responsive to carers needs. Services should;

- Routinely assess carers wellbeing and identify carer specific needs.
- Provide carers with information or psychoeducation intended to assist them to identify their own needs and to look after their own wellbeing.
- Facilitate access to relevant supports for carers and family members (such as counselling, support groups and respite) by providing information on services and referrals.
- Facilitate access to relevant supports for the whole family (such as family therapy or parent coaching) by providing information on services and referrals.

Support for Relationships between Consumers, Families and Carers

Family and carer inclusive practice requires services to assess the impact of relationships on consumer wellbeing. Services can support consumers and their families to improve the quality of their relationships by providing strategies to improve communication, set appropriate boundaries and to identify and alter any unhealthy patterns of relating to each other. Although relationships with families and carers are often highly supportive and beneficial to consumers. Relationships can have a negative impact for a variety of reasons. Services which implement family and carer inclusive practice are more likely to identify when relationships are unhealthy because these services ask consumers about their relationships with others and seek to engage family members and carers. Family and carer inclusive practice requires practitioners to exercise clinical judgement to assess relationships and respond appropriately in situations where relationships are unhealthy. This may involve providing consumers, carers and family members with strategies to improve the relationship. In cases where a relationship is abusive, an appropriate response may involve supporting the person to remove themselves from the abusive situation and working with the person to reconnect with or to establish other relationships which are supportive of their wellbeing.

Inclusion of Family Members and Carers in Organisational Governance and Practice

Families and carers experiences of mental health services provides unique and invaluable insight for quality improvement and is critical to service design and evaluation. Family and carers inclusive practice requires family and carers to be routinely be involved in service design and service provision. This can be facilitated by;

- Employing carer peer workers.
- Implementing processes to seek continual feedback from family members and carers on their experience of service.

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- Appointing family and carer representatives on all governance committees.
 - Including family and carers in all consultation and co-design activities.

Drivers of Quality Improvement in Carer Inclusive Practice

MHCN strongly supports draft recommendation 13.3 which identifies several opportunities to improve access to family focused support and to drive quality improvement in carer inclusive practice. MHCN believes that all of the reforms described in draft recommendation 13.3 are of benefit to family and carers including; implementation of the Carer Experience of Service Survey (CES), a trail of dedicated family-focused practice staff and amendments to the Medicare Benefits Scheme (MBS) to fund family therapy and family/carer consultations.

The Productivity Commission has identified implementation of the CES Survey as the key driver for quality improvement in carer inclusive practice across the public mental health sector. MHCN was heavily involved in the introduction of the Carer Experience of Service Survey in NSW and is pleased that the Productivity Commission has identified the importance of monitoring and reporting in addressing the gaps between “quality standards in theory and the experience reported by carers in practice” (page 499 of the draft report). Public reporting to the AIHW as recommended by the Productivity Commission

in addition to the Carer Experience of Service Survey, MHCN would like to see the Productivity Commission explore the evidence for other drivers of quality improvement in carer inclusive practice in the final report. Key drivers for quality improvement include;

- Mandated best practice guidelines and mandated staff training in family and carer inclusion.
- Development of the carer peer workforce through dedicated carer peer worker positions within all LHNs.
- Employment of staff dedicated to drive improvements in family and carer inclusion and provide family focused care within LHNs.

State and Territory Government Leadership

The draft report has correctly identified that “there is guidance and training available to mental health professionals and numerous options for documentation related to carers and information sharing.” However, feedback which MHCN has received from professionals indicates that service managers and healthcare practitioners are often overwhelmed by the sheer volume of best practice guidelines and optional staff training within the mental health sector.

Mental health practitioners are often time poor and given the huge variety of training available, staff are unlikely to devote their time to upskill in family and carer inclusive practice unless this training is mandated. Likewise, services are unlikely to elect to devote their time to implement best practice guidelines in family and carer engagement when their focus is divided between care provision, administrative tasks, mandated monitoring and reporting requirements and other areas of quality improvement. Although the implementation of the CES survey will act to somewhat incentivise carer inclusive practice, it will compete with other monitoring and reporting requirements. In service

settings where a culture of individual recovery and family/carer exclusion is prevalent, family and carer engagement is unlikely to ever be placed high on the agenda for quality improvement.

State and territory governments can play a key role in incentivising services to devote attention to quality improvement in family and carer inclusive practice by;

- Mandating carer inclusive practice training for all health staff employed at LHN mental health services.
- Developing or refining comprehensive guidelines for Family Inclusive Practice such as “A Practical Guide for Working with People with a Mental Illness” through a process of co-design, promoting the guidelines to service leaders and mandating the implementation of Family Inclusive Practice guidelines within LHNs.
- Promoting relational recovery as an integral component of mental health service culture.

Development of the Carer Peer Workforce

Carer peer workers have distinct roles. Although carer peer work shares some similarities to consumer peer work, it differs from consumer peer workers in the type of supports provided and the outcomes of their role. There is a great deal of variety in the type of support provided by carer peer workers across different services, however, carer peer roles often focus on or include direct support for family members and carers. Several studies indicate that carer peer workers are highly valued by families and carers. Family and carers often find that carer peer workers are highly relatable due to their similar lived experience. For instance, one study found that carers highly valued carer peer workers because they felt ‘accepted, understood and not judged’ when they spoke to someone with similar experiences.⁹ Other studies have found that carers value the opportunity to talk about the caring role and that having access to a staff member with similar lived experience helped to reduce distress and make carers feel comfortable and supported.¹⁰

Several studies and evaluations of carer peer support programs demonstrate that carer peer workers can;

- Improve carers wellbeing
- Enhance carers capacity to manage their caring role
- Improve carers knowledge of available supports and recourses
- Assists carers to effectively navigate the challenges of an inpatient admission
- Manage and process emotional responses to loss of a family members’ mental health and to inpatient admissions and;
- Facilitate carers to voice concerns related to treatment and care to service providers.¹¹
- Studies of parent peer workers also found that peer workers decreased the number of missed appointments, decreased the use of high end care and residential placements and increased student graduation rates.¹²

⁹ Foster, K. (2011). ‘I wanted to learn how to heal my heart’: Family carer experiences of receiving an emotional support service in the Well Ways programme. *International Journal of Mental Health Nursing*, 20, 56-62.

¹⁰ Eastern Health and Monash University. (2009). Evaluation of COPES services in Central and Outer East. Prepared by students L. Cunningham and G. Mathanasenarajah.

¹¹ ARAFEMI (2011), “Best Models for Carer Workforce Development: Carer Peer Support Workers, Carer Consultants, Carer Advocates and Carer Advisors”, ARAFEMI Victoria, Available at <https://helpingminds.org.au/wp-content/uploads/2018/07/Best-Models-for-Carer-Peer-Workforce-Nov-2011.pdf>

¹² Purdy, F. (2011). Certification of Parent Support Providers. Certification Commission, National Federation of Families for Children’s Mental Health.

Australian state and territory governments have made concerted efforts to expand the peer workforce over the past decade, however, the Productivity Commission has correctly identified that the peer workforce is underutilised (chapter 11 of the draft report). MHCN supports the Productivity Commission’s draft recommendation 11.4 which is intended to further develop the peer workforce. However, MHCN notes the need to specifically support the employment of carer peer workers. The number of carer peer workers remains limited with only 1 carer peer worker employed per 1000 staff within NSW Local Health Districts.¹³ Carer peer workers are critical, especially with regards to family inclusive practice. As such all LHNs should be funded to develop and trail dedicated carer peer worker positions in addition to consumer peer work positions.

Dedicated family and carer staff

The Productivity Commission has rightly identified evidence which indicates that staff dedicated family-focused practice in families where a parent has a mental illness significantly improves outcomes for children and parents (pages 492-495 of the draft report). Staff dedicated to family-focused practice and family and carer engagement is also likely to have a positive impact for families without children. The NSW government provides funding for Local Health Districts to employ staff dedicated to family and carer engagement through the Family and Carer Mental Health Program.

The Family and Carer Mental Health Program has not been formally evaluated, however feedback from carers indicates that they highly value staff members dedicated to family and carer engagement when they have access to them. Local Health District staff employed through the Family and Carer Mental Health Program have also been instrumental to drive quality improvement in carer inclusive practice. Staff are involved in a range of quality improvement activities such as; providing education and training to LHD staff on family and carer engagement, facilitating feedback from family members and carers and providing advice to LHD staff on family and carer engagement when requested. The Productivity Commission could consider adding recommendation to trial and evaluate staff dedicated to facilitate family focused practice with all families, in addition to a trail which focuses on parents and children.

Recommendation:

Productivity Commission should amend the section “Supporting Information Sharing Between Services and Carers”. The Productivity Commission should;

- Change the subtitle from “Supporting Information Sharing Between Services and Carers” to “Driving quality improvement in Family and Carer Inclusive Practice”.
- Define Family and Carer Inclusive practice and briefly outline key elements of family and carer inclusive practice such as ‘information sharing’, ‘family and carer involvement in care’.
- Clarify the difference between Family and Carer Inclusive Practice and Family and Carer Inclusion.

¹³ Mental Health Commission of NSW (2019), “Indicator 5: The Peer Workforce”, available at <https://nswmentalhealthcommission.com.au/indicator-5-peer-workforce>.

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- Explore the evidence for additional drivers of quality improvement in Family and Carer Inclusive Practice such as; the development of a dedicated carer peer workforce, mandated staff training and service guidelines on carer inclusive practice within all LHNs and employment dedicated family support staff within all LHNs.

Recommendation:

The Productivity Commission should amend draft recommendation 13.3. In addition to the reforms identified in draft recommendation 13. 3, The Productivity Commission should include the following;

In the medium term

- State and Territory governments should mandate training in carer inclusive practice for all clinical staff employed at LHN mental health services.
- State and Territory governments should develop and implement guidelines which relate to mandatory practice standards for family and carer inclusive practice including appropriate information sharing, with and without capacity and/or consent.
- The National Mental Health Commission should receive funding to commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services to improve outcomes for families and for children of parents with a mental illness.
- State and Territory governments should fund dedicated carer peer worker positions within in all State and Territory Government mental health services.

Carer Support Services

MHCN is pleased that the Productivity Commission has devoted an entire section of the draft report to carer support services (pages 481-489 of the draft report). MHCN is supportive of the recommendation to shift the responsibility for mental health carer support services to State and Territory governments, as described in draft recommendation 23.3, on the proviso that *funding to carer support services is not reduced*. Clarifying the roles of State, Territory and Commonwealth governments in the provision of carer services has potential to identify gaps in mental health carer support services and to prevent service duplication.

The Productivity Commission has identified several challenges for governments in carer support service planning namely that;

- “there are few publicly available evaluations of the programs run in Australia. Therefore, it is not clear the extent to which the mix of services available here is effective and aligns with best practice.” (page 483 of the draft report)
- There significant “challenges in summing current expenditure on carer support services for mental health carers” (page 487 of the draft report).
- “The Commission has not been able to estimate the current level of unmet need for carer support services” as “Australian Government services are in transition, State and

Territory Government are fragmented and data available is not sufficient for this purpose.” (page 487 of the draft report.)

- “It is too early to know how well the ICSS and NDIS will meet the needs of mental health carers” even though the Commonwealth and some states have withdrawn funding for carer services with the expectation that mental health carers will receive support through the ICSS and the NDIS (page 484).

The Productivity Commissions findings point to the critical importance of evaluative data. Although all available evidence indicates that “a substantial proportion of carers have unmet needs for carer support services” (page 485 of the draft report), the lack of comprehensive data and evaluation on family and carer inclusion has previously been cited by decision makers as a rationale to avoid further investment in mental health carer support services. Data on carer services is critical to ensure that expenditure on carer services is set at a level adequate to meet carer need. Evaluative data is required by decision makers to determine the right mix of carer services and to ensure that carers have access to the type of supports that they need.

Recommendation:

Given the findings of the Productivity Commission outlined above, the final report should include recommendations intended to improve mental health carer service data collection and evaluation. In the short term, while the ICSS provides support to mental health carers, data should be collected on;

- The number of mental health carers who interact with the carer gateway
- The number of mental health carers who receive services through the ICSS;

In the medium-term State and Territory governments should;

- Commission the evaluation of current mental health carer services which are funded by State and Territory Governments including the Family and Mental Health Carer Program in NSW.

Agree upon a set of outcome measurements for NGO mental health carer services which should be incorporated into the Mental Health Non-Government Organisation Establishments National Minimum Data Set.

System Governance

Carers and consumers expect a mental health system that is **predictable** (what is delivered is what was advertised, promised or recommended, is the same as what was provided before or for others, and is appropriate for consumer and carer needs), **safe** (services take responsibility for the safety of their loved one while caring for them and ensure they are discharged only when no longer at risk, or handed on when appropriate to new services without being ‘lost to care care’ or harming themselves or others in the process), **reliable** (services are delivered in a consistent and timely manner every time), **fair and equitable** (what is available to people in one location is also available, with the same speed and efficiency, to others with similar needs who are in another location), and meeting required **standards** (that are measurable, are measured and are reported). The governance system should be accountable to **consumers and carers** through meaningful structures that are empowered to implement real consequences for services and jurisdictions which fail to meet service targets or quality.

Governance

In reference to chapter 22 on systems governance MHCN supports the following findings:

Chapter 22 page 881:

- Unclear responsibilities between the two tiers of government prevent the system from operating effectively and efficiently to benefit the community.
- Strategic planning in mental health focuses on the health sector without adequately integrating other sectors.
- The mechanisms for holding jurisdictions accountable for mental health outcomes are weak and poorly developed.
- A lack of consumer and carer involvement in developing strategy, major programs and accountability processes lowers the quality of decision making and system performance. MHCN notes that the current structure of the governance framework (figure 22.1, page 886 in Volume 2) provides no opportunity for involvement of carers and consumers other than through the state and commonwealth Mental Health Commissions which have only an advisory role.
- The absence of a robust culture of program evaluation impedes innovation and continuous improvement in system efficiency and effectiveness

MHCN supports the following suggested actions identified by the Productivity Commission with additional comments identified in green:

- The Council of Australian Governments (COAG) should set clear divisions of responsibilities in a new National Mental Health and Suicide Prevention Agreement.
- The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023.
- The COAG Health Council should agree on a set of targets and specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.
- The Australian, State and Territory Governments should collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation and create accountability mechanisms that make service providers and jurisdictions accountable to a body representing carers and consumers.
- Additional actions required include:
 - The National Mental Health Commission should have statutory authority to lead the co-evaluation of mental health and suicide prevention programs, in collaboration with consumers and carers. This is strongly supported by MHCN and should be duplicated in those States/Territories that have local Mental Health Commissions.
 - COAG should develop a new whole of governments National Mental Health Strategy that aligns the collective efforts of health and non-health sectors to improve mental health outcomes. This strategy should have measurable targets and goals and clear accountability mechanism (unlike the current 5th National Mental Health Plan and Suicide Prevention Plan) as is suggested on page 890. MHCN strongly supports the findings of the review where the PRODUCTIVITY COMMISSION states that 'It also lacks detail that would enable stakeholders to hold governments more accountable for outcomes' page 890.

New National Mental Health and suicide prevention Agreement

MHCN strongly supports the formation of a new *National Mental Health and Suicide Prevention Agreement (NMHSPA)* Recommendation No. 22.1 as outlined in Chapter 22 page 891 and the inclusion of consumer and carer representatives (page 893)

New Government Strategy

MHCN supports draft recommendation 22.2 — a new whole of government mental health strategy with the aim to integrate ‘services and supports delivered in health and non-health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long term’ Page 905.

Systematic Advocacy

MHCN strongly supports draft recommendation 22.3 — enhancing consumer and carer participation Page 912 particularly regarding ‘consumers and carers having the opportunity to participate in the design of government policies and programs that affect their lives’ This recommendation proposes that

- The Australian, State and Territory Governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation – Furthermore, this recommendation should state that future strategies and plans should not be accepted by governments until they have first been approved by a national body representing consumers and carers.
- COAG should instruct the National Mental Health Commission to monitor and report on total expenditure by individual jurisdictions on systemic advocacy in mental health that is provided by peak representative bodies and should make recommendations based on these observations on the level of contribution by governments towards organisations providing **systematic advocacy**.

Outcome Targets

MHCN supports draft recommendation 22.4 — establishing targets for outcomes within the limitations of target setting that the report outlines; that they are realistic, based on well-established baselines and indicate the level of government that is accountable for the target.

Evaluation

MHCN supports draft recommendation 22.5 — building a stronger evaluation culture in relation to granting The National Mental Health Commission (NMHC) “statutory authority to lead the evaluation of mental health and suicide prevention programs funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors. As part of its annual planning cycle, the NMHC should prepare and publish a rolling 3 year schedule of program evaluations.” MHCN recognises that this will require some challenging negotiations with state and territory governments about the role of the NMHC in evaluating their services.

Clinical governance

Clinical governance is defined by the Australian Commission on Safety and Quality¹⁴ as:

¹⁴ ¹⁴ Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework. Sydney: ACSQHC; 2017 Page 2.

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- the set of relationships and responsibilities established by a health service organisation between its state or territory department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.
 - an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving. Clinical governance is an integrated component of corporate governance.

Both the public and the private systems, and the primary health care and specialist medical services, are based on funding systems that lack rigour in the accountability placed on clinicians. There are good systems in place in some clinical specialities for establishing agreed outcome measures (for instance surgery measures infection rates, deaths, readmission rates, etc. and obstetrics measures caesarean rates, deaths, complications of delivery etc.). This is less so in mental health where the achievement of reportable outcomes is still a work in progress. In addition, clinicians and hospital funded from state and commonwealth programs, both in the area of mental health and across health systems generally, are rarely held to account for deliverables other than for reportable incidents. Deliverable that related to prevention, early intervention, access, timely responsiveness to service delivery, reliability, consumer and carer engagement, communication skills, consumer and carer satisfaction and outcomes are rarely measured in any meaningful way and are unlikely to be included in funding agreements. These performance measure should be built into employment and funding agreements.

Until this level of accountability is addressed then individual service delivery organisations at the state and private system level will find it difficult to agree to specific targets of performance with funding bodies. Clinical governance is an important area and the discussion of the accountability and transparency of service delivery that is missing from this report.

Recommendation

The Productivity Commission should include a section on clinical governance in chapter 22 of the report. The Productivity Commission should include a recommendation that both the Federal and State Governments introduce into funding agreements and funding arrangements more accountability mechanisms in relation to clinical performance and the outcomes achieved for consumers receiving care.

Federal roles and responsibilities

Mental Health Carers NSW supports the findings that (page 926)

- Federal roles and responsibilities for mental healthcare and psychosocial and carer supports are not clearly defined.
- Neither the Australian Government nor State and Territory Governments face adequate incentives to invest in services for closing the gaps in the service system.

Intergovernmental funding arrangements dissuade State and Territory governments from investing in community-based care.

- Recent efforts at incremental reform are impressive given these structural impediments, but their success is far from guaranteed and they have largely disregarded non-health services.

The Productivity Commission has correctly identified that there are gaps in services related to the 'missing middle' (Page 928); that is, those individuals who have mental illness beyond the scope of primary health care yet are not sufficiently ill that they require acute mental health services. Some of this group access private mental health services, however, many do not have private insurance and the burden of care for these individuals often falls on carers. These gaps are caused by structural flaws in the funding and responsibility for mental health services, clearly outlined in the Productivity Commission's report, which are split between the commonwealth and state/territory governments. It is critical that these structural flaws in the mental health system are addressed to ensure that state and territory governments are held responsible for providing care and rather than untrained carers.

MHCN agrees that there are two possible models for a rearrangement of state and federal funding responsibilities as has been recommended by the Productivity Commission. However, MHCN requires further development of the 'Rebuild Model' prior to supporting it.

MHCN supports the recommendations that:

- The Independent Hospital Pricing Authority should continue pursuing activity-based funding for community ambulatory mental healthcare services, but a review is needed to ensure that the proposed system is fit for purpose.
- State and Territory Governments should take on sole responsibility for psychosocial and carer supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding, *on the proviso that funding for carer services is not reduced.*

Funding Models for inpatient and community mental health services

The lack of productivity and the low level of face to consultations provided by community based mental health services and the failure to grow community mental health services has a direct impact on carers caring for consumers at home. It is therefore critical that mental health funding arrangements for LHNs encourage the provision of community based services.

MHCN supports draft recommendation 23.1 (see page 936) to review proposed activity-based funding classification for mental healthcare. MHCN shares the Productivity Commission's reservations concerning the robustness of the current Mental Health Care Classification system to accurately reflect the cost of care and that it may establish perverse incentives within the mental health system. The findings of the Productivity Commission's research suggest that the current arrangements of funding inpatient services on an activity based system and community mental health services on a block funding bases establishes distortions in the provision of care and may encourage health services to provide more inpatient services and not encourage them to provide more community based services. These distortions should be rectified.

The Productivity Commission draft report outlines the challenges inherent in developing an **activity-based funding model** for community-based health services. However, MHCN also shares the

Productivity Commission's concerns about the productivity of community based mental health services. These services are currently funded on a **block grant basis** and this method of funding does not encourage improvements in productivity, it discourages face to face interactions with consumers in favour of telephone contact and does not provide incentives for growth in the volume of services provided.

Consequently, we believe that there is merit in the Productivity Commission's recommendations to explore the funding of community based mental health services on a **fee-for-service basis**. A **fee-for-service payment system**, while not ideal, as outlined in the Productivity Commission report, this system would be likely to provide incentives for providers to increase the percentage of time spent on face to face consultations, visits to the home and support for carers than the current block grant system of funding.

Psychosocial and carer support services

MHCN notes the Productivity Commission's analysis of the issues related to the funding of psychosocial and carer support services outside the NDIS and **agrees** with their arguments that these services should both be funded by the same level of government. Furthermore, MHCN agrees with the Productivity Commission's arguments that state/territory governments are better suited to fund these services than is the commonwealth government for the reasons stated in the report. MHCN therefore supports draft recommendation 23.2 that State and Territory Governments should take sole responsibility for commissioning psychosocial and mental health carer support services outside the National Disability Insurance Scheme.

The **Renovate** option for reforming the mental health architecture

MHCN notes the Productivity Commission's arguments in relation to the limitations of the current funding mechanisms and the gaps and duplications that the current mix of commonwealth and state/territory funding creates. Consequently, we support draft recommendation 23.3 that:

"The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding."

MHCN supports the Productivity Commission's conclusion in the **Renovate Model** that a preferred option is to maintain the system in place under the National Health Reform Agreement. This is based on the Productivity Commission's arguments that:

"the principal argument in favour of maintaining an ABF system for intergovernmental transfers is that it provides incentives for the Australian Government to improve the quality of primary mental healthcare (to prevent people requiring more acute mental healthcare, for which the Australian Government foots part of the bill). These incentives would not exist if the Australian Government just provided block transfers to State and Territory Governments, as is the case under most intergovernmental funding agreements." (page 954)

MHCN is in favour of this argument because increases in the quality and quantity of primary mental health care services provide greater support for carers for consumers with mental illness living at home.

The *Rebuild* option for reforming the mental health architecture

MHCN notes the strong arguments for the establishment of separate Regional Commissioning Authorities (RCAs), which would purchase mental health services on a regional basis. MHCN assumes that the purchasing model would be indifferent as to the nature of the provider – public, private or not-for-profit – but be based on the assessment that the service provider could deliver the volume of services to the required standard. This model has considerable merits based on efficiency, financial and economic arguments. However, there are several aspects to this model from a practical aspect that require more development before we could support it as the preferred model:

Flexibility to purchase from different providers

MHCN assumes that in this model the RCAs would be given the flexibility to purchase services from different providers. This could take the form of contracts with private hospitals to provide care for mental health patients under involuntary treatment orders. Such patients are currently treated in public hospitals. Naturally, all aspects of the care under such contracts would need to meet relevant safety and quality standards.

The advantage of such an arrangement would be to meet the demand for more acute mental health beds in LHNs with high population growth or where there are out-dated or poor-quality public sector inpatient facilities. This would relieve the public sector of the need to find the considerable capital investment needed to build new facilities. Access capital for new facilities had been an impediment to commissioning within the public sector within the WA experience where the WA Mental Health Commission has sought to commission new community health services but is hampered by the failure of the public sector to provide the physical facilities. This is detailed on Page 963 of the Productivity Commission's draft report. It also opens the opportunity for new and different services outside the public sector and opens the opportunity for legacy standalone mental health hospitals to grow new services by competing for funding for mental health services against acute public hospitals.

While commissioning of services for involuntary patients outside the public sector may initially raise some issues related to individual Mental Health Acts, there no fundamental reason why such contracting could not occur should the appropriate safeguards be put in place. Similarly, RPAs could purchase community mental health services from providers other than public health providers.

The potential adverse consequence of such a purchasing arrangement is the loss of confidence in public sector mental health services should their services diminish and their role as the preferred provider of mental health services be eroded. In addition, some LHNs may choose to opt out of mental health services in their public hospitals over time and rely on other providers, such as those in the private and not-for profit sectors, to provide these services under contract. The implications of this practice could be the loss of integrated acute health care services in public hospitals and the loss of vertical integration between inpatient and community mental health services in those states and territories with these services are currently provided by the same health authority.

The opportunity for competitive contracting would generate a market for mental health services and may see competing providers bidding to be the lowest price provider. Experience in other jurisdictions, such as the UK and the USA where market forces have been allowed to dominate consideration for contracts, has resulted in lower costs and associated lower quality of care. That is market forces in

health services are good at reducing costs but are not good at encouraging quality where the consumer has little choice and inadequate access to information about quality.

Carers have concerns about the capacity of commissioning to create uncertainty about service provision, facilitate a loss of confidence in the public health services should their services decline, and market forces drive costs, and quality, down. A competitive market may also tempt RCAs to purchase services outside their geographical region for some service where special expertise is available, services are already established and there is no advantage for the RCA to pay more for local services to be developed.

The extent that these scenarios are a real risk and likely to arise or whether they could be overcome with judicious commissioning, require considerable debate prior to the endorsement of such an arrangement.

Transaction costs

Establishing separate purchasing bodies which are separate to the state health authority will establish considerable transaction costs for the receipt of funds from both the commonwealth and state governments and in relation to the purchasing of services from service providers. The multiple number of negotiations and agreements to be reached between the Commonwealth government, state and territory governments, PHNs, RCA and LHNs would be a deadweight cost to the system with no potential savings from current administrative costs. The larger the number of RPAs the higher the transaction costs particularly if there are cross regional purchasing arrangements.

Carers would be concerned that the administrative costs of the RPAs may erode the available funds to be spent on service delivery.

Size of the region for the purpose of purchasing

The size and number of RPAs should also be subject to further debate. If RPAs were to be based on PHNs (as has been suggested in the Productivity Commission's report) some would be relatively small in terms of the size and diversity of services to be purchased from mental health providers. For example, the Western NSW PHN covers two LHNs – Far West LHD and the Western NSW LHDs – with a total population of about 309,000 people. Mental health service providers are limited and geographically dispersed. There are currently about 400 general practitioners and few private or not-for-profit operated facilities within the PHN. Public sector mental health services in this PHN are provided from five moderate to small hospitals and five community health services. While the establishment of a purchasing arrangement by an external agency may have advantages in generating efficiencies and transparencies, the lack of alternative providers to create a competitive market and the effort required to establish such as small purchasing authority would need to be given serious consideration.

RCAs with small populations would need to purchase some services outside the region, such as, long-term residential care or rehabilitation services, specialist Mental Health Intensive Care Unit services, child and adolescent services. More debate is needed on the scope and range of services to be purchased by an RPA to make it a viable within a single PHN.

Recommendation:

The Productivity Commission should be given to a smaller number of RCAs within a state or territory to make the effort of establishing a commissioning structure a realistic prospect. Consideration should also be given to the establishment of a single RCA within a state or territory (as is the case in WA) that would undertake the purchasing of all mental health services on behalf of both the Commonwealth and State/Territory governments. Such an authority would be able to develop the crucial attributes of size to attract the skills and expertise needed in such as specialised service. A single RCA could establish multiple advisory bodies to provide input on regional issues while giving it a broader perspective of the range and development of mental health services across the jurisdiction. Those states that have an established Mental Health Commission could potential develop these bodies into commissioning authorities in the manner of the WA Mental Health Commission (Page 963 of the Productivity Commission's report

Carers and consumers would be attracted to such a model provided there were appropriate structural mechanisms built within the model to enable them to have real say in modelling and purchasing decisions.

Skills and expertise required by the RCAs

Commissioning mental health services would require the staff of each RCA to have a range of specialist skills. These include, **health services planning** (including high level skills in analysing population data, mortality and morbidity statistics and estimating the demand for future services), skills in **health informatics** (to understand coding and health utilisation data), financial skills related to the costing of health services, and the legal, management and negotiating skills required to achieve effective contracts from service providers. The same range of skills would also be necessary within the service provider organisations negotiating contracts from their side.

An assumption in this model is that the planning, costing and negotiating skills and experience of service providers would be matched by those of the staff within the RCA. Should RCAs be located with small PHNs, as is one possibility with the current proposal, there is a potential that the skills and expertise of the RCAs would be overshadowed by large well-established LHNs. The establishment of too many RCAs within a state or territory may create a shortage of available staff with these skills.

Governance arrangements and political influence

As the Productivity Commission has noted there would need to be a level of separation of the RCAs from undue political process in making purchasing decisions. Such an arrangement is challenging within our current political system. On the other hand, the RCAs would need to have a level of accountability to the government of the state or territory. Consumers and carers would need to be satisfied that the purchasing decision of RCAs would not be unduly influenced by inappropriate political influence yet have appropriate oversight by the elected government.

Impact on horizontal integration of services within public hospitals

As mentioned above the potential exists, with a purchasing arrangement, that the RCA could (over time) contract with services other than the public hospitals for acute inpatient mental health services

and post-acute community mental health care. This would have the potential for a diminishing the availability of mental health staff in public hospitals as their specialist mental health services decline. This scenario would have an impact on the emergency departments of public hospitals, and other areas of the hospital, who currently rely on their mental health services within the hospital for assistance with the assessment and care of presenting individuals and inpatients with mental illness.

Again, while the problems envisaged by a reduction in the volume to acute mental health services provided in public hospitals may be overcome by new mechanisms for purchasing and contracting of services, consumers and carers would need to feel confident that these new arrangements would not achieve cost savings and the cost of currently integrated services. More debate is needed as to the reality of such a scenario.

Risk of failure in planning and commissioning

Planning and commissioning are not without risks. Planners can err in predicting the need for services and contracting carries with it the inherent risk that the volume of service purchased is underestimated or the mix is not ideal. More discussion is needed on the risks associated with the establishment of commissioning arrangements and how contracting and commissioning would operate in practice before consumers and carer would feel confident with the model proposed.

Governance arrangements for RCAs

MHCN largely support the comments provided in Box 23.1; “Proposed corporate governance arrangements for Regional Commissioning Authorities.” However, what is missing from this proposed governance arrangement is the influence on decision making that carers and consumers would have on the RCAs business processes.

MHCN strongly believes that carers and consumers should have a powerful role at the most senior levels of governance and management so that the decisions of the RCA are not dominated by economic and financial issues at the expense of access, equity and quality of care issues.

Contact

Jonathan Harms, CEO
Mental Health Carers NSW

P: (02) 9332 0777

A: Suite 501, Level 5, 80 William St, Woolloomooloo, NSW, 2011

W: www.mentalhealthcarersnsw.org

Contributors

Richard Baldwin
Jonathan Harms
Peta Smit-Colbran