Productivity Commission Inquiry into Mental Health – Supplementary Submissions

Background

Australians for Mental Health (AFMH) is a grassroots movement made up of individuals who have experienced mental illness, their families, carers and supporters all bound by the idea that we can and must build a better mental health system.

We do this by making mental health a top political priority in Australia, achieving meaningful policy commitments from decision makers and holding them accountable, raising awareness of mental illness and in doing so helping to end stigma in our community.

AFMH thanks the Productivity Commission for the opportunity to address the inquiry about the mental health and well-being of Australia's population. The important work undertaken by the Commissioners to date is acknowledged and AFMH is supportive of those reforms that will best serve our members and, ultimately, all Australians.

AFMH's primary objective aligns with that of the Commission's – achieving long term systemic change to Australia's mental health system. AFMH have long recognised that currently there is no vision for what our mental health system should look like in the future, and no agreed or effective national service model that facilitates proper prevention and care for people experiencing mental ill health, their carers and families.

To date, Australia has lacked an overarching mental health "architecture". AFMH is optimistic that this inquiry will form the foundations for meaningful and enduring structural reform. We hope that the recommendations flowing from the Productivity Commission will feed into the emerging opportunity to create equity in mental health care that mirrors the support provided for physical health.

Introduction

This document has been prepared in response to questions posed to AFMH by the Commissioners during testimony given by Mr Steve Michelson at the public hearing in Melbourne on 19 November 2019. Mr Michelson, in his capacity as official spokesperson for AFMH, gave evidence at this hearing to supplement to our written submission of April 2019.

During his address Mr Michelson advocated that people with a lived experience of accessing the mental health system, and those who care for people receiving mental health care, should have a hand in both the design of reform and the determination of how future investment is distributed. Commissioner Abramson invited AFMH to articulate, in a further submission, how lived experience participation can bring a more practical focus to this work.

Professor King subsequently asked for an overview from AFMH in terms of how regional planning can be improved and how the Commission can ensure the right balance is struck between centralised planning and service delivery on the ground.

AFMH will deal with each topic separately and this document is designed to be read in conjunction with our earlier written submission together with the oral testimony given by Mr Michelson.

Lived Experience Participation:

AFMH exists to amplify the voices of people with lived experience to drive systemic change. We assert the involvement of individuals with lived experience will ensure better representation and an opportunity to redesign service delivery systems to provide appropriate access to higher quality care for all Australians.

AFMH acknowledges the crucial work undertaken by peak bodies in this sphere, both to date and into the future as we reform the mental health system. We do, however, consider that advocacy *on behalf of those* with a lived experience alone is insufficient and future models should draw heavily upon principles of co-design.

1. **Why is it necessary?**

   Genuine engagement of the individual in the management of their mental health is, in our submission, critical to positive outcomes of those living with mental ill health.

   People experiencing mental ill health find the system fragmented and difficult to navigate. Listening to the voices of those who have both negative *and* positive experiences will create clearer pathways to care and improved access for consumers and their carers.

   Designing mental health services requires recognition that mental ill health occurs on a continuum. The needs of people experiencing mental ill health change and they may need access to different services at different times. Such nuances are rarely factored in when the experience of consumers and carers is omitted from the design of mental healthcare.

   AFMH submit that an inclusive approach to the redesign of Australia's mental health care system will help develop informed and inspirational policy approaches to the delivery of mental health care, benefitting all Australians.

2. **What do we want Lived Experience Participation to look like?**

   AFMH advocate the appointment of people with lived experience at appropriate governance levels, including on boards, subcommittees and advisory panels during the redesign phase.

   Governments at all levels should commit to include people with mental ill health who are typically under-represented in policy design and decision making:

   - Culturally and linguistically diverse communities
   - Regional and rural communities
   - Young people and their families
   - Members of the LGBTIQA+ community
   - Homeless people and people who do not have ease of access to health care

AFMH asserts that people with a lived experience of accessing the mental health system and those who care for them should be involved in the delivery of mental health services beyond co-production. Whilst the voice of the lived experience should be central in terms of planning policy, the role of lived experience representatives should continue beyond the initial consultation period in a variety of roles across all tiers of the system.

AFMH supports parity of representation for lived experience representatives in the practical implementation of services. Further, people with a lived experience who participate in service design and delivery should be remunerated for their time. The National Mental Health Commission's Paid Participation Policy is instructive in this regard[1]. Failing to do so is to undervalue the time and perspectives of people with lived experience, and indicates to the community that their contributions and expertise are less valuable than that of professionals and clinicians who are duly paid for their work.

People with lived experience of the mental health system should have a place at the table when services are under review. Evaluation *and* complaints procedures should involve external participants, these processes should not be limited to professionals and clinicians. This promotes a three dimensional approach to ongoing management and to refine service delivery.

3. How would Lived Experience participation be implemented?

Engagement of people with a lived experience of accessing the mental health system and those who care for them must be adequately planned and should commence prior to policy options being mapped out and commissioned.

Governments at all levels must ensure that the relevant agencies have resources and expertise to facilitate effective engagement. External participants should be equipped with the requisite skills and knowledge to participate in a meaningful way. This may involve training and/or the provision of materials and time for lived experience representatives to make an informed, meaningful contribution.

Once these preparations are in place, agencies should encourage organic interface with lived experience representatives. They should also conduct regular audits of their lived experience participants, to ensure appropriate diversity of backgrounds, cultures and perspectives. It is an error to consider lived experience community as homogenous. Panels or pools of individuals which the sector draws upon should therefore reflect the diversity of our broader community.

[1] National Mental Health Commission (March 2019) Retrieved from: https://www.mentalhealthcommission.gov.au/getmedia/affffd63-8100-4457-90c7-8617f2d3c6d6/Paid-Participation-Policy-revised-March-2019

Regional Commissioning:

Further to Mr Michelson's oral evidence, the following information is provided to help inform the Productivity Commission on issues surrounding a transition to Regional Commissioning Authorities, as set out in the Draft Report.

1. **What are the benefits of regional commissioning?**

   The Australian community is a diverse one, and therefore the spectrum of services and range of support options provided for mental health should be similarly diverse. Respecting the needs of people from different regions and backgrounds is critical to developing a responsive and functional mental health service system.

   People living in rural and regional areas of Australia sadly face even greater hurdles in accessing appropriate care than people living in metropolitan areas. There is often less diversity of care and treatment options in regional Australia, and many people face the added strain of long travel times in reaching their appointments. These stressors can, predictably, deter people accessing or continuing treatment, leading to poorer mental health outcomes in these communities.

   On 1 July 2015, the Federal Government established Primary Health Networks ("PHNs") throughout Australia. The Department of Health states that "Primary Health Networks have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time."[2] Whilst this aim is admirable, in practice PHNs provide inconsistent commissioning of services, frequently depending on the nature of personal networks and connections of the PHN CEO and staff.

   Regional commissioning, provided it is done well, may offer communities a more responsive, targeted and community-driven suite of treatment services. It has the potential to adapt to different communities and respond to their particular needs and preferences. As recommended in option 2 of the Productivity Commission's draft report, the "rebuild model" avoids the complications inherent in the existing PHN model, where two tiers of government must try to act as one. However, a governance shift of this magnitude does not come without challenges.

2. **What are the risks or weaknesses of the regional commissioning model? How might we mitigate these?**

   AFMH considers that there are two key risks facing this new approach to regional commissioning: a continuation of inequitable and inconsistent commissioning of mental

[2] Department of Health (1 July 2015) Primary Health Networks, retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks

health services between catchments, and a loss of specialised services and programs which have proven successful in certain regional communities. These two challenges do involve a degree of competitive tension – on the one hand there is an expectation in the community that no one ought to be disadvantaged due to their geographic location. On the other, different communities need different approaches, as not all communities are the same. AFMH recognises the difficulty inherent in balancing these issues, and submits the below additional information to guide the Productivity Commission in their deliberations.

Inequitable and inconsistent commissioning

From a consumer and carer perspective, the different approaches to commissioning of services across catchments is problematic when it results in a lower standard of care in any area, as compared with an equivalent community elsewhere. A positive consumer experience is impeded when the quality of care received becomes a lottery. This undermines community confidence in the system, and may even deter some people from help-seeking behaviour where they sense that they will receive a poorer quality of care in their region, as compared with others. For this reason, AFMH believes that the Productivity Commission should consider providing some direction to the proposed new Regional Commissioning Authorities about establishing a uniform, minimum standard of care across rural and regional communities.

The proposed development of a National Mental Health and Suicide Prevention Agreement and new monitoring, reporting and evaluation frameworks for State and Territory Governments are positive steps in the right direction. We propose the addition of more granular instruction on what is the minimum mental health service provision requirements for communities, to be published and widely accessible. This will empower consumers and carers to know their rights and better advocate for themselves and their loved ones.

Loss of specialised services and programs

During the oral evidence of Mr Michelson, AFMH was asked to reflect on how the Productivity Commission might get the balance right between correcting the deficiencies of the existing PHN model, and not losing some of the specific service elements in different locations which have been successful and have come to be relied upon by the local community. Per page 46 of the Productivity Commission's Overview of the Draft Report, "*[w]here regional expertise has become established in PHNs, it would be important to draw on this to assist in the operation of the RCAs."* AFMH fundamentally agrees with this proposition.

AFMH submits that there are two key considerations which may assist in avoiding the loss of successful, specialist services where they have a proven track record of supporting their local community: early and consistent input from lived experience representatives; and flexibility in commissioning arrangements to best account for existing, unique structures.

On the first point, as outlined in the earlier section, the ongoing input of consumers and carers is integral to a responsive system of commissioning. Locals with lived experience of the system are in the best position to advise on which structures have worked and which have failed. In any redesign of the commissioning structures, it is vital for the decision makers to include the advice of local community members who are consumers and/or carers in determining the future service provision of a given region. This allows for any specialist, unique services to be accounted for if and when the local community is keen to see them continue.

Secondly, the proposed Regional Commissioning Authorities must avoid commissioning guidelines which are so rigid as to exclude innovative, potentially "off the beaten track" local solutions. A strong analogy for this problem is observed in the roll-out of the National Disability Insurance Scheme ("NDIS"), which has seen several well-trusted, innovative programs and services essentially shut down because their historic funding sources were transferred into the NDIS through various bi-lateral agreements. In some cases, NDIS participants wished to continue accessing these specialist services with their own funding packages, but were not able to due to the guidelines for the use of NDIS funds. Many small organisations who were servicing a small but unique portion of the community were made unsustainable due to these unforeseen policy changes.

We submit that the Productivity Commission must find the right balance between ensuring minimum standards of care and allowing for a diversity of services and supports. This will remain a challenge moving forward, which is why the voices of those with lived experience must remain front and centre during the design, implementation and operational phases.

Conclusion

AFMH congratulates the Productivity Commission on its Draft Report and we are grateful for its invitation to provide additional supplementary information, in addition to our prior written and oral submissions.

In the spirit of ongoing cooperation with the Commissioners' work, AFMH would be delighted to be involved in the development of the final recommendations and the implementation of those important reforms.

Should you require any further information please do not hesitate to contact Steve Michelson at steve@australiansformentalhealth.org.au.