Community Mental Health Australia submission to the Productivity Commission inquiry into Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform – Preliminary Findings Report

Introduction

Community Mental Health Australia (CMHA) thanks the Productivity Commission for the opportunity to comment on the Preliminary Findings Report (the Report) for the inquiry.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for over 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA has a significant interest in the Productivity Commission's inquiry, as people living with a mental illness will be one of the main groups impacted by the reforms proposed. Mental health is already undergoing significant reform in relation to how services are provided, most notably through the inclusion of mental health in the National Disability Insurance Scheme (NDIS), as the Productivity Commission recognises in the Report.

There are impacts already being experienced for mental health with the NDIS, in particular regarding the pricing structure for services and retaining qualified mental health staff. A key issue for CMHA with the NDIS, and any reforms impact mental health, is how the system will respond to people with psycho-social disability to assist individuals to both reduce the disabling impacts of their illness (community-based rehabilitation including intervention, prevention and promotion) and to gain high quality disability support. This also applies to introducing competition and contestability in the areas the Productivity Commission has identified in particular social housing, services in remote Indigenous communities, and grant-based family and community services (which includes mental health and homelessness services).

In considering introducing competition and contestability a key consideration must be how you continue to provide a service to people with very complex cases, who in many instances will not have a decision-making capacity. The services provided will also need to be built on relationships of trust and understanding. The fundamental question that must be addressed is does competition actually provide better services.

The Report needs to better explain the rationale for the areas for reform it has identified, in particular remote Indigenous services. It needs to build a stronger case to justify the significant expansion of competition and contestability in human services, and that competition and contestability is an effective strategy to improve the human services sector.

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The Report doesn't address the costs and impacts that have been associated with competition and contestability in social, community and human services. There needs to be an analysis of the adverse impacts of competitive processes, which is included for the sectors and Productivity Commission's considerations.

This submission from CMHA highlights some of the issues raised by CMHA in relation to the NDIS, which are of relevance to the Productivity Commission's current inquiry, and addresses some of the areas for reform identified by the Productivity Commission. CMHA urges the Productivity Commission to give a proper and thorough consideration to mental health in their deliberations.

Issues with the NDIS relevant to this inquiry

CMHA's submission to the Senate Community Affairs Legislation Committee Inquiry on the *National Disability Insurance Scheme Savings Fund Special Account Bill 2016* raised some overall issues regarding providing services to people living with a mental illness in an environment of competition and informed user choice[1]. As noted above, a key issue for CMHA is how the system of service provision will respond to people with psychosocial disability to assist individuals to both reduce the disabling impacts of their illness (community-based rehabilitation including intervention, prevention and promotion) and to gain high quality disability support.

The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact, with there seeming to be a misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports.

A recent piece of work by CMHA led by the Mental Health Coordinating Council (MHCC) in New South Wales (NSW), on the impact of the NDIS on the mental health workforce, found that:

> an overall perspective from the study that many service providers consider the NDIS to be a 'challenging' environment, with pricing constraints and perceived rigidity in the Catalogue of Supports (now the National Disability Insurance Agency/NDIA Price Guide) seemingly making it

[1] Community Mental Health Australia submission to the Senate Community Affairs Legislation Committee Inquiry on the National Disability Insurance Scheme Savings Fund Special Account Bill 2016. http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/NDISSavingsFund/Submission

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difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner.[2] [3]

The NDIS pricing does not officially set mental health sector workers' wages, however, it does have a significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders have noted that pricing was not sufficient to purchase a suitably skilled workforce that engaged in complex 'cognitive behavioural interventions' as well as direct personal care.[4]

A 2015 report by VICSERV on the NDIS Barwon trial concluded that the NDIS wasn't effectively delivering rehabilitation focused services and that these services and disability support services are both important parts of the continuum of care for people living with a mental illness. The commonwealth and the state/territory governments should ensure both receive secure and ongoing funding.[5]

Issues identified in the Productivity Commission Report

Competition and user choice in mental health

CMHA strongly supports the principle of increased user choice and engagement, however competition and contestability are not the only mechanisms to increase consumer choice. While competition and contestability might increase choice for those with the ability to pay, it can have the opposite effect and limit choice for many other groups, including those on low incomes.

The mental health sector has been a leader in facilitating a more active role and greater choice for service users (and carers and family members). This includes development of recovery approaches, employment of peer workers, co-production and co-design of services, provision of person-centred care and services and the active participation of people with lived experience of mental illness and mental health issues. This has been achieved through commitment, campaigning and advocacy and collaborative partnerships between service users, carers and their families and service providers.

Many people with mental health issues have few choices to exercise and at certain times, for example, when they are unwell, are unable to exercise choice. They may lack sufficient knowledge and information about services and programs and due to the nature of their condition, they may lack

[2] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

[3] The report was commissioned and funded by the NDIS Sector Development Fund as part of an NDIS Capacity Building Project delivered by Mental Health Australia.

[4] Community Mental Health Australia (2015). Op cit.

[5] Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

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capacity at certain times to make effective and informed choices. The risk is that in a competitive market people with mental health issues who lack capacity at certain times or knowledge of what is available, may access an inappropriate service or be exploited by service providers.

In 2013 the Victorian Government recommissioned a range of mental health and alcohol and drug services using a competitive tendering model. Competition was designed to introduce some new service functions and streamline existing service delivery arrangements. An independent review of the process found that the number of people able to access mental health and drug and alcohol services fell by 20% and the number of people in treatment feel dramatically. Access to services for people with mental health issues was diminished, with the most disadvantaged groups being the most impacted. The review concluded:

> '.. since the recommissioning process, vulnerable victims who were seeking help have found it more difficult to access treatment and support because the system was harder to navigate".[6]

Further feedback on the process included:

- Established partnerships and collaboration between service providers were damaged.
- Due to the loss of funding, many services ceased providing services and some popular and effective service models, such as centre based/group programs were lost. The result was reduced choice for people with mental health issues.
- There was a significant loss of capacity from the sector due to the loss of experienced staff.
- The changes made it harder for people in need to get into and receive help from the system because it was more fragmented and siloed and there were more delays and blockages.
- Consumers had reduced choice due to the loss some highly valued service models and the overall lack of services.[7][8]

People with mental health issues have complex and ongoing care needs that require the right mix of services working together. The client's health and wellbeing go beyond treatment and care services and involve housing, employment, health, education and training and daily living support. Problems already exist due to the separate silos of mental health, health, employment, drug and alcohol services, and housing. However, it is essential to achieve a coherent and "joined-up approach" across all age range

[6] Silburn, K. (2015) Recommissioning community mental health support services and alcohol and other drugs treatment services in Victoria: Report on findings from interviews with senior personnel from both sectors, August 2015. Australian Institute for Primary Care and Ageing, La Trobe University.
[7] CoHealth, Submission to Recommissioning processes for MHCS and AOD, https://www.cohealth.org.au/wp-content/uploads/2016/05/cohealth-response-CSRC-Recommissioning-Consultation-Process.pdf
[8] Psychiatric Disability Services of Victoria (VICSERV), Submission to the Community Sector Reform Council. Reflections from VICSERV on the recommissioning of community managed mental health support services, http://www.vicserv.org.au/images/documents/Mental_Health_reform_2013-14/VICSERV_Submission_to_the_CSRC_-_August_2014.pdf

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and population groups and across government, non -governments and private sector agencies. Competition and contestability can exacerbate fragmentation and service silos and hinder the achievement of more integrated and joined-up services and care. Competitive processes also create a situation where service providers compete against each other rather than collaborating.

The health and wellbeing of people with mental health issues is reliant on agencies sharing information, referring clients to specialist providers, partnering for clients benefit and collaborating to meet the full range of client needs. When agencies compete for funding or for clients, collaborative and integrated service delivery suffers. As such competition does not provide the best outcomes for people with mental health issues.

Decision-making capacity

The issues raised above are relevant to the current Productivity Commission inquiry, in that how do you provide and maintain high quality services to people with complex conditions and cases in an environment which focuses not just on quality but price, and where trust in the service is a vital element to people using it. Also, how do you do this for people who won't in many instances have a decision-making capacity either due to their condition or other circumstances, such as the ability to access information. Often for people living with a mental illness, the illness itself takes away the decision making ability, which means they may not seek assistance.

The populations that would be impacted in the areas identified by the Productivity Commission, including social housing, services in remote Indigenous communities, and grant-based family and community services (which includes mental health and homelessness services), will in many cases experience the aforementioned issues.

CMHA acknowledges that in some instances, introducing competition and contestability and informed user choice can improve the effectiveness of human services. However, this will not happen if you do this in areas where people don't have the capacity to make an informed decision and don't have, or are not allowed access to, someone they trust to help them to make an informed choice, such as for people who are homeless. This situation has occurred in trial sites for people with a mental illness in the NDIS.

The Report states that there would need to be the development and implementation of consumer safeguards, however, it is more than having safeguards and assisting people who are vulnerable. As the mental health experience with the NDIS has demonstrated, there needs to be processes in place to allow people without a decision making capacity to have assistance; there needs to be an awareness amongst services and those assessing for services about people without this capacity; and there needs to be an awareness in any policy developed that this will impact people's willingness to access services.

A further significant issue is the need for people with complex conditions to have coordinated, wrap-around services. The idea of multiple, competing services interferes with this coordinated service provision. Competition can lead to fragmentation, including through tender processes where services

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may be 'cut up' or divided between many rather than with a consolidated service provider. This must be something the Productivity Commission takes into account.

Access to reliable data

CMHA agrees with the Productivity Commission that high quality data important in improving the effectiveness of human services, but for this to occur the data must exist in the first place. Community managed mental health is an area where there is incomplete and poor data. For this to be a part of any areas for reform identified by the Productivity Commission, such as with grant-based family and community services, developing thorough and complete data must be a priority so as not disadvantage a sector due to a lack of data.

A further issue is that current data sets don't match up and are not published in a timely manner. All data sets need to be accessible and assessed over time to ensure they are applicable and useable.

Areas identified for reform

As noted above, the three most relevant areas for mental health identified by the Productivity Commission are social housing; human services in remote Indigenous communities; and grant-based family and community services.

With regards to social housing, CMHA would generally support more choice for people who require social housing. However, we would not support this when it comes to people requiring emergency, crisis or homelessness services. As per the comments made above about decision making capacity, this is an area that will be assisting people with complex cases, of which people with a mental illness will be a part of this, and many people accessing the services won't be capable of exercising choice. The other key factor is that the element of 'choice' in many cases will have been taken away from people and they will essentially accept whatever they can get. This situation mitigates against choice, and if actual choice is to be applied, it must be real choice by their choosing. Also these are the types of services where people will need to trust those services they are accessing, and services established in the sector will have often worked over a number of years to develop this trust, understanding and knowledge of these population groups.

Likewise, human services in remote Indigenous communities, of which mental health and suicide prevention and postvention will be significant parts of these, require the same level of trust, knowledge and understanding. Best practice culturally relevant policy would be that a service takes time to go into a community, meet with community elders and work closely with the community to develop services.

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There are already existing services in most remote communities either being provided externally, for example TEAMhealth (Top End Association for Mental Health[9]) or internally through the Northern Territory Government Health Clinics. There needs to be a good understanding of current services to then identify the possible gaps. Once gaps are identified then service providers need to work in collaboration to fill these gaps on behalf of the client and not in competition. With Indigenous services, when competition is introduced it is typically done so through tenders which cuts or divides services and results in fragmentation. As noted earlier, the impact of competition through tender processes must be something the Productivity Commission takes into account.

With rural and remote communities, the experience has generally been that competitive processes can reduce choice, result in deskilling locally based service providers and lead to the loss of existing and established service arrangements. Competitive processes often result in larger regional or metropolitan based service providers winning contracts to replace smaller local providers. Experience and expertise gained over many years working with mental health issues is lost and service models often change to being provided on a regional, sessional or visiting (fly in fly out). The result is a loss of local expertise and capacity, loss of service continuity and disruption to the service system.

In rural areas there is often one or a small number of service providers, who are locally based and managed services provided by local people with local connections and knowledge of service systems and client needs. Local service providers take their connections to the community seriously and the loss of locally owned and delivered service options can fracture supports and collaborative relationships.

There is undoubtedly a significant lack of services in remote areas, some of which is related to issues of distance. CMHA agrees with the Productivity Commission's statement that the outcomes of services provided to Indigenous communities should be holistic rather than program driven. However, introducing 'more services' in an area where there are few services already may not achieve the desired outcome. It should be about genuinely working with communities and through Aboriginal Medical Services to provide a service that is what the community needs.

Grant-based family and community services is an area of importance to community managed mental health. CMHA agrees with the Productivity Commission's statements that government engagement with service providers needs to improve; that short contracts provide significant uncertainty for providers; and that contracts often limit provider's ability to develop flexible responses. CMHA would want to ensure that if there is reform applied in this sector and that there are changes to the way services are commissioned by government, that it's not only based on government's taking a 'stronger stewardship role' (as the Report states), but about developing a framework in partnership and collaboration with, for example, the community managed mental health sector and their representatives. It should also be

[9] TEAMHealth – Top End Association for Mental Health Inc. http://www.teamhealth.asn.au/. Accessed 24 October 2016.

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about the Government's own performance and evaluating that accordingly. Genuine reform will not be the outcome if this does not occur.

Conclusion

CMHA has a significant interest in the Productivity Commission's inquiry, as people living with a mental illness will be one of the main groups impacted by the reforms. Mental health is already undergoing significant reform in relation to how services are provided with the inclusion of mental health in the NDIS.

There have been impacts for mental health with the NDIS regarding the pricing structure for services and retaining qualified mental health staff. A key issue for CMHA with reforms impacting mental health, is how the system will respond to people with psychosocial disability to assist individuals to both reduce the disabling impacts of their illness and to gain high quality support. This also applies to introducing competition and contestability in the areas the Productivity Commission has identified, as a key consideration must be how you continue to provide a service to people with very complex cases, who in many instances will not have a decision-making capacity.

The main issues and recommendations from CMHA are:

1. There needs to be processes in place to allow people without a decision making capacity to have assistance; there needs to be an awareness amongst services and those assessing for services about people without this capacity; and there needs to be an awareness in any policy developed that this will impact people's willingness to access services.
2. CMHA agrees with the Productivity Commission that high quality data is important in improving the effectiveness of human services. However, developing thorough and complete data must be a priority so as not disadvantage a sector due to a lack of data, such as community managed mental health. All data sets need to be accessible, published in a timely manner and assessed over time to ensure they are applicable and useable.
3. CMHA would generally support more choice for people who require social housing. However, we would not support this when it comes to people requiring emergency, crisis or homelessness services. The element of 'choice' in many cases will have been taken away from people and they will essentially accept whatever they can get. This situation mitigates against choice, and if actual choice is to be applied, it must be real choice by their choosing.
4. With human services in remote Indigenous communities, introducing 'more services' in an area where there are few services already may not achieve the desired outcome. A scoping study of existing services should be undertaken to identify the possible gaps. It should also be about genuinely working with Indigenous communities and Aboriginal Medical Services to provide a service that is what the community needs.

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5. CMHA would want to ensure that if there is reform applied to grant-based family and community services that this is about developing a framework in partnership and collaboration with, for example, the community managed mental health sector and their representatives, and that the Government's performance is also evaluated.
6. The community managed mental health sector, and associated human services, is one which is familiar with competition through tender processes. The consequence has been fragmented services, where the application of competition and contestability hasn't improved services. CMHA strongly supports the principle of increased user choice and engagement, however competition and contestability are not the only mechanisms to increase consumer choice.

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