Response to

Primary Health Tasmania
Mental Health Commissioning Intentions 2016-1017
Consultation Draft

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As the peak body representing the interests of the community mental health sector, The Mental Health Council of Tasmania (MHCT) welcomes the opportunity to respond to the Primary Health Tasmania Mental Health Commissioning Intentions 2016-2017 Consultation Draft.

MHCT provides a public voice for people affected by mental illness and the organisations in the community sector that work with them. The Council advocates for effective public policy on mental health for the benefit of the Tasmanian community as a whole and has a strong commitment to participating in processes that contribute to the effective provision of mental health services in Tasmania. We strongly support the principles of preventive health and strategies to ensure stronger and healthier communities across population groups.

One of our member organisations, Flourish, which is the peak consumer organisation in Tasmania, noted that 'in the document the word 'help' is used', pointing out that 'consumers do not take kindly to the use of the word help with referenced to them.'

In putting together this response MHCT has consulted with the Mental Health Leaders Forum and the broader MHCT membership at recent meetings of these groups. We thank our members for their input and support.

General comments

Our member organisation Eureka Clubhouse would like to stress the importance of a value-based, relational model. PHT needs to develop close connections and formal relationships between services, especially across public, primary and community mental health services. In a recent article in the Australian Journal of Primary Health, 'Something old, something new, something borrowed, something blue', the authors reviewed the evidence on commissioning and health services, concluding that 'this evidence suggests that commissioning is more than simply a technical or operational process, but one that is value-based and relational. This is not to downplay the technical aspects, which in many jurisdictions have resulted in explicit and evidenced-based approaches to planning and priority setting. However, if new commissioning organisations, such as Primary Health Networks, are to have an impact, they need to balance the operational and relational elements of commissioning.'[1]

Careful management of relationships – with communities, consumers and carers, health professionals and service providers (whether contracted or not) – is critical to maintain awareness of emerging issues, foster collaboration and realise synergies. We would encourage PHT to build a strong engagement process that includes regular consultation with all stakeholders to ensure that needs and gaps are continuously identified, to determine with those stakeholders how best those identified needs can be met and to build capacity by fostering collaboration.

[1] Suzanne Robinson, Helen Dickinson and Learne Durrington, 'Something old, something new, something borrowed, something blue', *Australian Journal of Primary Health*, vol. 22, no. 1, pp.9-14 http://dx.doi.org/10.1071/PY15037

Does Primary Health Tasmania need to extend the scope and extent of stakeholder engagement, if so who with?

Engaging people who use services and their carers is at the heart of effective commissioning but commissioners also need to engage with people in the wider community to define outcomes that reflect the needs, preferences and aspirations of people who will use services in the future, and their carers. Community engagement also serves to identify needs (especially among underserviced groups and those who lack 'voice') and obtain feedback on commissioned services. Furthermore, opening this process up to the wider community can also prompt discussion around the utilisation of 'natural supports' within the community. Due to the disparity of communities in Tasmania, resources are limited but many communities are 'rich' with natural resources and those requiring supports can be very resourceful in seeking out and utilising these resources. The concept of people with lived experience utilising natural supports to compensate for the lack of MH resources can result better recovery outcomes for them. The use of natural supports can assist to alleviate service saturation and service dependency and reinforce the notion that people with lived experience are quite resilient due to the challenges they have faced, that they are in fact very self-reliant and very resourceful.

Broader community engagement can be achieved through a partnership with stakeholders in developing methods of engagement that allow them to communicate to their members and cohorts and support them in their understanding of the new mental health context in Tasmania and at the same time, taking feedback from these groups back to PHT.

What priority or further validation might be required with regard to the information and intentions made in the Consultation Draft document?

MHCT believes that more information is required on commissioning intentions beyond the summary that appears in the Executive Summary. In its current form, the level of information most service providers and stakeholders would require from the paper would need to be extrapolated from the detailed information provided. MHCT concurs with Danny Sutton of Richmond Fellowship Tasmania when he notes that:

- The data provided by the governments to the AIHW has varied in quality over a number of years and in some cases the data is annotated that it is not comparable due to things like industrial action by Tasmanian Government employees.
- The data sets you have selected appear to be single year data with no trend views or long term averages to support conclusions.
- The data does not provide an assessment of the consumer outcomes of the services. On that basis the focus it is possible to provide a broad commentary on the system and its investments to date rather than a focus on how to influence future outcomes.[2]

2 Danny Sutton (2016) , Response to the Primary Health Tasmania Mental Health Commissioning Intentions 2016-1017Consultation Draft

Given that data is patchy and in many cases, does not align or lend itself to reliable forecasting, how will PHT establish a benchmark and parameters for the work of establishing needs and gaps? It would therefore be useful to know more details about the Needs Assessment and Regional Plan process that the PHN has been tasked with. In particular, how it has been conducted / or planned to be conducted and who has been consulted /or will be consulted for information beyond the data sets and population statistics.

Central to achieving the goal of successful commissioning is integration – 'in order to provide more effective and efficient mental health care, it is important to improve integration between the primary, secondary and tertiary sectors, and across mental, physical and social services...the potential benefits of integrated mental health care are widespread, including not only improving the quality of care individuals receive but also reducing costs for health systems.'[3].

Although integration across different systems is complex and challenging, addressing the challenges of local health system integration is a fundamental role for PHNs. Alison Verhoeven of the Australian Healthcare & Hospitals Association notes that 'specifically, the roles for PHNs can be categorised as follows:

- Comprehension: develop and document deep understanding and knowledge of mental health issues; patient and provider experiences; system practices, processes and dynamics; and, service needs and gaps in the PHN catchment.
- Connection: meaningfully engage with consumers, carers, health care providers (primary, secondary, tertiary), social services and other stakeholders operating across local systems to understand service complexities and gaps so that seamless service links and pathways can be built.
- Coordination: applying a person-centric view of services and systems that span the care continuum and assume leadership in designing, facilitating, incentivising, and programming/commissioning services in ways that facilitate system and behavioural change (e.g.: patient journey health pathways).
- Education: conducting targeted education activities for consumers (e.g.: awareness raising, health literacy, self-care promotion, prevention, etc.) and practitioners (e.g.: practitioner training, local needs and system awareness, early intervention, care pathways, etc.).
- Innovation: stimulating collaborative pilot initiatives between consumers, health care providers and other stakeholders to address local needs in new and better ways; and sharing these innovative approaches across the broader health sector in Australia.
- Evaluation: developing and applying robust performance evaluation approaches to local programs and initiatives, considering qualitative and quantitative measures of processes, costs and outcomes, and using evaluations to inform continuous quality improvement.
- Redesign: providing a platform for service review and redesign which will better meet the needs of the whole person, as opposed to the person fitting into the eligibility requirements of each service within the system. For PHNs seeking to realise effective and lasting

[3] P T Bywood, L Brown and M Raven (2015), 'Improving the integration of mental health services in primary health care at the macro level', *PHCRIS Policy Issue Review*, Adelaide: Primary Health Care Research and Information Service.

improvement in mental health outcomes through integration within local health systems, there are significant challenges to overcome. [4]

The development of some of these issues in the Commissioning paper would provide the rationale upon which commissioning intentions are based.

Are there any gaps or issues that have not been adequately captured that could or should be considered?

Apart from the issues raised above, there is a role for the PHT in understanding and forecasting needs and reviewing these regularly. There is also a need for contingency plans to deal with assessed risks and unforeseen challenges and the development of exit strategies for services which no longer meet needs or deliver best value, taking full account of the impact on people who use services and their carers. These processes must be developed in close consultation with consumers and carers and their advocates and are areas that need to be covered in a more comprehensive description of the commissioning process.

A key principle of the model is that the commissioning process should be equitable and transparent, and open to influence from all stakeholders via an on-going dialogue with people who use services, their carers and providers. Outcomes for people are at the centre of the model and the best way of ensuring this is to involve people with lived experience of mental illness in all aspects of this work – from planning and commissioning to service delivery and evaluation. The PHT could provide details that demonstrate how it will be facilitating this kind of consumer and carer involvement.

It would also be useful to ensure that clinicians, communities and other stakeholders are aware of what commissioning is **not**. The Western NSW PHN has done this in its paper *Western Health Alliance Ltd Commissioning Framework*, stressing that commissioning **is not**: -

- 'passive purchasing – it involves much more than simply signing contracts and making payments;
- constrained by the status quo – our communities' healthcare needs are constantly changing and 'business as usual' may not always be the best solution so we will work with providers to help them ensure their services also evolve and we will be open to new ways of working and willing to engage with new services that can meet emerging needs;
- deliberately disruptive – while focused on achieving positive change commissioning must also recognise the value of established roles and relationships and the financial, emotional and intellectual investments that service providers and users may have made in existing arrangements;
- purely transactional – while formal contracts are key to defining expectations they are only part of an ongoing and close relationship between a commissioner and a service provider; able to address all unmet needs – commissioners work within fixed budgets and so they need to ensure that both the 'what' and 'how' of their investments achieve the best possible

[4] Alison Verhoeven, (2015), Mental health AHHA primary health network discussion paper series: paper two, Deakin West, ACT, Australian Healthcare & Hospitals Association pp. 4-5, https://ahha.asn.au/sites/default/files/docs/policy-issue/phn_discussion_paper_two_-_mental_health.pdf

health outcomes for every dollar that is spent and, at the same time, commissioners, service providers and communities must recognise that priorities have to be set and some needs will inevitably remain unmet.' [5]

What are the priority primary mental health care outcomes for Tasmania?

Wide consultations with stakeholders at every level and representing every population group were held during the Rethink Mental Health project in Tasmania. Many of these were facilitated by the Mental Health Council of Tasmania and we learned a great deal from them, including areas that most participants prioritised as needing particular focus within a new mental health system. These priority areas include:

- A greater emphasis on promotion of positive mental health, prevention of mental health problems and early intervention
- Reducing stigma
- An integrated Tasmanian mental health system
- Shifting the focus from hospital based care to support in the community
- Responding to the needs of specific population groups
- Chronic and complex care
- Better and informed access to services
- Services for people with co-occurring mental health and substance abuse and/or other comorbidities
- Supporting and developing the mental health workforce
- Mental health literacy and 'one language' (especially important to progress integration between the primary, secondary and tertiary sectors, and across mental, physical and social services)
- The concept of person centred practice and people self-directing and having choice and control over their decisions. This can mean different things to consumers, staff, services/organisations. There needs to be a consistent work practice approach.

Many of these will also be common to other Primary Health Network regions. However, in the case of Tasmania many of these priorities are complicated by the fact that we serve a dispersed population across a difficult geographic area and health outcomes are poorer among rural/remote communities, with few private sector health providers in many parts of our state.

[5] Western Health Alliance Ltd Commissioning Framework (2015), Dubbo, NSW, PHN Western NSW, p. 5, http://www.wnswphn.org.au/uploads/documents/corporate%20documents/Commissioning%20framework%20(Version%201).pdf