

**Submission
No 32**

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

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Mental Health Commission
of New South Wales

Inquiry into the Management of Health Care Delivery in NSW

***Submission by Mental Health Commission of New South Wales
to the Public Accounts Committee***

July 2017



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The Mental Health Commission of NSW

The Mental Health Commission of NSW is an independent statutory agency responsible for monitoring, reviewing and improving mental health services and the mental health and wellbeing of the people in NSW. It works with government agencies and the community to secure better mental health and wellbeing for everyone, to prevent mental illness, and to ensure the availability of appropriate supports in or close to home when people are unwell or at risk of becoming unwell.

The Commission promotes policies and practices that recognise the autonomy of people who experience mental illness and support their recovery, emphasising their personal and social needs and preferences as well as broader health concerns.

The Commission is guided in all of its work by the lived experience of people with a mental illness.

Should you wish to discuss any of the issues raised in this submission in more detail please contact Ms Sarah Hanson, Executive Officer, on 9859 5200 or at sarah.hanson@mhc.nsw.gov.au.

Transparency and Accountability of Mental Health Funding in NSW

The framework for funding, reporting and performance management of health services in NSW, including mental health services, has changed significantly over the past five years. These changes have not been well understood by all players in NSW, contributing to the continuing debate and concerns about mental health funding.

The Commission noted these concerns in *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* and recommended a number of actions to improve governance arrangements. However, with clinicians and the sector continuing to voice concern about the accountability and transparency of mental health funding, in mid-2016 the Commission initiated a review of the transparency and accountability of mental health funding within NSW Health, in order to better understand how the funding that is notionally allocated to mental health is actually invested in services that support consumers.

The report arising from the review has recently been provided to the Minister for Mental Health and is awaiting tabling. Once the report has been tabled, the Commission will ensure that the Committee receives a copy.

At a high level, the report notes that there have been three principal drivers for the substantial and significant change in the funding, reporting and performance framework for mental health services in NSW:

1. the adoption by the Ministry of Health of a purchasing framework for the funding of health services under one Service Agreement between the Ministry and each health service
2. the extension of activity based funding to mental health services
3. a policy decision by Government and the Ministry to move from centralised control of health services towards a more devolved accountability framework.

Additionally, in conjunction with reform by NSW Treasury of NSW Government agency budget reporting, the reported expenditure on mental health services by NSW Health has changed from the aggregated quarantined expenditure and revenue budgets for mental health services to an estimate

calculated using a detailed costing methodology aggregating direct, indirect and corporate overhead costs.

The funding provided to Local Health Districts (LHDs) and Specialty Health Networks (SHNs) for mental health has progressively moved to Activity Based Funding (ABF), with payment for most acute and subacute services now funded on a per unit of activity basis (NWAU) up to the cap set out in the Service Agreement with the Ministry. With the change to activity based funding and devolved decision making, determination of service mix, staffing levels and models of care is now increasingly the province of the local health service.

While the ABF framework certainly provides greater transparency regarding the allocation of funding against activity, the LHDs and SHNs still operate in a capped budget environment. This means, for example, that increased presentations at emergency departments inevitably means that LHDs and SHNs must make decisions about how to cover these costs, with community based services often losing out. This creates a vicious circle with community based services that could divert or reduce hospitalisations being reduced to address the immediate demand of the hospital. Australian Institute of Health and Welfare data indicates that the total proportion of NSW mental health investment that was directed to in-patient services increased from 53.5 per cent to 55.2 per cent between 2011-12 and 2014-15.¹

The difficulties at the national level in developing an ABF model for mental health, has further contributed to the confusion and even scepticism within the mental health community regarding funding of services. This is particularly the case in relation to community based services where the model is still being refined with ongoing concerns that ABF favours hospital based care.

Further work is required to ensure the availability of comprehensive, person centred, high quality, and evidence based models of care for persons experiencing a mental health problem, including improved community based services in line with the *Living Well* reforms.

The report recommends the adoption of an integrated governance and accountability framework, comprising:

- Needs based service planning (based on national evidence based standards);
- Adequate funding (including utilising the ABF framework where appropriate);
- Strengthened Service Agreements with more appropriate KPIs
- Accountability for performance.

Critical to the future success of mental health services in NSW will be the development of partnerships between LHDs and Primary Health Networks. While some already do have mechanisms for collaboration in place, it will be increasingly important for LHDs and PHNs to work together in assessing local population need and designing and planning for a continuum of services to meet those needs.

¹ <https://mhsa.aihw.gov.au/resources/expenditure/>

Seclusion, restraint and observations

The Commission notes that this inquiry was re-opened and extended in view of the tragic events at Lismore Base Hospital and the arising concerns related to seclusion, restraint and observations in NSW health facilities. The Commission further acknowledges the current review of those issues being led by the Chief Psychiatrist, Dr Murray Wright, and that one of the Commission's part-time Deputy Commissioners, Dr Robyn Shields AM, is a member of the review panel.

The Commission has been concerned about seclusion and restraint practices for some time. In 2013 the Commission joined with the National Mental Health Commission to commence a national project working to reduce the use of seclusion and restraint. Former part-time Deputy Commissioner, Mr Bradley Foxlewin, co-chaired the Core Reference Group for this project which saw the development of the Seclusion and Restraint Declaration –

I believe that seclusion and restraint of people with mental health problems is a human rights issue.

I believe that the use of seclusion and restraint is not therapeutic.

I believe that the use of seclusion and restraint is distressing to everyone involved.

I believe that seclusion and restraint is an uncomfortable topic that we need to talk a lot more about.

I believe it is a failure in care and a sign of a system under stress.

I believe that reducing seclusion and restraint reduces injury to people, including staff.

I know that there are alternatives to seclusion and restraint. I believe that staff including nurses, doctors, peer workers, allied health workers, police, ambulance officers, community sector workers, wardens and others must receive adequate support, resourcing and training that support these alternatives.

I believe we need consistent, national data that gives an accurate and meaningful account of what's really going on.

I believe all Australian governments must take responsibility for acting on that data and addressing the use of seclusion and restraint, and reporting on progress.

I believe that when seclusion and restraint happens the circumstances that lead to it must be talked about and reviewed so that better outcomes can be achieved next time for all involved.

I believe we all have a part to play in calling for change.

The National Mental Health Commission also released a Position Paper: A Case For Change, based upon work commissioned from the University of Melbourne which presented research findings and

options for reform relating to reducing and eliminating the use of seclusion and restraint on people with mental health issues.²

According to the latest figures available from the Australian Institute of Health and Welfare, the rate of seclusion events in NSW sits slightly above the national average (8.7 per 1,000 bed days compared to 8.1 nationally)³. However, we know that there is great variability in the rate of events not only from facility to facility but from unit to unit, and moreover, between age groups.

Without wanting to pre-empt the conclusions of Dr Wright's review, the Commission believes there are several areas that need to be further addressed if we are to see a sustained and consistent reduction in seclusion and restraint in NSW and improved practices with regards to observations.

Culture & Training

While policy and practice standards are important in addressing seclusion, restraint and observations, the critical challenge is changing the culture within mental health units. The Commission commends NSW Health for the training that has already been undertaken to reduce seclusion and restraint, including education on the harm to both staff and patients and training on alternative de-escalation techniques. Such training needs to continue and be complemented by further efforts to support culture change, including the growth of the peer workforce (that is mental health professionals employed to utilise their skills and experience as having lived with mental illness) and the promotion of trauma-informed approaches within mental health units.

A part of culture change is also about not tolerating unacceptable professional practice. The Commission acknowledges that when NSW Health has acted to discipline and dismiss individuals for unacceptable practice, this move has sometimes been frustrated when the decision has been overturned on judicial review.

Quality & Safety

Core to reducing seclusion and restraint and improving observation practices is having robust quality and safety mechanisms. Unfortunately, the historic 'siloing' of mental health within health has meant that there has been confusion and at times a vacuum in relation to quality and safety in mental health care.

For example, upon its creation the Commission reached out to the Clinical Excellence Commission and Agency for Clinical Innovation (ACI) in NSW. At that time each agency had done limited work in the mental health space, with both NSW agencies stating their belief that the then Mental Health & Drug and Alcohol Office within the Ministry of Health performed the relevant roles for Mental Health. At the time it was also true that the Australian Commission on Safety and Quality in Health Care (ACSQHC) nationally had done limited work in the mental health space. The Commission

² refer <http://www.mentalhealthcommission.gov.au/our-work/definitions-for-mechanical-and-physical-restraint-in-mental-health-services/our-position-paper-a-case-for-change.aspx>

³ Australian Institute of Health and Welfare *Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2011-12 to 2015-16* <https://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/>

subsequently raised concerns in relation to these and related issues in 2013 with a paper exploring governance issues in mental health provided to the Ministry of Health, and again in *Living Well*.

It is pleasing to see some shift in relation to the activities of these agencies over the intervening years, including ACI establishing a Mental Health Clinical Network, and the ACSQHC establishing a Mental Health Advisory Group in 2014 and undertaking a range of projects including National Standards, Recognition and Response to Clinical Deterioration and Medication Safety. The Commission commends these agencies for taking up issues in relation to safety and quality in mental health care and hopes that these efforts will continue and be expanded.

However, the Commission believes that there is one key area that should be further strengthened in relation to safety and quality. Unlike all other Australian jurisdictions, NSW does not provide for the role and functions of a Chief Psychiatrist in its legislation. The Commission believes that legislative provisions should be enacted to strengthen the role of the Chief Psychiatrist in NSW, particularly to oversee the safety and quality of mental health services. The following provisions, common to most other states, are a good starting point to ensure the independence and accountability of a statutory chief psychiatrist and to provide adequate oversight of treatment and care in mental health services.

- In Western Australia, South Australia, Queensland and Tasmania the role of Chief Psychiatrist is an independent statutory appointment.
- In all other states the Chief Psychiatrist reports and/ or advises the Minister for Mental Health (or equivalent).
- All other states include provisions for the Chief Psychiatrist to be supported in carrying out its functions by staff and/ or to delegate those functions.
- In all other states the functions of the Chief Psychiatrist include issuing standards for treatment and care and/ or monitoring treatment and care.
- In all other states the Chief Psychiatrist has a role in relation to seclusion and restraint, Electro-convulsive Therapy (ECT) and other similarly sensitive practice and policy areas.
- Western Australia, South Australia, Victoria and Queensland grant the Chief Psychiatrist own motion investigation/ inspection powers.
- Western Australia includes fines for non-compliance and penalties for obstructing the Chief Psychiatrist
- All other states have a legislative requirement for the Chief Psychiatrist to issue an annual report.

Complaints Mechanisms

Another critical element in ensuring individual safety is to have a robust complaints mechanism that not only responds to individual matters, but is able to identify and pursue systemic issues.

The Commission notes that the Health Care Complaints Commission currently has this power with its functions not only covering responding to individual complaints but also:

Investigat[ing] the delivery of health services by a health service provider directly affecting the clinical management or care of clients which may not be the particular object of a complaint but which arises out of a complaint or out of more than one complaint, if it

appears to the Commission that:

- (a) the matter raises a significant issue of public health or safety, or*
- (b) the matter raises a significant question as to the appropriate care or treatment of clients, or*
- (c) the matter, if substantiated, would provide grounds for disciplinary action against a health practitioner.⁴*

The Mental Health Commission itself, while not a complaints body, is also able to undertake reviews of *mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness.*⁵

While these provisions exist, there are currently some practical factors which inhibit both the Mental Health Commission and the HCCC from being able to pursue systemic issues in a timely way. From the Mental Health Commission's perspective this includes:

- not receiving regular information, such as on critical incidents within health, to be able to assist it in identifying systemic issues
- limited provisions in relation to accessing relevant information to support its functions
- no legislative mechanisms to refer to or partner with other relevant agencies, such as the HCCC.

With the Government's five year statutory review of the Mental Health Commission about to commence, the Commission will seek legislative amendments to address these issues, specifically that:

- where the conduct of a review requires direct access to both the services physical premises and information related to the service, its legislation be amended to ensure the Commission has the necessary access. To trigger these provisions, the Commission proposes that it should:
 - (a) Notify the Minister of its intent to commence the relevant review
 - (b) Seek the Minister's approval in relation to specific information requests which may include:
 - Ability to enter and inspect any premises
 - Inspect any document or thing in connection to the service
- Specific provision be made for the Commission and HCCC to be able to refer matters to each other for review or investigation, and to be able work jointly in undertaking reviews where appropriate.

Transparency of Data

Another area the Commission has been concerned about since its establishment is the public availability of information about the mental health system. While NSW Health has an impressive

⁴ Section 59 *Health Care Complaints Act 1993*

⁵ Section 12(1)(c) *Mental Health Commission Act 2012*

system in terms of collecting and making available to LHDs and SHNs information about mental health services, this information is not made publicly available on a routine basis.

This concern led to the Commission to commence a project with the Bureau of Health Information to develop a regular public report about mental health service performance in NSW. Unfortunately, this project was discontinued due to the unavailability of data from the Ministry of Health to support the production of these reports.

Making data available and transparent plays a number of important roles, including driving improvement both in the delivery of services and in the quality of data itself, as well as improving public confidence.

While some information on seclusion and restraint rates in NSW is publicly available, such as the rates available through the Australian Institute of Health and Welfare referred to above, more could be done locally in terms of making information on seclusion and restraint accessible. This could include:

- Regular public reporting by LHD/SHN
- Having unit based information posted in public area on each ward benchmarked against facility/LHD rates.