Submission on the Integrated Carer Support Service: Regional Delivery Partners: Regional Delivery Model

Department of Social Services Consultation

Joint Submission by Mental Health Carers Australia and Community Mental Health Australia

11 May 2018

Mental Health Carers Australia (MHCA) is Australia's only national advocacy group solely concerned with the well-being and promotion of the needs of mental health carers. MHCA represents 7 national and state-based community organisations, all of who provide services to, and advocate for, Australia's 240,000[1] mental health carers. Collectively, MHCA's member organisations[2] represent all States and Territories of Australia.

Community Mental Health Australia (CMHA) is a coalition of the eight peak community mental health organisations from each State and Territory. CMHA was established to provide leadership and direction to promote the importance and benefits of community mental health and recovery services across Australia.

Summary of our concerns

We welcome the Department of Social Services' work to improve carer services, and support the intention of Integrated Carer Support Service (ICSS) to make government carer supports easier to navigate and more accessible by carers.

However, we highlight our three central concerns that emerge from the discussion paper:

1.) **The proposed standardised service offerings outlined in the discussion paper (and appendices) do not reflect many of the key themes and findings that emerged during the ICSS 2016 consultation period;**

As the Department will recall from its own reporting, several key themes emerged from the 2016 consultation period into the proposed overarching ICSS service delivery model. Central among these themes was that "*service providers, peak bodies and other government departments stressed it was important to recognise that a one-size-fits-all approach would not be appropriate. In their submissions, carers indicated they were looking for support which was relevant to their needs and not merely standardised services*".

This concern has been inadequately addressed within the overall architecture of the ICSS model as outlined in the discussion paper and appendices.

In both models, Regional Delivery Partners (RDPs) have a central role in the delivery of carer services. They will serve as the first point of human contact for all carers, and the primary source of

[1] Diminic S, Hielscher E, Lee YY, Harris M, Schess J, Kealton J & Whiteford H. The economic value of informal mental health caring in Australia: technical report. Brisbane: The University of Queensland; 2016

[2] Mental Health Carers Tasmania, Helping Minds, Mental Illness Fellowship NT, Mental Health Carers Arafmi Queensland, Mental Health Carers NSW, Tandem, Mind Australia.

information and assistance for carers. We are told that RDPs will work closely with carers to identify their needs, provide them information, and facilitate and/or deliver a range of support services.

To achieve this, RDPs will operate a *de facto* non-specialist service at scale, to deliver a "structured intake process (delivered via telephone) support carers to identify suitable support and services and identify those carers most in need".

Given the vast scale of the RDPs' mandate, a standardised and generalist gateway service is inappropriate, and is likely to negatively impact mental health carers. As a sector, we have repeatedly seen the difficulties posed by the introduction of standardised gateways into services. We can look to the NDIS as an example of this, whereby the National Disability Insurance Agency last year retrospectively introduced a specialist psychosocial gateway. This followed extensive reporting from the Joint Standing Committee, the Productivity Commission, and the wider mental health sector about deficiencies and unintended consequences of the standardised processes previously applied. A more proactive approach to ICSS will see the need for a later change avoided.

2.) **In both proposed service delivery areas, there is a lack of alignment between RDPs and existing and aligned health structures that support carers, including Primary Health Networks.**

The development of the two proposed models has been informed by carer population and location data, data on current carer and mainstream services, as well as consideration of the service regions currently utilised. This approach, whilst valuable in part, has failed to consider the seemingly obvious benefits of aligning the RDP service areas to the 31 existing Primary Health Networks (PHNs) across Australia.

PHNs have existing commitments to recovery-oriented mental health services, aligned with the 'National framework for recovery-oriented mental health services' (2013), the National Standards for Mental Health Services (2010) and the National Safety and Quality Health Services Standards (2012). In parallel, RDPs will be mandated to establish and maintain relationships with social, health and other groups, to (inter alia) promote regional carer services.

Neither Option A nor Option B aligns with the existing PHN map. If aligned with PHNs, RDPs would be better placed to access relevant primary health and related data, align services directly with (and promote carer services within) healthcare providers, and reduce the administrative costs of engaging with multiple and overlapping PHNs within their service area.

3.) **Cost and efficiency savings assumed by the proposed new model(s) are made without clear evidence, and appear to have been prioritised over the Government's central objective to "*improve carer wellbeing, increase their capacity and support their participation, socially and economically*".**

We welcome, in principle, the proposed move towards an aggregate reduction of fixed costs within a new service delivery model, so as to release more funding for direct service provision activities to benefit carers. We are, however, cautious to infer that this will translate into a larger funding pool for carer support services. The overall funding pool for carer support services remains unclear at the time of writing. Accounting for the additional $85.6 million of funding (over 4 years), Appendix A states that "once ICSS is fully implemented… there will be approximately $120 million per year for

carer specific support". This tracks against prior total DSS funding of $175 million and $176 million for carer support service programs in 2016-17 and 2017-18 respectively[3].

It is our view that Option B (11 service areas) is manifestly unsuitable, irrespective of assumed (and unquantified) economies of scale. Place-based service delivery is important in human services, requiring substantial service planning in order for effective service delivery to be achieved. A larger region, by definition, means that fewer resources can be dedicated to this work. It will increase the pressure on a lead provider to manage multiple subcontracts (or consortia members).

Within the binary options presented, Option A (20 service areas) is preferable, but we reassert the opportunity cost of a failure to align the RDP model with the existing PHN structure.

Are there any alternate RDP service area models that you think the Department should consider? If so, on what basis? Your statistical analysis and/or evidence base should be provided to support this.

Compared to other types of care, mental health care has a greater focus on emotional support, managing crises, and supervision of behaviour. Mental illness has a younger age of onset than many other conditions such as cardiovascular, musculoskeletal and neurological disorders[4]. Therefore the economic impact on mental health carers can be experienced for longer. There is stigma associated with the caring role. Unexpected fluctuations in support needs, together with an average of 60 hours per week 'on call' for primary carers[5] precludes the ability of many mental health carers to take up stable and predictable employment patterns. The RDP model as outlined in the discussion paper proposes rationalising, mainstreaming, and simplifying government carer service delivery models to such a degree that it heightens the risk that the unique support needs of mental health carers will be overlooked. Mental health carer organisations should be engaged from the outset in the regional delivery of the ICSS. This will act to ensure service continuity, the maintenance of existing infrastructure, and the maintenance of a specialist workforce.

In response to submissions highlighting concerns regarding the lack of specific support for specific cohorts of carers, DSS stated in 2017 that the model "would include support for carers in different cohorts…[and that] further design of the specific nature of these supports will be undertaken should the Government decide to proceed with the implementation of the model"[6]. At this juncture, where the Government clearly *has* committed to implementing the model, there is no evidence of this further design work.

Our shared view is that as a minimum, a specialist mental health carer gateway should be embedded within the RDP model.

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[3] Senate Community Affairs Committee, 2017-18 Budget Estimates Hearing, Answer to Question on Notice No. SQ17-000469

[4] GBD 2016 Disease and Injury Incidence and Prevalence Collaborators (2017) Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet 390 (10100):1211-1259

[5] Diminic S, Hielscher E, Lee YY, Harris M, Schess J, Kealton J & Whiteford H. The economic value of informal mental health caring in Australia: technical report. Brisbane: The University of Queensland; 2016

[6] Department of Social Services. 2017. Public consultation on the draft Service Delivery Model: Summary Report, Australian Government, Canberra, pp.13

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