Mental Health Matters 2 Ltd
PO Box 5050, Centrepoint, Midland WA 6056
ABN 62647638444
Telephone: 0413 861 049
Email: mentalhealthmatters2@gmail.com
Webpage: www.mentalhealthmatters2.com.au

Submission to the Independent Governance Review of the Health Services Act 2016

Introduction

Mental Health Matters 2 Ltd (MHM2) is a lived experience led charity which acts to achieve positive, effective systems change with and for individuals and families with experiences of mental health, alcohol and other drug use challenges and possible involvement with police, court or prison. We do this by promoting a broader understanding and highlighting the importance and benefits of embedding lived experience expertise at all levels of decision-making.

MHM2 was convened as a community action and advocacy group in 2010 as a response to concerns by individuals, family members, supporters and community members about the adverse consequences for individuals who were 'falling through the gaps' of siloed service delivery and possibly into the criminal justice system, including prison. Many of the individuals also had experiences of poverty, discrimination, compromised physical health and insecure housing or homelessness. The need for systemic advocacy and action to address these situations was identified, actioned and continues to be lived experience led.

MHM2 has been values-led from the beginning. This involves working in ways that are:

- *Gracious* – maintaining kindness and consideration particularly at challenging times.
- *Informed* – speaking from up-to-date knowledge and understandings which may challenge the status quo.
- *Just:* being fair, equitable and inclusive in our engagement with others.
- *Hopeful:* exploring possibilities while acknowledging challenges.
- *Resolute:* being purposeful and determined.

We appreciate the opportunity to provide this submission to the Independent Governance Review of the Health Services Act 2016 (HSA16) and thank our volunteer input to enable it to do so in the absence of paid staff.

While the focus in this submission is in the areas of mental health and alcohol and other drugs, it is recognised that many individuals with these conditions also experience compromised physical health which requires equitable access to and effective service provision from a range of general health services.
This submission considers a range of key issues, including:

- the new sector governance arrangements established under the HSA16;
- the importance of a shared understanding of what health system transformation means and the role of leadership and governance in driving transformation;
- Priority areas for improving the System Manager role, including by addressing gaps and lack of clarity regarding accountability and monitoring and compliance; and
- Specific gaps in accountability mechanisms such as performance agreements and service agreements.

Background

The Health Services Act 2016

The Health Services Act 2016 (HSA16) shifted governance of the WA health system from a centralised to devolved model. Key intentions of the HSA16 which replaced the 1927 Act are to support clearer responsibility for the delivery of services and have decision-making happen closer to the delivery of service and care of individuals in order to achieve better outcomes.

The HSA16 established:

- the Department of Health (DoH) as the System Manager responsible for the overall management, performance and strategic direction of WA Health.
- Health Service Providers (HSPs) which operate as separate legal, board-governed entities which are responsible for the safety and quality of the services they provide, amongst other elements. The HSPs which provide mental health, alcohol and other drug services include North Metro (NMHS); South Metro (SMHS); East Metro (EMHS); Child & Adolescent (CAHS) and WA Country Health Services (WACHS)

The intended benefits of these changes were that[1]:

- health services would be more responsive, flexible and innovative to meet the needs of the people who used them, their families and communities and the people who worked in them.
- safety and quality of the services would be improved and it would be easier to identify who / which area is accountable for specific processes and outcomes.
- a more sustainable health system would be achieved.

The extent to which these intended benefits have been achieved is unclear. For example, in terms of sustainability, WA Health's annual budget has increased by 30.9% since 2016-17 to a total of $11.6 billion[2]. While some of this increase may be linked to COVID responses, there is little evidence that public mental health services are embracing or proactively developing strategies to move away from an unsustainable focus on bed-based and acute/crisis responses to co-produced community treatment and support initiatives and peer-created and led initiatives.

Planning for and investing in community-based responses closer to where the individual lives will be highly likely to accrue cost savings and benefits to the individual and community. Ensuring that services are co-designed and co-produced with communities will help to ensure that they are fit-for-purpose for local community requirements, including that they are culturally secure for the people who use them. This is particularly important for people living in regional, rural and remote areas.

Key reports

Since the HSA16 was implemented, a number of key reports have clearly identified the need for transformational reform in the WA Health System, including in the area of governance. These include:

- Report on the Clinical Governance of Public Mental Health Services (2020)

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[1] WA Health Reform Fact Sheet - The Health Services Act 2016: A Snapshot. Department of Health (2016) https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Health-Reform/Fact-Sheet---The-Health-Services-Act-2016---Snapshot.pdf

[2] https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/05/New-record-for-health-and-mental-health-investment-in-2022-23-State-Budget.aspx#:~:text=Under%20the%20McGowan%20Government%2C%20WA,a%2030.9%20per%20cent%20increase.

- Sustainable Health Review (SHR) Final Report (2019)
- Access to State Managed Adult Mental Health Services (2019)
- Review of Safety and Quality in the WA health system (2017)

The need to do business differently and deliver co-designed, innovative services to better meet person-centred care requirements in culturally secure ways are also reflected in key strategic documents including the WA Mental Health and Alcohol and Other Drug Services Plan 2015-2025 and Update (2018).

A number of key national reports have also identified the need for transformation in the areas of mental health, alcohol and other drugs including the need to co-design and co-produce services and initiatives with people with lived experience (PWLE). In this document the term PWLE includes individuals with a personal experience of mental health, alcohol and other drug challenges as well as families and supporters.

These include:
- National Mental Health and Suicide Prevention Plan (2021)
- Productivity Commission Inquiry into Mental Health (2020)
- National Suicide Prevention Advisor Final Advice (2020)
- Fifth National Mental Health and Suicide Prevention Plan (2017)

It is not intended to reference these reports in each instance where they are relevant however, individually and collectively they provide a clear mandate for doing business differently and for actively disrupting business as usual. This includes in the areas of governance and leadership.

<u>New Sector Governance Arrangements</u>
In 2020 new sector governance arrangements were implemented to ensure more effective communication, closer collaboration and increased transparency and accountability between the Department of Health (DoH); Mental Health Commission (MHC) and the Health Service Providers (HSPs).

The Mental Health Commission (MHC) is the state body responsible for the funding and commissioning of mental health and alcohol and other services in WA. The MHC is unique among national mental health commissions insofar as it is a funding body as part of its commissioning role.

The sector governance changes include the establishment of:
- The Mental Health Executive Committee (MHEC) which has HSP representation at Chief Executive level and (subsequently) the Mental Health Sub-Leads Committee whose members include Executive level mental health or senior clinical leaders in HSPs.
- The Community Mental Health, Alcohol and Other Drug Council (CMC) which relates to the community mental health sector and has representation at Chief Executive Officer level.
- A new position of Chief Medical Officer, Mental Health (CMOMH) at the MHC which provides senior clinical leadership in system development.

Senior Lived Experience representation is delivered via an Independent Consumer Representative and Independent Family/Carer representative. These appointments were made following an open Expression of Interest recruitment process.

The Lived Experience representation provided by the two identified positions provides important perspectives within the governance structures however, these are inherently constrained by the fact that they are limited to individual positions. A more effective,

sustainable, comprehensive and capacity building approach would be to also establish a Lived Experience Leadership Group, whose members can support each other and provide a breadth of strategic expertise across the range of governance structures.

The Lived Experience representatives, the Mental Health Commissioner and the CMOMH are members of both the MHEC and CMC thereby providing the opportunity for communicating and integrating the work being undertaken across both the clinical and community areas.

It is hoped that these new governance arrangements have supported a specific aim of the HSA16 which is to 'co-ordinate the provision of an integrated system of health services and health policies'.

Recommendation: That an independent evaluation process be undertaken on the processes and outcomes of the new sector governance arrangements to specifically identify what is working; barriers to effective partnership and strategies to overcome them; impact of the changed governance structure on outcomes.

Recommendation: That a Lived Experience Leadership group be established – similar to the Mental Health Sub-Leads group – and sustainably supported to provide strategic advice, direction and decision-making to the MHEC and CMC.

Transformation

The landscape in which these new governance arrangements have been implemented is that one of transformation. This transformation is identified as being required in the reports previously mentioned for a range of reasons which will not be repeated here. However, overall the outcome sought from such transformation would be to design, deliver, manage and monitor services to a person and their family and community in ways that best fit for them by a range of practitioners, including Aboriginal health workers and Lived Experience (Peer) workers.

However, in order for that promise to be fulfilled there needs to be an agreed definition of transformation and what it involves as well as an investment in the change management capabilities, people and processes required to deliver it effectively and equitably.

Without agreeing on what transformation is, there are likely to be a number of perspectives that will be pulling in different directions, albeit well-intended. People who use public mental health services have consistently advised that they want responses and resources which help them recover or discover health and wellbeing through connection, meaning and purpose, access to employment or education in communities of their choice. They have consistently asked that these responses and resources – many of which may be outside traditional service types – are delivered with humanity, dignity, in culturally secure ways and in a manner which demonstrates that they are expert partners.

For others involved in leading and delivering public mental health services, 'transformation' may mean improving the current system without changing any of its foundational elements. This could be reflected in the continued dominance of a narrow bio-medical model. This is despite the national and international evidence as to the importance of social determinants and social and emotional wellbeing frameworks which view people and their health in their entirety and context, and which take social justice and human rights as key foundational elements.

In 2020, the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health delivered a paper[3] which built on a 2017[4] paper in which he states: "Mental health systems worldwide are dominated by a reductionist biomedical model that uses medicalization to justify coercion as a systemic practice and qualifies the diverse human responses to harmful underlying and social determinants (such as inequalities, discrimination and violence) as "disorders" that need treatment. In such a context, the main principles of the Convention on the Rights of Persons with Disabilities are actively undermined and neglected. This approach ignores evidence that effective investments should target populations, relationships and other determinants, rather than individuals and their brains. How that dominance is overcome requires transformative human rights action. However, action that focuses only on strengthening failing mental health-care systems and institutions is not compliant with the right to health. The locus of the action must be recalibrated to strengthen communities and expand evidence-based practice that reflects a diversity of experiences. Such community-led recalibration enables the necessary social integration and connection required to more effectively and humanely promote mental health and well-being".

Recommendation: That the meaning of transformation and the required change management processes around achieving it, including at a governance level, in public mental health services is discussed and agreed.

The role of language in transformation is also important. It both shapes and reflects the understandings and paradigms in which people are operating. Language can be a powerful tool with which to engage and include or exclude and 'other' another human being. Therefore, it is a governance and leadership responsibility to use and promote language and concepts which are recovery-focused and which describes human experiences and human beings in dignified, hopeful and respectful ways.

The role of Governance and Leadership in Transformation

In his 2017 review, Dr Hugo Mascie Taylor notes[5], 'as with any program of change, governance changes are likely to mark the beginning rather than the end of the transformation process'.

The success of any governance arrangement relies on each party fully executing and being accountable for its identified roles and responsibilities and for those to be effective in achieving the end result – improved health outcomes for WA communities. Within a landscape of transformation this requires people in governance and leadership roles to:

- have a broader understanding of what impacts on a person or community's mental health, alcohol and other drug use;
- prioritise the development and implementation of responses and resources, including services, which are grounded in social determinants and social and emotional wellbeing approaches;
- be enthusiastic and open to working – and learning to work - in equitable partnerships with people with lived experience to improve outcomes;

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[3] Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: note / by the Secretary-General. A/HRC/44/48
Puras, Dainius; UN. Secretary-General; UN. Human Rights Council. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2020)

[4] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN Human Rights Council. A/HRC/35/21(2017)

[5] Review of Safety and Quality in the WA Health System (2017) p17.

- show a keen willingness to work outside the traditional boundaries of health and develop genuine alliances in the areas of housing and homelessness, family and domestic violence, justice and other relevant areas;
- demonstrate a commitment to transparent, outcomes-based results;
- develop and initiate meaningful collaborations, alliances and partnerships which demonstrate new power-sharing arrangements, including with PWLE and under-represented communities and population groups;
- invest in accessible and transparent continuous quality improvement processes based on qualitative and quantitative data and
- be genuinely open to new ways of doing business and embracing true innovation which often needs to be nurtured from grassroots origins.

To do business differently and better meet the needs of people and communities, there needs to be a greater diversity of perspectives informing and shaping planning, decision-making, implementation, continuous quality improvement and evaluation.

Within this there needs to be a focus on diversity given the greater prevalence of mental health, alcohol and other drug challenges within particular communities and age groups. For example, given that alarming rates of self-harm and suicide among young people in the Trans community, there is an urgent need to effectively and sustainably engage – and be led by - them in service design and delivery and evaluation as well as address any service, system or structural discrimination they may experience.

This transformation also requires a genuine commitment to embedding sustainable, diverse and robust Lived Experience Leadership within the System Manager, HSPs and the MHC in governance and leadership roles.

These designated senior and executive roles will be in addition to planned growth in designated roles at each level of decision making within the range of entities. While ensuring that there are independent representatives in strategic decision-making forums, embedding senior and executive Lived Experience leadership roles is a more equitable approach for which there is precedent.

Recent examples include the National Mental Health Commission's appointment of a Director, Lived Experience in 2021. In 2022, following a key recommendation from the Royal Commission into Mental Health in Victoria to employ people with lived experience in leadership positions within the Department, it appointed an Executive Director of Lived Experience in the Mental Health and Wellbeing Division of the Department of Health.

Recommendation: That the System Manager, HSPs and MHC develop designated and embedded Senior/Executive Lived Experience Leadership roles within governance as part of the priority implementation of the Lived Experience (Peer) Workforce.

The 2019 Review into Clinical Governance in Public Mental Health Services highlighted the lack of mental health leadership roles at an Executive Level within HSPs.
This results in lack of clear, experienced leadership for practitioners who have been frustrated in managing frontline services without the necessary support at executive level.

Recommendation: That each HSP have one Executive-level position dedicated to Mental Health, Alcohol and other Drugs.

HSP Boards
It is also important that HSP Boards have at least one member who has the necessary contemporary knowledge and background to promote and advocate for effective supports for

mental health, alcohol and other drugs in that setting. Optimally, that position should be a designated Lived Experience position which is fully supported.

HSP Boards should also have a mechanism whereby they hear directly from people using mental health, alcohol and other drug services independently as part of their governance and leadership responsibilities.

In a 2020 Statement of Expectations (example of that sent to EMHS provided[6]), the Minister for Health, Mental Health advised of his expectation that the Board would - "provide opportunities for patients and families to connect with their healthcare providers and share their health care experience, I expect the Board to maintain a firm focus on the promotion of consumer engagement and patient experience platforms, including through the Patient Opinion system".

The System Manager role

The effective performance of the System Manager role as outlined in the HSA16 provides the opportunity to reduce inefficiencies and inequities and to provide leadership across public mental health, alcohol and other drug services.

Binding Policy Frameworks

This can be achieved in a number of ways including by instigating and monitoring the effective implementation of binding policy frameworks across HSPs. To reflect contemporary practice and particularly within a transformational landscape, these policy frameworks should be co-produced to ensure that the perspectives of people using services (or choosing not to use them); families and communities as well as frontline practitioners are meaningfully partnered with in the policy design, delivery, monitoring and evaluation.

This will help to ensure that people who use services can expect to and in fact receive a congruency of service within and across HSPs, while the policies can maintain flexibility and relevancy for local conditions.

Ensuring that traditionally under-represented groups are informed in the policy development which prefaces a binding policy framework is particularly important. This may help to address discrimination or lack of contemporary, culturally secure practice experienced by people within Aboriginal and Torres Strait Islander communities or ethnic minority communities. It is also important to include individual communities grouped under the LGBTIQA+ umbrella, for example, the Trans and Intersex Communities who may face specific and less visible barriers to accessing consistent quality, safe service.

Workforce

Workforce is currently a key, critical issue which affects how services – and if – services are designed and delivered.
A clear, across-system Workforce Strategy developed with key stakeholders and implemented by the System Manager would have helped to address the challenges of each HSP vying for the same pool of qualified and experienced staff and remove the significant burden from them of responsibility for this key area. This should be addressed as a matter of priority.

[6] Accessed at https://emhs.health.wa.gov.au/~/media/HSPs/EMHS/Documents/About-Us/ministers-statement-expectations-2020.PDF

It is important that when the System Manager develops this strategy that it is inclusive of Aboriginal health workforces and the Lived Experience (Peer) Workforces to support new models of care and service delivery in mental health, alcohol and other drug public services.

Data

There have been longstanding problems with the inadequacy of the PSOLIS system which is the key information system in public mental health services. The System Manager should be addressing this as a matter of priority and also looking to linked data opportunities within broader systems as previously mentioned (housing / homelessness, justice, FDV).

Monitoring and Compliance

It is critical in any effective partnership that there are clear roles, responsibilities and areas of accountability outlined as well as mechanisms to monitor and evaluate how effectively they are being executed. While the HSA16 outlines roles and responsibilities, it does not provide detail on how these should be informed by, monitored, reported upon or evaluated, particularly by people who use services and their families and communities.

Section 20 of the HSA16 identifies the functions of the System Manager role[7] which includes but is not limited to:

- (a) 'advising and assisting the Minister in the development and implementation of WA health system-wide planning';
- (b) 'providing strategic leadership and direction for the provision of public health services in the State';
- (d) 'promoting the effective and efficient use of available resources in the provision of public health services in the State';
- (l) 'overseeing, monitoring and promoting improvements in the safety and quality of health services provided by health service providers';
- (m) 'monitoring the performance of health service providers, and taking remedial action when performance does not meet the expected standard';
- (n) 'receiving and validating performance data and other data provided by service providers'.

Section 21 bestows significant powers on the System Manager to perform these (and additional) functions under HSA16 citing that it may do 'anything necessary or convenient'.

What individuals and families want and need is for the System Manager to perform these functions in a transparent, lived-experience informed and accessible way. This is particularly true for individuals and families who are managing multiple health conditions while also trying to navigate critical, ongoing experiences such as housing insecurity, discrimination and poverty. Some of the individuals and families may be accessing services in one HSP whereas others may be moving between HSPs. In the latter case, it is particularly important that the System Manager has robust processes to gather live qualitative and quantitative information to monitor the performance of HSPs and take remedial action when required. Without this, people, particularly from marginalised communities, will continue to have no option but to access Emergency Departments, 'fall into the cracks' and have life-limiting or tragic outcomes.

There is no transparent or accessible mechanism whereby a person using a public mental health service can contact the System Manager if they have exhausted complaints mechanisms within the HSP, which they experience as providing sub-optimal or sub-standard service. It is reasonable to ask how then the System Manager monitors the performance of

[7] Health Services Act 2016. Page 17. Accessed at https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13760_homepage.html

the HSP public mental health service if the people using the services have no means of communicating their experience to it? It might conversely be the case that an individual has benefitted greatly from a new recovery-focussed service and wishes to ensure the System Manager has that feedback given their overall monitoring role.

While quantitative data has a place in monitoring and evaluation, there is no clear process by the System Manager to capture, monitor and evaluate the HSPs based on qualitative input, ie. people telling of their experiences and having that recorded simply and in the language and format which best suits the person or family / supporter.

In relation to monitoring the System Manager in the execution of that role, there does not appear to be significant processes available, only than a direction by the Minister.

Recommendation: That the System Manager establish clear and accessible processes to hear from people who use services to assist in their monitoring of HSP service performance.

Recommendation: That the System Manager establish as a matter of priority Lived Experience leadership positions with roles in planning, resource allocation and performance monitoring. These Lived Experience leadership positions would also provide clear points of access and contact for Lived Experience leadership roles being established in HSPs as part of the establishment and expansion of a robust and sustainable Lived Experience (Peer) Workforce in mental health, alcohol and other drug services in WA.

Accountability

As the HSA16 clearly outlines, the role of the System Manager in the governance of public mental health services is significant. The System Manager role in monitoring and keeping HSPs accountable is clearly outlined. There is however, a lack of monitoring and accountability mechanisms to respond to a situation where the System Manager is not performing its role and functions as outlined. This needs to be addressed.

A significant portion of the state government expenditure into mental health is invested in HSPs. There however, appears to be little transparency on how that money is spent; what services are being delivered and in what areas to which population groups; how these services are being monitored and if they are delivering the outcomes which individuals, families and communities have said that they want and need.

Section 19 of the HSA16 advises that the overall management of the WA health system is the responsibility of the System Manager and that the relationship between the System Manager and the HSPs is governed by service agreements between the System Manager and the HSPs. However, there is no requirement for a service agreement to be made between the HSPs and the MHC.

Section 114 states that there will be a performance agreement between the System Manager and the HSP Chief Executives however, there is no requirement for a performance agreement to be made between the MHC and the HSP Chief Executives.

The HSA16 should be amended to ensure the inclusion of transparent and rigorous accountability mechanisms so that the MHC can ensure that the services designed, developed and delivered by HSPs are contemporary and fit-for-purpose to meet the needs and preferences of people across WA who need to access mental health and alcohol and other drug support.

Recommendation: That the Minister review the role of the System Manager in relation to the original intention of the Act.

Public monies are, after all, meant to benefit the public. There is insufficient data to determine whether the Act has resulted in the improvement of and efficient budgetary impact of the Act as originally intended.

Recommendation: The Auditor General review the financial efficiency achieved from the introduction of the Act.

Margaret Doherty
Margaret Doherty
Founder/Chairperson
On behalf of the Board

23 May 2022