



Mental Health Carers Australia

Response to the Productivity Commission Draft Report into Mental Health – *January 23, 2020*

Introduction

Mental Health Carers Australia is pleased to present its response to the Productivity Commission's draft report into mental health. This submission is intended to be read in conjunction with our original submission dated April 2019. The priorities in our original submission have been refined here following an iterative conversation with our membership base, and the broader sector on the release of the draft report, and additional insights gathered through our engagement at subsequent public hearings.

Mental Health Carers Australia (MHCA) is a national peak body focused solely on the needs of mental health families and carers. We are made up of seven state and territory organisations, including one national - refer to the last page for a list of our members. Our aim is to work constructively with governments to improve policies and programs that directly and indirectly impact mental health families and carers. More information about our organisation is accessible at: mentalhealthcarersaustralia.org.au

Why is mental health caring different from other types of caring?

Mental Health caring is unique; there are some similarities with other forms of caring but the episodic and emotional support needed to successfully undertake this role is significant. It takes fortitude to be able to provide the support required ensuring that as a carer your wellbeing is maintained – in the absence of dedicated carer supports, it essentially requires piecing together your own support system. The episodic nature of mental health caring can make holding down a full-time job, engaging in education or simply maintaining social connections impossible at times. This can then lead to emotional, physical and financial strain.

Having the understanding of the implications of mental health caring and how to manage the role to reduce the impacts on family life is crucial. Currently there is a move to group all carer supports together – physical and psychosocial. However, it is essential to recognise the unique differences required for mental health caring in designing a successful mental health system where the specific needs of mental health carers are included.

The University of Queensland and Mind Australia study, *The Economic Value of Informal Mental Health Caring*¹, details the economic impact of mental health caring highlighting the hidden costs that Mental Health Carers provide the Australian economy annually. It is vital that this is taken into account and the potential impact that ignoring the specific needs of mental health carers may result in a huge financial and economic cost to Australia in the longer term.

¹ Diminic S, Hielscher E, Lee Y, Harris M, Schess J, Kealton J, & Whiteford H, (2016) *The economic value of informal mental health caring in Australia: technical report*



Overall feedback

MHCA would like to thank and acknowledge the work of the Productivity Commission in producing its draft report into mental health. We endorse many of the recommendations made by the Commission and hope to see a reformed mental health sector that truly places the person at the centre of their recovery journey, surrounded by their closest allies such as family, friends and other supporters.

As part of preparing our response to the draft report, Mental Health Carers Australia undertook a coordinated approach with our member organisations to ensure congruency of our presentations at the public hearing. We have also collaborated with other key sector groups to ensure our response reflects emergent thinking in relation to best practice in mental health service delivery. These collaborative efforts have informed this submission.

Our overall feedback is presented below followed by detailed responses to specific recommendations.

An ideal mental health sector would see:

- a priority on funding to build the capacity of families and communities to support mental health as a key foundation of national economic and social well-being
- better integration of clinical and psychosocial services with a no wrong door approach and clear referral pathways between systems
- psychosocial supports funded at all steps of the stepped care model, based on need and tailored to individual life circumstances, needs and goals (addressing the social determinants of mental health with a focus on the whole person)
- targeted support for people with mental ill-health and their families/carers to navigate service systems and advocate for their needs and rights.

It is well known that Australia's mental health system is failing consumers, their families and carers. What is needed is transformational change, the kind of radical change that led to the design of the National Disability Insurance Scheme (NDIS). The progressive social changes that led to the introduction of the NDIS included:

- a move away from a medical model of support that recognised the individual beyond a diagnosis with full rights to citizenship as any other member of the community
- people with disability supported to engage with their families, friends and wider community
- people with disability wanting more choice about the types of supports they receive and who they receive it from
- people with disability being supported to pursue their personal goals and achieve greater independence.

While the NDIS has experienced a number of implementation issues, its foundational legislation in promoting human rights and autonomy for people with disability remain strong. Many of the documented and significant short-falls in NDIS around mental health³ are currently being addressed in the design of the new psychosocial pathway NDIA are currently developing – which includes changes to better include and support mental health carers in their own right. The productivity commission reform vision could still include similar concepts to envision the radical change required. A scenario has been prepared from a Mental Health Carer's perspective at **Attachment A** to illustrate the current paradigm for families and carers, and what could be possible if the ideal mental health system was realised.

³ 2019 Tune review of the NDIS Act and the new NDIS Participant Service Guarantee

Greater recognition of the vital role of families and carers in supporting mental health

MHCA requests that the final report should more strongly assert the integral role families and carers play, as well as consider the needs of families and carers in all recommendations. For example, the section related to early intervention and prevention should consider how families and carers are supported particularly at the diagnosis stage across all age groups.

We want the Commission to articulate more explicitly in the opening overview, key points and factors, the critical role of families and carers who are propping up a system that depends on the informal support provided in order for it to be economically sustainable⁴.

Relational recovery

We want to see the final report also clearly articulate a vision for a reformed mental health sector that has quantifiable economic and social benefits through appropriate investment in families, relationships and community. Ideally the final report will recommend policy levers that will enable commissioning of person-centred and *relational recovery* approaches across service delivery programs.

What is relational recovery?

The relational recovery concept moves beyond individual recovery. It is based on the idea that human beings are interdependent creatures; that people's lives and experiences cannot be separated from the social contexts in which they are embedded. It asserts that people are *inherently* relational beings.

Family and social relationships are decisive determinants and enablers for recovery. Relational recovery addresses the needs of people and their relationships with their social environment, rather than exclusively on issues with mental health. It is primarily community focused, has family life at its heart and deals with the real world.

The two previous iterations of conceptual recovery were clinical and personal recovery. In both these concepts, the locus of the problem and therefore onus of recovery is placed on the individual as an intra-personal process ("no one is an island") while the familial, social, material, educational, economic and political contexts of mental ill-health and recovery are largely obscured⁵.

Recommendations for mental health reform should be made through the lens of a relational recovery approach. As this is a relatively new concept in Australia, the Commission could consider funding options to research, fund and evaluate new mental health services based on relational approaches to recovery.

⁴ Diminic S, Hielscher E, Lee Y, Harris M, Schess J, Kealton J, & Whiteford H, (2016) *The economic value of informal mental health caring in Australia: technical report*

⁵ Relational recovery: beyond individualism in the recovery approach, Price-Robertson et al, 2016

Detailed feedback

Section/ recommendation	Page #	MHCA's recommended changes
Suggestions to reinforce the crucial role of carers and families play in the Mental Health system		
Key points - <i>Australia's mental health: A generational shift is needed</i>	Page 2	Add a dedicated dot point that describes the critical role of family and carers in supporting the mental health system and consumer outcomes. In addition, mental health families and carers should not just be included, but be supported in their own right to pursue their own goals and enable sustainability of the caring role
A path for maintainable long-term reform: <i>Reform area 3, Investment in services beyond health</i>	Page 3	<p>Add a dot point that links the recommended improvements to healthcare funding to psychosocial and family/carer supports outside of the health care system (to reflect a relational recovery approach)</p> <p>Include a reference to the major gaps in psychosocial supports and that these should be adequately funded (under a relational approach to recovery e.g. as delivered under the former Partners in Recovery program) to complement the health care system by providing wrap around supports to consumers and carers.</p>
A path for maintainable long-term reform: <i>Reform area 4, Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness:</i>	Page 3	Edit to read "assistance for people with mental illness and impacted family/carers to get into meaningful work and enable early treatment of work-related mental illness"
A path for maintainable long-term reform: <i>Reform area 5, Fundamental reform to care coordination, governance and funding arrangements:</i>	Page 3	<p>Add a dot point: to establish a national co-design framework to be applied where the development of any new services and products is undertaken in conjunction with consumers and family/carers.</p> <p>Edit the dot point to include a reference to families and carers and the key role they play i.e. an amended sentence could read: "care pathways for people using the mental health system need to be clear and seamless with: single care plans for people receiving care from multiple providers, which include connection to their families and carers, care coordination services for people with the most complex needs; and online navigation platforms for mental health referral pathways that extend beyond the health sector".</p>

Section/ recommendation	Page #	MHCA's recommended changes
Specific recommendation changes		
<p>Draft recommendation 11.4 Strengthen the Peer Workforce</p>	<p>Page 64</p>	<p>MHCA supports the Commission's recommendations in relation to the development of the peer workforce and a national body to represent peer workers, and this must include both consumers and carers.</p> <p>The final report recommendation needs to more explicitly call out both consumer and carer peer workforce both in the recommendation title (eg Strengthen Consumer and Carer Peer Workforce), and supporting commentary.</p> <p>The Mental Health Commission guidelines currently being finalised already include both consumer and carer peer workers. The recommendation commentary could include acknowledgement that the roles of consumer and carer peer workers are distinctly different as consumers and carers have different needs and experiences of the mental health diagnosis and recovery process.</p>
<p>Draft recommendation 13.1 Reduce barriers to accessing income support for mental health carers</p>	<p>Page 70</p>	<p>MHCA is broadly supportive of the recommendations related to carer income supports.</p> <p>The final report needs a more explicit reference asserting that maintaining eligibility for carers who do not reside with their care recipient needs to be continued going forward – the current final dot-point recommending the removal of specific criteria for these carers does not emphasise protecting access to this carer cohort.</p> <p>In addition, we suggest inclusion of a review of the Carer Allowance and Carer Payment forms and related processes.</p>
<p>Draft recommendation 13.2 Employment support for mental health carers</p>	<p>Page 71</p>	<p>MHCA agrees that the Carers and Work program should be subject to an evaluation. MHCA is a member of the Caring Fairly coalition and endorses the Caring Fairly response to this recommendation.</p>

Section/ recommendation	Page #	MHCA's recommended changes
<p>Draft recommendation 13.3 Family focused and carer inclusive practice</p>	<p>Page 71</p>	<p>MHCA supports the Carer Experience Survey as a useful tool to gauge mental health family and carer satisfaction. However, it is only one side of the equation. Mandated carer inclusive practice standards based on the Practical Guide to Working with Carers of People with a Mental Illness (Practical Guide) (or equivalent) would provide the compliance mechanism; and the Carer Experience Survey the feedback mechanism to test the effectiveness of the implementation of carer inclusive practice.</p> <p>MHCA has repeatedly heard that services are 'too busy' to develop and implement effective family and carer inclusive policies. The lack of sector standards and voluntary codes of practice are not binding and therefore are ineffective.</p> <p>Furthermore, MHCA has heard that issues of consent and confidentiality are often put up as barriers to implementing carer inclusive approaches; however, the Practical Guide supports services to work through and resolve these issues.</p> <p>In 2019 a review of four Practical Guide demonstration projects was conducted. The review found that while there was a commitment to improving practice, cultural change and upskilling is required in services.</p> <p><u>Given the above, MHCA proposes that in its final report the Commission includes a recommendation to mandate carer inclusive practice and fund training programs based on the Practical Guide⁶. See APPENDIX C.</u></p>

⁶ https://helpingminds-startdigital.netdna-ssl.com/wp-content/uploads/2016/12/A Practical Guide for working with people with a mental illness February 2016_002.pdf

Section/ recommendation	Page #	MHCA's recommended changes
<p>Draft recommendation 16.7 Non legal individual advocacy services</p>	<p>Page 81</p>	<p>Funding for individual family/carer support roles (otherwise known as individual advocacy) should be recommended with the roles co-designed with mental health families and carers. The role would walk alongside the family/carer from diagnosis to recovery. Some of our MHCA member organisations already provide this service and have strong foundations and frameworks to incorporate in any future co-design process.</p> <p>The types of functions this role could perform include practical and emotional support for families and carers to:</p> <ul style="list-style-type: none"> • find appropriate services for the consumer at the right time when the consumer is unable to do this on their own • understand the language of the mental health system • navigate, apply for and receive carer support services • understand and build capacity to self-advocate for their rights when using services • manage transitions to or from work due to the fluctuating nature of episodic illness • to attend appointments or meetings, write letters etc. <p>understand and build capacity to manage the impact of the caring role on their own social and emotional well-being.</p>
<p>Draft recommendation 17.5 Wellbeing leaders in schools</p>	<p>Page 86</p>	<p>MHCA proposes that this is funded and delivered through existing community managed organisations and independent of the education system. It is crucial these programs incorporate a relational understanding of mental illness and recovery meeting the specific needs of young people.</p> <p>A good example of this service in practice is the Beyond Blue programs being delivered in early learning, primary and secondary school, and tertiary settings. These programs emphasise proven methods, tools and support to help schools work with parents, guardians, carers, health services and the wider community. Another example is Orygen's Guide to Family Inclusive Practice.</p>

Section/ recommendation	Page #	MHCA's recommended changes
<p>Draft recommendation 22.3 Enhancing Consumer and Carer Participation</p>	<p>Page 101</p>	<p>MHCA suggests that the Commission strengthens the recommendation 'should ensure they collaborate' to 'recommends that a national framework is developed to inform co-design approaches across all jurisdictions'. The framework would include information about the continuum of consultation, guiding principles on how to establish governance mechanisms, how to identify and engage key stakeholders and provide funding to ensure effective engagement.</p> <p>The national framework should be developed in such a way that it can be adapted for use at different levels of government and across Community Managed Organisations. Examples of frameworks currently in use can be found at: https://www.dhhs.vic.gov.au/publications/mental-health-lived-experience-engagement-framework, and at: https://www.mhc.wa.gov.au/about-us/consumer-family-and-carer-participation/statewide-engagement-framework-and-toolkit/.</p> <p>Re Peak funding: the following recommendation:</p> <ul style="list-style-type: none"> ○ The Australian, State and Territory Governments should strengthen systemic advocacy by extending the funding cycle length for peak bodies to a minimum five years to improve business planning and capability development <p><u>should be amended to:</u></p> <ul style="list-style-type: none"> ○ 'the Australian government should provide ongoing funding to support national mental health carer peak activities. This funding should be adequate to support research and project roles to develop resources for mental health families and carers.
<p>Draft recommendation 23.2 Responsibility for psychosocial and carer support services</p>	<p>Page 103</p>	<p>MHCA recommends further consideration is given to this recommendation to ensure that:</p> <ul style="list-style-type: none"> • there is <u>no loss</u> of funding for carer support services across all jurisdictions • the commissioning model supports carers who are caring more than one person, including those carers who support people with support needs other than mental health e.g. disability, aged care • the needs of young mental health carers are given special attention • consider reversing the cuts to the carer respite services nationally as this is a critical service.

Our MHCA Members



Arafmi Queensland Inc – QLD Member

Providing support services for families and friends of people with mental illness and/or psychiatric disability.



Mind Australia – National Member

Mind Australia is a leading provider of community mental health services. They support people to live connected, productive and satisfying lives.



HelpingMinds (formerly Arafmi) – WA Member

HelpingMinds (formerly Arafmi) is the pre-eminent mental health services and carer support organisation in Western Australia.



Mental Health Carers ARAFMI NSW Inc – NSW Member

ARAFMI NSW provides support, education and advocacy for the carers, family and friends of those experiencing mental illness across NSW.



Mental Illness Fellowship of Australia (NT) – NT Member

Mental Illness Fellowship of Australia (NT) is a non-government organisation providing services for people living with a mental illness and their carer's and families.



Tandem Inc. – VIC Member

Tandem is the Victorian peak body representing family and friends supporting people living with mental health issues.



Your trusted voice in mental health

Mental Health Families and Friends Tasmania is a statewide leader in the provision of mental health carer support.

APPENDIX A – A Mental Health Carer Perspective for the Future Vision

Jane's Current Experience – before the PC Recommendations are Implemented

Jane is a mental health carer in her late forties. She has been a carer for over ten years for a family member. The person she supports was in her early teens when she became seriously unwell and is now in her early twenties.

'tired of the idea of the heroic carer'

Currently Jane still provides a high level of support – more than ten years on since her family member became seriously unwell. There are some positive signs that her daughter is finally receiving more regular community-based supports and some supports through the NDIS. The family member is getting help with strategies to manage her illness as well as an understanding of recovery. However, many of these supports Jane has had to fight and advocate for. None of them would be there without that work. Jane has had to really push to get supports and although that has equipped her with advocacy skills it has added a different level of work to her unpaid caring role. Jane is tired of the idea of the heroic carer. She would like to see some of this advocacy work undertaken by a skilled worker who has oversight for the family and all its members where needed and appropriate. She also knows from her involvement with mental health carer organisations, that many carers are not able to advocate and they miss out. There is too much of a reliance on carers themselves to manage too many dimensions.

'excluded and without dedicated carer and family supports'

Jane and the other family members are often excluded and are without dedicated carer and family supports – especially at the start. Not asked, at that first or subsequent interactions: “how are things going for you and what would help?” And, more importantly, “these are the supports we can offer for your own wellbeing”. There is a gap in supports such as counselling, psychosocial education, as well as practical help such as cleaning, meals, and supports for other children to ensure the illness has minimal impact on their education, and on their development.

Mental health carer networks have played a significant role in information and tools to cope, but these are small and not extensively resourced. Jane believes they are not a replacement for funded supports for families and carers. What supports Jane has pieced together are still lacking in a broader carer and family relational approach, as well as a recovery approach – and are generally limited to more of a managing the crisis approach.

'hidden trauma trying to support'

The family also experiences lots of hidden trauma trying to support someone who is really unwell particularly when there are behaviours of concern – suicide attempts, self-harm, running away, risk behaviours. This is generally unacknowledged, and Jane has struggled to navigate what is age or relationally appropriate for the family member she supports. Sometimes the support she is being asked to provide doesn't feel appropriate within the context of a relationship – and it can undermine the relationship.

'unable to envisage returning to full-time work'

Jane still can't envisage returning to full-time work but has been able to stay engaged through study and part-time work. She is grateful that she at least has that choice. But she also realises that now she is ten years older than she was and that she has missed out on critical parts of her career and skill development. She feels a bit left behind and lacks confidence in work she used to feel really competent doing. Sometimes she feels guilty about the fact that she has some choices. She knows there are mental health carers in more difficult, sometimes dire, situations and are more vulnerable economically. Mental health carers who haven't been able to remain in the paid workforce however marginally, or who have been caring intensively for decades with no option to re-engage with life outside of the carer role. This guilt is almost a survivor guilt.

'trying to get on top of health issues that are a direct result of her caring'

Jane is also trying to get on top of health issues that are a direct result of her caring work. Long term stress and anxiety has physical as well as mental health consequences and making the time for her own health is a novelty.

Jane's New Experience – after the PC Recommendations are Implemented

When the PC recommendations are implemented Jane's experience of being a mental health carer is very different. Jane now feels more confidence around the future, where families and relationships are included at the centre of treatment for all concerned.

'more dedicated supports in place using a relational and recovery approach'

First of all, it is less isolating, confusing and traumatic. There are more dedicated supports in place using a relational and recovery approach that respond as needed by Jane and the family, and in the context of their family member who is seriously unwell. There is a recognition through all services and within clinical practice, that sustaining the relationships that are important to the person with the illness is paramount. Jane and her family are now offered counselling education and practical advocacy to ensure that other family members have their needs met too.

'recovery plans are developed for everyone that wants or needs one'

There is an emphasis - in all systems engagement - on planning to keep everyone safe and to avoid as much as possible the development of crisis situations. Recovery plans are developed for everyone that wants or needs one. In the context of their relationships as well as in the context of their own lives and expectation for the future.

'choice about how much care and support she is able to manage'

Jane is also given a choice about how much care and support she is able to manage. Her economic and social context and her own health and well-being is taken into account. Her experience with the system is much more positive and she feels supported. Her insights and input are listened to. Safety and health and well-being are made a priority for her. Her own health is supported as part of a life journey plan. And as part of inclusive practice standards that are mandated. She feels like things could move forward regardless of how unwell the person might be.

'access to a carer support and advocacy worker to avoid a crisis in her own health'

Jane has ongoing access to a carer support and advocacy worker who assists with planning, advocating and supporting her in her caring role, and in relation to the other areas of her life she is struggling with. This support helps to avoid a crisis in her own health, and the loss of wider relationships, and helps to facilitate and encourage engagement in her life outside of her caring, in the expectation that her caring role should lessen over time.

'the opportunity to join a workplace'

She also now has opportunities to think about the future in positive ways. She has a workplace, or the opportunity to join a workplace, that is informed about the impact of mental health caring on the lives of employees and on their work. She has an employer with policies that recognise the importance of keeping skilled staff on board and not losing workers at critical stages in their working lives to a long-term caring role. If she feels unable to engage in work, she knows that there are funding arrangements in place such as: an adequate carers allowance and payments; rebates on medical costs; and contribution to a carer's superannuation scheme and funds for everyday needs when in crisis.

Jane – some supporting background on her experience

Before her family member became unwell Jane had just moved from part-time work back into a full-time role. She was deciding whether or not she would apply for more senior roles in her workplace. Or return to study. When her family member became ill, she could barely stay in the workforce at all for at least three years and when she returned struggled to maintain work at the level she was previously employed.

Mental health treatment was generally crisis driven and in-between times there was an expectation that she had over-sight for managing her child's illness. And worse, responsibility for watching her if suicidal or self-harming, with little training or advice on how and where to set limits and how to keep her family safe. Sometimes she felt she was being judged. Often, she wished people with more training and competency were on hand regularly and in a planned way to support her family member and her family. She often felt guilty for not having time or energy for her other children, or her partner or other significant relationships.

Her Employer had some knowledge of her 'family issues' but there were no clear carer policies in place, or broader workplace understanding or education regarding mental health caring. She had no clear plan for her own needs and no plan for the best way to be of support. She muddled along stressed and anxious about the impacts on her other children. Sometimes she couldn't sleep for worry. Her work suffered, her relationships suffered, and her sense of her own agency suffered. She was isolated and depressed. Feeling hopeless. It was only her connections with other mental health carers, and organisations like MHCA that helped to contextualise her experience -- you are not alone - But these connections couldn't solve key issues.

Reflecting on her experience she wishes that from the get-go she and her family had had more supports to manage the everyday. To be given tools to manage, as well as support and choices when she was not managing. Jane feels strongly that it is not OK to ask families and carers to live with someone who is highly distressed and becoming more unwell, and to be told there is nothing that could be done until they needed to go to hospital. She wishes there was a broader career and family relational approach to these supports, as well as a recovery approach - not just a "managing the crisis" approach.

Jane would like to see, as part of a response to the realities of mental health caring, facilitated conversations regarding what is age or relationally appropriate. And to listen to mental health carers and their families so that the intensity of what they experience is understood. Sometimes the support you are being asked to do is not appropriate within the context of a relationship. It can be too hard. It can undermine the relationship. Sometimes she just wants to be a parent. Jane believes that the mental and physical health of carers needs to be a priority. Research shows the consequences of ignoring this.

She believes that different but no less important supports are also needed at the stage when you are trying to rebuild your life, when you are often exhausted, deskilled and isolated from networks. This should include financial support including a super contribution and funds to support education and training. Returning to a life outside an intense caring role takes time, effort and key supports.

Jane also feels that as people age and change, there needs to be a recognition of the impacts. Encouraging mental health carers to think about where they would like to be, and what they would like to be able to have choices about is a part of the conversation that is missing. Managing a crisis for a few months may be OK (though this can have traumatic consequence if managed without supports) but not ten, twenty, thirty years of it.

APPENDIX B - Brisbane North PHN Stepped Care Approach to Mental Health⁷

FACT SHEET

Stepped Care Approach to Mental Health at Brisbane North PHN: connecting people to the right services, at the right time and in the right place

Brisbane North PHN is committed to ensuring people receive the right services at the right time and in the right place. Using our primary mental health care funds we will purchase services within a stepped care approach. Through our regional planning role we will promote a stepped care approach across the mental health system.

This paper explains our approach to stepped care and what we are doing to turn it into a reality. We recognise that for many people, their experience is very different to the vision we outline below. Together with stakeholders across the region, we will work to ensure that over time, people get the right services, at the right time and in the right place.

What do we mean by stepped care?

Brisbane North PHN has produced a short video to explain stepped care from a consumer's perspective.

To view the video, visit: myvoice.brisbanenorthphn.org.au/mental-health-and-alcohol-and-other-drugs-planning-engagement-hub/videos



In a stepped care approach, a person seeking support is connected to the services that meet their needs and as their needs change, the services change with them. A person does not need to start at the 'lowest' step, but will be connected to the right level of service for them. This is a person centred approach to care.

Where has the stepped care approach come from?

The Australian Government's response to the National Mental Health Commission's review of mental health services and programs commits the government to introducing a stepped care approach to the mental health system, including primary mental health care funding provided to PHNs.

Refocusing primary mental health care programmes and services to support a stepped care model

Primary mental health programmes and services will be redesigned within a stepped care model, moving from the 'one size fits all' approach to better match services to individual need. The PHN flexible pool will support provision of services within this stepped care model. Consumers will benefit from better targeted services.

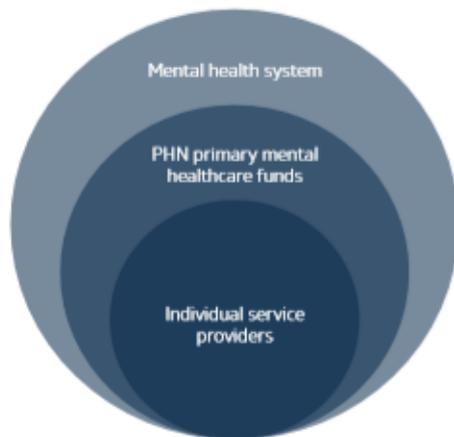
Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services, page 3.

⁷ <http://www.brisbanenorthphn.org.au/content/Document/Fact%20sheet%20-%20stepped%20care.pdf>

A stepped care approach seeks to:

- reduce the under-servicing and over-servicing of some consumers
- emphasise early intervention and self-care
- match the level of service to consumers' need and change services as their needs change,
- shift focus to services that help prevent the need for acute and crisis intervention
- offer the full continuum of services from low intensity through to high levels of care
- ensure consumers have the choice of a broader range of services, better targeted to their needs
- increase the use of digital mental health services
- strengthen support for GPs in undertaking assessment to ensure people are referred to the right service

A stepped care approach can be implemented at various levels.



The whole mental health system needs to be organised in a way that facilitates easy access to services matched to consumers' needs. PHNs are to use primary mental health care funds to purchase services within a stepped care approach. Individual service providers may deliver multiple services at various levels of intensity and actively connect consumers to different services, internal or external, when their needs change.

Stepped care has five core elements:

1. stratification of the population into different 'needs groups'
2. defining distinct interventions for each group – this is necessary because not all needs require the same intervention

3. a comprehensive 'menu' of evidence based services to respond to the spectrum of need
4. matching people to services, based on their needs
5. providers delivering services at the level the person requires and adjusting as needs change

Needs Groups

To help connect people to the service/s that are best for them, we need to understand their situation. This can occur through discussion, assessment tools or screening and triage processes. Based on their needs, people can be stratified into one of the following eight needs groups.

- **Keeping healthy (whole population)** – all people can benefit from being physically and mentally healthy throughout their lives
- **Community & Family** – much support comes from family, friends and other natural supports in the community and they may have their own support needs as carers
- **Early intervention/at risk** – people with signs of distress, including from life events such as a relationship breakup or losing a job, may be at risk of developing mental illness if support isn't provided early (23% of population)
- **Mild** – people diagnosed with mental illness (including feeling depressed or anxious), that impacts on wellbeing and functioning to a level that is concerning but not overwhelming and is less than 12 months duration (9% of population)
- **Moderate** – people diagnosed with mental illness, which causes significant disruption to daily life, wellbeing and functioning and can be over 12 months duration (5% of population)
- **Severe** – people diagnosed with mental illness, which is very disruptive to daily life, wellbeing and functioning, may include risks to personal safety and is either persistent or episodic (3% of population)
- **Severe & Complex** – people with a diagnosed mental illness which is severe in its impact on wellbeing and functioning and where there are additional complexities such as difficulties with housing, employment and daily living (0.4% of population)
- **Crisis** – people with or without diagnosed mental illness who are in crisis, including self-destructive behaviour, suicidal behaviour, and harm to self or others and immediate action is required

Services

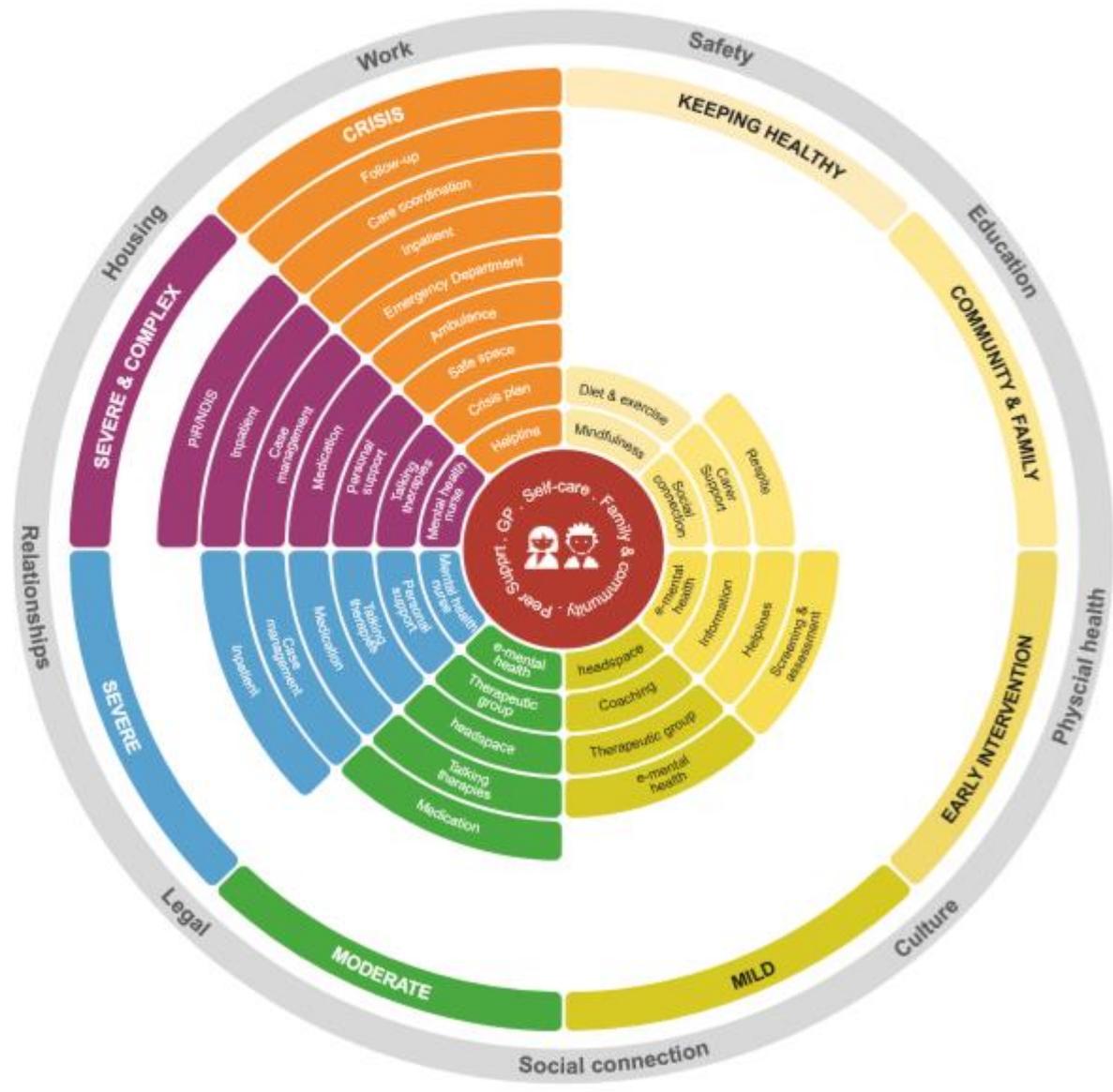
There are core services and supports that people in all needs groups benefit from:

- self-care
- family & community
- peer support
- general practice

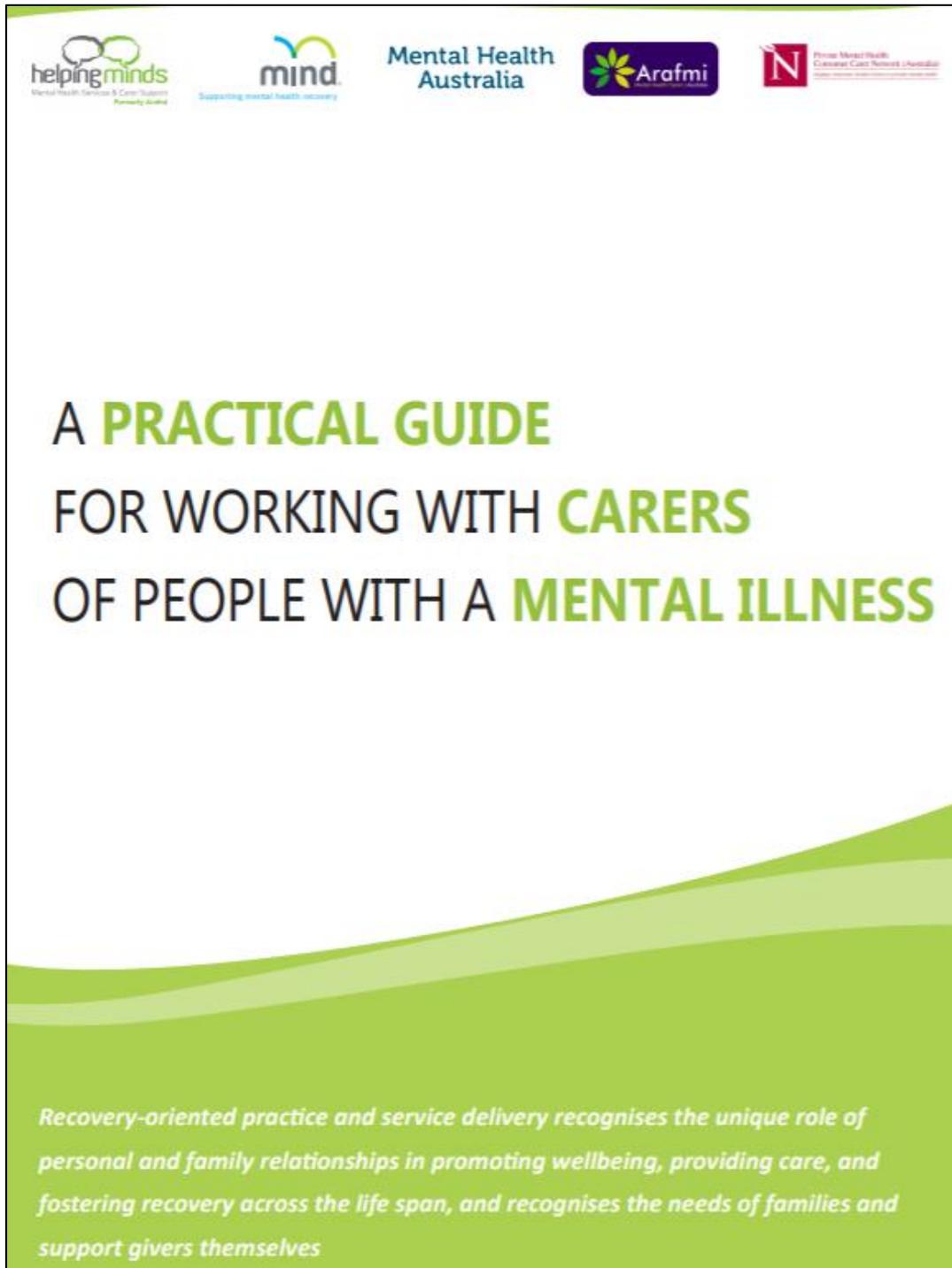
Specific service types for each needs group are outlined in the following diagram (the list of service types is not exhaustive).

People can wrap the services and supports around them that they need. A person can continue to benefit from less intense services even if they have higher needs, as long as those higher needs are being attended to. As people's needs increase they can 'dial up' the range of services and supports they use. When things get back on track, they can 'dial down' the services and supports.

People do not need to start at the lowest level and work up nor are they limited to just those services suggested for their level of need.



APPENDIX C - Practical Guide to Working with Carers of People with a Mental Illness (Practical Guide)⁸



⁸ <https://helpingminds-startdigital.netdna-ssl.com/wp-content/uploads/2016/12/A-Practical-Guide-for-working-with-people-with-a-mental-illness-February-2016-002.pdf>

Partnership Standards in Practice

The six Partnership Standards are designed to improve outcomes for consumers by combining the knowledge and skills of staff with the knowledge and lived experience of family and other carers in a partnership approach to service delivery across all settings.

The Six Partnership Standards

1. Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.
2. Staff are carer aware and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and sharing of information are in place.
4. Defined staff positions are allocated for carers in all service settings.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care settings.
6. A range of carer support services is available.

The Partnership Standards can be applied across all settings and incorporate age-related and cultural needs.

The processes associated with identifying carers and providing basic information to them can be broken down into simple actions that can be undertaken by all staff at:

- an organisational level
- an individual staff level

All services are required to undertake a process of accreditation, either by individual professional bodies such as service agreements for CMOs responsible for service delivery or by organisational surveys via accreditation agencies against specifically agreed standards such as National Safety and Quality Standards, Australian Commission on Safety and Quality in Health Care. These processes require services to demonstrate evidence of partnering with carers in service delivery.

Implementation of the Partnership Standards will provide a framework for demonstrating organisational commitment to working in partnership and to meeting the various requirements of the accreditation processes.