**Mental Health Council of Australia Submission to:**

**ATAPS Flexible Care Packages for People with Severe Mental Illness Discussion Paper February 2011**

## Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

The MHCA welcomes the opportunity to provide comments on the Flexible Care Packages (FCPs) for People with Severe Mental Illness Discussion Paper.

The MHCA broadly supports the introduction of FCPs for mental health consumers experiencing severe mental illness for treatment in primary care settings.

Consumers with severe mental illness and carers constitute one of the most disadvantaged and marginalised groups in terms of access to services and complexity of issues. Consumers with severe mental illness, and their carers, frequently experience financial hardship, housing issues and homelessness, unemployment or underemployment, alcohol and other drug use and other physical health complaints. They have complex needs and require an integrated and holistic approach to care and support that addresses not only their mental health but also supports their full participation as valued members of the community.

## Accessing the discussion paper and stakeholder consultations

The MHCA is extremely concerned at the belated and restricted dissemination of this discussion paper and the short timeframes which have been set for the return of comments.

It is evident from the discussion paper that the FCP program will require the collaboration of multiple stakeholders across multiple levels of government and across community, private and public sectors, and therefore, the Government needs to support cross-sectoral dialogue through the facilitation of feedback and commentary from a diverse range of stakeholders.

MHCA members in attendance at stakeholder consultations held across the country reported limited consumer and carer representation, particularly from local consumer and carer groups, minimal representation of local NGOs and state-based mental health services, minimal or no representation of CALD or Indigenous groups, alcohol and other drug (AOD) services, and state/territory community mental health and AOD peak bodies (see Table 1). Upon querying the lack of diversity in stakeholder representation, one attendee was informed that:

*The Department of Health and Ageing requested the National Advisory Council for this project to suggest the names of peak organisations which were then approached via invitation to nominate their members to attend the consultation. We relied upon those members to name the appropriate bodies in each State and Territory. We did not make contact with each State and Territory to determine other peak bodies that may exist and needed to be a part of this consultation.*

This approach is insufficient to ensure a strong cross-section of stakeholders. It puts the onus on peak bodies rather than ensuring the Department of Health & Ageing undertakes its own robust consultations. MHCA strongly recommends that further consultation rounds be undertaken to ensure that the expertise of unrepresented or underrepresented stakeholders, particularly NGOs, state/territory mental health services, and consumers and carers, is incorporated into the design and implementation stages of this program.

The scheduling of consultations in Perth four days prior to the closing date for submissions and the proposed rescheduling of the Brisbane consultation after the closing date for submissions further restricts stakeholders' ability to provide comprehensive and considered feedback.

We also have concerns about the ability of consumers and carers to access the discussion paper. A number of state and territory consumer and carer peak bodies were unaware that the discussion paper had been released until they were informed recently by the MHCA. Moreover, carers and consumers on low incomes may not have internet connections and those living in rural and remote areas may only have dial up internet connections, which would have made it difficult for them to download the paper.

The MHCA believes that providing sufficient time for public comment and encouraging diversity in representation at stakeholder consultations is fundamental to effective community consultation, and encourage future consideration of strategies to ensure more accessible and inclusive consultations.

**Table 1. Reported attendees by Profession/Sector at ATAPS Consultations**

| | Hobart | Canberra | Adelaide | Perth | Darwin |
|---|---|---|---|---|---|
| GP Division | 4 | 3 | 6 | 1-2 | 0 |
| Psychiatrists | 0 | 0 | 0 | 0 | 0 |
| Psychologists | 2 | 6 | 6+ | 6 | 4 |
| MH Nurses | 0 | 2 | 2 | 1-2 | 3 |
| Social Workers | 0 | 1 | 6 | 1-2 | 1 |
| Occupational Therapists | 2 | 0 | 5 | 0 | 1 |
| Other Clinical Worker | | | | | 2 |
| Other MH Worker | | | | | 2 |
| NGO services | 0 | 2 (not local) | 0 | 6+ (unsure about locality) | 0 |
| State/Territory MH services | 0 | 0 | 0 | 1-2 | 3 |
| Consumers | 1 | 0 | 1 | 1 | 1 |
| Carers | 0 | 1 | 0 | 1 | 1 |

## Does the definition of severe mental illness fit the purpose of FCPs?

In relation to the definition for severe mental illness detailed in the FCP discussion paper, the MHCA recommends the following:

- The definition for severe mental illness be brought in line with the definition detailed in the *Mental Health Nurses Incentive Program* to support ease and continuity in clinical assessments.
- That eligibility to clinically diagnose mental illness be broadened to include allied health practitioners with appropriate clinical skills and qualifications. This is particularly important in rural and remote areas where GPs and psychiatrists are not easily accessible.
- The term 'disability' to be broadly defined to include psychosocial aspects that prevent someone from fully and effectively participating in their community, i.e. housing, employment and social support. These aspects are often more applicable to the lives of people experiencing severe mental illness, than physical impairments commonly associated with the term 'disability'.
- Multiple examples of symptom intensity, chronicity and manifestation of disability be provided as a guide to the referring practitioner.

It is also worth noting that the requirement for a clinical diagnosis in order to access FCPs may act as a barrier to mental health consumers and carers seeking treatment for their mental illness.

## Are there other clinicians who would be appropriate to refer people with severe mental illness to the FCP program?

> *32% of consumers with disorders classified as severe are not receiving mental health care.*[1]

The MHCA recommends establishing a multi-entry referral pathway that broadens referral eligibility to include appropriately skilled allied health practitioners and ensure that mental health consumers and carers are able to access the program through their preferred practitioner.

The FCPs discussion paper assumes that GPs and psychiatrists alone are best placed to make clinical diagnoses and assess symptoms, chronicity and functionality. A significant number of consumers with severe mental illness, however, remain marginalised within our primary healthcare system despite the fact that there have been increases in funding for mental health services in primary care settings in the last fifteen years through programs like *ATAPS* and *Better Access*. Eligibility to refer into these programs is too often limited to one or two professions (GPs and psychiatrists), which are already experiencing significant workforce, accessibility and availability issues, including:

- declining rates of bulk-billing GPs
- workforce shortages of both GPs and psychiatrists (particularly in rural and remote areas)

[1] Department of Health and Ageing (2010), *National Mental Health Report 2010: Summary of 15 years of reform in Australia's Mental Health Services* under the National Mental Health Strategy 1993-2008. Commonwealth ofAustralia, Canberra.

- consumer and carer difficulty in identifying GPs with an interest and/or training in mental health care
- consumer and carer difficulty in accessing the 'long' appointments necessary to undertake an assessment.

Allied health practitioners and mental health nurses on the other hand are often more readily available and affordable to the target client group, and possess both the clinical qualifications and skill set required to assess and work with them. Allied health practitioners and mental health nurses are also often found in a variety of service settings outside of the healthcare system (i.e. schools and NGOs) making them an ideal entry point for those consumers disengaged from the healthcare system.

Incentives could also be provided to community agencies to have their medical staff (i.e. allied health and mental health nurses) become engaged in the ATAPS program as both referring agents and clinical service providers. This approach would considerably increase the pool of available labour and enhance community access to care.

## What arrangements should be put in place to facilitate seamless transition between Commonwealth and State funded mental health services to meet the changing needs of individuals?

See '*How can divisions (and later Medicare Locals) establish partnerships with local NGOs to ensure integration and coordination of services?'*

One of the biggest weaknesses in the design and implementation of the FCP program is the limited consultation of relevant stakeholders, particularly state funded mental health services. If the Commonwealth is committed to facilitating seamless transition between Commonwealth and state funded mental health services then it must invite them to the table in both the design and implementation stages of this program and ensure that open communication and dialogue relating to these issues is happening well before this program is expected to be rolled out.

Practically speaking, the 'no wrong door' principle should be central to both Commonwealth and state funded mental health services to ensure consumers and carers are receiving services they need regardless of where and how they present.

## How can divisions (and later Medicare Locals) establish partnerships with local NGOs to ensure integration and coordination of services?

There has been little systematic support for the development of best practice collaborative care models between NGOs and clinicians for consumers with longer-term (chronic), complex, persistent or episodic illnesses. This is largely the result of the divisions' over-emphasis on bio-medical treatments, doctor-centred care and support of the small-business, fee-for-service clinic model that lacks responsiveness to the needs of people with a mental illness. The focus on remuneration for single occasions of service and reluctance to reward enhanced management of episodes of care has focussed care away from socio-economically challenged, geographically-isolated and other high risk groups and perpetuated inequity and poor access.

Establishing effective and collaborative partnerships between divisions and NGOs will require divisions to take a social view of mental health where clinical services are supported by NGO services that address the social determinants of poor health (i.e. housing insecurity, unemployment, financial stress and social isolation). Only once divisions recognise the value

of NGO services in the treatment and maintenance of mental illness will integration and coordination of services occur.

MHCA member organisation, the Mental Health Coordinating Council NSW (MHCC), identified a number of factors that underpin successful health partnerships between governments and service providers in its 2010 mapping exercise of the NSW community managed mental health sector[2] [3] including:

- a history of collaboration
- mutual respect and trust
- open and frequent communication
- shared vision and values
- a framework on how Government will link with the NGO sector, including dealing with difference
- role delineation
- interagency events and other partnership initiatives, i.e. MHCC's *Meet Your Neighbour* program[4]
- maintaining a central database of referral services
- adequately paid staff
- skilled leadership.

The first step to ensuring integration and coordination of services cross-sectorally is establishing a strategy that exemplifies these factors and providing complementary funding and incentives to parties who demonstrate their commitment to the strategy. Moreover, funding formulas that mix performance based and activity based incentives will ensure responsiveness to service demand and encourage the development of innovative service models (i.e. telephone, web-based and mobile outreach) that target hard-to-reach client groups. Funding incentives tied to participation in collaboration and cross-sector initiatives would also support further integration and coordination of services.

Supporting partnerships between the Commonwealth, GP Divisions (Medicare Locals), clinicians and the NGO sector is integral to care coordination and cross-sector collaboration and without these partnerships the vision of the FCP program will not be realised.

## What type of clinical and non-clinical services may be needed for individuals receiving FCPs?

Clinical services funded by the FCPs should be evidence based therapies that are widely known to be effective. Where it is clinically and culturally appropriate, increased use of group therapy could also be considered to make the most of limited staff resources. Particular attention must be paid however to privacy concerns in small communities.

Non-clinical services funded by FCPs should focus on supporting individuals in their day-to-day lives. Commonwealth funded programs like Personal Helpers and Mentors (PHaMs) and Day to Day Living should be complemented by the diverse range of services provided at a

[2] Mental Health Coordinating Council (2010). *The NSW Community Managed Mental Health Sector Mapping Report 2010* (pp. 119). NSW Australia .
[3] Cheadle, A., Senter, S., Solomon, L., Beery, W. & Schwartz, P. (2005). *A Qualitative Exploration of Alternative Strategies for Building Community Health Partnerships: Collaboration- Versus Issue-Oriented Approaches* (pp638-652) Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 82, No. 4. cited in Mental Health Coordinating Council (2010). Op. cit.
[4] See http://www.mhcc.org.au/sector-development/meet-your-neighbour.aspx

local level that specifically address the needs of the local communities. Non-clinical providers would include employment and housing services (including emergency accommodation), dentists, education and training agencies, social and peer support programs, leisure, recreation or exercise programs and respite etc.

## What arrangements need to be put in place to facilitate access to clinical and non-clinical services?

See '*How can divisions (and later Medicare Locals) establish partnerships with local NGOs to ensure integration and coordination of services?'* and '*Are there other clinicians who would be appropriate to refer people with severe mental illness to the FCP program?'*

Marginalisation of mental health consumers and carers from existing mental health services and supports can often occur as the result of geographic isolation, lack of affordable transport, financial instability or lack of social supports. Outreach models of care and support[5] are essential to overcoming these barriers and facilitating access to clinical and non-clinical services. Community service hubs that combine health services with other essential community supports, and are located conveniently to the population (not just in city centres), also support greater access to clinical and non-clinical services.

Information regarding the ATAPS program, including FCPs, will also need to be properly disseminated to local NGOs. This will support greater knowledge and awareness of the program in the community and amongst consumers and carers and hopefully lead to fewer individuals 'falling-through-the-cracks' of both state and Commonwealth funded mental health service systems.

## What quality issues need to be addressed?

All service providers should be prepared to demonstrate they meet agreed standards of care in their practice. Audits and other checks against actual service performance should be a regular feature of the mental health system to promote community confidence. These must include an assessment by mental health consumers and carers about what is working well and what is not. Findings need to be integrated with ongoing continuous quality improvement processes which develop solutions to problems identified. Funding devoted to ensuring quality improvement in the delivery of services is essential.

## Who should be responsible for implementing any quality framework that may be developed?

The quality framework must be set and monitored at the Commonwealth level, with consumer and carer input, to ensure equal standards and equitable access to the program across all jurisdictions. Some variance in the application of specifc standards may be necessary to ensure local community needs are able to be met.

## How can we best support interface to allow Divisions to work effectively with state based services?

See '*How can divisions (and later Medicare Locals) establish partnerships with local NGOs to ensure integration and coordination of services?'*

[5] Outreach models can either take the form of services being offered at a place that is convenient and safe to the client, and/or the client is supported by case coordinators or peers to participate in treatment and other activities.

## What constitutes a best practice model?

A best practice model is committed to the following principles:

- recovery-oriented
- addresses social determinants of health
- person-oriented
- supports self-determination and choice
- sensitive to diversifying characteristics (i.e. gender and sexuality, CALD background, indigenous background, age, disability and comorbidity etc.)
- supports consumer and carer input in the design, implementation and evaluation of services and standards.

These principles are currently absent from the discussion paper and need to be incorporated into all future FCP policy and procedural papers.

## What specific elements are needed to appropriately support allied health professionals in ATAPS delivering FCPs?

An expansion of the GP Psych Support service and supporting local professional networks would be useful supports to allied health professionals in ATAPS.

## Conclusion

The MHCA supports the broad direction of the FCPs program and are pleased to have contributed to this important consultation. We encourage the Department of Health and Ageing to further engage with relevant stakeholders throughout the design, implementation and evaluation stages of this program.

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