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February 16, 2011

Re: Discussion Paper – Flexible Care Packages for People with Severe Mental Illness
(The Access to Allied Psychological Services/ATAPS Component of the Better Outcomes in Mental Health Care Program)

To Whom It May Concern,

The Mental Health Coordinating Council (MHCC) is the peak body representing non-government community managed organisations (NGOs/ CMOs) working for mental health in NSW[1]. Please find attached the MHCC submission in response to the above Discussion Paper. MHCC thanks you for the extension of time and opportunity to provide this submission and contribute to the ongoing discussion about National Hospital and Health Reform (NHHR) as this relates to achieving recovery oriented service provision (ROSP) within the community mental health sector. We are also providing you with a copy of our submission in response to the Medicare Locals Discussion Paper on Governance and Functions (November 2010, Attachment 1) along with numerous other documents which are referenced and listed at the conclusion of this cover letter.

The *"Fourth National Mental Health Plan: An Agenda for Collaborative Government Action 2009-2014"* (2009) commits all governments to achieving a mental health system that enables recovery, prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and support to enable them to participate fully in the community. Knowledge of the concept of recovery is critical for achieving these outcomes as it is about so much more than the absence of mental illness and related symptoms or the availability of hospital beds and medication. Effective implementation of the Flexible Care Packages (FCPs) will require GP Division/Medicare Local ATAPS allied health professionals to have knowledge and skills to coordinate care with a broad range of community services as well other health professionals.

[1] The NSW not-for-profit, non-government mental health sector prefers the language of community m organisation (CMO), community based services and community managed mental health sector etc. a positive affirmation of our value, identity, history and function.

MHCC is the peak body for mental health organisations in NSW and is funded by NSW Health

The "*National Mental Health Policy"* (2008) defines recovery as:

"*A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources."*

More simply stated, recovery is about being connected to the community in meaningful ways and facilitating this is where the strengths of the community managed mental health sector lie. The importance of the concept of recovery to mental health treatment and support service provision was further emphasised during recent review of the *"National Standards for Mental Health Services"* (2010) with the introduction of a new standard *"Supporting Recovery"* and *"Principles of Recovery Oriented Mental Health Practice".*

Achieving the government's stated policy objective of ROSP requires the evidence base for the social and environmental determinants of health to be better understood and to inform the development and implementation of programs and policies. The continuity, coordination and range of primary, multidisciplinary and sub-acute health and community services available to meet the health and social needs of people living with mental illness also needs to be better understood and strengthened. The World Health Organisation (WHO) provides guidance on the optimal mix of community mental health services (MHSs) required for achieving recovery outcomes and this service delivery model is highly reliant on informal, community managed MHSs which need to be considerably further developed in Australia (Attachment 2). Achieving recovery outcomes also requires access to a range of other community based services and this most notably includes, but is not limited to, employment and housing.

Creating a strong health system capable of supporting recovery also requires more focus and investment in primary healthcare and the FCP initiative is an important new mental health program toward achieving this and it will have a high impact on the community managed mental health sector. $60M is to be directed to CMOs providing "non-clinical" mental health rehabilitation and support services over three years from 2011/12 (i.e. $20M per annum from the Commonwealth government's 2010 *"Taking Action to Tackle Suicide"* policy). This is to complement the original $58.5M allocated over four years from 2010/11 for what will now be clinical and case coordination services delivered through GP Division/Medicare Local ATAPS providers (i.e. this was originally to be a mixture of clinical and non-clinical services). We appreciate that a major focus of the FCP initiative – other than increasing MHS access – is increasing the capacity of allied health professionals in primary healthcare settings to more effectively work with people with severe mental illness (i.e. as opposed to clients with mild to moderate low prevalence disorders like depression and anxiety). However, a cost of this focus is insufficient thinking and planning regarding the inclusion of the community managed mental health sector in the FCP initiative.

Overall, we find that the Discussion Paper has an inappropriate emphasis on clinical/medical interventions (i.e. diagnosis, symptom monitoring, hospitalisation, medication) and insufficient emphasis on non-clinical psychosocial rehabilitation (PRS) and support approaches including the importance of housing and employment in supporting recovery. There is not sufficient understanding of the mental health CMO sector and the services it provides or inclusion of the role/functions of ATAPS "case coordinators" in working with CMOs to assist people with mental illness to address the social determinants of mentally ill health.

Furthermore, the mental health workforce knowledge and skills required to increase access to non-pharmacological interventions, including both PSR and "talking therapies" (i.e. non-illness or medical model focused services), have not been sufficiently considered. The risk of not adequately considering these approaches during planning is that the FCP services will have – as has been the case with public mental health services despite 20 years of a National Mental Health Strategy – a hospital based psychiatric crisis management emphasis instead of supporting the recovery of people living with severe mental illness.

The community managed mental health sector has a lengthy history that predates the advent of psychiatric medication, deinstitutionalisation and community mental health treatment. There are about 800 not-for-profit organisations that deliver a complex and diverse range of mental health rehabilitation and support services nationally. These CMOs employ about 20,000 skilled mental health workers and more than 70% have tertiary qualifications (i.e. allied health degrees, vocational qualifications). The skills and role of CMOs are critical for achieving the government's stated policy objectives of recovery and social inclusion for people living with mental illness.

MHCC is greatly concerned that the CMO sector – a key stakeholder in the FCP initiative and with significant experience in working with people with severe mental illness, including in the "clinical" domain - has not been involved in the initial rounds of consultations to inform planning. We became aware of the Discussion Paper from a NSW GP Division. Upon contacting your office to enquire about the date of the Sydney consultation we were informed that it had already occurred and had intentionally included mostly clinical MHS providers (both public and private but not CMO). We were further informed that a written submission would be the main pathway for CMOs to contribute to planning.

MHCC is a member of the Community Mental Health Australia (CMHA) alliance which comprises peak representation from all eight States and Territories. Attachment 3 provides the contact details for CMHA alliance members. The Department of Health and Ageing (DOHA) are strongly encouraged to work with the State and Territory mental health CMO peaks and the CMHA alliance in planning implementation of the FCP initiative. MHCC has a lead role nationally in the area of sector and workforce development on behalf of CMHA and would appreciate the opportunity to speak with you further about our FCP submission. Additionally, you may wish to participate in a CMHA meeting to discuss implementation of the FCPs.

MHCC is particularly concerned that the level of funding allocated for CMO/"non-clinical" service provision will not be sufficient for addressing the needs of the planned 25,000 FCP clients. While the Discussion Paper provides estimates for clinical service delivery contacts it does not provide estimates for non-clinical contacts. MHCC estimate that this equates to about 1.5 hours per person/per week for FCP rehabilitation and support services (i.e. $60M for 25,000 people is $2400 per person/per annum. At $30 an hour this is 80 hours per annum or about 1.5 hours per week). Our sector's experience in working with people with severe mental illness tells us that this will not be sufficient time for conducting activities that promote wellbeing and recovery.

According to the *"National Mental Health Report 2010"* (2010), the community managed mental health sector is already considerably under funded by international standards at just 8.3% of the total mental health budget. Access to much needed non-clinical rehabilitation and support services is greatly constrained by this funding reality. The majority of this funding has been directed to the CMO sector in just the past 4 years as a result of programs established under the *"COAG National Action Plan for Mental Health 2006-2011"* (2006, e.g. Personal Helpers and Mentors, Day to Day Living, Mental Health Carers Respite, Community Based Activities). Furthermore, there is enormous variability in mental health CMO funding across the States and Territories and between metropolitan and regional/rural communities. The Mental Health Council of Australia (MHCA) has proposed that CMO MHSs should be funded at 15% by 2013/14 and 30% by 2020 to adequately address the non-clinical MHS needs of people with moderate to severe mental illness.

The FCP assumption that existing Commonwealth and State/Territory funded "non-clinical" programs be accessed is reasonable and requires further and more informed planning – including the participation of the CMO sector in these discussions. Given the funding levels described above, it is unlikely that the mental health CMO sector will be able to optimally meet the demand for non-clinical rehabilitation and support services above and beyond the 1.5 hours a week funded through the FCP without engaging in discussions regarding priority of access. The risk of not involving the community managed mental health sector in planning for access to FCP non-clinical services is likely to be inefficiencies associated with purchasing CMO services and this could erode service

availability, quality and effectiveness and the success of the FCP initiative. In the absence of strong community sector linkages there will also be added systemic costs associated with the undue need for psychiatric emergency services.

The Discussion Paper also fails to consider recent and innovative programs within the CMO sector where clinical services have been made available through contractual arrangements with private allied health professionals using a variety of Medicare Benefits Scheme (MBS) mental health care items including ATAPS. An example of this is the Time Out sub-acute MHS in Queensland. Some of these innovations in providing services to adults with severe mental illness arose from experiences gained in implementing the headspace program. The highly successful headspace program, which is now being further rolled-out nationally, is essentially a partnership between primary healthcare providers including private practitioners, State/Territory public MHS and community managed MHS. Indeed, a common feature arising from the more successful headspace partnerships seems to be where a CMO is operating as the lead agency and this is likely due to the CMO strength of collaborative approaches in addressing the social determinants of mentally ill health.

The community managed mental health sector essentially views the FCP initiative as an under-funded and inadequately planned adult headspace model. Similar proposed approaches have been recently developed/costed by MHCC and discussed with NSW Health and are provided as Attachments 4 & 5 (i.e. Recovery and Wellbeing Locals, Step-up and Home Based Outreach MHS). The Recovery and Wellbeing Locals proposal brings together an emphasis on access to physical healthcare and talking therapies along with PSR to support recovery. The Step-up and Home Based Outreach proposal is a sub-acute model that emphasises prevention of psychiatric crisis. As is the case with the Time Out model, these proposed innovations are a partnership between primary healthcare providers including private practitioners and community managed MHSs using MBS funded mental health care items. Additional funding is also required for non-clinical rehabilitation and support services for the model to be effective and viable.

MHCC would welcome the opportunity to further discuss with you the content of our submission. Should you require additional information please don't hesitate to contact either myself (Ph 02 9555 8388 Ext 102, jenna@mhcc.org.au) or Tina Smith, Senior Policy Officer (Ph 02 9555 8388 Ext 111, tina@mhcc.org.au). Once again, thank you for the opportunity to comment on the FCP Discussion Paper.

Respectfully yours,

Jenna Bateman
Chief Executive Officer

Attachments

1. MHCC Submission in Response to the Medicare Locals Discussion Paper on Governance and Functions (November 2010)
2. World Health Organisation Optimal Mix of Mental Health Services Pyramid
3. Community Mental Health Australia Alliance Members
4. MHCC Project Proposal - The Design, Trial and Evaluation of Recovery and Wellbeing Locals: One Stop Shops in the Community for Mental Health Recovery, Improved Health and Wellbeing and Social Inclusion (November 2010)
5. MHCC Proposal to Pilot a Community Managed Step-up and Home Based Outreach (Sub-Acute) Mental Health Service in NSW 2011-2014 (November 2010)
6. Care Planning Process: From Managed Care to Self Directed Care (Glover, 2006)
7. The NSW Community Managed Mental Health Sector Mapping Report 2010 (MHCC, 2010)
8. Mental Health Articulation Project Synthesis Report – Main Findings and Recommendations (Community Services and Health Industry Skills Council, 2009)
9. Housing and Accommodation Support Initiative (2006, program guidelines)
10. The NSW Community Managed Mental Health Sector Data Management Strategy Report - Phase 1 (MHCC, 2010)
11. United States Psychiatric Rehabilitation Association Core Principles and Values (2009)

Discussion of Key Issues

Bearing in mind the need for flexibility and the FCPs target population, does this definition of severe mental illness fit the purpose of the FCPs?

Yes - the definition of severe mental illness does fit the purpose of the FCPs in that it includes a considered mix of illness/symptoms, chronicity and disability including both health and social circumstances. However, MHCC has concerns about the current skills and capacity of many GPs and psychiatrists to make such complex mental health psychosocial diagnosis at the present time (see further comments on this issue below).

Are there other clinicians who would be appropriate to provisionally refer people with severe mental illness for FCPs?
If so, what special conditions should be placed on those referrals?
What is considered to be a reasonable time period for clients to have a Mental Health Treatment Plan developed if they have been provisionally referred by other than a GP or psychiatrist?

Other clinicians/service providers to refer

More planned engagement of GPs with Mental Health Nurse Practitioners through the enhanced Mental Health Nurse Incentive Program (MHNIP) may be required for achieving diagnosis and facilitating effective referral pathways, especially in the early stages of implementing FCPs. This partnership would not require special conditions.

However, the *"National Standards for Mental Health Services"* (2010) suggest that anyone should be able to refer to the FCP program (i.e. a "no wrong door" approach to service delivery). This would ideally be through a GP and should also allow opportunity for referrals from: the consumer (consistent with self-managed care); their family and carers; and, other involved services (most notably public, private and community managed mental health services).

We note that private mental health service providers include not just psychologists, social workers and occupational therapists but also a large number of other certified counsellors and psychotherapists that are well skilled to identify and refer potential FCP clients (i.e. Psychotherapy and Counselling Association of Australia/PACFA and Counselling and Psychotherapists Association of NSW/CAPA).

MHCC has additional concerns about the proposed role of psychiatrists as key gatekeepers for FCP referrals and believes that the focus of these roles should ideally be specialist consultation for the purpose of diagnosis and prescribing pharmacological interventions (and talking therapy and PSR interventions where this skill base exists and has been vocationally credentialed). With a range of mental health and community service professionals involved in referral to FCP the availability of psychiatrists, which are in short supply nationally and especially outside of metropolitan areas, would be increased allowing for greater access to diagnosis, medication and other specialist consultative services (e.g. GP Psych Support).

[2] Note: To be read in conjunction with accompanying cover letter which includes feedback on other relevant information, omissions and alternative approaches.

Time Frame for Mental Health Treatment Plan

The FCP initiative is not about just medical/psychological treatment. People living with and recovering from severe mental illness require assistance with a diverse range of complex social issues in addition to needing health services. For this reason, we advocate that the term Mental Health Care Plan be used for the FCP as opposed to Mental Health Treatment Plan. Not using the right language to inform the required practice will likely result in an inappropriate emphasis on pharmacological and psychotherapy interventions and at the cost of the social determinants of mentally ill health being adequately addressed.

The *"National Standards for Mental Health Services"* (2010) defines care as: *"All services and interventions provided to a person with a mental health problem and/or mental illness by health and other sectors, community organisations, family and carers*". Treatment is defined as: *"Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning".* The FCP partnership of clinical and non-clinical MHS provision requires a coordinated care planning approach.

The time frame for developing a Mental Health Care Plan requires consideration of a range of care coordination mechanisms beyond the vocational role of the proposed GP Division/Medicare Local ATAPS "case coordinator" including: referral/service entry; assessment (both initial and comprehensive); care planning/goal setting; review; and service exit. This too should be done against the requirements of the *"National Standards for Mental Health Services"* (2010). Generally speaking, a comprehensive referral document can form the basis of an initial Care Plan and should be proposed at the time of referral by the referral agent and then further developed by the FCP ATAPS clinical service provider assessing for eligibility. A more comprehensive Care Plan should be developed by three months and then reviewed at least every three months thereafter or sooner if needed. We note that the timeframe for developing and reviewing a comprehensive Care Plan for a person with severe mental illness and complex health and social needs: can be considerably longer than that developed for people with mild to moderate mental illness; involve a much larger group of other stakeholders (both service providers and families and carers); and, be influenced by the need for more frequent and comprehensive review.

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

Seamless Transition/s Between Services

The three monthly Care Plan review meetings also create an opportunity for discussing service exits thus facilitating transition between services (i.e. the goal of ROSP is always about facilitating self-managed care). This will not just be a Commonwealth/FCP or State/public MHS transition and will also involve transitions between GPs, other private allied health and CMO MHS providers and this will sometimes be both with and without ongoing Commonwealth and/or State MHS involvement. Other structures will be required for considering FCP referrals and service entries (i.e. intake meeting including wait list management) and these could be attached to or separate from Care Plan review meetings. There will likely be an overlap of people attending the two meetings.

While the above provide suggestions to facilitate seamless transition between services they are really just two examples of activities that should be included in FCP care coordination guidelines and that should extend across a range of health and community service providers and not just be the domain of the GP Division/Medicare Local ATAPS case coordination role. The Queensland Time Out initiative and MHCC's proposals to establish innovative CMO programs making use of MBS mental health care items (Attachments 4 & 5) illustrate care coordination approaches where multiple health and community service providers are involved as opposed to single provider case

management approach. Collaborative practice that promotes client self-directed care respects and encourages the client to be their own case manager and thus strengthens service transitions.

Service provider directed case management approaches are predicated on a "managed care" service delivery model (i.e. doing to the client) and this is not consistent with recovery oriented practice. ROSP is more inclusive of "person centered" and "self-directed" care approaches (i.e. doing with and supporting client self-care respectively). A brief article that speaks to these very important practical differences, written by Helen Glover who is both an Australian psychologist and identified consumer, is provided as Attachment 6. The key goals of preventing/reducing disability and increasing social inclusion for people living with severe mental illness involve a broad range of health and community service providers and require a client self-directed care coordination approach.

Self-directed coordinated care approaches are supported by the Royal Australian and New Zealand College of Psychiatrists who have recently developed an online learning resource for working with people with chronic/severe mental illness (http://clearinghouse.adma.org.au).
It is made up of six modules and aims to strengthen the capacity of psychiatrists to work in collaborative practice.

Establishing Partnerships

Many CMOs, including the State/Territory peak bodies, already have existing collaborative practice and care coordination relationships with a range of health and community service providers including GP Divisions. These experiences are a strength of the sector and have informed submissions in response to NHHR including the *"Medicare Locals Discussion Paper on Governance and Functions"* (MHCC's submission is provided as Attachment 1). MHCC's feedback in response to that Discussion Paper speaks to three key issues from the perspective of the community managed mental health sector:

1. Absence of details regarding inclusion of primary community mental health services;
2. The role of CMOs in ensuring consumer, carer and community engagement; and,
3. Specific recommendations for ensuring consumer, carer and community participation in the governance and functions of Medicare Locals.

Consumer, carer and CMO representation on GP Division/Medicare Local governance, advisory and/or operational bodies is critical to achieving effective service delivery partnerships.

We are also providing you with a copy of MHCC's recent publication "*The NSW Community Managed Mental Health Sector Mapping Report 2010"* (2010) which benchmarks existing CMO MHSs per 100,000 of population within each NSW Health Area Health Service (AHS, Attachment 7). The project methodology was indicative only and identified 247 CMOs delivering 347 mental health programs in NSW. The seven core CMO MHS types identified by the project are listed below with many CMOs providing more than one service type:

- Accommodation support and outreach;
- Employment and education;
- Leisure and recreation;
- Family and carer support;
- Self-help and peer support;
- Helpline and counselling services; and,
- Promotion, information and advocacy.

The partnership arrangements required to deliver these MHSs were also explored with more specialist CMO MHSs having a greater number of formal partnerships. While this information will be of value to both the Commonwealth and GP Division/Medicare Locals in establishing FCPs

there are project recommendations that additional work be undertaken to develop a comprehensive directory of mental health CMO services and programs and to further population benchmark CMO service types. This work could be achieved against the newly established Local Hospital Network (LHN) or soon to be established Medicare Local population catchments. This work is necessary toward achieving MHCC's proposed *"Care Coordination Strategy"* given the increasingly complex mix of public, private and CMO mental health service providers.

State and Territory CMO peaks have the capacity to work with LHNs and GP Divisions/Medicare Locals to help establish and further develop partnerships with CMOs. MHCC recently conducted a desktop audit of the 33 NSW GP Divisions to ascertain existing mental health programs that they delivered and partnerships with which they were engaged. Generally speaking, CMO programs and partnerships were more developed in regional and rural than metropolitan areas. More information on the results of this audit – especially as this relates to facilitating access to MHSs – is provided later.

There are CMO peaks in all eight States and Territories and we represent about 800 CMOs providing a complex and diverse mix of mental health rehabilitation and support services across Australia (see Attachment 3). Both DOHA and the GP Divisions/Medicare Locals are strongly encouraged to work with the State and Territory mental health CMO peaks and the CMHA alliance in planning implementation of the FCP initiative and toward becoming aware of the variety of existing mental health interagency networks in various geographic areas, their terms of reference, and frequency of meetings.

The mental health peaks play a valuable role in knowing which CMOs provide what mental health programs in their States and Territories as well as understanding where knowledge and service gaps exist. They also have knowledge of and often convene interagency meetings to promote care coordination and sector development. For example, in NSW MHCC has been convening local community level *"Meet Your Neighbour"* events to promote sector knowledge and partnerships for the past two years and GP Divisions can attend or even host these meetings. In 2011, we will be convening a series of regional interagency meetings most likely to occur at the GP Division/Medicare Local geographic level. More standardized and structured approaches to interagency meetings that include effective CMO representation and participation by GP Divisions/Medicare Locals and FCP staff/stakeholders can be implemented via the State and Territory CMO peaks.

Types of Services to be Provided

What type of clinical and non-clinical services may be needed for individuals receiving FCPs?
Where could these services be purchased from?
What arrangements need to be put in place to facilitate access to clinical and non-clinical services?
What would be the case coordination activities?

Clinical & Non-Clinical Services

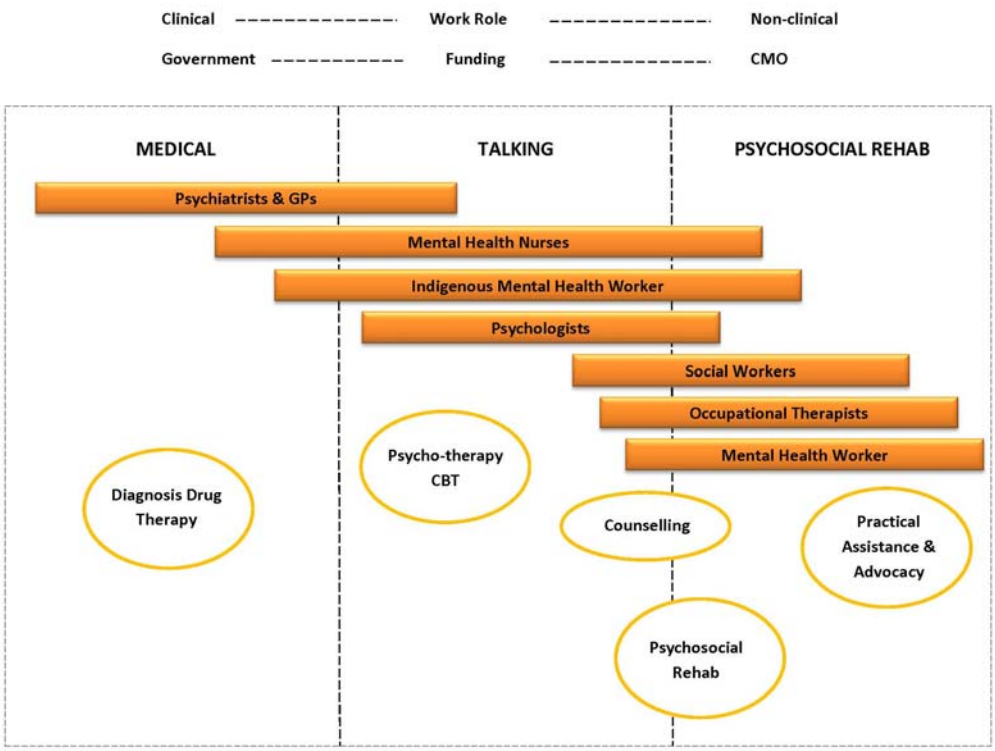
A proposed typology of non-clinical CMO mental health rehabilitation and support services was presented above (i.e. categorisation arising from MHCC's *Sector Mapping Project*). However, there is currently no nationally agreed non-clinical community MHS typology or even an model for community MHS provision (see Attachment 2 - The WHO Optimal Mix of MHSs Pyramid). The question of what is a clinical and non-clinical MHS is a vexed one that has been the subject of much discussion between State/public and community managed mental health services. The most recent and comprehensive discussion of the artificial government/non-government, higher education/vocational education and training (VET) silos that have resulted in this most unhelpful discourse is the Community Services and Health Industry Skills Council/CS&HISC *"Mental Health Articulation Project Synthesis Report – Main Findings and Recommendations"* and, in particular,

the *"Mental Health Services and Workforce Study"* research component of the project (2009, Attachment 8).

The CS&HISC research identified three broad areas of skill in the delivery of MHSs in the community:

- Medical – the diagnosis and treatment of mental illness through medication.
- Talking therapy – the utilisation of particular techniques including cognitive behavioural therapy (CBT) and counselling.
- Psychosocial rehabilitation (PSR) – assisting mental health consumers to make cognitive and functional gains towards their recovery. Activities connect consumers with services and the community with the aim of independent living and social integration. Tasks are diverse and might include assisting consumers in establishing a daily hygiene and nutrition routine; helping them to negotiate the welfare and housing systems; helping them to sustain accommodation and overcome fears associated with everyday tasks such as shopping; encouraging participation in social activities and possibly in training or work; and ensuring medical appointments are kept (even accompanying consumers if requested).

Figure 1: Practice and Occupational Boundaries in the Community Mental Health Sector



They note that these three broad areas of service delivery/practice are mostly undertaken by a variety of workers employed (or contracted) by public and CMO MHSs. Figure 1 illustrates how these tasks are broadly distributed between relevant mental health occupations. The "Mental Health Worker" category is primarily CMO staff who may be allied health professionals, VET qualified (e.g. Certificate IV in Mental Health, Diploma in Community Services – Mental Health and/or Drug & Alcohol) or, infrequently, unqualified. Vocationally qualified and unqualified Mental Health Workers may also be employed in public mental health settings. MHCC acknowledge that these three areas of community mental health practice are also increasingly provided by private practitioners and primary healthcare organisations although these groups were not a focus in the CS&HISC research.

The CS&HISC report speaks to the significant shortage in PSR knowledge and skills and an under-analysis/under-valuing of PSR work that is contributing to the government's failure to achieve quality and coordinated community MHS for people with severe mental illness. More meaningful engagement and planning with mental health CMOs in implementation of the FCPs provides an opportunity to redress this.

A similar project is to be undertaken by DOHA in 2011 via the National Mental Health Workforce Advisory Committee (MHWAC) to identify the vocational competencies of clinical, community and peer (i.e. consumer and carer) workers in public, private and CMO settings. This is accountability under the *"Fourth National Mental Health Plan"* (2009).

Where Can Services Be Purchased From?

The key issue appears to be where will the funding to purchase non-clinical services sit? The $60M for non-clinical services should not be given to GP Divisions/Medicare Locals to purchase services as they are not sufficiently knowledgeable of the community managed mental health sector or its services. There are also concerns about the skills and capacity of GP Divisions/Medicare Locals to perform CMO tendering or effectively administer Funding and Performance Agreement contracts in what is already an overly complex sector development and capacity building environment for the rapidly expanding mental health CMO sector. Conversely, related issues could also arise in non-metropolitan areas where the CMO sector is under-developed.

Funding and performance arrangements for CMOs are complex and the introduction of the FCPs has the capacity to further increase this complexity. For example, MHCC's *Sector Mapping Project* identified 26 different funding sources for NSW CMOs. These were mostly a variety of State (44%) followed by Commonwealth (22%) funding sources. Furthermore, the *"NSW Health NGO Grant Program Review Recommendations Report"* (2010) advises a reduction in government red tape for funding and performance arrangements including the centralisation of all NSW Health funded CMO programs. The 2010 review of the ATAPS program found similar concerns with GP Division administration costs planned for 15 % but expended at 25%. At the Commonwealth level, the streamlining of tendering and contracting processes for CMOs is to be progressed as part of the government's Social Inclusion Agenda by the recently established Not-for-Profit Sector Reform Council.

In recent years, MHCC has moved beyond its traditional brief as a peak body (i.e. advocacy and representation) to become increasingly involved in activities supporting sector development and capacity building. This has included us undertaking roles in sub-contracting funds on behalf of NSW Health (e.g. Capacity Building Grants, Mental Health Drug and Alcohol Research Grants). CMO peaks play a strong role in contributing to quality improvement and workforce development but as a key stakeholder have a conflict of interest in distributing program funds.

In relation to the purchase of CMO services and given issues related to funder/provider conflict of interest and competing stakeholder interests, there is a case to be made for purchase of CMO non-clinical rehabilitation and support services to sit with an independent mental health authority but this would currently only be possible in Western Australia through their newly established Mental Health Commission. In the absence of an independent authority in each state or at the national level we would recommend that purchase of non-clinical mental health services sit with a commonwealth agency such as DOHA or Dept. Families, Housing, Community Services and Indigenous Affairs (FAHSIA) in line with other "*COAG National Action Plan on Mental Health 2006 -2011"* (2006) funding to CMOs.

Facilitating Access to Services

Access to services will largely depend on the FCP care coordination guidelines and mechanisms that are established and which were previously discussed. MHCC suggests that access to non-

clinical rehabilitation and support services should be via direct referral from the GP Division/Medicare Local FCP ATAPS provider to the mental health CMO providing the desired services (assuming knowledge of available services). Alternatively, access could occur via a centralised referral/intake meeting to an appropriate CMO. It is anticipated that more consumers will be referred for access to FCPs than there are packages available. The care coordination guidelines should also address priority of access criteria (i.e. who gets in first and why) and provide guidance on wait list management.

Should interagency referral/intake and review/exit meetings be established then these should be governed with clear Terms of Reference, an over-arching Memorandum of Understanding and include adequate consumer and carer representation. These structures will help to ensure quality improvement including a strengthening of care coordination and service delivery partnerships over time.

As previously mentioned, MHCC recently completed a desktop audit of the 33 NSW GP Divisions which highlighted poor knowledge of and networks with community managed MHSs. Phone calls were made and conversational interviews conducted with Division staff working with mental health programs and internet sites were also reviewed. Generally speaking, GP Divisions tend to give more attention to working with and building relationships with public health services, public community mental health services and private allied mental health professionals but seem uncertain about working with CMOs and/or are unclear about their services or value. Many GP Divisions expressed difficulty in strengthening channels of communication and alliances between GPs and AHS/LHNs and see this as a priority.

Regional GP Divisions covering isolated areas are much more likely to know about all MHSs available in their area due to a shortage of services on the ground and the need to access whatever is available in difficult to reach communities. They are more likely to adopt a stronger community based approach to mental health care and to be more aware of the gaps and what is actually needed. They tend to utilise more diverse approaches to service delivery including accessing ATAPS funding. Strategies are more often applied to meet broad and complex mental health needs by combining and linking programs and referrals from one program to another. These are approaches that metropolitan GP Divisions/Medicare Locals should be encouraged to adopt.

Regional GP Divisions that cover rural and/or remote areas often have established a partnership or agreement with CMOs around clinical support, direct access and referrals to health professionals. This is particularly important in areas where the AHS/LHN is under-resourced. They are also more often participating in local interagency meetings and networking with available services.

By contrast metropolitan GP Divisions are more hesitant to work with CMOs, though some have a good awareness of community based services through participation in local network meetings, and are engaging with CMOs through their program work and include them in their own program reference groups. Those GP Divisions that attend network or interagency meetings with an inclusive range of members are better informed and feel connected to a wide range of mental health services in the area including CMOs. However, some GP Divisions are not aware of local interagency meetings they could attend and there is often insufficient CMO representation.

A key issue that arose and was highlighted in nearly every interview conducted was the need for an accessible directory of mental health services and programs. While a few GP Divisions manage to create their own directories they often fall short of covering what is available in terms of CMOs and current programs in the area. This is not surprising given the breadth, complexity and rapid expansion of the mental health CMO sector. Part of the reluctance of metropolitan GP Divisions to work with and promote CMOs to GPs is at least part due to a lack of access to a mental health service directory.

Case/Care Coordination Activities

The lack of coordination between various public, private and community managed MHSs was identified by the Mental Health Minister, Mark Butler, as a key theme arising from the 15 national consultations he conducted in late 2010. The MHCA report on the national consultations goes on to recommend better integrated approaches that must also include employment and housing services (i.e. coordinated care).

The critical differences in approaches to care planning (i.e. case management, person cantered and self-directed) and the impact of these on care coordination activities was previously discussed. In summary, care coordination mechanisms/guidelines would include activities such as: referral/service entry; assessment (both initial and comprehensive); goal setting (both the clients personal goals and the service delivery goals); goal/care review; and service exit. While some activities occur one-to-one with the client, others involve the client and their family and carers meeting as a group with a variety of health and community service providers.

Treatment, rehabilitation and support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. All service providers should use a person-centered planning process to help promote consumer ownership of the Mental Health Care Plan (i.e. towards achieving self-directed care). Such methods actively engage and empower the consumer, and their family and carers, in leading and directing the design of the Mental Health Care Plan and, thereby, ensure that the plan reflects the needs and preferences of the consumer in achieving the specific, individualized goals that have measurable results and are specified in the plan.

Perhaps one of the best examples of well coordinated care involving a variety of clinical and non-clinical service providers known to MHCC is the NSW Housing and Accommodation Support Initiative (HASI). The guidelines for this program are provided as Attachment 9 and they provide templates and direction for formal service level agreements to achieve care coordination at the client, service delivery and organisational levels. It is these that have helped to ensure the success of HASI care coordination arrangements. This includes an agreement on role delineations for the various service providers although this work needs further development. Another set of well-developed care coordination guidelines including formal agreement templates were developed for the now defunct NSW Joint Guarantee of Service for People with Mental Health Problems and Disorders (JGOS) initiative.

Quality Assurance

What quality issues need to be addressed?
Who should be responsible for implementing any quality framework that may be developed?
How can we best support interface to allow Divisions to work effectively with State based services?
What constitutes a best practice model?
What information would best support service provision?

Quality Issues

Compliance with the *"National Standards for Mental Health Services"* (2010) is essential and accreditation with the Australian Council on Healthcare Standards using the mental health Standards should be pursued by FCP programs. The approach to FCP implementation that has been discussed throughout this submission is consistent with the best practice requirements of the national mental health Standards – especially the new *"Supporting Recovery"* standard and overarching *"Principles of Recovery Oriented Mental Health Practice".*

Responsibility for Quality Framework

Responsibility for implementing other quality frameworks that may be developed is the responsibility of the organisation delivering the service (i.e. GP Division/Medicare Local for clinical services and CMO for non-clinical services). Quality requirements should be built into contracts and related Funding and Performance Agreements with CMOs.

Support to GP Divisions

Support to GP Divisions to work with State and Territory based services – both public and CMO – should be provided by DOHA. Jurisdictional Health Departments (e.g. NSW Mental Health Drug and Alcohol Office), GP Division peaks (e.g. GP NSW) and the State and Territory CMO peaks can also provide support. Ideally, this support would be delivered via an independent and accountable State/Territory based office of mental health such as the Mental Health Commission in Western Australia. This would allow competing stakeholder interests to be more effectively managed against individual and population needs.

Best Practice Model

A best practice FCP model needs to provide the following features as discussed throughout this submission:

- A recovery oriented, consumer self-directed care focus;
- Treatment, rehabilitation and support service provision;
- Medical, talking and psychosocial therapies; and,
- Integrated and coordinated care.

A full discussion of what constitutes evidence based practice (EBP) in community mental health work and clinical/non-clinical roles is outside the scope of this submission. However, we so far know these EBPs generally work and work better in combination (this list is from the US Substance Abuse and Mental Health Services Administration/SAMHSA website and has been adapted from numerous other references):

- Medication (with true informed consent can be helpful to regain control thus allowing the basic needs of social inclusion to be addressed – relationships, accommodation, work, income, education);
- Skills training (in illness management and recovery);
- Integrated mental health & drug and alcohol services;
- Supported (open) employment;
- Family (psycho) education; and,
- Assertive Community Treatment.

There is also rapidly emerging evidence for:

- Supported (open) accommodation;
- Supported (open) education;
- Peer support and advocacy; and,
- Promotion and prevention.

It is notable that with the exception of some specific medication related activities (i.e. prescribing activities as opposed to education and support) these are all psychosocial not medical therapies. This evidence base is consistent with the WHO recommendations for the optimal mix of mental health services which encourages reliance on informal MHSs (Attachment 2). SAMHSA is developing EBP Toolkits for each of the above service types to assist with their routine implementation in MHS delivery with several already available at their internet site.

Talking therapies that have a strong and complex evidence base in mental health work include but are not limited to:

- Cognitive Behavioural Therapy;
- Motivational Interviewing;
- Dialectical Behaviour Therapy; and,
- Trauma informed care and practice.

Information to Support Service Provision

As previously noted, a directory of public, private and CMO MHS information for each GP Division/Medicare Local catchment area will be essential as will mechanisms for keeping this information current. In addition, consideration will need to be given to minimum data set collections for service delivery, workforce and consumer outcomes for both clinical and non-clinical services and outcomes. The MHCC has recently completed a *Data Management Strategy (Phase 1)* that explores current systems related to data collection and proposes a minimum data set for mental health CMO data collection (Attachment 10). This data set is currently under consideration for adoption by both the Australian Institute of Health and Welfare (Mental Health Branch) and DOHA's Mental Health Information Subcommittee.

Service provision would also benefit from additional information about best practice in PSR and care coordination as discussed throughout this submission. The FCP Discussion Paper seems to be more knowledgeable about medical interventions and talking therapies than CMO sector delivered non-clinical PSR and support services.

Skills of Allied Health Providers

What aspects of credentialing should be considered when engaging allied health providers to deliver Flexible Care Packages?
What information do GP Divisions need to facilitate credentialing and define the scope of practice for ATAPS service providers?
What support mechanisms are needed for GP Divisions?

Credentialing

FCP ATAPS allied health providers will need skills in talking therapies, PSR and care coordination. However, to ensure quality and effectiveness of the FCP initiative this question should be inclusive of the credentialing required for non-clinical rehabilitation and support providers also. The CMHA alliance and their 800 member organisations have agreed in principle to the Certificate IV in Mental Health or equivalent as a minimum standard for work in the sector. The reality is that most workers in the CMO sector are qualified at and above this level with, for example, a training needs analysis conducted by MHCC in NSW showing that 70% of direct care workers had tertiary qualifications. This workforce pattern has been repeated in other states/Territories and similar findings are expected for the National Mental Health NGO Workforce Scoping Study recently completed by Health Workforce Australia.

A commitment to providing professional development opportunities to ensure compliance with the *"National Practice Standards for the Mental Health Workforce"* (2002) within two years of recruitment would help to ensure minimum practice standards and quality in service delivery. The Practice Standards currently only apply to the five key mental health professions working in public MHSs (i.e. psychiatry, nursing, psychology, social work, occupational therapy). The Practice Standards will soon be revised against the new *"National Standards for Mental Health Services"* (2010) – particularly the new *"Supporting Recovery"* standard and overarching *"Principles of Recovery Oriented Mental Health Practice"* - and be extended to other MHS settings and work roles. The CS&HISC Articulation Project research previously discussed demonstrates that the competence and role delineations between clinical and non-clinical workforces are not well understood and review of the Practice Standards may help with that discourse. Additionally, there is accountability in the *"Fourth National Mental Health Plan"* (2009) to develop competence

standards for clinical, community and peer (i.e. consumer and carer) workers that may progress a shared understanding of clinical and non-clinical role delineation.

The Articulation Project research findings also provide a strong case for the introduction of higher level community mental health qualifications and progressing this is on the CS&HISC continuos improvement plan for 2012. A Vocational Graduate Certificate or Diploma qualification and/or national competency standards in community mental health practice would provide those with VET qualifications professional development opportunities. The new Vocational Graduate qualification could also be available to degree-qualified allied health workers, many of whom are currently not optimally equipped to work with mental health consumers in a community setting – this is especially the case for new graduates. While new standards for mental health content in undergraduate degrees may ameliorate this situation for new graduates it is likely to take some time to change university curricula and VET could provide a more expedient pathway to increasing PSR skills and credentialing inclusive of care coordination skills.

Information toward Credentialing

Australian credentialing for the provision of PSR MHSs, including care coordination, which will be required does not currently exist. This will require GP Divisions/Medicare Locals to have a greater knowledge of mental health CMOs and VET and increased engagement with allied health professional bodies, State and Territory CMO peak bodies, DOHA's Mental Health Workforce Advisory Committee (MHWAC) and the new statutory authority, Health Workforce Australia. In 2011, MHWAC developed a draft *"National Mental Health Workforce Strategy/Plan"* which is inclusive of the public, private and CMO settings as well as university and VET qualified and unqualified mental health workers and this is awaiting endorsement before being publicly released and implemented.

One example of PSR credentialing is the United States Psychiatric Rehabilitation Association (USPRA) who issues the Certification of Psychiatric Rehabilitation Practitioner (CPRP). Pathways to this credential are flexible to accommodate both clinical and non-clinical mental health workers with diverse qualifications and/or experience. USPRA, formerly known as the International Association of Psychosocial Rehabilitation Services (IAPSRS), is a professional association for practitioners of the field of psychiatric rehabilitation and people and families living with psychiatric disabilities. Founded in 1974 by the Directors of the original 13 psychosocial rehabilitation centers in the United States, USPRA promotes the uptake of evidence-based practice. USPRA's *"Core Principles and Values"* for achieving recovery oriented MHSs are provided as Attachment 11.

Support Mechanisms for GP Divisions

GP Divisions/Medicare Locals need support to become better informed about what public and CMO mental health PSR and support services are and where they are available in their local area. They also need to know what mental health networks and interagency meetings occur in their local area. They will also need access to clinical support for strengthening PSR and care coordination practice.

Clinical Support for the Workforce

What specific elements are needed to appropriately support allied health professionals in ATAPS delivering FCPs?
Would an expansion of the GP Psych Support Service provide this support?
If a different support mechanism is preferred, how could it be structured?

Support Mechanisms for ATAPS Allied Health Professionals

GP Division/Medicare Local allied health professionals providing ATAPS and care coordination services need knowledge of PSR and support services in their local area. They would also benefit

from access to professional development and line management supervision – both internally and externally - to develop knowledge and skills in PSR.

Expansion of GP Psych Support Service

Yes. The GP Psych Support Service may need to be expanded to provide specialist consultation in the area of PSR practice. This specialist advice will need to be made available to GPs as well as GP Division/Medicare Locals ATAPS allied health professionals. The PSR knowledge and skill base is not well developed in either public or private MHSs in Australia and mostly exists within the community managed mental health sector where it is regrettably under-valued as a specialist area of competence.

Alternate Support Mechanisms

Alternatively, the CMHA alliance and/or the State and Territory mental health CMO peaks could be resourced to provide a PSR information and consultancy service as well as pursuing activities to achieve credentialing/certification in PSR and other related community mental health workforce development activities.

The historical silos of government/non-government, health/community and clinical/non-clinical MHS delivery obscure an objective assessment of community mental health sector and workforce development needs. These old dualisms are a barrier to providing recovery oriented MHSs and supporting the recovery of the two in three Australians that need MHSs that are not currently accessing them. There is an urgent need for a systematic evaluation of the effectiveness of community mental health interventions, especially in PSR work, so that the required knowledge and skills can be identified and prioritised and an agreed community MHS delivery model that aligns with the recommendations of the WHO (Attachment 2 – Optimal Mix of Mental Health Services Pyramid) - and is inclusive of a strengthened and more clearly articulated role for both CMO MHS and primary healthcare providers - can be identified and developed.

Attachment 2 – World Health Organisation Optimal Mix of Mental Health Services Pyramid

The WHO (2008 & 2003) model for mental health service delivery is based on known best practice and promotes the involvement of individuals in their own mental health care, a community-based orientation, a human rights focus and embraces the following principles:

- No single service setting can meet all population health needs;
- Essential components of any mental health system include: support, supervision; collaboration; information-sharing and education across different levels of support; and,
- Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

WHO note that mental health services should exist in primary health care, community-based and institutional settings. For community based settings there should be both "formal" (i.e. treatment) and "informal" (i.e. support) mental health services. The Optimal Mix of Services Pyramid developed by WHO 2007 indicates that:

- Psychiatric hospitals should be the least frequently used service type in the mental health system;
- Psychiatric services based in general hospitals and specialist community mental health services should be available;
- Primary healthcare is an essential component supporting mental health; and,
- Informal community mental health services provide broad based, general support.

Figure 1 shows an extraction of the community mental health services components of the Optimal Mix of Services Pyramid which was elaborated upon by WHO and the World Organization of Family Doctors in 2008. The model indicates that "informal" mental health services (comprising of "informal community care" and "self-care") should be the most frequently used mental health support followed by mental health services through primary care and then "formal" community mental health services. Informal mental health services are delivered by CMOs.

Figure 1: Community Mental Health Component Adapted from the WHO Optimal Mix of Services Pyramid (2007 & 2008)

The WHO model provides a good vision for a best practice system for service delivery but it does not give guidance as to how countries might best re-orient service delivery in-line with the model or the nature of the services (i.e. medical, psychological and social interventions) to be provided. To re-orient services in Australia it is critical to strengthen the research and development base of the mental health sector and this must also involve improved service delivery, workforce and consumer/population outcome data collections as well as a more clearly articulated model/s of community mental health services

The development of the community managed mental health sector in Australia has been defined by both organic and government funded strategic growth at different points in its history. Despite strong evidence for the effectiveness of recovery oriented approaches and the clear role the community sector has in promoting and applying the recovery principles and supporting social inclusion for mental health consumers and carers, the dilemma for the sector in the large majority of the eight Australian States and Territories lies in its struggle to fully take its place as an integral and contributing part of the mental health system in its own right.

References

World Health Organisation & World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (2008) Integrating mental health into primary care: a global perspective. Geneva. Switzerland.

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World Health Organisation (2003) Organisation of services for mental health. (Mental Health Policy and Service Guidance Package). Geneva.

Attachment 3 – Community Mental Health Australia Alliance Members

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