

22 November 2010

Assistant Secretary
Policy Development Branch
Primary and Ambulatory Care Division
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**Re: MHCC Response to Medicare Locals
Discussion Paper on Governance and Functions**

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. We thank you for the opportunity to provide comment on the Medicare Locals Discussion Paper on Governance and Functions and greatly appreciate the extension of time provided for our response.

The Australian government's agenda for National Hospitals and Healthcare Reform (NHHR) and to establish a National Health and Hospital Network (NHHN) is ambitious in scope and the establishment of "Medicare Locals" (i.e., primary healthcare organisations/ PHCOs) are an important aspect of the changes proposed. MHCC notes discomfort with the term Medicare Locals. We find this language confusing and don't think it will contribute to engagement of key stakeholders that are not healthcare practitioners (i.e., consumers, carers and communities) or in ensuring that consideration of the preventative and social determinants of health become part of the culture and practice of Medicare Locals (i.e., non Medicare Benefits Schedule/ MBS reimbursement related health and community development activity). We currently prefer the title of PHCOs and would also like to see further consultation regarding other possible alternatives for the generic name for these strategically important organisations.

Medicare Locals are intended to be a main driver of NHHR in responding to local population needs and therefore the accountable involvement of consumers, carers and communities – and not just healthcare professionals – in the management and governance of all levels of service planning, delivery and evaluation is critical. The Discussion Paper emphasizes the importance of ensuring community engagement in Medicare Locals and MHCC agrees with this important direction. However, the philosophical principle of achieving community engagement will in practice likely be corrupted unless clear guidelines for doing so become part of the new Medicare Locals' constitution/s, policies/ procedures and performance/ funding agreements.

The social determinants of health have been well documented (e.g., income, housing, employment) and primary healthcare services, including Medicare Locals, will need broad and strategic partnerships with a range of human



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*MHCC is the peak
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organisations in NSW
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service providers toward preventative population health planning to achieve both NHHR and the government's social inclusion agenda. The health and social inequities experienced by millions of Australian's affected by mental illness, despite having a targeted National Mental Health Strategy for about 20 years, speak to the challenges of achieving this with access to much needed mental health treatment and support services remaining at levels that are increasingly difficult to justify. While close relationships between Medicare Locals and Local Hospital Networks/LHNs are critical there will likely be a continuing emphasis on acute and hospital based service delivery - as has regrettably been the case with mental health sector reform - without strategic inclusion of other human service agencies in governance and function including strong representation from the community sector.

MHCC's feedback in response to the 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.

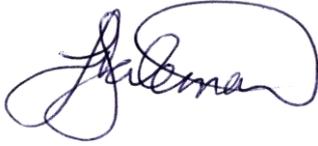
More detail of each of these three issues is provided as an Attachment. We are also providing you with a copy of MHCC's recent publication "*The NSW Community Managed Mental Health Sector Mapping Report 2010*" which benchmarks existing CMO mental health services per 100,000 of population within each Area Health Service. While this information will be of value to both NSW Health and GP Divisions there is a project recommendation that additional work be undertaken to population benchmark the seven core CMO mental health service types identified by the project:

- 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.

We hope you will find this a useful resource in providing a picture of the mental health CMO sector as well as current activity and future directions for both sector development and population health research in this much needed area.

In addition to the above, and by way of much broader and non sector specific feedback, MHCC notes the recent establishment of Health Workforce Australia and that on 17 November legislation was passed to establish a Commonwealth Health Prevention Agency. We mention these important statutory authorities in that the governance and functions of the Medicare Locals must incorporate mechanisms that have strategic linkages to both health workforce development (i.e., where will sufficient staff -including vocationally trained service providers from the CMO sector - with the right skills to deliver services come from ?) and preventative population health planning for true change in primary healthcare to be achieved. Functional linkages between Medicare Locals/PHCOs and population health planning authorities will also need to occur at the state and territory levels.

Once again, thank you for the opportunity to comment on the Medicare Locals Discussion Paper on Governance and Functions. For any further information concerning this submission please contact either myself or Tina Smith, Senior Policy Officer at tina@mhcc.org.au or telephone (02) 9555 8388 EXT 111.

A handwritten signature in blue ink, appearing to read 'Jenna Bateman', with a large, stylized flourish at the end.

Yours sincerely,

Jenna Bateman
Chief Executive Officer

MHCC Response to Medicare Locals Discussion Paper on Governance and Functions

Absence of details regarding inclusion of primary community mental health services

With regard to function, clarification is needed regarding what constitutes a primary community mental health service and the role of Medicare Locals with regard to these services.

The Discussion Paper asks the following questions:

- What will Medicare Locals do?
- What will Medicare Locals look like?
- How will Medicare Locals interact with patients and providers?

However, the Discussion Paper makes four references regarding the role of Medicare Locals in relation to mental health which makes responding to the above questions from the perspective of the non-government community managed sector difficult:

- P4 “... supporting better coordination of mental health services into the future.”
- P5 “... improving access to mental health primary care services ...” (Note that this is part of the narrative for Objective 4 - Facilitation of the implementation and successful performance of primary health care initiatives and programs).
- P6 “...expansion of the Access to Allied Psychological Services program.”
- P8 “... to ensure continuity in the services currently being provided by (GP) Divisions, such as allied health and psychological services ...”.

While we acknowledge that the broader content may apply to mental health there is a lack of clarity in NHHR regarding this. As is the case in the health sector generally, the mental health sector in Australia consists of a complex and increasingly fragmented mix of public/government, private for-profit & not-for-profit non-government CMO service providers with multiple layers of Commonwealth and state/territory government policy, planning and funding levers. In particular, we note the enhanced role of the Commonwealth in the funding of community mental health services resulting from the COAG National Action Plan for Mental Health 2006-2011 with 45% of the projected \$1.9B expenditure being delivered by CMOs (ie, more than \$800M over 5 years). This role had previously been the domain of state/territory health jurisdictions. The new role of the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) in providing community mental health services is especially noteworthy (ie, the Personal Helpers and Mentors Program/PHAMs, Community Based Programs/carer support services and Mental Health Carer Respite. The transfer of these services to Medicare Locals is not supported by the CMO sector as the focus on community mental health programs under Commonwealth agencies is producing a much needed incorporation of mental health perspectives and mental health literacy across the broad spectrum of human services.

Reform of mental health services in Australia will continue to be stalled in the absence of forward thinking regarding the positioning of community mental health services in the context of NHHR. Continuing development of community based primary and secondary mental health services is essential for ensuring access to services for the two in three Australians who need mental health services and do not receive them (a rate of access that has remained unchanged since first benchmarked 10 years ago). These services must not continue to be acute care focused and hospital based and need to be inclusive of the social determinants of health and wellbeing (eg, income, employment, housing).

The introduction of the MBS Mental Health items has also changed the landscape of mental health in primary care in Australia. The capacity to access psychological services via GP referral is a significant development. The introduction of the Mental Health Nurse Incentive Program is also a relatively new development in primary and secondary mental health care. The referral rate for

mental-health problems managed by GPs is 10.9 per 100 mental health problems in 2006/07. The most common referrals were to psychologists (3.6 per 100) and to psychiatrists (1.9). This pattern of referrals has reversed since the data from 2003/04, probably reflecting introduction of the items¹. The most common way in which GPs manage mental health problems is through a medication being prescribed, supplied or recommended: two thirds were handled in this way (66.7 per 100 mental health problems managed). The second most common form of management was provision of a procedure, other treatment or counselling (42.8 per 100), with psychological counselling by far the most common². We note review of the MBS Mental Health Items that is underway with a report expected late 2010 and express concern about the lack of access to these programs by allied health professionals employed within not-for-profit non-government organisations. Many of these CMO workers also have expertise in psychosocial rehabilitation interventions, an area of skill that is not especially recognised or valued in current mental health service delivery models in Australia despite the strong evidence based for their effectiveness.

On 20 April 2010, COAG agreed to transfer full policy and funding responsibility of primary health care services currently funded by states and territories to the Commonwealth. This will include responsibility for mental health care services delivered in a primary care setting. This has been interpreted by some as meaning services that target the more common disorders (eg, anxiety and depression of mild to moderate severity), however, what constitutes a primary mental health service needs clarification - especially in the context of people that may have varying degrees of disability resulting from a psychotic disorder or have complex/diverse co-existing health and social problems as is typically the case, for example, with mental health CMO clients. Concerns around further defining the primary community mental health client population and partnerships with existing community managed mental health services will soon arise in planning the \$58.5M over four years introduction of coordinated flexible care packages to better support people with severe mental illness in primary care. This program/function is intended to be delivered through Access to Allied Psychological Services arrangements and managed by Medicare Locals. Similar issues will also arise in planning establishment of sub-acute services which are intended to be community-based residential mental health beds to ease transitions from hospital to the community and reduce the need for hospitalisation. The establishment of these programs highlights the need for strong referral and care coordination pathways and this will need to involve CMOs other than headspace for achieving inclusion of adults with mental illness.

All governments (through COAG), with the exception of Western Australia, have agreed to undertake further work on the scope for additional mental health services reform for report back to COAG in 2011 (the "COAG comeback on mental health"). This work will involve looking at roles and responsibilities, and the mental health system from the ground up, to identify what works and what doesn't. The role and contributions of the community managed mental health sector including the psychosocial rehabilitation and support services that they provide must be considered in this process.

It is challenging to provide feedback on the discussion Paper without consideration of the larger context of uncertainty as to where mental health is situated in NHHR as described above. Given that, it must be said that the lack of either detail or transparency with regard to the specific plans for or impact upon mental health services – especially for non-government community based mental health services and in their interface with primary healthcare services – is of considerable concern and makes providing feedback quite difficult. Of particular note, NHHR decisions need to be made beyond consideration of public and private primary mental health services and include decisions about whether funding and policy responsibility for non-government community managed (ie, NGO/CMO) mental health services are to be transferred to the Commonwealth government.

¹ AIHW (2008) *Mental Health Services in Australia 2005-06*. Mental health series no. 10. Cat no. HSE 56 Canberra, AIHW.

² AIHW (2008) *Mental Health Services in Australia 2005-06*. Mental health series no. 10. Cat no. HSE 56 Canberra, AIHW

This will require discussion about whether CMO mental health services are primary or secondary healthcare services (or even healthcare services at all).

The role of CMOs in ensuring consumer, carer and community engagement

With regard to governance, MHCC supports the establishment of Medicare Locals as non-government community managed organisations (CMOs). Traditionally, and still today, community organisations form in response to unmet need in communities. Otherwise stated, the strengths of CMOs are to be found in their connections to their members and other stakeholders and in their capacity to identify and respond flexibly to individual and community need. A risk in establishing Medicare Locals as new CMOs is that, in many if not most cases, they will be establishing new relationships with non-health practitioner members and stakeholders. Without strategies to address this risk it is again likely that the culture and services of the new organisations will remain acute health care service and hospital focused. It is also likely that the focus will continue to be mostly on physical healthcare only and not as inclusive of behavioural health (eg, mental health and substance use issues) as preventative primary healthcare organisations ought be. This risk can be reduced through ensuring connections to existing services and networks that have for many years successfully engaged with consumers, carers and communities. Existing services, networks and service delivery/population planning models within the community managed mental health sector are described below to illustrate.

The CMO mental health sector in most states and territories of Australia has a relatively low public profile and is not well understood despite having a documented history dating back more than 100 years (ie, pre-dating the advent of psychiatric medication, deinstitutionalisation and the more recent establishment of public community mental health services in the mid-80s). The sector is believed to consist of more than 800 organisations nationally and is thought to be much larger and more complex than this figure would suggest with organisations varying in size, function, approach and target population. The sector has not been defined or mapped nationally and there are no comprehensive or consistent approaches to sector data collection or outcome measurement although this work does occur at the state/territory level to some degree and preliminary work at the national level has commenced (eg, the National Mental Health NGO Workforce Study which is being conducted by Health Workforce Australia).

Community managed mental health rehabilitation and support services help keep people well and out of hospital; they can also be important in reducing the intensity and duration of episodes of mental illness and psychiatric crisis thus freeing up specialist treatment services for people with acute care needs. CMOs need to be recognized by Australian governments as providing core, and not just complimentary, mental health services. This fact is well recognized by the World Health Organization (WHO, 2008) but not yet embedded in mental health sector policy or planning within most state/territories in Australia.

Each of the eight states/territories in Australia has a peak body representing the community managed mental health sector. These organisations established a formal alliance in 2007 called Community Mental Health Australia (CMHA) in recognition of their shared activities, challenges and potential to effect change. CMHA works with all levels of government, community groups and other interested stakeholders – including consumers, carers and communities - to promote better mental health throughout Australia.

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,

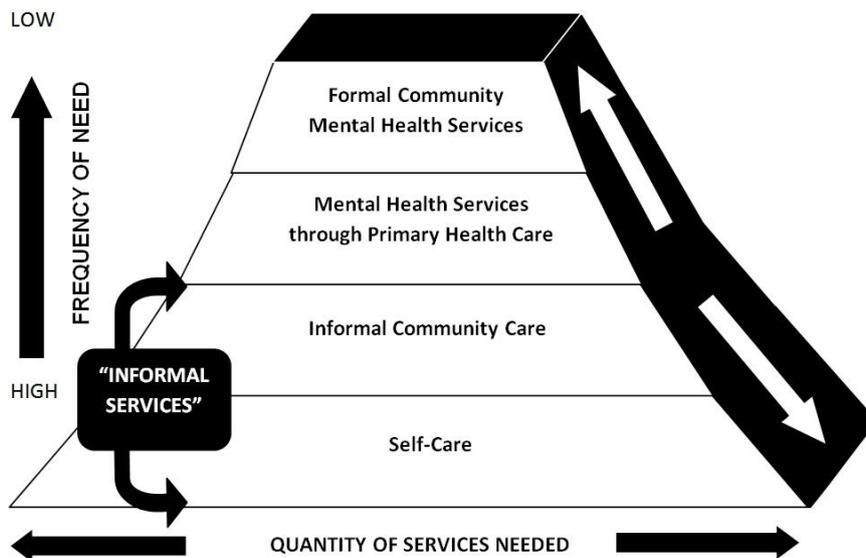
- Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

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” (ie, treatment) and “informal” (ie, support) mental 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 Managed Mental Health Component of WHO Optimal Mix of Services Pyramid (2007 & 2008)³



³ 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.

World Health Organisation (2007) The optimal mix of services for mental health. Mental Health Policy, Planning and Service Development Information Sheet (accessed July 2009). Geneva.

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

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 (ie, 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.

Specific recommendations for ensuring consumer, carer and community participation in the governance and functions of Medicare Locals

With regard to ensuring participation by non-health practitioner members and stakeholders in the governance and functions of Medicare Locals, it is MHCC's position that the three broad principles/objectives in establishing the NHHN can only be achieved through more transparent and accountable inclusion of consumers, carers and the community managed sector at all levels in the operations of Medicare Locals.

The discussion Paper anticipates that there will be crossover/complimentarity in the management and governance functions of LHNs and Medicare Locals. With regard to the establishment of LHNs - and in relation to ensuring consumer, carer and community participation - MHCC has advised NSW Health that all LHNs should have in place processes for meaningful and sustained consumer, carer and community participation in:

- Service governance;
- Service planning and development;
- Service evaluation, monitoring and quality improvement;
- Policy planning, review, development and implementation; and,
- Service delivery.

These processes must be made public and be accessible to consumers, carers and the community. The LHN Governing Councils should have at least 50% of consumer, carer and community representation. Furthermore, targets should be set for ensuring that over time at least 30% of this representation should be identified consumers. The Councils will have advisory groups from the various specialties within health that include, but are not limited to mental health, drug and alcohol, cancer, diabetes and maternity. These advisory groups will also have at least 50% non-health practitioner representation and work towards a benchmark of 30% consumer representation over time. With regard to the establishment of Medicare Locals, it is MHCC position that the formula underlined above should also apply to the governance and advisory structures associated with establishment of these organisations.

Australia is on the verge of major reform of its health care system. The Commonwealth is moving to take increased responsibility for hospital funding and for provision of comprehensive interdisciplinary primary health care services in the community with establishment of primary health care organisations tasked with supporting service coordination and responding to population based health planning indicators at the local level.

Despite the very substantial role community organisations play in prevention, rehabilitation, recovery and relapse prevention - across a range of State and Commonwealth funding streams - the role of the community managed sector in the health reforms has been treated as of marginal relevance only; reform of medical care to the community through hospitals and GPs being the main objective. In fact, with the possible exception of the Medicare Locals Discussion Paper, documents on the reform agenda to date fail to acknowledge the role community organisations play in supporting the health of the community in any of the health portfolio areas (Commonwealth of Australia, 2009 & 2010⁴). The exclusion of the community sector in this major health reform restructure illustrates the situating of community managed programs as complementary to core health services rather than as integral to the service system and achievement of broad health outcomes.

⁴ Commonwealth of Australia (2010) A national health and hospitals network for Australia's future – Delivering the reforms.

Commonwealth of Australia (2009) A healthier future for all Australians – Final report of the national health and hospital reform commission.