Submission in relation to ATAPS Flexible Care Packages Consultation

Introduction

The Australian College of Mental Health Nurses (ACMHN) is pleased that the Department of Health and Aging provided the opportunity for ACMHN representatives to attend consultation session in each capital city. The face to face consultation sessions followed by the submission responding to the discussion paper has been a successful method by which the College and mental health nurses can usefully contribute to the development of the program. This submission incorporates the views of other members who were not able to attend the consultation, including those from rural and remote areas.

The ACMHN believes it is important that people with severe mental illness have access to coordinated clinical and non clinical services within the community. We recognise that the Flexible Care Packages (FCPs) are an attempt to address some of the primary needs identified by the mental health sector – namely help to navigate multiple services, and access to community / social support services. The FCPs have great potential to meet these needs for people with severe mental illness, and the College is keen to work with the Department and Divisions of General Practice (and the soon to be formed Medicare Locals) to achieve this goal.

The ACMHN considers it critical that the FCPs are designed to enhance existing services, both clinical and non clinical. This will ensure that the limited funding available for FCPs has maximum reach, and will reduce concerns about cost shifting between state and federal governments and public and private health systems. Another fundamental design imperative is that FCPs must not contribute to the array of referral requirements and services to be navigated by the consumer, the primary mental health care workforce, or the non government mental health sector. Mental health nurses and other professionals working in primary care already struggle with the variety of funding models and referral requirements provided by public, private, State and Federal programs. Further additions or layers to this would only complicate or confuse the referrers. The ACMHN is keen to work collaboratively with the Government to ensure this program is complementary to existing programs that have expertise and a service delivery focus on chronic / complex mental health care.

A significant concern of the College and mental health nurses who attended the consultation sessions is the great potential for the FCPs to overlap with the Mental Health Nurse Incentive Program (MHNIP). The MHNIP enables general practices, Divisions and privately practicing psychiatrists to engage a mental health nurse to provide clinical nursing services and coordinate clinical services for people with severe mental illness.
While not specifically identified as a function performed by the mental health nurse as part of the program, it is clear that they also liaise with non clinical services on behalf of clients. In essence, clients receiving services under the MHNIP receive the same services being proposed under the FCPs.

The College strongly recommends that the potential overlap between FCPs and the MHNIP be addressed in the development of the FCPs. We are gravely concerned that if the interaction between the two programs is not addressed, there will be a direct impact on the utilization of both programs and unintended consequences for people seeking to access both programs, and the workforce delivering services under both programs. Our recommendations to address the potential overlap are detailed below. However, we would welcome the opportunity to collaborate with the Department and other stakeholders on other options that support the best outcomes for people with severe mental illness.

**Ensuring FCPs complement the MHNIP**

Mental health nurses providing services under the MHNIP currently deliver extensive individualised services to people with severe mental illness. Mental health nurses provide clinical care (for example focused psychological strategies, other evidence based interventions, medication management, mental state assessment and risk assessment), non clinical care (e.g. supporting clients to manage their day to day living, establishing peer support groups, coordination of services) and coordinate access to other services.

There is great potential for the FCPs and the MHNIP to work in a complementary way by allowing greater focus on the strengths of the MHNIP and targeting FCP to deliver the aspects of care that are not accommodated well by the MHNIP. In this context, the relevant strengths of the MHNIP are the funding model and the skills of the workforce.

The MHNIP funding model has flexibility to meet the needs of the target client group and deliver consumer centred care. It allows for unlimited sessions with the intensity of the sessions adapted to the needs of the client. The program also accommodates non face to face services (particularly important to follow up clients by phone when they fail to attend appointments), family / carer support and education and liaison with other clinicians / agencies as required. The fee for service model used for other Medicare services and ATAPS Tier 1 do not allow clinicians to undertake these much needed services.

The skill set and experience of the mental health nursing workforce is uniquely suited to provide clinical treatment and clinical care coordination to people with severe mental illness. Mental Health Nurses have specialized training aimed at providing a holistic approach to assessment, treatment and intervention for people suffering from mental health concerns. They have extensive experience in developing an appropriate plan that encompasses clinical, pharmacological and non-clinical strategies. The Mental Health Nurse Credentialing process ensures that Mental Health Nurses with appropriate qualifications, high standards of ongoing professional training and who have extensive
clinical experience can be identified. Over 80 percent of credentialed mental health nurses have more than 15 years experience working in mental health, with the majority of this experience within specialist mental health services.

The ACMHN advocates that the MHNIP be used as the principal mechanism to provide the clinical treatment and clinical care coordination to people with severe mental illness through the primary care system. It is logical that the MHNIP be the primary program accessed to provide the clinical care coordination and treatment required. The funding for FCPs could then be concentrated on the care coordination and access to non-clinical services for people with severe mental illness.

The ACMHN acknowledges that the MHNIP will need to grow to meet an increased need for services. However, there would need to be growth amongst the primary mental health care workforce irrespective of the model adopted for the FCPs. Current data suggests that the MHNIP is reaching a significant number of people and, with some additional support for Divisions and mental health nurses, could be scaled up further. The ACMHN estimates that around 35-40% of Divisions have engaged mental health nurses to deliver services under the MHNIP. In addition to this, there are many mental health nurses working with GPs, Psychiatrists, and Aboriginal Health Organisations providing services under the MHNIP. Since it commenced, 53,280 people have received services under the MHNIP (to August 2010). There number of people who had received services increased by 25,000 from August 2009 to August 2010. There are 850 mental health nurses who hold an ACMHN credential and are therefore eligible to deliver services under the MHNIP.

We believe further growth can be achieved by promoting the MHNIP and FCPs as complementary programs among the Divisions and supporting Divisions to establish the MHNIP. To address the workforce supply, professional support must be made available to mental health nurses working in primary mental health care. The level of professional support made available as part of the establishment and ongoing management of the MHNIP has been minimal, and is in stark contrast with the support available to professions under other primary mental health programs administered by the Department. The FCPs also provide greater funding flexibility to Divisions to attract mental health nurses to deliver services under both programs. This would help address one of the major barriers to the growth of the MHNIP.

The ACMHN recommends:

\[ a. \] The $60 million available over three years from 2011-2012 to extend funding pools under FCP measure to enable access to non-clinical support services should be accessible directly by all clients receiving clinical and care coordination services under MHNIP. Divisions must establish processes that allow all providers delivering services under MHNIP in their geographic area to access this funding.

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1 Data provided in correspondence to ACMHN from Nursing, Allied Health and Indigenous Workforce Branch, Department of Health and Ageing.
b. To maximize the $58.5million funding for FCP clinical services and care coordination, Divisions must seek to use existing clinical and care coordination services for people with severe mental illness, primarily the MHNIP. The ACMHN is keen to work with the Department and Divisions to increase the number of Divisions delivering services under the MHNIP.

Responses to issues raised in Discussion Paper

Issue 1: Definition

The Department of Health and Ageing has already created a definition of severe mental illness for the MHNIP. This definition is well accepted by the organisations that use the MHNIP. It has similar features to that proposed in the discussion paper, including:
- Diagnosis: must have a DSM IV or equivalent diagnosis
- Disability: Disablement to social, personal and occupational functioning
- Intensity: A history of hospitalization or at risk of hospitalization
- Chronicity: expected to require treatment over the next two year period

Rather than using a similar, but slightly different definition, it is recommended that FCPs use an identical definition to the MHNIP.

The program guidelines should also clearly identify that there is no age restriction in the definition of eligibility and that the program is open to children.

Given the amount of funding available under this measure, the ACMHN anticipates that the Divisions will need to prioritise funding by some method. The program guidelines should provide a high level framework to guide Divisions prioritisation of access to the program. In addition Divisions should be required to work with local stakeholders including NGOs providing services to people with mental illness, mental health nurses working in the MHNIP, specialist mental health services, paediatricians and local psychiatrists. Many ACMHN representatives attending the consultation sessions expressed concern that there is no consistency in the way Divisions currently run their ATAPS programs and allocate the funding. A framework within the program guidelines supplemented by criteria agreed to by local stakeholders can help address this concern.

Issue 2: Who can refer people for FCPs? Is a Mental Health Treatment Plan required?

The ACMHN strongly advocates that a broad range of organisations should be able to refer people for assessment to receive an FCP. Many people with a severe mental illness do not have easy access to a GP or a psychiatrist; however they may be connected with a non clinical service provider. These organisations and a broader range of health professionals should be able to refer clients for a FCP. This will help target people who are not already receiving clinical care for mental health issues. It is recommended that the following groups should be able to refer clients for assessment to receive an FCP:
- Mental health nurses
- Psychologists
- Paediatricians
- Occupational Therapists
- Social Workers
- CALD/Refugee workers
- Alcohol and Drug Sector
- Child Health Nurses
- Case managers at specialist Mental Health Services
- Aboriginal Liaison Officers “Bush Nurses”
- Rural remote health nurse
- Suicide prevention organisations
- PHAMS providers
- Job Services Australia providers
- Specialist mental health services
- Community health services
- Drug and alcohol services
- Housing / Homelessness services
- Centrelink.

To accompany a wider pool of referring organisations, a triage and assessment process must be established by the Divisions to:
- determine whether an client meets the eligibility criteria / definition
  - it may be necessary for the eligibility to be based on a provisional diagnosis (such as a nursing diagnosis) to be confirmed by a GP or psychiatrist.
- their priority for receiving an FCP
- their acceptance in the program
- an assessment of the clients need and development of mental health plan for the client.

The ACMHN does not support the position that all clients referred for an FCP must have a GP Mental Health Treatment Plan prepared under the MBS prior to being accepted in the program. Rather, the ACMHN believes that an appropriately skilled and experienced mental health professional should be engaged under the FCP program to assess people who are referred without a plan and then prepare a mental health plan for those people accepted into the program. The Mental Health Plan should be developed in collaboration with a GP or psychiatrist, and in the case of children/youth, a paediatrician wherever possible.

Where the client does not have a GP or psychiatrist, it would be a priority, once the client is accepted into the FCP program for their clinical care coordinator to help the client access a GP or psychiatrist. Importantly, to ensure the FCPs and MHNIP can work together as recommended by the ACMHN, the client should be able to access any necessary immediate services under the MHNIP and FCPs while access to a GP / Psychiatrist is arranged.
Further, the ACMHN would suggest the Credentialed mental health nurses have an ideal skill set to undertake such assessments. Mental Health Nurses have specialized training aimed at providing a holistic approach to assessment, treatment and intervention for people suffering from mental health concerns. They have extensive experience in developing an appropriate plan that encompasses clinical, pharmacological and non-clinical strategies. The Mental Health Nurse Credentialing process ensures that Mental Health Nurses with appropriate qualifications, high standards of ongoing professional training and who have extensive clinical experience can be identified. Over 80 percent of credentialed mental health nurses have more than 15 years experience working in mental health, with the majority of this experience within specialist mental health services. It is envisaged that Divisions could use FCP funding to engage mental health nurses to undertake the assessment process.

**Issue 3: Integrated referral pathways (intersections) between Commonwealth and State funded mental health services and with Non-Government Services (NGOs)**

The ACMHN believes that seamless transition between specialist mental health services and primary mental health care (and vice versa) is essential for people with severe mental illness. However, it must be acknowledged that this can be very hard to achieve. Some of the things that can help to achieve this are:
- High level support from all organisations involved
- Adequate resources committed
- Clear and simple processes
- Staff with good networks and knowledge of the various organisations involved

Several State jurisdictions have established programs to improve the transition between specialist mental health services and primary care. For example, in Western Australia GP Liaison Nurses co-ordinate and takes responsibility for the relationship between State Mental Health Services and Primary Care providers. The GP Liaison Nurse supports GPs and the Mental Health Service in understanding each other, offering a point of contact for both services to smooth out problems for the patient transitioning to either service. Existing arrangements such as this should be used as far as possible, rather than establishing new arrangements.

There are many NGOs who deliver non-clinical services to people with severe mental illness. The sector is diverse and can be hard to navigate as there are many small organisations delivering services targeting specific cohorts of people. The ACMHN is concerned that relationships between primary health care organisations (Divisions, general practices and other clinicians), and these organisations are minimal in many cases. Individual clinicians have difficulty navigating these services and often rely on the specialist mental health service to keep them updated and suggest more appropriate avenues for services. It is likely that Divisions will need to build their relationships with such organisations. At the same time, non government organisations are often under resourced and have limited capacity to build a partnership without funding.
Advice and assistance should be sought from the peak mental health bodies in each state to ensure appropriate organisations are targeted and to support those organisations to respond to Divisions. Divisions should also strive to employ a coordinator with good personal relationships and linkages with relevant non government organisations.

There are some successful projects and models where collaboration between health services and NGOs have been established. Integrated employment services have been established in several mental health services, based on a model developed by Dr Geoff Waghorn of the Queensland Centre for Mental Health Research. Another relevant model is the No Wrong Door project established by Ovens & King Community Health Service in 2005, now in the second phase. (www.nowrongdoor.org.au). It is strongly suggested that Divisions review existing arrangements and research in this area and build on what is working already rather than establishing new partnerships and approaches.

**Issue 4: Type of Services to be Provided**

The experience of mental health nurses providing services under the MHNIP is that the clinical services that may be needed for people with severe mental illness include, for example:

- Comprehensive psychosocial biological assessment,
- Risk assessment
- Mental state examination and ongoing monitoring,
- Psycho education
- Medication education and monitoring,
- Specialist assessments such as Cognitive and Speech and Language Assessments
- Evidence based therapies such as family therapy
- Management of physical disorders within the mental health dimension e.g. obesity, pain management,
- Drug and alcohol services
- Group therapy
- An outreach model of care that allows the clinician to observe how the client functions in the home environment

The non-clinical services they need include, for example:

- Transport to attend appointments and access services.
- Cleaning and home care
- Daily living skills and support (e.g. with shopping, attending appointments etc)
- Participation in physical activities by subsidising gym membership, meditation or tai chi classes etc.
- Respite services
- Financial counselling
- Legal aid
- Parenting skills
- Provision of stable and safe housing and support to maintain tenancy.
**Vocational support**

An issue that was raised in the consultation sessions related to who should coordinate the clinical and non clinical services under the FCPs. As outlined above, the ACMHN recommends that clinical services be primarily provided via the MHNIP. The coordination of the clinical services can also be undertaken by mental health nurses under the MHNIP.

However, a coordinator with a different skill set and range of experience is needed to coordinate access to non-clinical services for clients. The two roles would need to work collaboratively to put together the most appropriate and cost effective package for the client. In some circumstances, the mental health nurse would need to undertake coordination of clinical services and non-clinical services where this is in the best interests of some clients due to issues of trust and vulnerability.

In principle, the ACMHN recommends that clinical services be primarily provided via the MHNIP. Where the client needs additional clinical services, for example drug and alcohol services, these should be accessed via existing programs where possible. However, where this would involve long waiting periods or the service is unavailable, FCP funding should be used to purchase the required service.

Similarly, to maximise the funding available under FCPs, non-clinical services should be accessed through existing programs wherever possible. However, where no services exist or has a long waiting period, non-clinical services could be purchased.

**Issue 5: Quality Assurance**

The ACMHN believes that it is important to monitor and measure who is and is not receiving FCPs, how easy it is to access FCPs, and whether the FCPs are effective in terms of clinical and non clinical outcomes.

An important part of the quality assurance for the FCPs must be to measure and respond to consumer feedback. A nationally consistent tool to measure consumer feedback should be used.

Patient outcome measures should be consistent with other programs. The MHNIP utilized Health of the National Outcome Scales (HONOS), and it would be appropriate for this program also.

While it is important to monitor and measure performance of the program, the methodology established to do so but be time and cost efficient. In particular, the need to monitor program performance must not result in Divisions requiring inappropriate reporting on clinical / client information.

**Issue 6: Skills of Allied Health Providers**

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The ACMHN recommends that all mental health nurses working under ATAPS, including FCPs, must be credentialed by the College. The ACMHN can and does provide extensive support to mental health nurses seeking their credential. The ACMHN can advise and support Division to recruit credentialed mental health nurses.

The program guidelines should identify the scope of services (clinical and non-clinical) that can be delivered under FCPs and the skills and experience required to deliver those services. This should be developed in consultation with the relevant professional bodies. The Divisions should not make determinations about whether particular professions have the scope of practice to deliver those services. This has been the case under ATAPS Tier 1 and it has resulted in some Divisions making arbitrary decisions about which professional groups it will use to provide services. As stated above, the ACMHN recommends that clinical services required by people with severe mental illness should be provided through the MHNIP, supplemented by other clinical services where necessary.

**Issue 7: Clinical support for the workforce**

The ACMHN is pleased that the need for clinical support for the workforce is being considered as part of the consultation. The experience of mental health nurses providing services under the MHNIP is that there has been very limited support provided as part of that program.

Mental health nurses and other clinicians require support to access advice on clinical issues. The expansion of the GP Psych Support Service to cover all mental health professionals working primary mental health care (not just those working under ATAPS) would be beneficial. This expansion must accommodate the needs of the different professional groups.

Other supports include ensuring mental health nurses are funded to access clinical supervision (as part of their ‘work time’ if employed by the Division, or that cost is recognised as part of their remuneration if their services are contracted). Peer support groups and other networks would be useful. The Mental Health Professionals Network should be used to deliver this type of support. Support to maintain continuing professional development is also required. Training and learning activities that are funded by the Department should be appropriate to and available to all professions.