

# Mental Health Funding Methodologies

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# Executive Summary

Mental health services are the most complex set of health services, covering birth to death, prevention, early detection, treatment and co-morbidities with the largest array of clinical and human services care partners. The scale of mental illness is huge, mostly arising in adolescence or youth, accounting for a third of the burden of illness, with about 40% of all disability (physical and mental) being due to mental illness. About one third of those presenting to General Practitioners have mental health problems. The cost to the Australian economy is about \$20 billion each year<sup>1</sup>.

“Every system is perfectly designed to achieve exactly the results it gets”  
(Berwick, 1998)

Mental health service provision crosses numerous Commonwealth, state and territory agencies and service providers. The range of service provision locations and the number of agency providers involved in mental health care limits the ability to provide a continuity of care that is integrated and person-centred.

Recognising the recent establishment of the National Mental Health Advisory Council, there is still no single agency, organisation or level of government with the remit and responsibility for the setting of strategic mental health policy or for oversight, monitoring and operationalisation of mental health care. Funding methodologies and funding amounts vary between jurisdictions and have traditionally not been based on population need. This, and the range of agencies and providers involved in the provision of mental health care, has led to inequities in access, service provision, quality and health outcomes.

In the window of opportunity presented by the new Labor Government to structurally reform health services, for mental health the following questions need to be answered:

- What changes in current funding and payment methodologies are required to create an environment in which the problems confronting mental health can be addressed?
- Can the problems that confront mental health be fixed while responsibility is split between two levels of government and, at the national level, between various Commonwealth departments?
- If not, which level of government should be responsible for mental health services?
- If split responsibilities continue, which level of government should be responsible for the supply, remuneration and equitable distribution of mental health clinicians?
- If split responsibilities continue, which level of government should be responsible for the equitable distribution of mental health funding and the broader human services that have an essential role in recovery from mental illness?

This policy paper provides a suggested funding model for mental health care provision that seeks not only to reduce the current burden of disease but also to intervene early and prevent disease and disability from occurring. Best-practice care provision should occur across a continuum and be provided by clinicians in an integrated and coordinated fashion – a challenge for the current system with its multiple providers, funding and governance structures.

The allocation of sufficient funds to provide accessible and high-quality mental health services is also a major problem addressed by many investigations and reports, and in spite of recent increases in funding by Commonwealth and State governments, the level of recurrent and capital expenditure is well below the investment needed. This issue will not be taken up in detail in this paper, though it will touch on ways where better use could be made of the funds currently available. It is taken as a given that considerably more investment needs to be made in mental health, particularly in regard to infrastructure, workforce and organisational governance.

The paper presents the case for change and reform in the mental health system. The case for reform is based on a number of challenges that are inherent within current system, funding and governance structures. While detailed further in Section 2, the issues include:

- that mental health care provision requires a unique approach due to the burden, complexity and scope of mental health services
- that current funding methodologies (particularly ‘fee-for-service’ arrangements) do not drive collaboration, continuity, integration and quality of service provision across the range of mental health service providers.

The final section of the paper details a blueprint for reform. We propose that the Commonwealth Government, in conjunction with the states and territories, **strengthen the governance of mental health services** and implement a reformed funding system with **regional commissioning** of mental health and other linked services. Based on Australian and international evidence, this is the only mechanism for implementing a vision of strong governance that requires the development of and adherence to clear functional roles for key participants in the health system.

We envisage quite a different structure for our mental health system from that which currently exists – though our recommended model has been tested in various forms throughout Australia. The proposals outlined in this paper are necessarily schematic at this stage and will require further development following a decision to explore the model further. This is particularly so in regard to workforce supply and distribution.

Reform in mental health service delivery requires appropriate commissioning, contracting, development and management of consumer-centred models of care which span the care continuum. We propose the establishment of a new model of working, where

mental health and related services are commissioned with contracts managed by Regional Mental Health Funding Authorities. These authorities are not intended to be duplicative of current structures or unwieldy resource intensive bureaucracies. RMHFA structures may vary dependant on size and geographical location of the region. They could be achieved through auspice arrangements with current government or health authorities or be constructed as stand alone authorities. They require adequate size and skilled resource to plan, commission, monitor and oversight mental health service provision within their allocated region. Outcomes based service contracts with the range of local and state specialist mental health, education, employment, NGO and private providers would be implemented and closely monitored to achieve regional collaborative and coordinated care. A range of service contract and blended funding models would be utilised to fund the RMHFA, service providers and drive cross agency service provision

Overseeing these authorities would be the states and territories, with benchmarking and whole of system monitoring and accountability through an Australian Mental Health Board (or Commission) and the Commonwealth Government Department of Health and Ageing (DoHA). The Australian Mental Health Board would set the national standards for mental health care, develop the funding methodologies and commissioning principles, develop and oversight macro performance management and benchmarking frameworks. Currently, no one agency has responsibility to set the direction or monitor the state of mental health services in Australia. This is an essential first element to achieving better outcomes for mental health consumers. The Board/Commission could be achieved through an enhancement of the role of the National Mental Health Advisory Council. At a minimum, it should have the remit and authority to achieve the above roles.

The second recommendation is for a revised funding approach for mental health. It is clear that there needs to be a common national standard of mental health care. In order to better provide for the Australian population with mental health care needs, consideration should be given to introducing an integrated funding approach for mental health. This does not mean the separation of mental health from the rest of the health system. Rather, it recognises that effective mental health care requires a whole of government approach that includes other human services such as housing and employment. The limitations of existing historical models along with the cross agency, jurisdiction, provider and care setting nature of mental health care requires a different approach. However the model could be expanded to other health sectors following implementation in the mental health sector.

This reformed funding approach must be founded on a robust needs-based resource allocation methodology that covers the continuum of care, and includes both the public and private sectors with aligned incentives. A blended funding model would be used to distribute funds from the RMHFA to service providers which includes the use of capitation, fee for service, case mix and outcomes based incentives. Such models have been implemented and trialed by the national Mental Health Integration Projects and currently used by the New Zealand District Health Boards and Primary Health

Organisations. In such models, fee-for-service and output based funding models continue for those able to negotiate the system or requiring short term episodic care. Other funding models are used for those requiring coordinated, collaborative, cross agency packages of care (e.g. housing, employment, mental health, primary care).

As a first step, funding for mental health should be partitioned within the Australian Health Care Agreements to allow the directing and monitoring of resources to this national health priority area.

The recommendations are not a radical change from current systems in that they do not dispel the need for fee-for-service or episode funding. Rather, they allow for the pooling of funds and provide robust governance structures to allow the effective and efficient use of these resources.

The proposed model aims not be isolationist; rather the scope of the resource distribution and governance model is highly relevant to and may include drug and alcohol, all long-term, persistent and recurrent medical conditions, and other appropriate clinical services within the population needs based funding system as required. A particular model of care is not recommended as regional funders and providers would have the responsibility for the commissioning and delivery of services and models based on local needs.

# Contents

Executive Summary		i
1	What the optimal mental health system should look like	1
	1.1 Principles to guide Mental Health Services	1
2	The case for change in mental health	4
3	What a reformed mental health system might look like	14
	3.1 Reforming mental health governance structures	15
	3.2 Reforming mental health funding: aligning funding allocation models with incentives	20
	3.2.1 Allocating resources	20
	3.2.2 Aligning incentives	27
	3.2.3 Achieving better outcomes for consumers - RMHFA commissioning of cross-agency services	30
	3.2.4 Implementation and next steps	32
Appendix A	Essential Service components and ensuring their provision	33
Appendix B	Transition to implementation	46
Appendix C	References	52

# 1 What the optimal mental health system should look like

There is widespread agreement around the required standards, structures and services within a mental health system based on proven and emerging practices locally and globally.

We suggest the following principles and elements should underpin mental health service planning as a starting point for considering national strategic directions and framing the role of an Australian Mental Health Board/Commission. They are based on the current or emerging evidence of what works in improving health outcomes for people with mental illness. Further detailed information on these elements and service structures is contained in Appendix A.

## 1.1 Principles to guide Mental Health Services

Table 1-1 highlights the system principles of: integration; access and continuity; community and recovery focus; workforce; and effectiveness and evaluation. The system principles should also include an express recognition of the need for the provision of early intervention services and that mental health services are provided through and across a number of government, non-government and private agencies.

Mental health services require a particular focus on integration and partnership. Integration needs to occur for the individual and health service team and continue through to the health and human services systems. Partnerships are required with other private and non-government mental health providers, alcohol and other drug services, service providers for physical illnesses (e.g. GPs and chronic illness teams), and physical and intellectual disability services.

Access to services should be streamlined with the ability for a consumer or carer to access services close to their usual place of residence (e.g. shopping or community centres). There needs to be a shift in the centre of gravity of services – a movement to community-based and hospital in-reach. Care needs to be provided across a continuum, allowing the consumer to move through the journey of recovery with ongoing support, but to exit and re-enter the system easily.

A consumer, carer and recovery focus should underpin all services and be provided by an expert workforce that works from a strong evidence base and evaluation mind set.

**Table 1-1: Mental Health System Principles**

<b>A: Integration</b>
<ul style="list-style-type: none"><li>• Integration from the micro to macro levels of: the individual and family/ carer mental health journey, coordinated by a care manager; the interdisciplinary team; mental health services including coordinating public, private and non-government components; the health service with the health/human services systems; and input into developing and sustaining health and wellbeing services for defined populations</li><li>• Integration between clinical disciplines to foster collaborative partnership arrangements to manage co-morbid conditions, including services for drug and alcohol, physical illness and permanent disabilities.</li></ul>
<b>B: Access and Continuity</b>
<ul style="list-style-type: none"><li>• Mental health services should be fully accessible, with multiple portals of entry, both in the community and at the local hospital. Community mental health teams should be based in central shopping and transport hubs, where they are most convenient to service users and families, while readily providing home-visit assessment, treatment and support.</li><li>• Access should be equitable for all socio-economic groups in all geographic regions; ongoing continuity of care as long as needed, with ensured rights and strategies to exit mental health services when appropriate; and guaranteed ease of access to timely re-entry to such services if and when required.</li></ul>
<b>C: Consumer, Carer and Recovery Focus</b>
<ul style="list-style-type: none"><li>• The mental health service values, enables and strongly supports consumer and carer participation.</li><li>• The concept and process of recovery is operationalised within broader models of care delivery.</li><li>• Services are provided wherever possible on a least restrictive predominantly voluntary basis, routinely seeking consent from and consultation with service users, and with permission, their families. Informed decision-making on, and the upholding of human rights of service users and families should be embedded within mental health services.</li><li>• Programmes should be implemented which challenge and counter stigma and discrimination in relation to mental illness, and should promote mental health well being. These programmes should include community awareness and mental health promotion.</li></ul>
<b>D: Workforce</b>
<ul style="list-style-type: none"><li>• Investment in an expert workforce, through professional development and training, regular supervision and adequate levels of staffing. This will require an interdisciplinary balance of professionals, a flexible discipline mix, including the potential for professional substitution to bridge particular professional shortages, and the encouragement of the training, certification and employment of service users and carers as peer support specialist workers.</li></ul>

#### E: Effectiveness and Evaluation

- Interventions provided and the sub-systems delivering those interventions should be based on the most rigorous quantitative and qualitative evidence (see Appendix A, Table A-3).
- An evaluation of performance against a framework of nine domains, as outlined in the National Health Performance Framework (from Key Performance Indicators for Australian Public Mental Health Services 2005):
  - i effectiveness and quality
  - ii appropriateness
  - iii efficiency
  - iv accessibility
  - v continuity
  - vi responsiveness
  - vii capability
  - viii safety
  - ix sustainability
- Outcome measurement should not be restricted to symptoms, but should include psycho-socio-cultural functioning, and desirable outcome priorities from the viewpoint of service users and family carers (e.g. employment, education, housing)
- Accountability for all Australian all-of-government Mental Health Initiatives and Reforms should be monitored and assured at arm's length

#### F: Early intervention

- Services should not be limited to the provision of care following onset of disease – services should be structured to prevent, detect and intervene at the commencement of illness.
- Training of the community and primary care sector should occur to reduce social stigma related to mental illness and assist in the early detection, referral and intervention in the disease process. These services should include Mental Health First Aid and social inclusion programmes.

#### G: Cross Agency

- Recognition should be given at all levels and structures to the need for collaboration across government, non-government, primary care and private agencies.
- Collaborative models should be developed which draw together housing, employment, education primary care and mental health care services into coordinated partnerships around providing better outcomes for mental health consumers and their carers.

## 2 The case for change in mental health

Coming from the historical housing of the mentally ill in separate large hospitals, mental health services have, for over 50 years, been exploring different ways to provide therapies and care in more normative and less restrictive environments. National Mental Health Plans have recognised the strong research base for improved outcomes in community based care. As with other parts of health, a key problem is the implementation of quality services based on the available evidence. There are many structural barriers that have been created by the failure to develop funding methodologies that reward the desired behaviours by governments, bureaucracies, facilities and clinicians. Where the right building blocks have been put in place, there has often been a lack of governance and understanding of the essential service systems psychology that leads clinicians, consumers and carers to have the confidence to work together in an integrated way. There has been a lack of fidelity to the effective interventions.

This section outlines the issues associated with the current state of mental health funding, service delivery and governance, and provides a case for change. We also explore the rationale for dealing with mental health as a sub-set of the health system that is integrated but 'ring fenced'.

The case for reform is based on the following challenges within the current system:

- care provision requires a unique approach due to the burden, complexity and scope of mental health services
- the mainstreaming of mental health services has led to an acute/hospital-centric approach
- there has been a lack of investment in community care - the location of choice for consumers
- current funding methodologies, particularly 'fee for service' do not drive collaboration, continuity, integration and quality
- mental health spending does not follow population health need and varies between locations and states/territories
- multiple agencies are required in the provision of mental health care but current cross-provider contracts are complicated
- funding methods do not support workforce reform
- consumer and carer choice and voice is limited
- the separation of Commonwealth and state/territory responsibilities for mental health is problematic.

### *Mental health care provision requires a unique approach*

More than any other clinical condition, mental health disorders require a unique approach to care provision. Mental health care crosses both the age and care location continuum. There are a myriad of service providers involved in care provision. Care providers are drawn from government health departments, government human services, private health providers and a range of non-government sectors.

The range of service provision locations and the number of agencies and providers involved in mental health care limits the ability to provide a continuity of care that is integrated and person centred.

There is currently no single agency, organisation or level of government with the remit and responsibility for setting strategic mental health policy or for oversight, monitoring and operationalisation of mental health care. Governance, funding methodologies and funding levels vary between jurisdictions and have traditionally not been based on population need.

The above issues have led to inequity in access, service provision, quality of care and improved health outcomes.

The unique nature of mental health service provision and its span across settings of care and jurisdictions, as well as the significant problems facing the system, means there is a requirement to reform the governance structures, funding and resource distribution methods (including the methods in which services are commissioned). Only in this way will Australia be able to reduce the burden of mental illness, ensure the appropriate provision of services and improve health outcomes.

### *The mainstreaming of mental health services has led to an acute/hospital-centric approach*

While most acute mental health beds have been progressively mainstreamed into general hospitals, the unforeseen effect has been the increasing hospital focus of care to meet hospital needs (i.e. more funding), rather than consumer needs. This has resulted in the diversion of funds from community-based mental health to hospital-based care that is sometimes supported by perverse financial incentives to exceed capped state-funded budgets (eg. through Medicare claims). Mental health budgets are often claimed to be quarantined, but the expenditure is not and much can disappear in “overheads” and slowed spending, to benefit the bottom line at the end of the financial year.

As a result of mainstreaming there are two distinct processes occurring in hospitals related to mental health – assessments (with care planning) and inpatient care.

The assessment process can be provided by hospital-based clinicians or community-based visiting clinicians. The hospital-based clinicians usually remain in the hospital and do not do assessments

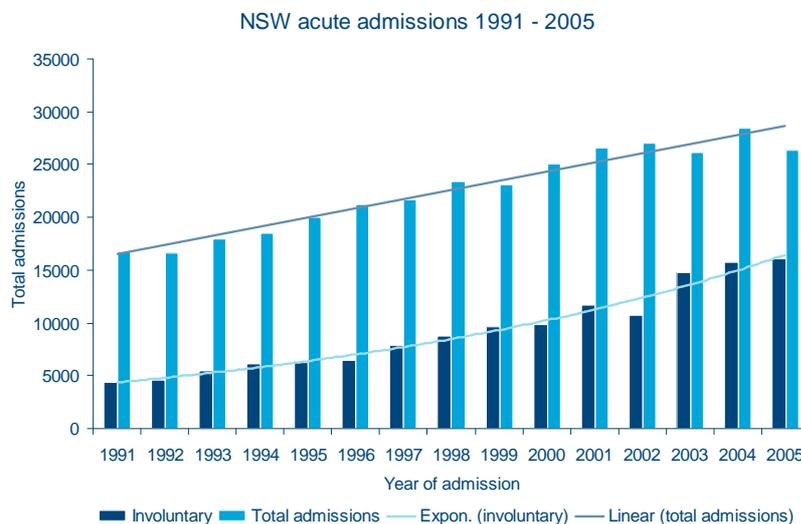
in the community or provide acute care in the community and so more often recommend a hospital admission.

They tend to be in small teams that lack the flexibility to match considerable fluctuations in demand. Community-based clinicians are more likely to be part of a larger multidisciplinary team providing both assessments and acute care in the 'hospital at home' and so have more flexibility to provide round-the-clock care and a range of services.

Inpatient care is about risk management - the only factors that should determine an admission are high risk of self harm, harm to others, or neglect. Otherwise, all forms of care and treatment can be provided at home. A lack of choices for community-based risk management, such as supported accommodation and own home support, mean that more people are admitted to 'one size fits all' acute units. Many of these units are poorly maintained and designed for a variety of care needs and are not able to be replaced or upgraded as a result of capital shortages.

Hospital care is in crisis in many places, due to a real change in the acuity and volume of mental health demand over recent years (mostly due to substance abuse and co-morbidity) and we need to actively manage the available capacity. Figure 2-1 demonstrates, for example, the increase in involuntary admissions in NSW between 1991 and 2005.

Figure 2-1: Increasing Mental Health Admissions in NSW 1991 - 2005<sup>2</sup>



Hospital avoidance and optimal lengths of stay (acute and longer term beds) depend on the capacity and quality of the community-based services.

Over 50 years of research has shown that the best outcomes occur when a community assessment team manages the consumer's journey – the intake process, triage, acute assessment, acute care

plan ('hospital at home' or hospital admission), monitoring the progress in hospital, "pulling" the person out when the risk level is manageable in the community, providing assertive follow up until discharge or transfer to a longer term case manager. To achieve this, the psychiatrists and other key clinicians need to be community-based, integrated with the assessment and acute care team and visiting the inpatient units to provide continuity of care. They can then prioritise the comparative risks and contribute to risk mitigation, reducing adverse events and suicides. Key performance indicators (KPIs) should be about the continuity of care provided going in, during and after occupying an inpatient bed.

Public hospitals are managed by the states and territories, where a lack of transparency means that the specific funds cannot be tracked. The current block funding model for hospital services, usually controlled by administrators, does not have incentives to promote best practice in mental health and other chronic disease management. Pure casemix funding is problematic for mental health inpatient services due to their complexity and the fact that the hospital outcome is most dependent on the community service activity, much of which is provided outside the health system. There is a need for more transparent methodologies where the components of service are separated, and commissioning can occur with specific budgets, incentives and KPIs.

*There has been a lack of investment in community care - the care location of choice for consumers*

The majority of common mental health disorders do not require hospital admissions. Approximately 96-97% of those being cared for by the state public sector are located in the community. Therefore, there is a need for key relationships and teamwork between mental health clinicians and primary care, community health and other community agencies. The essential ingredients are continuity of care, integration and collaboration.

Unfortunately, the balance between hospital and community care still gets distorted by traditional priorities: when resources become scarce, mental health funds are moved to general health, hospital mental health services are favoured over community, medical staffing resources fare better than non-medical staff, and acute services trump rehabilitation services. Community mental health centres are also often neglected due to the competition for capital expenditure.

Distribution of resources and services should reflect where the bulk of individuals with significant need for specialised mental health services live, and where intervention outcomes are generally better. As this is predominantly in the community, the services and the funds should align to such population needs. Hospital-based care is usually more costly; a factor that should be another important driver to shift provision, wherever possible, to the community.

However, sufficient funds are still required for more appropriate staffing in hospital care for those who require it.

“Improving the quality of M/SU [mental health and substance-use] health care – and general health care – depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients...Complimentary actions are also needed from government agencies, purchasers, and accrediting bodies to promote the creation of these linkages.”

*The Institute of Medicine of the National Academies. Improving the Quality of Health Care for Mental and Substance-Use Conditions. 2006*

In mental health the main intervention is ongoing psychological management for the consumer and family from the onset of a disorder. This form of care cannot be provided by low paid support workers or 6 minute GP visits. The case manager can be the broker for a range of discrete interventions, while providing assertive community treatment for those who require it.

Pressures on emergency departments are exacerbated because the failure to invest in community-based services means that many consumers only receive care during or after a crisis, and often too late in the development of the disorder.

Alternate models that change the focus to community-based care are possible. In Australia the public mental health budget in 2004/5 was split 49% hospitals and 51% community, with wide variations. However, in South Carolina, one of the best systems in the USA, they have reached a budget split of 70% community and 30% hospital (with measured increases in consumer and carer satisfaction)<sup>3,4</sup>.

#### *Current funding methodologies, particularly ‘fee-for-service’, do not drive collaboration, continuity and quality*

Current funding methodologies do not support the required continuity of care. The funding model needs to be flexible enough to provide for basic care through block grants, capitation and fee-for-service to reward desired activities based on local circumstances. The size of team required for critical mass for an effective 24/7 assessment and acute service means that mental health services do best if they have a defined catchment area.

If the funding body is independent of the providers of care, incentives could be put in place to achieve effectiveness, quality and efficiency. At present the state level funder may not be close enough to the action to receive good feedback on the use of funds for mental health. In this environment, the tendency towards “one size fits all” solutions can be ineffective, inefficient and not allow the implementation of the principles of best practice at the local level.

Currently the range and choice of services is greater than in the past, but service delivery remains patchy and poorly coordinated. This can increase the consumer’s confusion, isolation and stress leading to relapse, self harm, and in a small minority of cases, risks to the public if appropriate support is not available.

General Practitioners (GPs) have long been an essential treatment agency, often providing the ongoing care of those with mild to moderate disorders. Recent policy and funding streams implemented by the Council of Commonwealth Governments (COAG) assist GPs to provide clinic-based services as brokers, supported by on-site mental health nurses in some cases and with access to private psychiatrists, psychologists, occupational therapists and social workers.

However, the Commonwealth-controlled model of individual private practice, with simple time based rewards built into the Medicare Benefits Schedule (MBS), does not fit well with the evidence on ideal models of care. On the whole, the Medicare items only pay for face-to-face time with the patient, or a very structured case review, which is hard to organise and significantly underused. Psychiatrists maximise their incomes by seeing people for sixteen minutes, as the rate per minute progressively reduces thereafter. Even increasing the rebate for doing first assessments has not lead to private psychiatrists seeing more than one new patient a week, and there are no incentives in place to promote partnerships and support with GPs, as neither is paid for talking to the other.

With the recent increase in the number of private service providers (psychologists, social workers, nurses, occupational therapists) who can claim income under the MBS, it is essential that there is co-ordination and co-operation between these service providers and the rest of the mental health sector. Currently there is no mechanism to pay for or support this.

“Individual practice may be an impediment to the delivery of high-quality M/SU [mental health and substance-use] health care for multiple reasons ... the ways in which M/SU and other health care providers are separated are more numerous and complex than is the case for other health care generally.”

*The Institute of Medicine of the National Academies. Improving the Quality of Health Care for Mental and Substance-Use Conditions. 2006*

In June 2006, the Centre for Economic Performance's Mental Health Policy Group (chaired by Professor Lord Layard), at the London School of Economics, successfully proposed to the UK Government a major increase in expenditure on psychotherapy for depression and anxiety disorders. However, they strongly recommended that to achieve a quality service it must be provided by properly qualified people who work together in teams, which include senior therapists who can supervise junior therapists and monitor how patients progress. The report stated, “The clinical trials on which our case rests were obtained in conditions of strong quality control. To be sure we can obtain similar results nationally, we have to replicate that level of quality control.”<sup>5</sup> The current fee for service arrangements in Australia fail to meet the most basic standards for quality control.

#### *Mental health spending does not follow population health need and varies between location and state*

The recently released National Mental Health Report 2007 stated that in the financial year 2004/5, the private sector provided 22% of total psychiatric beds and employed approximately 9% of the mental health workforce, including private psychiatrists. This data is prior to the addition of Medicare payments to psychologists, social workers, and occupational therapists.

The proportion of the population seen by a psychiatrist, occasions of service per capita and the number of full time private psychiatrists have been falling for ten years. Distribution of psychiatrists also varies by region. This is a particular issue for highly complex psychiatric cases who require the regular input of a psychiatrist as part of a multidisciplinary team. However, the most startling fact is the huge variation in per capita expenditure between and within states and territories. The MBS per capita benefits paid varied from \$2 in the Northern Territory to \$14 in Victoria. While Medicare only provides data aggregated to the state or territory level, it is well

known that the lower socioeconomic areas of capital cities, other urban and rural areas receive very few private psychiatrist services, as psychiatrists congregate in the wealthier areas. The same phenomenon is occurring with the entry to private practice by the additional professions now covered in the MBS (psychologists, social workers, nurses, occupational therapists). It should be noted that this is not unique to mental health professionals, and that it is also an issue with GPs. One level of government, or the new funding bodies proposed in our model, must provide mechanisms to ensure that subsidised private services are distributed equitably, on the basis of need, rather than the means to pay.

Another example of the constraints of the Medicare fee for service system is seen in the Commonwealth funded Headspace programme business model. After the initial infrastructure grant expires, the continuing infrastructure expenses are to be funded by facility fees charged to private practitioners using the premises. The fee-for-service funding model means the program is still likely to face challenges in areas where private providers are scarce. This approach also limits collaboration even though services are co-located, due to most Medicare items being for single episodes of care with few incentives built-in to promote care planning.

State-based public sector services are mostly paid for with historically-based block grants to an area health service or hospital. In NSW, the state resource distribution formula does not apply to mental health and, despite periodic enhancements for specific programs, there has been a central assumption that core service elements have been adequately funded. This assumption has occurred in spite of increased acuity of conditions, volume of demand and population growth. Victoria appears to have similar problems, according to data in the 2006 document *Improving Mental Health Outcomes in Victoria – The Next Wave of Reform*, which shows major variations in the level of publicly-funded community EFT staff per 100,000 population, ranging from 60 to 150<sup>1</sup>.

Burgess<sup>6</sup> findings highlight the disparity between per capita spending on mental health throughout Australia. While the study utilised 1997/8 data and acknowledged the exclusion of GPs and some other community providers from its assessment, public sector expenditure and publicly funded private sector expenditure was able to be compared for each "mental health area" across the country. Total per capita expenditure ranged from \$21.12 in the Central West area in Queensland to \$159.06 in the Inner South East area in Victoria.

Another problem with state block grants is that enhancements may be based on initial consultations, but the details are then developed centrally and politically announced, leading to providers often having to implement unworkable strategies that result in low effectiveness and/or efficiency. Local negotiation with consumers and providers would be much more effective, while still ensuring evidence-based practice and no payment for anything as vague as "more clinical interventions" or ill-defined and poorly-monitored support services.

*Multiple agencies are required in the provision of mental health care but current cross-provider contracts are complicated*

Mental health consumers and carers benefit from the expertise and support of the primary care, non-government and government agency services. However, contracting support services can be problematic and the previous Commonwealth Government's Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and Department of Health and Ageing (DoHA) initiatives are designed for independent, fragmented service provision rather than cooperative and integrated care. The programs (e.g. Personal Helpers & Mentors, Support for Day to Day Living, Practice Incentive Mental Health Nurses, Respite Care) have been set up as unconnected silos of funding with a lack of clear roles, communication and fit within an integrated model of care.

Some of the criteria for contracts mean that smaller communities miss out on locally-based services that would assist collaboration. Where there is a small community that can only support one or two NGOs with critical mass, then combined contracts covering several related services with the same target group (Helpers & Mentors, Day to Day Living, Respite Care, HASI etc) could be awarded. This will not occur in the current environment of multiple funding agencies and different levels of government involved.

While recent changes now allow Private Health Insurance (PHI) to cover the cost of out-of-hospital care in certain circumstances, the range of services covered by PHI remains narrow and comes nowhere near meeting the needs of those with a serious mental illness.

*Funding methods do not support workforce reform*

Currently the Commonwealth Government is responsible for the production of clinicians through controlling tertiary education (doctors, nurses, psychologists, occupational therapists and social workers). However, much of the undergraduate and post graduate clinical training has been cost-shifted to the state/territory public sector services through withdrawal of university tutoring staff. There has also been significant under-production and maldistribution of mental health clinicians and professionals which will take many years to correct. Whatever model is implemented, there is a requirement that the Commonwealth adequately addresses this issue.

In the case of psychiatrists, the perceived lack of relative value of the high level cognitive inputs by psychiatrists compared to much higher paid proceduralists means that psychiatry is less popular as a specialty. The pre-occupation with risk in the public sector combined with the narrow focus on severe mood disorders, psychosis and dual diagnosis with substance abuse, and the insufficient numbers of psychiatrists employed, leads to major recruitment problems. Indeed, psychiatrists are the largest group of Area of Need professionals being sought from overseas. The inflexible remuneration provided by industrial awards, or Visiting Medical

Officer determinations, have failed to compete with private practice rewards to recruit and retain trained clinicians or to ensure equitable distribution of psychiatrists and other disciplines in the public sector. The overworked senior clinicians in the state public sector train the next generation in clinical practice, so the training experience has deteriorated and this will have long term negative effects. Many psychiatrists in the public sector have been choosing to go into private practice part-time and progressively reduce their hours in the more difficult public environment, leading to problems with continuity of care and public sector teamwork. Remaining full-time staff are left to carry the service cohesion and risk management responsibilities.

Since the addition of other disciplines to the Medicare fee-for-service system and practice incentive mental health nurses, there has been a movement of the more experienced and competent staff into private practice and more are indicating this is their intention, lured by higher income. This is already weakening public sector training and supervision. Thus the states must respond by either paying more or trying to cost-shift to other mechanisms through hybrid employment (eg. billing Medicare as occurs with medical staff specialists).

The current employment market is working too well and the negative spiral must be stopped by flexible rewards that can be locally negotiated. The new Commonwealth industrial laws will not include awards for those earning over \$100,000, so enterprise agreements or common law contracts will be the options. There needs to be one level of government responsible for the remuneration of clinical staff (with time and financial incentives for teachers/trainers) to balance out the various confounding factors and achieve equity of geographic distribution and access.

#### *Consumer and carer choice and voice is limited*

Current funding systems do not give the consumer real choice or a real voice in the processes of decision-making about investments in mental health services and funding methodologies. The closer the decision-making is to the locality, the more opportunities arise for consumer involvement. The funding management structure should include consumers and carers as key members of allocation committees, and centrally determined policies and guidelines should allow for flexibility in achieving KPIs. This involvement helps to keep the professionals honest and to curb excessively self-interested behaviour.

#### *The separation of Commonwealth and state/territory responsibilities for mental health is problematic*

From the above, it is clear that mental health service delivery is generally inefficient and ineffective as a hospital-centred activity, and has more affinity with primary care and community health, as well as other chronic fluctuating disorders. Current reports from the National Health and Hospitals Reform Commission suggest the movement of

responsibility for community services to the Commonwealth and hospital-based services to the states and territories.

Mental health does not fit this delineation as, more than any other discipline, service provision crosses acute, community and primary care settings. There needs to be a common national standard of mental health care, strong governance across the whole mental health system (wherever and whoever is providing care) and the development of and adherence to clear functional roles for all stakeholders in the system.

Cost-shifting is a major issue, particularly given the known under-funding of mental health in Australia. In one direction, fee-for-service funds from the Commonwealth allow for somewhat expanded mental health services, though we have noted above that this model does not result in services where they are most needed or the required coordinated care. In the opposite direction the states and territories have also been subject to cost-shifting by the Commonwealth in areas of clinical training (using under-resourced public hospital staff), rehabilitation and supported accommodation (particularly with the aged). There is currently insufficient money to buy all the services needed for people with mental health disorders, so rationing is occurring. Today we have a most unfair methodology based on the geography of higher social class. To stop the blame and eliminate the incentives to cost-shift in unproductive ways, we need a structure that enables integrated care with the funds carefully allocated and equitably directed to provide for priority consumer needs.

### 3 What a reformed mental health system might look like

In this section we present the case that the unique needs and challenges of providing optimal mental health care require a new approach to funding and organising the system.

Much-needed reform in mental health services and delivery requires appropriate commissioning, contracting, development and management of person-centred models that cross the care continuum. We propose a new model of *funding* based on better use of existing financing mechanisms, where mental health services are commissioned and contracts managed by Regional Mental Health Funding Authorities (RMHFAs). Overseeing these authorities would be the states and territories, with benchmarking and whole-of-system monitoring and accounting through an Australian Mental Health Board and the Commonwealth Department of Health and Ageing.

While the model proposed is a clear enhancement of a number of current structures, the proposal leaves open the possibility of future integration into new reform models. There are also a number of interim stages to our proposed reform model that allow for progressive implementation with the capacity to evaluate inputs and outcomes at each stage (see section 4).

The model is a recommendation to strengthen the organisation, governance and quality structures which develop and monitor mental health services in line with international trends (see Section 3.1). Our second recommendation is to improve the equity of resource distribution through a population health-needs funding model and to allow the pooling of funds to better provide care across the health and social service continuum for those most in need of coordinated care (see Section 3.2). Mental health funders and service providers will be able to design services and respond based on local needs with carer and consumer involvement.

We are not recommending a specific mental health model of care as part of this proposal. The Regional Mental Health Funding Authorities would have the responsibility for developing models of care, in line with the National Mental Health Standards and Mental Health planning principles that would be set by the Australian Mental Health Board.

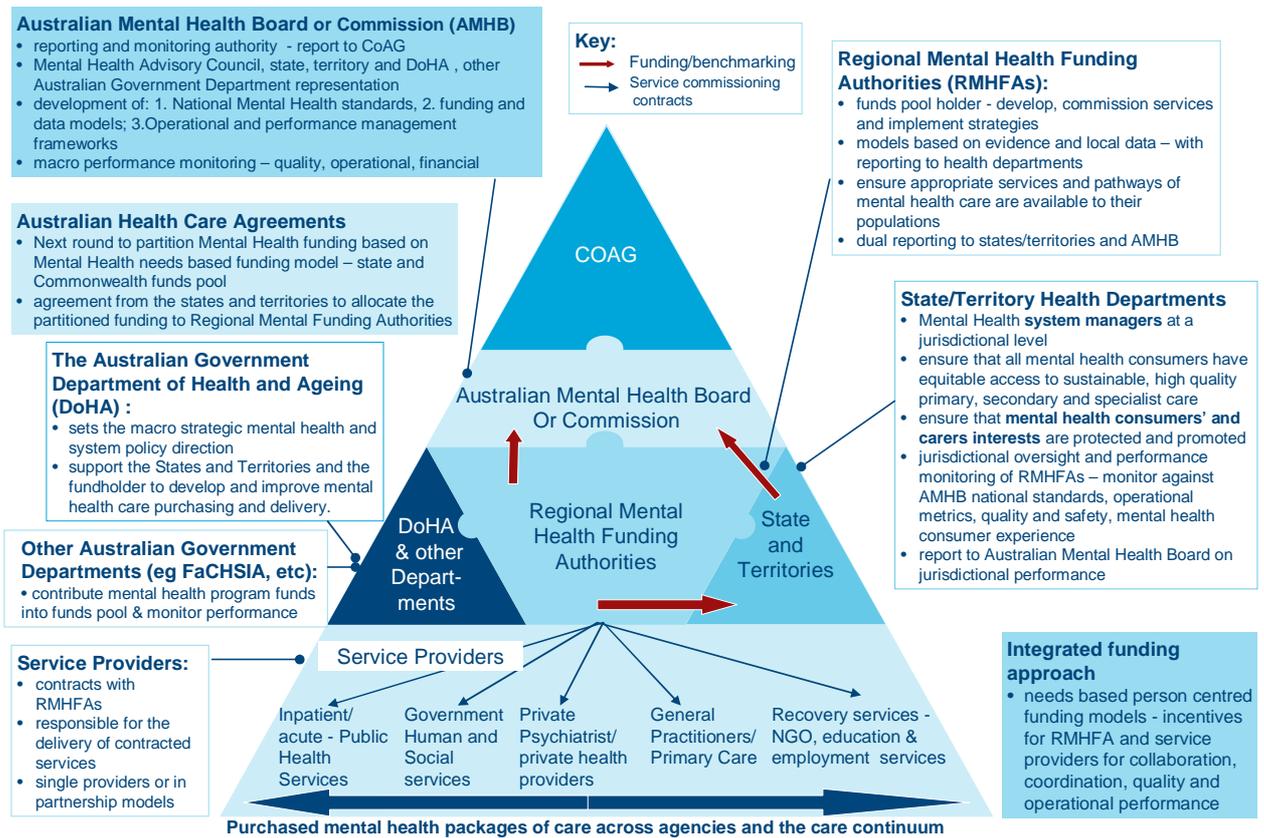
This model is not a radical change from current systems. It does not suggest removing fee-for-service or episode funding, but allows the pooling of funds and provides the governance structures to allow for more effective and efficient use of these resources. The model is also not designed to be a pilot of new models or systems. Rather, it is staged implementation of proven local models such as the Illawarra Health Service Integrated Mental Health Project.

### 3.1 Reforming mental health governance structures

*Recommendation 1: Implement a mental health care system with strengthened governance structures at all levels and regional commissioning of mental health services.*

The following diagram (Figure 3-1) presents a concept for how the mental health system could be structured to achieve the level of accountability and coordination that is required, facilitated by strong governance and innovative funding mechanisms.

**Figure 3-1: Proposed Mental Health System Management Structure**



#### Department of Health and Ageing (DoHA)

Within the proposed model, DoHA continues to have a primary role in setting national strategic mental health policy directions and for liaison with COAG, but with an emphasis on greater coordination across portfolios through the overarching view of the Australian Mental Health Board.

DoHA would set the broad policy framework in consultation with other Commonwealth agencies, states/territories and Regional Mental Health Funding Authorities (RMHFA). Mental health reform would occur with the implementation of the strategic policy through the Australian Mental Health Board (AMHB) and the Regional Mental Health Funding Authorities (RMHFA). The terms of reference and performance expectations for the AMHB would be developed in conjunction with DoHA and other key agencies.

Mental Health initiatives and programmes currently under the management of DoHA would be devolved to the RMHFAs, as would initiatives administered by agencies such as FaHCSIA. The mechanisms and scope for enabling this transfer would need to take into consideration the current consolidation of the Specific Purpose Payments (SPPs).

### *Australian Mental Health Board*

Success of the model is dependent on the strength of all levels of governance – central, jurisdictional and regional. To manage this, there is a need to establish a governance and monitoring body such as an *Australian Mental Health Board* (or Commission). We expect that the newly established National Mental Health Advisory Council forms a basis for this Board, with the likely need for broadened representation from the Commonwealth, states/territories and other key stakeholders. The Board would have four recommended terms of reference:

- central planning and oversight through the development and propagation of National Mental Health Standards – detailing access, outcome and prevention expectations for mental health consumers, carers and all Australians, with cascading responsibility and accountability for delivery of these standards and their outcomes;
- macro service planning and delivery across the mental health continuum of care for individual Australians;
- development and implementation of the funds/resource distribution and data collection models; operational, quality and consumer/carer experience performance indicators; and
- monitoring and benchmarking mental health by region, in conjunction with state/territory health and human services departments, with reporting on quality, operational and financial performance to DoHA, FaHCSIA, COAG and back to the community.

The Board would build on the work of the National Advisory Council on Mental Health with enhanced functions and a critical monitoring role. While the Board/Commission may have some of the elements of the current Council structures it is essential that the role is greater than just advisory. Similar bodies have been constituted in New Zealand (the New Zealand Mental Health Commission), Canada (the Canadian Mental Health Commission) and the United Kingdom (the National Institute of Mental Health), while the United States used the

President's New Freedom Mental Health Commission to drive mental health 'transformation' or reform. Ireland's Mental Health Commission is also considering moving towards a more monitoring and oversight role, and the Scotland Mental Health Commission has similar potential.

The AMHB operational and performance frameworks would identify the operational and quality performance targets required to be delivered by each RMHFA.

Suggestions for developing the service planning and needs-based funding models which may be used by the AMHB are described in section 3.2

### *Regional Mental Health Funding Authorities*

The next Australian Health Care Agreements should be used as the vehicle to reform the mechanisms for mental health funding and the distribution of these resources. Currently resource distribution does not follow need and there are no unified standards or methods for funding or staffing allocations.

We propose that funding be allocated by the Commonwealth, states and territories to Regional Mental Health Funding Authorities (RMHFAs). While the idea of the RMHFAs requires further development, we suggest they would have the following features:

- cover a population area of up to 500,000 to provide statistical credibility and to enable a pragmatic approach to sufficient volume and mix of hospital beds and service providers (this would accommodate entire jurisdictions such as the ACT and Tasmania)
- preferably align with current or revised health service boundaries to allow service provision in line with existing funding and organisational structures
- be independent health authorities, or arms-length bodies auspiced by the state/territory health department with a management board comprising representatives of the public health service, government social services, non-government services, Division of General Practice, consumer and carer representatives and other key stakeholders
- using a needs-based model, receive pooled funds from MBS, state/territory mental health services, Commonwealth Mental Health programs and other government funds
- develop a service plan that demonstrates an understanding of the mental health needs of the catchment population
- commission and contract mental health services as required across the continuum of care (methodology described in section 3.2)
- incentivise service providers to collaborate, coordinate and provide quality care in the most risk appropriate and least

restrictive environment possible (based on international commissioning and pay for performance models)<sup>7</sup>

- monitor performance and manage service providers against the contracted services, including independent random audits of the quality and range of services purchased
- report and benchmark on quality, safety, consumer/carer experience, operational and financial performance with dual reporting to state/territory health departments and the AMHB.
- Publicly report on performance to the community served.

The exact structure of the RMHFAs requires further exploration. However it is likely that a 'one size fits all' approach will not be appropriate, with the consideration of the best model for remote and the varying state/region structures and sizes.

They should remain at arms length to the service provider organisations, but need to be structured so as to engage the variety of health, social, primary care and non-government organisations within their catchment. Reporting needs to be transparent and therefore a dual reporting line to the states/territories and the AMHB is suggested. This reporting model would be similar as that which occurs for the Compulsory Third Party car insurance providers where reporting is through to both the Motor Accident Authority and the Australian Prudential and Regulatory Authority.

A RMHFA as a stand alone authority for a region is one option. An alternative model would be to engage an auspiced organisation, similar to those used in the Second Round of Coordinated Care Trials for the Partnership of Aboriginal Care (PAC)<sup>8</sup>. PAC's aim was to increase access to healthcare for Indigenous people in the mid and north coasts of NSW. Specifically it aimed to increase access to health assessment, care coordination and chronic care management. The contracted organisation remained at arms length to the health service, with the PAC Board comprising the Chief Executives of the two Area Health Services and the two Aboriginal Community Controlled Health Organisations involved.

RMHFAs should not be overly bureaucratic or be an additional layer of health infrastructure. They are proposed as a realignment and enhancement of current state and Commonwealth structures and would require appropriate resourcing for knowledge, data collection, management capacity and authority to develop and manage contracting arrangements with the range of service providers in their catchments. Operating as the managers of the pool of funds from Commonwealth and state/territory sources, each RMHFA would be accountable for the mental health outcomes of its constituents and the management of relationships, quantity and quality of outputs from contracted service providers. They would be required to report on performance to their jurisdictional managers – the state and territory health authorities. Reporting would also occur directly to the AMHB with appropriate transparency and benchmark reporting to the public and the community served by the RMHFA.

### *State and Territory Health Departments*

As the system managers for the RMHFAs the state and territory health departments would remain involved in the governance of mental health services within their jurisdiction. While the RMHFAs would be the fund-holders and make purchasing decisions, the state and territory health departments would provide jurisdictional oversight through the benchmarking of RMHFAs. The framework for this would be articulated by the AMHB – with access, quality, financial, operational and consumer/carer experience measures that align with the National Mental Health Standards.

The states and territories would have a key role in identifying underperformance and supporting the RMHFAs development and implementation of recovery plans. Expertise and support would be provided to the states and authorities by the AMHB.

### *Service Providers*

Services and care packages may be drawn from a number of social service and health providers. Access to a broad range of services is required to provide the comprehensive and tailored mental health care for the variety of clients and needs within the regional catchment. Some consumers will require short-term episodic community intervention, and other consumers will need a package of care and multi-modality support across inpatient, community and primary care services. The range of providers whom the RMHFAs contract may include:

- acute inpatient public mental health services (emergency and long-stay beds)
- public community mental health services
- private hospitals
- private psychiatrists
- GPs and other primary care providers
- psychologists and other private mental health providers
- Government agencies – eg. housing, education/training, employment and vocational services, Centrelink.
- Non-government agencies - vocational, recovery and support services such as those funded through FaHCSIA Mental Health programmes.

The model of funding would be coordinated and provided through a number of mechanisms – allowing enough flexibility to access services on a fee-for-service, case-mix or coordinated care package basis. Service providers would be incentivised by the RMHFAs for the development of models that encourage cost efficiency, multidisciplinary and/or cross-agency management. For example, a contracted health service may be financially rewarded for the development of care packages or programmes which shorten inpatient length of stay and discharge patients with community team support consisting of coordinated care by a GP, community mental health nurse and NGO carer support.

## 3.2 Reforming mental health funding: aligning funding allocation models with incentives

Recommendation 2: Introduce an integrated funding approach for mental health as a specific sub-population of the health system, using a robust health needs based resource-allocation methodology across the continuum of care, that includes both the public and private sectors and aligned incentives.

In developing an overall funding structure for mental health it will be important to achieve a defined set of objectives and to align those objectives with incentives for all participants in the system. The major participants and the related objectives are:

- **payers (including government at all tiers and other fund-holders)** to achieve a sustainable health system, which implies appropriate access and outcomes while achieving value for money and thus containing costs to a level acceptable to the community
- **providers (at an organisational and individual clinician level)** to be able to deliver care and support which enables reasonable and necessary clinical freedom and appropriate rewards, within affordable parameters and which optimises quality
- **individuals** to enjoy a health system which encourages healthy living, prevents disease and provides access to necessary care at a cost appropriate to their means.

In recognition of these objectives, we suggest that an overall funding model be developed for mental health as a specific sub-set of the Australian health care system.

### 3.2.1 *Allocating resources*

The proposed mental health reform model is a significant change in health systems thinking. Proposed are structures and methods to allow mental health funding to be distributed equitably based on need - where services are delivered under a quality, operational and outcomes performance management framework managed at a regional level.

In order for mental health to be funded in this way we need to predict the expected service demand in as much detail as possible. Funded populations could be defined in a number of mutually-inclusive ways, such as geographically, by disease group, by membership of health insurers or by other special needs categories (eg. Indigenous Australians).

We suggest that mental health funding could be partitioned on a national per capita basis and then devolved to the RMHFAs using a needs-based approach. This will require replacement of the current AHCA formulas and the development of a model which incorporates population, social and mental health needs measures. Funding would also include the cashing out of current MBS and PBS expenditure according to needs-adjusted national averages to overcome historical funding inequities, as well as an increase in funding from these sources over time. This does not negate the need for fee for service payments for episodic care and this is able to be managed within a blended funding model that allows for coordinated resources for individual consumers with higher needs. MBS processing would remain through the Medicare system with MBS monitoring and other blended payments being managed by the RMHFA.

Private health insurers could engage directly with the states in coordinating funding to RMHFA for the purchase of additional or top-up services and care for their members.

### Allocation methodologies

There are a range of options regarding how resources might be allocated taking into account the expected service utilisation in an efficient delivery system. These options are ideally based on a combination of the population need and prior utilisation, giving an aggregated risk-based expenditure over a period (capitation).

An analysis of mental health need was undertaken by Burgess, and included the consideration of direct and indirect measures of need. The model was used to determine the population-based mental health needs of 76 geographical areas of Australia. Data was sourced from the 1997/98 National Survey of Mental Health and Wellbeing (NSMHWB). The Burgess study used three direct measures of need:

- 'caseness' - a measure of self report of the responders' experience of a mental illness or disorders within the last 12 months – illnesses were assigned to one of three groups dependant on the provider/setting where treatment normally occurred.
- perceived needs for care – i.e. required or unmet need
- service use for mental health services.

A series of indirect measures of need were also used (the Socio-Economic Indicators for Australia - SEIFA). By weighting each area based on its population structure the mental health needs of an area was able to be modelled. The indirect measures included:

- The Urban Index of Relative Socio-Economic Advantage (UIRSEA)
- The Index of Relative Socio-Economic Disadvantage (IRSED)
- The Index of Economic Resources (IER)

## What a reformed mental health system might look like

- The Index of Education and Occupation (IEO)
- The Rural Index of Relative Socio-Economic Advantage (RIRSEA).

Total expenditure on mental health was also assessed. Combined public sector expenditure and private sector expenditure (sourced from Health Insurance Commission data for specialist psychiatric services) were used to determine a total expenditure on mental health. Medicare data other than the above (eg. for GP and other primary care providers) was not used in the analysis.

A similar model to the Burgess study could be used to develop the needs-based resource distribution formula for mental health. A number of other measures would need to be considered for the funds pool model to capture the other Commonwealth-funded mental health programs under the National Mental Health Strategy and those programs provided by NGOs and other Commonwealth departments (eg. FaHCSIA) and state/territory government departments (eg. housing, employment, etc.). However, the above study does demonstrate that a measure of the relative needs of a region in relation to mental health is possible. A funds-pooling methodology was also developed and used in the Coordinated Care Trials and this methodology could be adjusted to suit mental health<sup>9</sup>.<sup>10</sup>. This methodology allocated funds based on the demographics of the population or region. It included parameters for the major diagnosis characteristics and historical service utilisation for the region.

## Distribution of Resources by the RMHFA

Each RMHFA would be given a 'capitation' for mental health services – that is, expected expenditure over a period as determined by need, allowing for variables such as age and gender and other relevant social determinants. The mental health resource allocation for the region for a period will then be the sum of each of their members' capitation amount. Distribution by the RMHFA to contracted/commissioned services would occur through a blended payment system, maintaining activity-based and fee for service elements as well as other approaches that incentivise cross agency models and fund on the basis of mental health consumer outcomes. An example of a blended model, the New Zealand District Health Board contract with the Primary Health Organisations, is provided in Figure 3-2.

**Figure 3-2 New Zealand District Health Board Primary Health Organisation contract**

The Primary Health Organisation (PHO) Agreement is the contract used for purchasing primary care from PHOs by District Health Boards. The objective of PHO Agreement is to provide a basis for parties to work together in a collaborative and equal relationship, in order to improve health outcomes and reduce health inequalities for the New Zealand people.

The Agreement is based on a blended/mixed payment model that includes elements of capitation, fee-for-service, performance payments and special payments. The services which fall under each of these elements are highlighted below.

### **Capitation**

The services funded, in the agreement, on a capitated basis include:

- health promotion services,
- services to improve access for High Need Groups, and
- Care Plus services.

The capitated payments are based on the following factors: age; gender; ethnicity; deprivation; High Use Health Care status; and Community Services Card status.

### **Fee-for-service**

The services funded, in the agreement, on a fee-for-service basis include:

- immunisation services, and
- general medical services for casual users.

### **Performance payments**

An example of a performance payment, as outlined in the PHO Agreement, is the Rural Bonus, which provides a bonus to rural General Practitioners (GP) with a rural ranking of 35 or above. These GPs have been found to comply with the requirements to provide or arrange services for patients at all times, provide comprehensive GP services to significant practice population, and participate regularly in an on-call roster.

### **Special payments**

The Rural Primary Health Care Premium is an example of a special payment which provides flexible resources to support locally devised solutions to primary health care workforce issues, and enable the retention and recruitment of a skilled workforce serving rural communities.

There are many challenges and difficulties that need to be considered in implementing such a system, including:

- While data exists to commence the implementation process enhancement of Australia's health data would be necessary in the longer-term, using linked and/or longitudinal unit records. A linked data repository would be required which contains measures of service use and health outcomes for mental health consumers
- The identifiers required to allocate funds on a person or sub-population basis would need to be comprehensive and thoroughly tested in Australian settings
- Mental health funding allocation would need to avoid gaming or cream-skimming to ensure equity, but the RMHFA model is designed to avoid this
- RMHFA catchments would need to be large enough to mitigate statistical variability of utilisation (experience and practical application of funds pooling models suggest a sub-population size of approximately 500,000 for statistical credibility and to enable a pragmatic approach to sufficient volume and mix of hospital beds and service providers)
- Even with large sub-populations, some means of equalisation or risk sharing would be desirable and perhaps inevitable.

It would be the role of the AMHB to develop the allocation method and implement it accordingly.

Person-based capitation has the great benefit of allowing sub-populations to be measured in terms of financial cost per unit of person-benefit; that is, person-based outcomes can be agreed, measured and compared across providers and populations. Service models can then be constructed using the accumulated evidence and, eventually, pay-for-performance type contracts can be negotiated with providers, based on person outcomes.

This model suggests the implementation of models that have already been piloted within Australia. The Illawarra Mental Health Integration Project (MHIP) is one example of this model (See Figure 3-3).

Once the RMHFA receives its allocated funds, distribution and purchasing of services from providers could occur through a number of mechanisms. Table 3-2 demonstrates the methods used elsewhere and the behaviours those payment methods induce. It is important that consideration be given to appropriate payment methods dependant on the mental health consumers' needs. Again, one size may not fit all and a combination of methods will be required to allow episodic care within packages of longer-term care.

**Figure 3-3: Example of Integrated Mental Health Programs**

### Illawarra Mental Health Integration Project (MHIP)

Operating between 2001 and 2003, the Illawarra MHIP was part of a national initiative of the then Commonwealth Government Department of Health and Aged Care. The aims of the Illawarra project were threefold, to:

- Improve access for consumers to a broader range of mental health services;
- Ensure collaboration with and support for GPs as primary carers; and
- Develop more formal partnerships between public and private mental health services and non-government organisations.

Rather than funding an integrated model of care (the original intention), the project focussed on improving mechanisms to support best practice in mental health service provision that would then achieve the aims above. Multiple sources of funding with different principles for distribution were seen as key barriers to implementing coordinated and integrated care.

Elements of the model included:

- Tripartite agreement between the Commonwealth Government, New South Wales Government and the Area Health Service;
- Funds pooled at the Area level and sourced from:
  - Australian Health Care Agreement (for the Area's public mental health activities, with 'cash-up' included to bring the amount available up to the state average per capita rate for private psychiatric consultations);
  - Medical Benefits Schedule ('cashed-out' based on the actual delivery of private psychiatric services in the previous year);
- (then) Illawarra Area Health Service as the coordinating organisation.

The principle behind focussing on the funding mechanisms was to drive behavioural change and therefore improved clinical practice and care coordination by using an approach that mitigated the effects of perverse incentives and cost inefficiencies.

The full evaluation report is available from the Department of Health & Ageing website.

What a reformed mental health system might look like

Table 3-2: Key Attributes of Healthcare Payment Systems<sup>11</sup>

	Cost Control	Administrative simplicity	Ability to use incentives for:				Specific attributes
			Efficiency	Productivity	Quality	Patient Satisfaction	
Salary (for GPs and physicians)	✓	✓	✗	✗	✗	✗	Clinicians unable to select patients on basis of complexity
Capitation	✓	✓	✓	✗	✗	✗	Could encourage underutilisation of care
Case payment (DRG and case mix)	✗	✗	✓	✓	✗	✗	May encourage admissions, early discharge
Fee-for-service	✗	✗	✓	✓	✗	✗	May encourage unnecessary services Encourages 'cherry picking' or case selection Does not support equitable distribution of clinicians due to population need
Budget	✓	✓	✗	✗	✗	✗	Dependable source of funding, but incentive is to spend full budget
Pay for performance	✗	✗	✓	✗	✓	✓	Incentives can be misaligned if they become too complex
Day rates, per diems (for hospitals)	✗	✓	✗	✗	✗	✗	Encourages admissions and longer lengths of stay, unless the locus of decision-making is community based.

A mental health case mix model which incentivises early transition to community-based models of care would be best for commissioning inpatient and some public health services. Fee-for-service payments would remain for GPs and private psychiatrists, but these would still be contained within a capitated payment (eg. for a six month package of care) which includes engagement of other services and service providers within the care plan and team.

The main point is that whatever method is used, performance and quality based contracts with service providers, and strong monitoring against these by the RMHFAs, would be required to obtain the necessary data and demonstrate positive health and provider performance outcomes.

### 3.2.2 *Aligning incentives*

In addition to the regular resource distribution and capitation methods, there are some other areas that should be included within, or incentivised by, the allocation model.

At a macro level health system costs are increasing at a rate demanding an increasing proportion of GDP. Controlling costs while at the same time meeting expectations and maintaining quality are paramount objectives. Two obvious ways of addressing this 'cost problem' are:

- harnessing the benefits of intra-agency and cross-agency care coordination to substitute more costly and restrictive forms of care (e.g. inpatient care) for less costly and coordinated treatments (e.g. community care).
- investing in cost-effective prevention activities to either curb the onset of disorders or mitigate the development of disorders to more severe proportions.

Both these initiatives deliver the added benefits of reducing the overall burden of mental illness on the system and enhancing people's quality of life.

### Care coordination

One of the challenges of mental health care provision is the manner in which it crosses a number of providers and settings. Acute medical or surgical illness case mix and fee-for-service models work well due to the episodic and hospital-based nature of these conditions. For mental health and other chronic diseases, care constantly crosses the locations and boundaries of providers.

'Care coordination' has been discussed for a decade as an opportunity to achieve better health outcomes through substitution and coordination of services. The first and second rounds of the Coordinated Care Trials (CCTs) were launched by Australian governments in order to explore these questions.

In particular, the primary objective of the Second Round of CCTs was:

‘to provide additional benefits to clients and communities through coordination and integration of care and effective use of resources for identified populations.’<sup>8</sup>

The ‘effective use of resources’ in this objective was predominantly concerned with the holding and application of pooled funds by each trial to allow the purchasing of services as appropriate from the range of interventions and providers available. With respect to this question, the national evaluation of CCT2 found that for the mainstream trials, a range of benchmarks were available including Australian norms, fund pooling and control group performance<sup>8</sup>. The key trends to emerge suggested that:

- intervention group participants had increased access to primary care services compared with the control group participants
- had the trials operated for longer, total intervention costs would have fallen below control costs, and may have absorbed the costs of care coordination
- inpatient utilisation was reduced for intervention participants relative to control group participants.

Many other countries and organisations work on the principle of resource allocation across agencies and across the continuum of care, including<sup>12</sup>:

- Canada, in which the Federal Government devolves funding responsibilities across the continuum of care to the provinces
- the NHS system in the UK, where Primary Care Trusts are ultimately fund-holders for all services and are responsible for commissioning of integrated local government, social and health services
- the New Zealand system, with its hierarchical allocation from government to District Health Boards to Primary Health Organisations
- the US Health Maintenance Organisations; e.g. Kaiser Permanente, which has more members in the US than the population of any Australian state
- Victorian Government NGO contract and cross-agency models of care coordination and case management models where the service provider is contracted to provide care/service coordination for mental health and justice system clients on an outcomes basis.

Additionally, much thinking has occurred in the Australian context regarding funding models which improve care coordination, including who might be the fund-holders and the place of private insurers, in particular in Scotton<sup>13</sup>, and the Coordinated Care Trials.

We therefore recommend the inclusion of incentives within the mental health funding model that better recognise the requirements to provide coordinated care across a continuum and based on the mental health needs of the individual and regional population.

## Prevention and mitigation

There are many examples of funding directed at public health initiatives with a view to prevention or mitigation of disease. Some have been very successful, through a combination of incentives to providers and public awareness programs through schools, workplaces and the community (for example, early childhood immunisation of a range of viruses, and workplace sponsorship of flu vaccination). A similar focus is required in mental health and should be included within the funding model.

Looking forward, there seems to be a strong case for a dedicated funding initiative directed at public health and mental health, with a view to reducing the burden of inpatient care integrated with primary care at a population level. Examples of where this has been either rolled out or trialled are:

- the Sharing Health Care Initiative in Australia, which found impressive results in a range of chronic disease self-management initiatives<sup>14</sup>
- the incorporation of a population health funding component in the allocation of resources to Regional Health Authorities by some Canadian provinces (e.g. Alberta)
- the Quality Outcomes Framework, introduced in the UK in 2003, which is the world's first pay-for-performance mechanism in primary care and aims to (among other indicators) reward GPs for chronic condition prevention and management activity<sup>7</sup>
- the trialling of the Health Benefit Groups and Health Resource Groups concept from the UK in Australian Indigenous populations, where populations are considered in terms of their potential to benefit from certain disease management initiatives<sup>15</sup>.

As such, the inclusion of some funding measures to incentivise mental health promotion and illness prevention would be beneficial and possible using a population health approach.

### *3.2.3 Achieving better outcomes for consumers - RMHFA commissioning of cross-agency services*

The aim of the proposed systems change is the improvement of care and health outcomes for mental health consumers. The proposed model is a reorganisation and rationalisation of existing layers at the Commonwealth, state and territory levels to achieve a more collaborative and coordinated approach to mental health care through regional commissioning, monitoring, support and accountability.

The model focuses on the first step – governance, structures and funding methodologies. This is necessarily a macro system view that initially focuses on the inputs to the system. While the longer term goal is to achieve equity of consumer outcomes, the first step is to ensure that all mental health consumers are able to access appropriate mental health care when they need it. Equitable access to mental health inputs is the necessary first step to achieving equitable mental health outcomes.

It goes without saying that the system needs to develop a greater focus on outputs and outcomes. Within the proposed model, this is achieved through the contracts between RMHFAs and service providers. Contracts will necessarily vary dependant on the requirements of the region, service provider and RMHFA. However, it is essential that both output and outcomes based accountability is built into all contracts.

Contracts will also need to include incentives and rewards for cross-agency collaboration, with funding conditional on collaboration at both the individual and service level. This would include collaboration of agencies around a case management model, with one agency possibly allocated the role as lead agency and care coordinator with other employment, health and education agencies incentivised to provide their specialist services into the mix. The funding authority can therefore 'purchase' case management/care coordination services and specify the outcome measures they are seeking.

There are various examples of local models of service commissioning that drive cross sector collaboration and are developed through contracting arrangements. A case study is outlined in Table 3-3 and is an example of outcomes based, cross-agency commissioning through using regional authority. We propose a staged implementation of this type of structure and model nationally.

**Table 3-3 Case example of improved outcomes for consumers and carers**

**Current consumer , carer and system problem**

You are a General Practitioner in North West regional centre. Your patient with chronic schizophrenia has become acutely unwell. The patient had previously been case managed by the local mental health service but was only seen infrequently due to the current stability of his condition and the large number of cases the community team has to manage. His level of functioning has meant that he has been unable to work in his normal position as an engineer for the last five years. He now lives at home with his mother who is unable to cope with the increasing aggressive episodes. The local mental health service crisis team is contacted who have no alternative than to transfer him to the local inpatient facility for review and admission. He remains in hospital for four weeks and is discharged back to his mother with a referral to the Community Mental Health Team. You are not advised of his discharge but receive a discharge summary one week post-discharge. As the patient is not on a community order he has a lower priority for review and is not seen for ten days. At this point his mother explains that her son has only been taking his medication occasionally despite her encouragement. The team visit the next week and are concerned about the patient's condition. He is brought back to the mental health inpatient facility and readmitted.

**Potential improvement with reformed system**

The region where you reside is part of the North West Mental Health Authority (NWMHA). The NWMHA has been auspiced by the local public area health service but has been set up as a separate small organisation with an independent board. The area has struggled to provide comprehensive mental health services and to attract qualified mental health staff in the past. However, the region has been assessed by the National Mental Health Board as an area of mental health need under the National Mental Health Needs Assessment Funding Model. The NWMHA holds the funds for all mental health services in the region, including funds for supported accommodation, community carers and some education and training. The RMHFA has conducted a regional needs assessment and found gaps in community based services. It provides innovation funding to develop and commission cross agency programmes for the region. A cross agency assertive case management and recovery team has been developed as a partnership between a local NGO, the Division of General Practice, TAFE, Centrelink, Department of Housing and the public mental health service. The North West Mental Health Partnership (NWMHP) contract has a strong care coordination focus and rewards the partners on a number of patient outcome measures - the number of mental health consumers managed, maintenance of readmission rate targets, number of consumers in supported accommodation and return to work and maintenance of gainful employment for a continuous period of 16 weeks. A significant percentage of NWMHP funding is contingent on meeting these outcomes measures. The NWMHP reports its contract outcomes measures, as well as the confidential functional measures of its client base, on a bimonthly basis. The data are provided to the National Mental Health Board quarterly and the State Health Department for benchmarking and performance monitoring purposes. The NWMHA has provided subsidised housing and education grants to attract and develop

mental health clinicians. This has gone some way to managing the workforce issues in the region. As a General Practitioner in the NWMHA area, you have received training in primary mental health care and early intervention services through an early intervention programme funded by the NWMHA and provided through the North West Division of GPs.

A mental health consumer with chronic schizophrenia and his mother present to your office. You are concerned that he is becoming acutely unwell and that his mother is not coping. Through the NWMHP you have a Mental Health Liaison team that visits your clinic twice weekly. You refer your patient and his mother to the service who set up a case conference the next day. Along with the consumer and his mother, you meet with the extended mental health care team. You are paid on a fee for service basis for your participation in the case conference and ongoing participation as part of the extended care team. These payments are through Medicare but monitored by NWMHA. The team consider the need for a short inpatient episode (under an episode based funding model) at the local public mental health hospital but it is agreed that assertive care can be provided in the community.

The consumer is supported during his acute exacerbation by the assertive case management team and moves to supported community respite accommodation provided by the local NGO and Department of Housing. The consumer is seen twice daily by the mental health nurse. He sees you weekly on a fee for service basis and is reviewed by the psychiatrist that visits the region on a sessional basis from the South West region. His medication is reviewed by the psychiatrist and the clinical pharmacist based in the community team. His condition stabilises and he meets again with the extended care team. He decides that his goal is to gain employment. The NWMHP transfers his care to the community recovery services team where the part time Centrelink Employment Case Management Officer (ECMO) works with him to develop a training programme through the local TAFE. The ECMO coaches him on employment skills and is supported by TAFE classes. The ECMO places him in employment where he remains for the next three months. He is supported by regular visits from the ECMO, GP, his mother and the Community Mental Health team. He plans to return to living with his mother next month. As his GP, you elect to receive a case management payment to support him and document his outcomes over the next six months.

### *3.2.4 Implementation and next steps*

The implementation of the strengthened mental health governance structures and the population health needs funding methodology will take some system enhancement and time. However, a number of interim steps are possible in the journey to a reformed mental health system. A draft transitional implementation plan has been developed as part of this paper (see Appendix B). At this point, the model is necessarily schematic and further work on the implications and implementation would be required following agreement to proceed to the next steps in development.

# Appendix A Essential Service components and ensuring their provision

## Integration

Thornicroft and Tansella advocate for a better balance between community-based and hospital-based mental health care<sup>16</sup>. Over the last two decades in Australia and New Zealand the debate over whether mental health services should be provided “primarily or exclusively” in community or hospital settings has been exposed as a contrived battle over a non-issue. For most of this period, clinical and other expert opinion leaders and policy-makers in this field have been advocating for integrated mental health services. This involves ensuring more than a balance in community and hospital service provision and resourcing (i.e. a weighting of resources towards community and away from inpatient care) – a necessary but insufficient precondition for effective design and delivery of mental health services.

In Australia, achieving balance has entailed shifting the dominance of hospital-centred over community-based mental health service funding. In New South Wales in 1984, 90% of the public mental health service resources were still retained by the psychiatric inpatient facilities, even though 90% of people with severe mental illness lived in the community<sup>17</sup>. By 1998, 41% percent of such recurrent resources in New South Wales were used for community-based services and the shift had all but stalled before reaching parity. In Victoria 64% of recurrent resources for mental health services were community-based by 1998<sup>17</sup>.

In response to the expressed need to achieve a better balance between hospital- and community-based care, some state policies propose that hospital to community professional workforce resourcing percentages should be approximately 30:70.

Another essential condition entails proceeding towards full integration of services. Whether provision between hospital and community-based services are balanced or not, both hospital and community sites have too often been run as stand-alone facilities with poor cross-site coordination. Psychiatric hospitals increasingly became repositories for long-stay patients with little throughput. Most of the functions of 'asylum' in the best sense<sup>17</sup> can now be provided in community settings. Both general hospital psychiatric units<sup>17</sup> and community mental health centres<sup>17</sup> tended at first to move up-market, and become over-selective or swamped by being accessible to mild disorders which would be better managed in general practice or shared care.

Integration should occur with local general health services and to some extent with local community care or social services, but with firm provisions that: a) the mental health budget is quarantined from more powerful interests; and b) components of comprehensive services are not hived off and merged with generic health rehabilitation or social services, so that mental health services do not begin to lose their coherence again. The levels and types of integration are described in Table A-1 Integration of comprehensive mental health services.

**Table A-1 Integration of comprehensive mental health services<sup>18</sup>**

Dimension of integration	
1.	Diachronic (historical time) <ul style="list-style-type: none"> <li>• Continuity of service through every phase of care</li> <li>• Assist through age-appropriate life transitions or rites of passage</li> </ul>
2.	Synchronic (present time) <ul style="list-style-type: none"> <li>• integrate psychological socio-cultural functional and physical facets of care</li> <li>• extend the kinship or caring network</li> </ul>
Levels of integration	
2	mental health individual & family journey
3	interdisciplinary mental health team
4	mental health service, coordinating public private and NGO.
5	health service system
6	human services system
7	integrated input into well-being and social capacity building of whole community or defined population

The best test of coherence and integration of a mental health service is via appraisal by discerning consumers or family caregivers, as to whether their care is continuously coordinated by one mental health worker and team, regardless of whether they are in an acute or community phase of care. Such appraisal is partially achieved in Australia by having a trained panel of national consumer and carer-surveyors for the National Mental Health Standards<sup>19</sup>.

## Access and continuity

### Service model

The National Standards for Mental Health Services (1996) define a comprehensive mental health service as one which brings together a number of components into a unified system, ensuring continuity of care for consumers with a focus on the role of public mental health services.

These components include:

Access to Mental health care must be located in the community and based on the local needs of the population

- a single point (or process) of entry into a service
- specialist crisis intervention, assessment, acute care, ongoing care and rehabilitation care across the consumer's lifespan
- a case management system
- multidisciplinary teams
- the active involvement of consumers
- a co-ordinated management system between inpatient, community and private provider services.

These elements are still the basis for integrated, comprehensive mental health services, whether the delivering agency is public, private or non-government. Current and previous National Mental Health Strategies have made a great deal of progress towards reforming mental health services. However they have not gone far enough in terms of defining and making specific recommendations to implement the strategies. An effective method of increasing the specificity, uniformity and fidelity of nationwide implementation is to define individual service components and staffing levels required to deliver a comprehensive, locality-based continuum of community care that addresses the needs of an average population of 200,000<sup>20</sup>.

In summary, service models need to be clearly defined; resourcing of services must be done on a rational basis, not simply on an historical basis; quality measures and standards must be meaningful and ensure good practice across multiple providers.

Further description of the service model is provided in Table A-3 at the end of this appendix. This details the evidenced-based components of care along with the suggested delivery systems or 'vehicles' for the provision of care.

### Access to services

Communities and those individuals with specialised needs must have access to appropriate services when and where they are

needed. There must be sufficient services with sufficient staff to meet individual and family/carer needs in a way that minimises impairment (clinical and social) and disability.

Public mental health crisis services (and extended hours services) are currently a critical component of a mental health system and indeed the main entry point to wider services. Access to services can be via any, or all, of several components of this complex system, including mental health acute assessment teams (based both in the community and in hospital emergency departments) police, ambulance, GP's and private psychiatrists, drug and alcohol, other community services and non-government organisations.

It is essential to offer low-key access via community mental health teams based near shopping and transport hubs, where convenience for service-users is maximised. This must also include capacity for mobile home visiting.

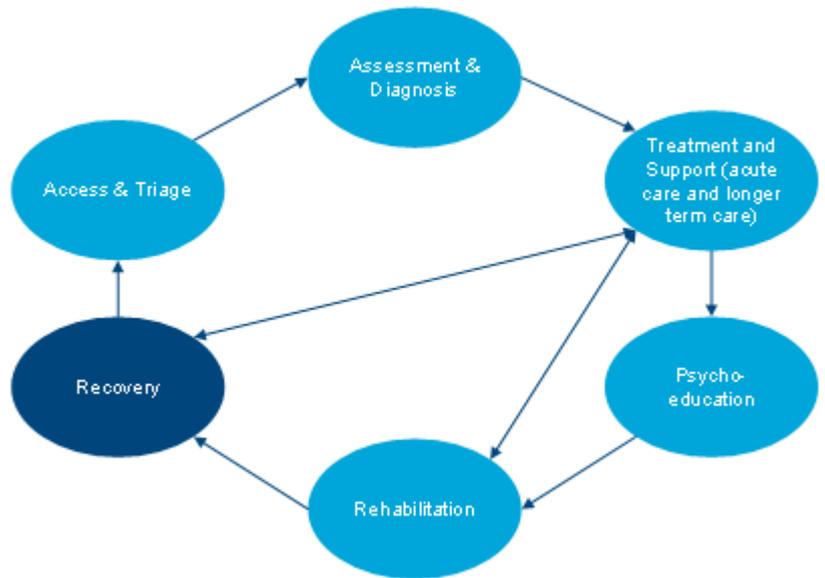
In accordance with international best practice, teams responding to people in crisis must have skilled staff with the ability to provide immediate access to:

- clinical triage and assessment
- case management/care coordination
- intensive psychological and practical support
- medication management
- family/carer support
- cultural assessment
- relapse prevention
- crisis planning
- inpatient care
- respite care options
- links to ongoing care/support
- a range of psychological interventions.

## Continuity of Care

For those individuals who need it, continuity of care is achieved through a sustained relationship with a case manager who delivers ongoing psychological care and support for the individual and their family/carers. Continuity of care is required through all stages of the clinical pathway as shown in Figure A-2 below:

Figure A-2: Simplified diagram of continuity of care – the goal is recovery



Continuity includes dealing with the trauma of the onset of a disorder, through treatment and rehabilitation, including the depression and grief that may arise from resultant difficulties obtaining work and achieving other goals in life. The case manager (also referred to as care co-ordinator, key worker or care provider) requires specific skills and training to be effective in helping the individual and family deal with these issues. For people with severe mental illnesses it goes beyond pure coordinating or “brokering” services by others to ensuring person-centred service provision occurs. They require “active response” care management which often involves assertive home delivery of treatments of services. Done well, ongoing case management speeds recovery and helps prevent relapses and adverse outcomes for consumers and their families/carers.

Mental health services have a responsibility to assist consumers to achieve well-being and a better quality of life. The consumer’s personal choice and rights are respected while at the same time the individual is encouraged and supported to take responsibility for their own journey towards recovery. Continuity of care is also dependent on a range of other services such as primary care through GPs, practice nurses and private psychiatrists/psychologists, as well as employment, education, housing, and community welfare services. These agencies sit outside the control and scope of public mental health services but are a vital part of the recovery team.

It is necessary for all mental health service providers (within a specific service, between programs and between mental health sectors/areas) to work in partnership to ensure the best outcomes for people with mental illness.

A person who has recurrent episodes or continuing severe disability may need to renew to the continuity cycle multiple times with an aim of at least partial recovery (see Figure 4-1). However, a person who has made a substantial and sustained recovery may require assistance to exit the mental health service system. The system should also allow rapid and easy re-entry if required.

### Specialist interventions and psychological therapies

In the last fifty years there have been great advances in therapies for mental illness, from the discovery of more effective medications to the development of effective specialist psychological therapies that help improve brain function. Arguably the most important product of mental health clinical services is psychotherapy and counselling. They enable people to take control of their health and deal with the onset of often stigmatising illnesses that threaten relationships, personal development and achievement of life goals. This essential work can be poorly understood by health administrators and is a reason why there has been insufficient investment in building an appropriately qualified and adaptive workforce. Greater investment is required in community staff with these skills to improve the experience and recovery of consumers.

### Mental illness prevention and early intervention

The various National Mental Health strategies have supported the idea that prevention programmes reduce the risk of developing a mental illness or prevent their re-occurrence. Effective prevention programmes must target populations that are more at risk of developing a mental illness, for example, young people. School-based prevention programs, which focus on protective strategies such as resilience building, must be a priority for reform.

Similarly, people whose symptoms are detected early and who receive intensive interventions during the initial onset of a mental illness are more likely to achieve full recovery<sup>2122</sup>. Early detection and intervention aims to prevent the early stages of a mental illness progressing to a chronic mental illness or developing into the first episode of a mental disorder. A focus on illness prevention and early intervention is a key strategy in reducing the burden of mental illness in Australia.

### Challenging Stigma and Discrimination: Community awareness and Mental Health Promotion

There is widespread fear about mental illness in the community. This is largely based on ignorance and the perception that those with a mental illness are a threat to personal safety and security. The overwhelming majority of people with mental illness pose no more

risk to the safety of others than that posed by the general population. Fear and ignorance often lead to stigma and discrimination. Some service users may have internalised stigma, and service providers can also be very stigmatising in their attitudes and interactions. For this reason, there is a need to implement programmes which counter this community stigma.

Communities require information, knowledge and assurance. In particular, the public needs to know:

- what is good mental health and well being, and how to attain and maintain it, including how to develop the relevant skills to increase resilience and quality of life
- how to recognise the first signs of mental illness
- how to access help for those developing a mental illness
- how to support and assist those who are affected by mental illness
- that mental health services do deliver effective treatments and support
- that there are secure facilities for those people with a mental illness who may be a danger to themselves or others
- how to challenge stigma and discrimination.

## Social Inclusion and Citizenship

Issues of social inclusion, community acceptance and citizenship must be addressed to ensure that people with a mental illness are afforded the best possible conditions for recovery. The Commonwealth Government has recognised this need and has recently developed programmes with an emphasis on social inclusion. Community campaigns must promote:

National, state and territory community initiated campaigns are needed to increase awareness about mental illness and its treatments

- advocacy for placement and support of service users in culturally valued roles in the community
- challenging all stigmatising or discriminatory practices on behalf of service users and others in the community
- advocacy against discrimination experienced by service users' families
- advocacy for service users to regain and sustain full citizenship in their communities.

## Consumer, carer and recovery focus

### Consumer and carer participation

Consumer and carer participation at all levels in policy, planning and treatment is a hallmark of a quality mental health system.

To be effective, consumer and carer participation as an element of service provision requires ongoing resourcing. Policies which outline the conditions of engagement with consumers and carers at all levels are required. Consumers and carers need ongoing training and support and provision must be made for quality assessment and development to ensure effectiveness and efficiency.

### Recovery-oriented mental health services

There is no real agreement on the term “recovery” however the trajectory of recovery should be kept in mind by all mental health services. Recovery refers to a process which focuses on enabling the individual to gain a sense of hope, self esteem, identity, independence, self sufficiency, dignity and personal fulfilment. Recovery does not always mean that people will return to full health, but it does mean that people can live well in spite of their illnesses. (Farkas 2007).

“Recovery is both a process and an outcome and is essential for promoting hope, wellbeing, and a valued sense of self-determination for people with mental illness” (*National Mental Health Plan 2003-8*)

Anthony et al (in Farkas 2007:2) point out that “the experience of recovery from mental illnesses includes not only regaining a valued role, but also recovering from the effects of having been diagnosed with a mental illness (e.g. discrimination, disempowerment, negative side-effects of unemployment, crushed dreams) as much as from the effects of the illness itself.”

“Psychiatric rehabilitation within mental health services increases the individual’s functioning in their own environment of choice with the least amount of professional intervention” (*Anthony et al, 2004:217*).

The Recovery approach requires mental health services to actively engage with the individual consumer to determine the most appropriate ways of managing and regaining control of their life and illness.

Table A-3 highlights the interventions and delivery systems that are evidence-based and required in a comprehensive mental health care system. While this discussion paper focuses on specialised mental health services a comprehensive services continuum needs to extend beyond primary health care and mental health to services such as housing, employment, education, and leisure activities available locally or provided from other sectors and local authorities.

While it is important to identify and provide accurate costings for evidence based interventions which should be provided by all comprehensive mental health services<sup>23</sup> (see column 1), it is equally important to identify and cost the essential infrastructure and evidence based vehicles or sub-systems which allow them to be appropriately accessed and delivered to the appropriate people in a timely manner at the most effective site (column 2).

**Table A-3: Evidence-based Components and Continuum of Care (from Rosen 2008<sup>24</sup>)**

Note: While it is important to identify and provide accurate costings for evidence based interventions which should be provided by all comprehensive mental health services<sup>25</sup> (see column 1), it is equally important to identify and cost the essential infrastructure and evidence based vehicles or sub-systems which allow them to be appropriately accessed and delivered to the appropriate people in a timely manner at the most effective site (column 2)

<b>Evidence-based (or promising) Interventions i.e. contents or care</b>	<b>Evidence-based (or promising) Delivery Systems i.e. facilities or vehicles for care</b>
1. GP liaison and shared care	1. Primary care mental health liaison team and supported transfer of care coordination systems (e.g. CLIPP)
2. Public health proactive approach to prevention, early detection and intervention seeking	2a) Mental Health First Aid Course 2b) telephone help lines, web-based mental health information and brief intervention services 2c) Prodromal assessment, monitoring and support service 2d) Early intervention team in youth health centre context
3a) Crisis and family intervention 3b) Home visit assessments interventions and reviews 3c) Acute respite care 3d) Emergency psychiatric services in general hospital emergency departments, including effective triage and brief, targeted, behavioural interventions as required	3a) & b) 24 hours or extended hours mobile community-based crisis intervention services 3c) 24 hour supervised community-based residential respite facility, as alternative to hospital admission, plus step up and down care 3d) e.g. 24 hour roster of psychiatric triage nurse consultants in busy emergency departments – emerging evidence of effectiveness, though should not replace crisis services. e.g. psychiatric emergency centres approximated to or in emergency departments – very costly, yet no evidence to support any advantage over less restrictive alternatives, such as 3.c) above. e.g. brief intervention clinic or role of crisis team in delivering repertoire of behavioural interventions following emergency dept presentation—emerging evidence.

Evidence-based (or promising) Interventions i.e. contents or care	Evidence-based (or promising) Delivery Systems i.e. facilities or vehicles for care
<p>4a) Active-response intake and mobile care coordination (case management) sub system</p> <p>4b) Assertive/Intensive community care management for individuals with persistently severe disabilities</p>	<p>4a) Local community-based mental health centre near shopping and transport hubs</p> <p>4b) Assertive community treatment team, meeting international fidelity criteria</p>
<p>5. <b>Biological Interventions.</b></p> <p>5a) Medications and other technologies</p> <p>5b) Attending properly to physical care of individuals with mental illness</p>	<p>5. <b>Biological Intervention Systems</b></p> <p>5a) Monitoring and adverse effects/interactions/polypharmacy minimizing risk management system, community pharmacist consultation and liaison service</p> <p>5b) Protocols, monitoring and intervention systems to minimize physical illness and risk factors in individuals with mental illness e.g. CVS and diabetes regular risk factor monitoring system  e.g. aerobic exercise and weight monitoring programs, individual and group</p>
<p>6. <b>Psychological Interventions</b></p> <ul style="list-style-type: none"> <li>– CBT</li> <li>– DBT</li> <li>– IPT</li> <li>– neurocognitive remediation</li> <li>– supportive psychotherapy</li> </ul>	<p>6. <b>Psychological Interventions</b></p> <ul style="list-style-type: none"> <li>– Delivery and supervision network, plus monitoring for fidelity.</li> </ul>
<p>7. <b>Social Interventions</b></p> <p>7a)</p> <ul style="list-style-type: none"> <li>– social</li> <li>– leisure</li> <li>– education</li> <li>– work</li> <li>– financial</li> </ul> <p>7b) Residential</p> <ul style="list-style-type: none"> <li>– Living in your own home wherever possible</li> <li>– A range of different levels of supervision in residential settings</li> </ul>	<p>7. <b>Social Intervention Systems:</b></p> <p>7a) e.g. clubhouse or equivalent e.g. leisure/recreation/aerobic physical activity program  e.g. expert vocational rehabilitation counsellors operating individual placement and support (IPS) programme e.g. financial counselling service</p> <p>7b) Residential – a range of supervised residential facility options e.g. support in your own home  e.g. 24 hour supervised community residential care plus medium to long term residential cluster home scheme  e.g. Medium to long term community residential with partial supervision.  e.g. 24 hour supervised care residential units on general hospital sites</p>

Evidence-based (or promising) Interventions i.e. contents or care	Evidence-based (or promising) Delivery Systems i.e. facilities or vehicles for care
<p>7c) Inpatient Interventions</p> <ul style="list-style-type: none"> <li>– Medical technologies, e.g. ECT, TMR, etc require up to date</li> <li>– Equipment, regular staff training and refreshers, daily pharmacist input</li> <li>– Minimize or eliminate restraint and seclusion</li> <li>– Minimize involuntary care</li> <li>– Psycho-education and adaptive communication and problem solving skills on an individual, group and family</li> <li>– Supportive psychotherapies on an individual group and family basis</li> </ul> <p>As there is little evidence to support inpatient admissions generally, seek less restrictive alternatives asap, whether for acute short term or supervised extended stay residential care</p>	<p>7c) Inpatient Team and facilities</p> <p>(Evidence sparse for optimal characteristics &amp; effectiveness)</p> <ul style="list-style-type: none"> <li>– On general hospital site</li> <li>– Small scale, semi-domestic atmosphere.</li> <li>– Attractive, welcoming spaces, softly furnished, calming use of colours.</li> <li>– Modularized unit, allowing separate</li> <li>– safe spaces for vulnerable or dangerous inpatients</li> <li>– Separate acute observational locked sub-unit and unlocked subacute sub-unit</li> <li>– Maximise staff: inpatient ratio and interaction</li> <li>– Minimise use of locked doors, restraints, seclusion, and restriction of leave.</li> <li>– Maximise indoor and outdoor spaces, so agitated inpatients do not feel so cooped up</li> <li>– Separate bedrooms with good sightlines for staff with acute observation inpatients</li> <li>– Minimise hanging points and other dangerous environmental features</li> </ul> <p><b>8.</b> Unobtrusive but effective duress alarm system for service providers, inpatients and visitors</p>
<p><b>8. Cultural Interventions</b></p> <p>8a) Microcultural:</p> <ul style="list-style-type: none"> <li>– Family education support and communication and problem solving skills intervention, including surrogates, confidantes and support persons.</li> </ul> <p>8b) Macrocultural:</p> <ul style="list-style-type: none"> <li>– Community awareness</li> <li>– Community education</li> <li>– Challenging stigma and discrimination</li> </ul>	<p><b>8. Cultural Intervention Systems</b></p> <p>8a)</p> <ul style="list-style-type: none"> <li>– Individual family intervention at home</li> <li>– Multiple family group intervention conducted by team which can systematically provide staff to work with families out of office hours</li> </ul> <p>8b)</p> <ul style="list-style-type: none"> <li>– Community awareness local</li> <li>– Meetings/local action committees</li> </ul>

Evidence-based (or promising) Interventions i.e. contents or care	Evidence-based (or promising) Delivery Systems i.e. facilities or vehicles for care
	<ul style="list-style-type: none"> <li>– Mental Health First Aid courses</li> <li>– Community awareness public/</li> <li>– Media campaigns</li> <li>– Challenging stigma local public media campaigns</li> <li>– Challenging stigma workplace</li> <li>– Programmes</li> </ul>
<p>9. Comorbidities</p> <ul style="list-style-type: none"> <li>– Dual interventions for:</li> </ul> <p>9a) Substance abuse and mental illness</p> <p>b) Intellectual disability and mental illness</p> <p>c) Specific learning disability and mental illness</p> <p>d) Brain injury and mental illness</p> <p>e) Severe physical disability and mental illness</p> <p>f) Eating/dieting disorders, physical and psychiatric components</p> <p>g) Forensic problems and mental illness</p> <p>h) Consultation-liaison psychiatric services to medical and surgical wards</p>	<p>9. Comorbidity Service Systems for a) to g).</p> <p>Service delivery system with professional expertise and facilities which will address both problems simultaneously, not making the treatment of one problem conditional and secondary to treatment of the other.</p> <p>h) Consultation-liaison psychiatric team for each general hospital facility – evidence that these significantly reduce lengths of hospital stay</p>
<p>10. <b>Bringing it all together</b></p> <p>10a) Integrative holistic comprehensive interventions</p> <ul style="list-style-type: none"> <li>i – continuity over time</li> <li>ii – integrated coordinated efforts at any one time</li> </ul>	<p>10. <b>Comprehensive Service Systems</b></p> <p>10a) Integrated at several levels:</p> <ul style="list-style-type: none"> <li>i care coordinator/case manager working closely together with service-users and family, to develop and review an individual care plan</li> <li>ii interdisciplinary mental health team <ul style="list-style-type: none"> <li>– with coordinated delegation of</li> <li>– tasks around service-user needs,</li> <li>– encapsulated in an individual care plan,</li> <li>– which is regularly reviewed</li> </ul> </li> <li>iii collaborative planning between: <ul style="list-style-type: none"> <li>– primary care, acute mental health</li> <li>– care and longer term rehabilitation</li> <li>– recovery work and specialist</li> <li>– health services</li> </ul> </li> <li>iv coordinated planning and service</li> </ul>

Evidence-based (or promising) Interventions i.e. contents or care	Evidence-based (or promising) Delivery Systems i.e. facilities or vehicles for care
<p>10.b) Recovery oriented services towards:</p> <ul style="list-style-type: none"> <li>i – growth throughout life</li> <li>ii – empowering service users</li> <li>iii – setting your own goals and priorities</li> <li>iv – control over your own life</li> <li>v - social inclusion and citizenship</li> <li>vi - resilience</li> </ul>	<ul style="list-style-type: none"> <li>– delivery between public</li> <li>– private and NGO mental health</li> <li>– services</li> </ul> <p>v coordinated planning and service</p> <ul style="list-style-type: none"> <li>– delivery between mental health</li> <li>– and all other relevant agencies, e.g. housing, work, education,</li> <li>– welfare, financial/benefits,</li> <li>– recreation and leisure – i.e. integrating efforts of State and Commonwealth funded agencies, with a coordinated all of government response</li> </ul> <p>10b)</p> <ul style="list-style-type: none"> <li>i Consumer peer support specialists               <ul style="list-style-type: none"> <li>– certified training and placement in</li> <li>– clinical teams</li> </ul> </li> <li>ii Recovery oriented experiential               <ul style="list-style-type: none"> <li>– workshop training for service</li> <li>– users, providers and families</li> </ul> </li> <li>iii Working with communal               <ul style="list-style-type: none"> <li>– organizations and workplaces</li> <li>– towards social inclusion and full</li> <li>– citizenship</li> </ul> </li> <li>iv Coping, resilience, buoyancy, work/life balance, hope instilling etc. skills training for service users, providers and families</li> <li>v Consumer &amp; Carer participation in service management, recruitment etc</li> <li>vi Consumer choices take precedence, where possible, in drawing up own individual plan</li> </ul>
<p>10c) Age-appropriate interventions provided specifically for each age group wherever possible</p>	<p>10c) Age appropriate delivery systems provided specifically for each age group wherever possible.</p>

## Appendix B Transition to implementation

Focus of reform	Strategy Options		
	Linkage (achievable in the short term)	Coordination (medium term)	Integration (longer term)
<b>Mental health individual &amp; family journey</b>			
8 Integration across the patient journey	Establish electronic referral systems at the local and regional levels	Establish common, shared electronic medical records, including standardised needs assessment tools.	Identify, through a Commonwealth audit process, best practice service standard community packages of integration care which could be introduced as standard practice across Australia.
	Establish standards of active case management to achieve the bringing together all elements of health and human services for and with the individual service users and their care givers (rather than just brokerage)		Promote population based care by linking the allocation of provider numbers to areas of need
2. Reforming primary care mental health provision	Establish mechanisms for active involvement of case management team providing continuity in every phase of care	Establish super clinics/Integrated Primary care Centres which include Mental Health services and other associated support services	Develop models which integrate primary care and public mental health service provision
	Review current Better Access and Fee for service models which support	Uncap or increase the numbers of mental health and allied health occasions of service funded under Medicare fee for service for Mental Health	Develop funding and service delivery mechanism that allow the purchasing of a package of mental health care support from multiple agencies using a capitated funding model

Focus of reform	Strategy Options		
	Linkage (achievable in the short term)	Coordination (medium term)	Integration (longer term)
<b>Mental Health team</b>			
1. Reforming primary care mental health provision	Develop and maintain electronic service and referral directories	Continue to test and formally evaluate coordinated care models for patient population groups who have chronic and complex health care needs.	Establish regional mental health service authorities that are responsible for managing and integrating health services in the region.
		Fund formal liaison structures at the local/regional level that bring together general practitioners, hospitals and community health care services.	
		Allow 'cash out' and funds pooling for specific the mental health patient populations.	
		Introduce blended payment models for GPs that include a mix of fee for service incentive (outcome) payments and some targeted recurrent funding (including testing some capitation models) with GPs able to select the payment model of their choice, including existing FFS arrangements.	

Focus of reform	Strategy Options		
	Linkage (achievable in the short term)	Coordination (medium term)	Integration (longer term)
<b>Mental Health Service</b>			
1. Service integration at the local/ regional level	Develop and maintain electronic service and referral directories	Continue to test and formally evaluate coordinated care models for patient population groups who have chronic and complex health care needs.	Establish regional mental health service authorities that are responsible for managing and integrating health services in the region.
		Fund formal liaison structures at the local/regional level that bring together general practitioners, hospitals and community health care services.	
		Allow 'cash out' and funds pooling for specific the mental health patient populations.	
		Introduce blended payment models for GPs that include a mix of fee for service incentive (outcome) payments and some targeted recurrent funding (including testing some capitation models) with GPs able to select the payment model of their choice, including existing FFS arrangements.	

Focus of reform	Strategy Options		
	Linkage (achievable in the short term)	Coordination (medium term)	Integration (longer term)
<b>Mental health system</b>			
1. Service delivery component integration	Implement MBS items that encourage and reward collaboration and liaison between Fee for service, other providers and carers e.g. phone and electronic consultations		
2. Service purchasing integration	Commence negotiation with private, public and NGO towards common planning and goal setting for mental health service provision for a defined region or population	Pooling of funds to allow purchasing and effective integration of services for private, public and NGO towards common	Establish Regional Funding Authorities to commission services
3. Health funding programs	Develop a clinical governance model for the whole of mental health care	Rationalise the multiple Commonwealth community aged care programs.	Establish regional health funding authorities (each with a population needs-adjusted share of Health funding that are responsible for planning and funding health services for regional residents. Funding could be pooled Commonwealth and State funds or full funding to be provided by one level of government.
		Use financial incentives within the fee for service system to achieve better equity (e.g., pay higher fees in geographic areas of need) and to encourage better allocative efficiency (pay more for those services and interventions that address high priority population health needs and less for discretionary health care.	
4. Policy and organisation - public/private	Commonwealth to assume full responsibility for the development of the health workforce with a view to aligning the demand for and supply of essential skills.	Use the AHCA to lever better coordination at the policy and organisational levels e.g., data, information management	Funds pooling or realignment of Commonwealth/State tax revenue sharing to create a single purchaser/funder.
		Population based funding at the Commonwealth level with outcomes based performance reporting at the State level.	

Focus of reform	Strategy Options			
	Linkage (achievable in the short term)	Coordination (medium term)	Integration (longer term)	
<b>Health and Human service system</b>				
1	<p>Integration of health and other human services e.g., disability, respite care</p>	<p>Create and resource regional forums for sharing information across the human services sector</p> <p>Develop and maintain electronic service referral directories (similar to the HSNNet initiative in NSW).</p>	<p>Coordinate the relevant Commonwealth / State agreements e.g., the Commonwealth State Territory Disability Agreement (CSTDA), the HACC Agreement and the AHCAs.</p>	<p>Creation of departments of human services with alignment of responsibilities at both levels of government. Expand the scope of the AHCAs to include all human services not just health.</p>
2.	Human and Health service care coordination models	<p>Review and redistribute current programmes to align and to serve same population catchments as mental health</p>	<p>Develop care coordination contractual models which assist mental health consumers and carers to engage with the relevant health and human services e.g. care purchasing and packaging arrangements</p>	<p>Optimal integration between health services and other human services required by people with mental illnesses, including disability services, domestic, vocational, and income support, respite care, recreation and education services.</p>
		<p>Identify most appropriate single agency to coordinate care for each service user</p>		

Focus of reform	Strategy Options		
	Linkage (achievable in the short term)	Coordination (medium term)	Integration (longer term)
<b>Whole of community</b>			
1. Integrated input into well-being and social capacity building of whole community or defined population	Develop and implement primary care and community mental illness prevention, early detection and intervention programmes e.g. Community awareness campaigns, Mental Health First Aid courses for youth, indigenous and all of community	Fund and implement Mental Health and Wellbeing Promotion programmes at community level  e.g. resilience or therapeutic optimism, quality of life skills and positive psychology programmes	Develop partnership models of wellness promotion with private, public and community partners
		Develop and implement 'Challenging mental health stigma, discrimination and promotion of social inclusion' campaigns with central media and local community action levels	Implement long term measurement of impact and sustainability of mental health, well being and destigmatising strategies

## Appendix C References

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