Mental Health Council of Australia
Community Mental Health and Primary Mental Health Care Background Paper

July 2010

Preamble

This background paper arose from the National Health and Hospitals Reform Commission (NHHRC) 2009 Final Report and its recommendations about future directions for primary health care. The recommendations for primary health care included 'community mental health', which led to concern that the scope and complexity of community mental health care had been overlooked or misunderstood.

This paper seeks to clarify points of overlap and difference between primary health care and community mental health. It also identifies how their linkages could be strengthened whilst ensuring maintenance of the capacity and integrity of specialist mental health services delivered in the community.

This paper came from discussions at a Mental Health Council of Australia (MHCA) Members Policy Forum, and was developed in consultation with MHCA members. It contains the following sections:

- Issues for community mental health in recent proposals
- Community mental health defined
- Primary mental health care
    - How primary mental health care is provided
- Secondary and tertiary mental health care
- Community-based clinical mental health care
    - Public Sector
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    - Community mental health support and recovery services
- Ways forward
    - Advantages of the proposed new structures
    - Disadvantages of the proposed new structures
    - Core prerequisites
    - Identifying effective models of care.

Introduction

The recommendations of the NHHRC 2009 Final Report seek to overcome existing problems with the provision of primary health care, such as the inequitable levels of access for those living in regional and remote areas, and in disadvantaged urban areas[1].

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[1] Department of Health & Ageing (2009a) *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy*; Canberra, Commonwealth of Australia.

The aim is to expand and strengthen primary health care so that it becomes 'the cornerstone of our future health system', a laudable objective.

This paper focuses on three particular recommendations in the NHHRC 2009 Final Report.

The first recommendation is that the Commonwealth Government take over policy and funding responsibility for all community health services presently funded by state, territory and local governments, including 'community mental health services'[2].

The next two recommendations refer to proposed arrangements for the management and provision of primary health care. Comprehensive Primary Health Care Centres and Services were to provide a 'one-stop shop' approach to primary health care[3] and regional primary healthcare organisations (PHOs) were to replace GP Divisions and be charged with planning, organising and monitoring the provision of primary health care for their regional populations[4]. Services would be purchased rather than actually provided by the PHO, and a 'hub and spoke' model could be used in areas with a widely dispersed population. However, these proposed structures have now been replaced by the establishment of 'Medicare Locals' as announced by the Federal Government in May 2010.

Issues for community mental health in these recent proposals
There are at least two major issues from these recommendations, which warrant attention for community mental health services.

One is that the NHHRC 2009 Final Report equates community mental health services with primary health care. This is misleading. In the mental health sector, the term 'community mental health services' covers much more than primary health care as it also encompasses a range of secondary and tertiary mental health care delivered by services based in community settings outside hospital campuses. This includes both clinical treatment, and support and recovery care. The second issue is that it is not yet clear how the new Medicare Locals will take into account primary, secondary or tertiary mental health care.

This paper provides an opportunity to examine these issues. It also considers how community mental health services could link to Medicare Locals in order to overcome or lessen current problems of service access, and further enhance continuity of care.

Community mental health defined
In simple terms, community mental health refers to mental health care delivered in community settings. These settings could be a residential facility in a neighbourhood street, a GP practice, a private psychiatrist's office, a clinic, a community-based non government organisation (NGO) day program, or a person's own home.

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[2] National Health & Hospitals Reform Commission (2009) *A Healthier Future for All Australians: Final Report of the National Health & Hospitals Reform Commission*; Canberra, Commonwealth of Australia, p148.
[3] Ibid, p103.
[4] Ibid.

It is important to reiterate that not all community-based or 'non-hospital' mental health services provide primary care. Primary mental health care is certainly an important component of mental health care provided in the community. However, as already noted, community mental health services also incorporate specialist secondary and tertiary mental health care, including support and recovery services delivered by non-government organisations in what has come to be called the community-managed sector.

The NHHRC 2009 Final Report's definition of community mental health does not reflect this practice reality. This has continued in the new Commonwealth Government's National Health and Hospitals Network (NHHN) Report, which proposes that the Commonwealth Government take over funding for primary health care, including 'community mental health'[5] .

No definition of 'community mental health' is given in the NHHN Report, so it can be presumed that the range of specialist mental health care provided in the community has again been overlooked or not understood. However, some room is given to states and territories to negotiate with the Commonwealth about what services would be included in this transfer[6] .

Primary mental health care
The 2008 WHO Report '*Integrating mental health into primary care - a global perspective'* uses the term 'primary care for mental health', defining this as 'mental health services that are integrated into general health care at a primary care level'[7]. All diagnosable mental health disorders are included.

The term 'mental health services' in this instance is used to cover 'first line interventions that are provided as an integral part of general health care', and also 'mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health care services'[8]. This captures how primary mental health care is usually the first port of call for mental health as well as other health problems, and how its practitioners are often involved in continuing care.

The WHO Report also explicitly acknowledges that primary mental health care is part of a spectrum or continuum of mental health care which must include specialist services.

The Report notes that:
> 'primary care for mental health forms a *necessary* part of comprehensive mental health care, as well as an *essential* part of general primary care. However, in isolation it is never *sufficient* to meet the full spectrum of mental health needs of the population'[9].

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[5] Commonwealth of Australia (2010) *A National Health and Hospitals Network for Australia's Future*. Canberra, Commonwealth of Australia, pps 13 and 40.

[6] Ibid, p41.

[7] World Health Organisation (WHO) (2008) *Integrating mental health into primary care: A global perspective*. Geneva, WHO, p9.

[8] Ibid, p10.

[9] Ibid, p10. Italics in original.

The WHO Report refers to primary care services for mental health as the 'first level of care within the formal health system'[10]. The list of services is comprehensive:

- 'Early identification of mental disorders;
- Treatment of common mental disorders;
- Management of stable psychiatric patients;
- Referral to other levels where required;
- Attention to the mental health needs of people with physical health problems; and
- Mental health promotion and prevention[11].'

Primary mental health care clearly has several dimensions. One not mentioned in the above list is access by a person with mental health problems to treatment of transient or ongoing general health conditions, which may or may not be associated with their state of mental health.

Another dimension is the issue of direct access. This is picked up in the Glossary provided in the NHHRC 2009 Final Report, where primary health care is described as comprising 'services in the community *accessed directly by consumers*[12]'. Community mental health is one of the services listed. However, until recently, direct consumer access has been the exception rather than the rule for specialist mental health care in the community. A visit to a GP or other health practitioner has usually been the first step before attending a private psychiatrist or public mental health service. Of course, a GP (or other primary health care practitioner) may continue to treat a person with a mental health problem without ever referring the person to a specialist mental health service.

More recently, this initial 'gateway function' of primary care services is also being provided by 24/7 mental health telephone and online services. In addition, 'walk-ins' are becoming more common at community mental health services, with people self-presenting and requesting an assessment. This may also be encouraged in relation to particular age groups. For instance, direct access to specialist mental health care for young people aged 13-25 years through self-referral is a component of the restructuring of Child and Adolescent Mental Health Services (CAMHS) in jurisdictions such as the ACT.

Access to community-managed support and recovery services would also usually follow referral from a private or public specialist clinical mental health service, in keeping with these services providing secondary rather than primary mental health care. However, referrals from other sources are increasing, especially in relation to recent initiatives such as the Commonwealth-funded Personal Helper and Mentors (PHaMS) program. Additionally, some services already accept self-referral.

How primary mental health care is provided
The need to improve primary mental health care in Australia has been recognised for some time. For instance, from 1996 to 2006, the Commonwealth funded a Primary Mental Health Care Australian Resource Centre (PARC) at Flinders University

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[10] Ibid, p 17.

[11] Ibid.

[12] National Health & Hospitals Reform Commission (2009), op cit, p289. Italics added.

Department of General Practice. PARC provided 'knowledge management, research, evaluation and information services to support Australian Primary Mental Health Care'.

Primary mental health care delivery has several strands, including the following:

- GPs are seen as the main providers of primary mental health care. However, this may be less applicable in areas where GPs are scarce, such as rural and remote parts of Australia and the socio-economically disadvantaged outer suburbs of the major cities.

- From the early 1990s, both the Commonwealth and states funded a range of shared care projects, which encouraged collaboration between GPs and public mental health services. An example is the Consultation and Liaison in Primary Care Psychiatry (CLIPP) program initiated by Professor Graham Meadows in Victoria[13] The CLIPP model has three components: regular psychiatric consultation, liaison and education for GPs to assist them to recognise and treat mental health problems; shared care of specific consumers with serious mental illness transferred from specialist mental health services; and mechanisms to encourage active follow up[14].

- In 2002, Victoria established primary mental health and early intervention teams to provide primary and secondary consultation, and education and training for primary care providers, particularly GPs[15]. Priority goes to assisting primary care providers treat people with high prevalence disorders (anxiety, depression) and young people with early psychosis. Teams vary in size across the state and are managed by local public area mental health services[16].

- In recent years, several Commonwealth and state-funded programs have been introduced to assist GPs by providing easier access for consumers to get help from other health professionals. An example is Commonwealth initiatives designed to enable GPs to refer people with mental health problems for therapeutic interventions from allied health practitioners. These programs include Access to Allied Psychological Services (ATAPS), which started in 2001, and Better Access to Mental Health Care, which began in November 2006.

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[13] Meadows, Graham B (1998) Establishing a collaborative service model for primary mental health care. *Medical Journal of Australia*, 168, 162-165; Meadows, Graham (2000) CLIPP (Consultation and Liaison in Primary Care Psychiatry) Manual. Downloadable from http://www.health.vic.gov.au/mentalhealth/clipp/index.htm.

[14] Meadows, Graham, Harvey, Carol A., Joubert, Lynette, Barton, David & Bedi, Gillinder (2007) Best Practices: The Consultation-Liaison in Primary-Care Psychiatry Program: A Structured Approach to Long-Term Collaboration. *Psychiatric Services*, 58,1031.

[15] Mental Health Branch (2002) *Guidelines for Primary Mental Health and Early Intervention Teams.* Melbourne, Victorian Dept of Human Services. Download at http://www.health.vic.gov.au/mentalhealth/pmc/catchment.htm

[16] Hurworth, Rosalind & Shrimpton, Bradley (2005) *Evaluation of the Primary Mental Health and Early Intervention Initiative - Volume II*; Melbourne, Centre for Program Evaluation, University of Melbourne. Download at http://www.health.vic.gov.au/mentalhealth/pmhei/index.htm

- Another 2006 Commonwealth initiative provides funding for GP practices (and also for private psychiatrists) to employ mental health nurses to improve the coordination of treatment and care, focusing on patients with serious mental illness.

- Primary mental health care is also increasingly available through internet-based programs. Examples are online cognitive behavioural therapy for depression and treatment for anxiety disorders.

- Telephone services such as Lifeline are a key community access point for support and referral for mental health care if required. There has also been an increase in government-funded 24/7 mental health advice and referral phonelines staffed by mental health professionals.

- Some community health centres employ professional counselling staff to work specifically with people with mild to moderate mental health problems.

- Primary health care for young people, with immediate access to mental health care, is now available in some parts of Australia through the National Youth Mental Health Foundation headspace. Funded by the Commonwealth and launched in 2006, headspace aims to provide multidisciplinary services for young people aged 12 to 25 years with 'mild to moderate mental health issues'. Services are delivered from 30 'Communities of Youth Service' sites set up across Australia, which provide a 'one-stop shop' for access to primary health, mental health, alcohol and drug services, and social and vocational support[17]. Funding for the establishment of a further 30 headspace sites was announced in the 2010 federal budget.

Secondary and tertiary mental health care
Like primary health care, primary mental health care faces problems in distribution and accessibility. Secondary and tertiary mental health care is more complex. What is provided, how, and by whom, currently varies across states and territories, and urban, rural and remote areas.

What services are available will often depend on where you live, and to some extent on your level of disposable income, rather than your treatment and care needs. Services also differ in terms of management, governance arrangements and sources of funding, and the titles of comparable service types. Another issue is whether and how the service is accountable to the community it serves.

This marked diversity reflects historical influences, local politics and government policy directions at both state/territory and federal levels. For example, until 1986, Commonwealth Disability Services legislation did not cover people with a psychiatric disability. Full inclusion of these people for funding purposes did not effectively start

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[17] Muir, K, Powell, A, Patulny, R, Flaxman, S, McDermott, S, Oprea, Ioana S, Gendera, J, Vespignani, T, Sitek, D, Abello, D & Katz, I (2009) *Independent Evaluation of headspace: the National Youth Mental Health Foundation;* Sydney, Social Policy Research Centre, University of New South Wales. Download at http://www.sprc.unsw.edu.au/media/File/Final_Independent_evaluation_of_headspace_report.pdf

until the new five-year Commonwealth/ State Disability Agreement (CSDA) signed in 1991.

Fortunately, there is now a commitment under the Fourth Mental Health Plan which promises to improve this situation. The first action under Priority Area 3 in the Plan, which is service access, coordination and continuity of care, is to 'develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models[18]'. The importance of this step is highlighted by carer experiences presented in the recent MHCA Report Adversity to Advocacy: the lives and hopes of mental health carers, especially 3.2.5 on p.28[19].

Secondary and tertiary mental health services delivered in community locations are sometimes referred to as post-hospital or hospital outpatient services. This is misleading. For decades, most clients of these services (whether in the public or private sector) have used only these community-based clinical services, without periods of inpatient care. A major reform challenge has been to ensure that the distribution of funds caught up with this reality, as historically the bulk of public mental health sector funding went to inpatient services.

Secondary and tertiary mental health services can be grouped into specialist clinical mental health services (public and private), and community-managed support and recovery services. Outlining the range provided in each category has value in showing the complexity of the mental health service system, which is often not well known.

Community-based clinical mental health care
Public Sector
Community-based public mental health services are usually part of a comprehensive mental health service for a particular area, together with acute and extended care inpatient services. Services are typically (but not always) managed as a whole, rather than as separate elements, in recognition of their interdependence and the way the functioning of one component affects the others. For instance, if a community-based acute team is unable to provide intensive home-based treatment due to under-staffing, there are likely to be more hospital admissions.

Like inpatient services, community-based clinical mental health services operate under mental health legislation. Amongst other responsibilities, they provide ongoing care for people who are subject to community treatment orders, which authorise provision of involuntary treatment when the person is living in the community outside an inpatient setting.

With the exception of mental health care for veterans, public community mental health services are funded by state and territory governments. In some jurisdictions, these services are managed by general hospitals or healthcare networks, rather than

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[18] Department of Health & Ageing (2009b) *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014*; Canberra, Commonwealth of Australia, p42.

[19] Mental Health Council of Australia (2009) *Adversity to Advocacy: the lives and hopes of mental health carers.* Canberra, MHCA.

a state or territory government instrumentality. In the case of mental health services for older people, management may be the responsibility of the local aged care service.

The community location of community-based services is integral to their effectiveness. For instance, by being based in the community they serve, rather than on a hospital campus, staff become part of local service networks. This fosters access to services that consumers need, such as housing, employment and recreation.

Starting in NSW from the mid-1980s, community-based clinical services began to organise their service delivery around teams with specific functions, following evidence from local and overseas experience that this resulted in better treatment outcomes. However, in country areas with dispersed populations, teams are typically multi-functional and work from satellite locations.

Community-based clinical services usually cover some or all of the following functions:
- Clinic-based acute and continuing care, typically delivered in a community mental health centre or clinic with street frontage in a neighbourhood street, may share premises with private practitioners.
- In rural and remote areas, both acute and continuing care is likely to be provided from satellite or out-posted locations, rather than from a major town.
- Acute assessment and treatment provided on a mobile basis at extended hours across a seven-day week.
- Intensive treatment (sometimes called assertive outreach) provided on an outreach basis, and available on an extended hours basis across a seven day week, for people with ongoing or recurrent serious mental illness and associated disabilities.
- Consultation with local GPs and other primary health care practitioners, and shared care in relation to specific patients referred to GPs for ongoing management[20].
- Shared care with private psychiatrists.
- Residential rehabilitation in community settings with 24/7 on-site clinical staff.
- In-reach to emergency departments.
- Tertiary level clinical care for specific groups such as forensic mental health clients.

Private Sector
- Specialist clinical mental health care is provided in the community by the private sector, including the following:
  - Private sector clinical care in community settings is provided by private psychiatrists and other private practitioners, with a small number of practices co-located with public mental health services.
  - In the private sector, treatment in the community is typically provided on an appointment basis in an office setting within business hours, although evening

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[20] Meadows (2000), op cit.

appointments may also be available. In addition, some private hospitals provide outreach programs.
- In 2000, the Commonwealth funded several time-limited National Demonstration Projects 'to improve formal linkages between public sector mental health services and private psychiatrists in order to maximise outcomes for consumers'[21]. These projects typically ran for two years. It is unclear whether they led to lasting changes.
- More GPs have taken on the mental health care of people with severe mental illness following formal discharge from mental health services, or where such services are not able to provide specialist care due to inaccessibility or lack of resources.
- One of the 2006 COAG Mental Health Initiatives provides funding for private psychiatrists and GP practices to employ mental health nurses to assist in coordinating the care of people with severe mental illness. This includes 'home visiting, medication management, and improving links to other health professionals[22].
- The 2006 Better Access to Mental Health Care program enables GPs, private psychiatrists and paediatricians to refer people to allied health practitioners registered as Medicare providers for rebatable sessions of psychological interventions (allied health practitioners include psychologists, social workers and occupational therapists).

Community mental health support and recovery services
Community-managed NGOs provide a wide range of community mental health support and recovery services. Their major source of funds is Commonwealth disability support funding, which is initially channelled through state and territory disability programs. However, this is typically augmented by additional funding from state or territory mental health budgets. In the ACT for example, 50 percent of the 2009-2010 mental health budget was directed to community-managed NGOs to provide support to consumers.

From 2006, under the Commonwealth-funded COAG Mental Health Initiatives, the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FAHCSIA) also directly funded a number of non-government organisations to provide the following services:
- Personal Helpers and Mentors (PHaMS)
- Day to Day Supported Living
- Additional respite care places.

Like clinical treatment services provided in community settings, the range and distribution of community mental health support and recovery services varies considerably across states and territories, and regional and remote and urban areas.

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[21] Pirkis, Jane, Livingston, Jenni, Morley, Belinda and Trauer, Tom (2003) *The Public and Private Partnerships in Mental Health Project - Final Evaluation Report.* Melbourne, Centre for Program Evaluation, University of Melbourne, p5.

[22] Coalition of Australian Governments (COAG) (2006) *National Action Plan on Mental Health 2006-2011.* Canberra, COAG, p10.

They include some or all of the following functions:
- Home-based outreach support, varying in level of intensity.
- Psychosocial rehabilitation provided in different community locations.
- Counselling and peer support.
- Supported housing, including support provided on an in-reach basis.
- Respite care for families and consumers.
- Support for families and other carers, including information and education about mental illness, and access to counselling.
- Step-up/step-down staffed residential care as an alternative to inpatient admission, or for a period of transition after hospital discharge, with clinical input from the local community-based clinical service[23].
- Residential rehabilitation with staff on-site during the day and sometimes overnight.
- Recreational activities, including gardening, art and craft.
- Adult education programs where the NGO is a registered training provider.
- Job placement and support services through links to or funded by a disability employment network.

To date, state and territory funding for organisations providing support and recovery services does not usually cover provision of clinical treatment. However, some agencies have organised access to specialist mental health clinical care for particular clients, such as psychological interventions drawing on philanthropic or other funding sources, or for hard to reach communities (either geographically or culturally).

Ways forward
As this paper shows, the complexity of the mental service system and its structural differences from the general health system seem to have been overlooked or misunderstood in the NHHRC Final Report proposals for the reorganisation of primary health care. However, this offers the opportunity to consider potential advantages and disadvantages of the establishment of the new Medicare Locals, and to identify how they could be used to improve the linkages between primary, secondary and tertiary mental health services in the community.

Advantages of the proposed new structures
There are potential advantages if community mental health services (clinical and/or support and recovery) were linked to Medicare Local organisations, and included in planning for primary health care services at a regional level.

Advantages include the following:
- Better access by all mental health consumers to primary health care, with improved recognition and treatment of physical health problems.

- Reduced stigma through mental health services being linked to a mainstream service.

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[23] Forwood, Anne, Reed, Cheryl, Reed, Mandy, Roose, David & Ryan, Siobhan (2008) *Final Report for Evaluation of the Prevention and Recovery Care (PARC) Services Project*; Melbourne, Mental Health & Drugs Division, DHS. Download at http://www.health.vic.gov.au/mentalhealth/publications/parc-evaluation.pdf

- More attention to the service needs of people with mental health problems and mental illness in service planning to meet the needs of the population of the region.

- The possibility of gaining priority access to regional resources and services which are fundamental in recovery for people with mental illness, such as housing and employment support.

- Provision of an appropriate setting for mental health preventive interventions, early identification of mental health problems and specialist prevention programs, such as for children of parents with a mental illness.

Disadvantages of the proposed new structures
There are also potential disadvantages attached to incorporating community mental health with primary health care, as follows:

- If community mental health services were more closely linked to primary health care, their purpose and range of functions could be misunderstood. Not all mental health services delivered in community settings are primary mental health care services. Secondary and tertiary level community mental health services are specialist services whose clientele are typically those with the most disabling and distressing conditions. These services are part of the needed spectrum of mental health care, and provide back up to primary mental health care.

- There is a risk that the target group for secondary and tertiary community mental health services could be shifted to people with less severe conditions, who would be the majority of people attending primary health care services. This program slippage occurred in the United States in the 1960s, Australia in the 1970s and Britain in the 1980s. The result was neglect of the service needs of people with serious mental illness living in the community. This led to increased pressure on emergency departments and on related service systems including corrections and services for homeless people, and a rising demand for hospital admission.

- Linkages between services for people with severe mental illness could be weakened or even ruptured, particularly the critical nexus between community-based and inpatient clinical mental health services, a nexus which is fundamental for a community-oriented system of care. This would be a major step backwards, as inpatient and community-based mental health services are interdependent and need to be managed as a whole, rather than as stand-alone separate components.

- The specialist focus of particular community mental health teams could be diluted or lost, despite evidence showing that it is this focus that has led to their effectiveness eg. mobile assertive outreach teams, acute response teams.

- There is potential for re-direction and loss of resources currently dedicated to services for people with the most severe conditions.

Core prerequisites

There is plenty of evidence, anecdotal and otherwise, that there are problems in how the different levels of mental health services interact, and about the negative effects this has for consumers, family carers and mental health practitioners alike. The question is whether and how Medicare Locals as the new primary health care structures could improve this situation.

The overall aim would be to maximise the benefits of the new arrangements, including improving the effectiveness of specialist mental health services delivered in the community. In outlining the agenda for a nationally agreed planning framework, the Fourth National Mental Health Plan foreshadows what should be covered, including requirements relevant to primary mental health and specialist mental health services[24]. The points below incorporate and build on this list.

- Delineation of roles and responsibilities across the community, primary and specialist sectors, including the private sector[25].

- Establishing pathways to care that are clear to the general community, consumers and family carers, as well as practitioners, based on the 'no wrong door' principle and minimise the number of access mechanisms (as distinct from entry points). The use of a single well-publicised 24/7 mental health phoneline is one such mechanism.

- Ensuring that primary mental health care is easily accessible and provided by practitioners knowledgeable and skilled in mental health problems and their treatment, and who have ready access to primary and secondary consultation with specialist mental health practitioners.

- Engaging consumers and their families in developing individual service plans which address their particular service needs, including making informed choice about the most appropriate services, especially where recurrence or relapse is likely and rapid access to care may be needed.

- Providing seamless transfer of care from primary to secondary or tertiary mental health services, and the reverse, with all key participants kept informed about any changes and the reasons.

- Establishing and maintaining effective collaboration between primary mental health care practitioners and those working in secondary or tertiary mental health services, including the coordination of care.

Identifying effective models of care

Apart from setting out what is needed for effective relationships between primary mental health care, including primary health care, and specialist mental health services, it is also important to identify models of collaboration and shared care already in place, and explore what other arrangements might work.

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[24] Department of Health & Ageing (2009b), op cit, pp 41-43.

[25] Ibid.

There are existing models of collaboration between primary mental health care and specialist mental health services which include consultation and liaison as well as shared care in relation to specific patients[26]. It would also be timely to examine the effectiveness of other mechanisms to assist collaboration. Examples are Primary Care Coordinators in Queensland[27] and Primary Mental Health and Early Intervention Teams in Victoria[28], both of which work across primary mental health and specialist mental health services.

Another arrangement which warrants attention is the co-location of specialist community mental health teams with community health centres, which has been tried in some jurisdictions. In addition to ways of improving service linkages, collaborative models of care which focus on the client should also be examined, such as that being developed in Western Australia. The emphasis here is planning and coordinating individualised care plans for clients which may well include primary health care as well as specialist mental health care.

A time of change can also allow the trialing of innovative models. For instance, given the success of headspace in using a one-stop shop approach to engage with young people, it might be timely to explore the value of such a service model for other groups. An example would be children up to 12 years of age and their families.

Lastly, there is value in learning from new models of primary mental health care being introduced in other countries. For instance, the Increased Access to Psychological Therapy (IAPT) program in England and Wales is designed to provide greater access at no cost for people with mental health problems to psychological therapies, and is now being rolled out across the country[29].

Conclusion

As a broadly representative body, the MHCA is well placed to capture a range of views in the mental health sector on these matters. This paper aims to present this diversity and be a resource in forming responses to developments which are imminent or already in train.

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[26] For example, the CLIPP program, see Meadows (2000), op cit.

[27] Queensland Government (2008) *Queensland Plan for Mental Health 2007-2017*. Brisbane, Queensland Government, p 18. Download at www.health.qld.au/mentalhealth

[28] Mental Health Branch (2002), op cit.

[29] NMHDU (National Mental Health Development Unit) (2008) *Improving Access to Psychological Therapies (IAPT) - Implementation Plan: National guidelines for regional delivery*; London, NHS. Downloaded from http://www.nmhdu.org.uk/our-work/improving-access-to-psychological-therapies/ Also see the website: http://www.iapt.nhs.uk/