National Health and Hospital Networks, COAG and Mental Health Reform

Position Paper

But while the Rudd Government's health care reform package has now been revealed, the details are missing and a response to many key issues – particularly mental health, dental health and Indigenous health – are also missing. The approach has been evolutionary rather than revolutionary, clearly designed to address short-term pressure points rather than needed long-term changes. Although the funding provided seems generous, on closer scrutiny funding for important new investments in health care delivery is in fact quite limited, and the real reform elements appear to be critically lacking.

Macroeconomics, June 2010

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Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

In April 2010 at the Council of Australian Governments (COAG) meeting, the Federal Government won the support of all states/territories (with the exception of WA) for the National Health and Hospitals Network (NHHN) Agreement.

This Agreement has three primary objectives:

- Reforming the fundamentals of our health and hospital system, including funding and governance, to provide a sustainable foundation for providing better services now and in the future.
- Changing the way health services are delivered, through better access to high quality integrated care designed around the needs of patients, and a greater focus on prevention, early intervention and the provision of care outside of hospitals.
- Providing better care and better access to services for patients right now, through increased investments to provide better hospitals, better infrastructure, and more doctors and nurses.

Of the $7.4 billion announced in the COAG Agreement and the 2010 Federal Budget for health reform, only $181.3 million over the four years was specifically directed to mental health. Of this, a mere $115 million was identified by the Government as new funding – the remainder either being redirected or restorative funding. This represented less than 1.6% of all new healthcare funding.

In February 2011, concerns from a number of state governments relating to the proposed Commonwealth takeover of funding resulted in a new Agreement between all state and territory governments. Despite this new Agreement, the situation for mental health remains unchanged. Moreover, changes in government at the state and territory level continue to threaten commitments enshrined in these two Agreements and further perpetuate a state of unease and uncertainty within the Australian health and mental health sectors in relation to these reforms.

The aim of this Position Paper is to briefly summarise commitments relating to the NHHN Agreement, set out the key issues arising from the NHHN reform as it pertains to the mental health sector, and identify MHCA position statements as part of a sector-wide response in the lead up to the 2011 Federal Budget and the next COAG meetings.

COAG and the Federal Budget

COAG has agreed to:

- Provide funds for the construction and recurrent costs for 1,316 sub-acute beds by 2013-14 for aged care, respite, mental health and palliative care clients.[1]
- The establishment of a national network of primary health care organisations "to improve access to services and drive integration across GP and primary care, hospital and aged care services" (note these were later termed Medicare Locals).
- The establishment of Local Hospital Networks (LHNs) "to ensure (that) local communities have a say in how their hospitals are run". LHNs will be made up of a single large or several smaller public hospitals and have local boards of governance.
- Consider mental health issues including the future of community mental health services at COAG in June 2011. However, as a first step COAG agreed that a number of Federal funded community mental health programs, worth a total of $612.5 million over four years, would transition to control under the new Medicare Locals.
- Consider alcohol and other drug service issues at COAG in December 2010.

Subsequent to and consistent with the COAG Agreement, the May 2010 Federal Budget provided for:

- Increased *headspace* mental health services – $78.8 million to double the number of locations from 30 to 60, "helping 20,000 more young people".
- Funding of $25.5 million to expand the Early Psychosis Prevention and Intervention Centre model (known as EPPIC).
- An expansion of the Mental Health Nurse Incentive Program (MHNIP) with an extra $13.0 million over two years providing "up to an extra 136 mental health nurses".
- A total of $58.5 million will be directed to the Access to Allied Psychological Services (ATAPS) Flexible Care Packages (FCPs) program to provide clinical services "to better support 25,000 people with severe mental illness in a primary care strategy", and a further $60 million has been awarded for the provision of non-clinical care under this program.
- Continuation for two years of the drought-assistance mental health program.

Other announcements with relevance to the community mental health sector included:

- Funding of $291 million to establish new primary health care organisations (Medicare Locals) to better develop and coordinate primary care services.
- Funding of $126 million for the establishment of GP after-hours services through Medicare Locals.
- Additional funding for community health services, Aboriginal Medical Services and for 23 communities to receive a new GP Super Clinic ($355 million).
- $523 million for training and supporting practice nurses in GP clinics.
- $467 million for the development of electronic health records.

[1] Note in a press release from Minister Roxon on 1 July 2010 she refers to a different range of priorities – notably a broader term "rehabilitation' is used without qualification. Mental health is not listed in the press release.

- $400 million for a new national pricing authority and new national quality and safety standards and more transparent reporting on performance.
- Anti-smoking campaign targeting high-need and highly disadvantaged groups who are hard to reach through mainstream advertising.
- Support for aged care workers and improved access to care for older Australians.
- Payments to states/territories to boost emergency department and elective surgery capacity in public hospitals, to improve access to services and reduce waiting times.

In summary, of the $7.4 billion announced in the COAG Agreement and the Federal Budget for health reform, only $181.3 million over the four years was specifically directed to mental health. Of this, only $115 million was identified as new funding by the Federal Government being the funds for *headspace* and the EPPIC program.

Looking at this Reform through a Recovery Framework

Recovery is now a dominant construct in mental health policy and, to varying degrees, in practice across all service settings. The National Mental Health Policy and Fourth National Mental Health Plan, and the various state/territory plans released over the past two years, all have recovery as a central tenet of mental health service reform. The National Standards for Mental Health includes principles of recovery oriented mental health practice to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers. These principles include:

- Uniqueness of the individual – personal, unique choice to be at the centre of care
- Real choices
- Attitudes and rights
- Dignity and respect
- Partnership and communication
- Evaluation of recovery

It is therefore appropriate that the COAG Health Reforms are viewed through the prism of a recovery framework to ensure they are moving to a more holistic, recovery-oriented model of care. Table 1 below draws together some of the key tenets and values of recovery from the literature.

Table 1. Key Recovery Tenets and Values (developed from Warner, 2010)[2]

Person orientation	The service focuses on the individual first and foremost as an individual with strengths, talents, interests as well as limitations, rather than focusing on the person as a "case", exhibiting indicators of disease or a diagnosis.
Person involvement	The service focuses on the person's rights to full partnership in all aspects of their recovery, including partnership in designing, planning, implementing and evaluating the service that supports their recovery.

[2] Warner, R. (2010). "Does the scientific evidence support the recovery model?" in *The Scientist* Vol. 34, p 3-5

Self-determination/ choice	The service focuses on the person's right to make individual decisions or choices about all aspect of their own recovery process, including areas such as the desired goals and outcomes, preferred service use to achieve the outcome, preferred moment to engage or disengage in service.
Growth potential	The service focuses on the inherent capacity of any individual to recover regardless of whether, at the moment, he or she is overwhelmed by the disability, struggling, living with or living beyond the disability.
Insight with low stigma	The services assists in developing insight into their illness for the person AND having mastery over their lives. A focus on empowerment and optimism.
The value of employment	The belief that working helps people recover from psychosis and severe mental illness.
Peer support	Provision of peer support significantly enhances outcomes and recovery.

Health Inequality, Inequity and the Social Determinants of Health

Internationally, and to a lesser extent within Australia, there is growing evidence that the predominance of the bio-medical model of healthcare has contributed to a widening of health inequalities[3,4,5] and in recent times there has been a fundamental shift towards understanding health and illness through the prism of social determinants. Health inequalities between groups of individuals and health inequities amongst groups of individuals are now overwhelmingly attributed to social, economic and environmental circumstances[6,7] yet in the context of the NHHN reform agenda, there is little in the reforms or major funding announcements to the end of 2010 that tackles social determinants of ill-health and mental illness.

For illnesses where there is widespread stigma, like almost all mental illnesses, access to any care is already poor across the entire population. For those in low income groups or marginalised populations, access is even worse. This in turn can contribute to higher levels of social problems (family violence, child abuse and neglect), addictive behaviours (gambling, alcohol and other drug misuse), poorer educational and employment outcomes, higher rates of imprisonment and further entrenched poverty.

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[3] Wilkinson, R & Pickett, K (2010). *The Spirit Level: why equality is better for everyone*. Penguin, London.

[4] Layard, R (2004). *Mental health: Britain's biggest social problem?* London School of Economics.

[5] Friedli, L (2009). *Mental health, resilience and inequalities.* World Health Organisation, European Regional Office.

[6] CSDH (2008). *Closing the Gap in a Generation: Health equity through action on the social determinants of health, Final report of the Commission on Social Determinants of Health,* Geneva: World Health Organisation (WHO).

[7] For example, sex, age, socio-economic status, employment status, housing status, locality, sexuality, cultural or indigenous background, caring responsibilities, co-occurring disability, illness or alcohol and other drug issue, experiences of violence, abuse or neglect, stigma etc.

A social determinants approach to mental health will allow both policy makers and practitioners to consider how different circumstances are experienced by individuals and how these factors impact:

- the causality, course and manifestation of mental illness
- the service needs of individual mental health consumers
- access to and understanding of information about illness prevention, management and control
- patterns of service usage
- perceptions of quality care.

A one-size-fits-all approach to mental health service delivery is not going to lead to equitable mental health outcomes for all Australians. Mainstream services need to be able to adapt and be flexible to the service needs of all clients no matter what their circumstances or where they attend. This is particularly important when we consider the experiences of mental health consumers with co-occurring substance misuse issues or dementia, who have been shunted and moved from service to service or across sectors due to their complex care needs. Establishing and supporting integrated and collaborative service systems across the mental health, aged care, disability, alcohol and other drugs, housing and employment sectors (to name a few) will advance flexible and holistic mental health service delivery models which address the unique needs of individual mental health consumers.

Local Health and Hospital Networks should be encouraged to identify marginalised groups in their local area, and supported to tailor and develop their services to provide the most appropriate and sensitive care to their constituency. For example, mainstream services in localities where new and emerging migrant communities are resettling, like the Southern Sudanese populations in Tamworth or Canberra, need to employ culturally sensitive and culturally specific models of care in order to achieve the best possible mental health outcomes for these population groups. Cultural competency tools or equivalent tools for working with other minority or marginalised groups need to be employed across all services.

The experiences and service needs of mental health consumers will differ as a result of their socio-economic circumstances (their social determinants) and only a national and fully integrated approach to mental health that takes the time to understand these diverse needs and tailors and adapts service provision to meet these needs will bridge the inequalities and inequities in mental health outcomes of Australians.

> *Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen. These inequities in health, avoidable inequalities, arise because of the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political social and economic forces.*
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> **Commission on Social Determinants of Health, WHO, 2008**

Issues for the Mental Health Sector

The Political Context

1. There is a growing chorus of concern regarding the direction and management of the NHHN Agreement. This is in part resulting from a lack of detail and analysis evident in the various announcements by the Federal Government since the April 2010 COAG meeting. While many stakeholders have adopted a 'wait and see' approach, there is growing concern that the Agreement will fail to deliver real reform.
2. The timeframe for the implementation for the COAG Agreement is effectively four-five years. This will present significant difficulties for all governments as new needs and issues arise compared with a diminishing capacity to respond. This is not just true of mental health but other obvious omissions in the Government's response – dental health, rural and remote health and indigenous health to name a few.
3. There is a level of concern regarding the bio-medical dominance of the COAG Agreement – that is, an almost exclusive focus on hospitals, emergency departments, waiting lists for elective surgery and medical practitioners at the exclusion of community health and the social determinants of health.
4. The tenets and values underpinning recovery practice in the community mental health sector do not sit comfortably with the bio-medical philosophy of hospitals (see Table 1).
5. Widespread public and professional criticism of the NHHN Agreement and the subsequent 2010 Federal Budget has come from a range of stakeholders including members of the National Health and Hospitals Reform Commission (NHHRC). Particular criticism has focussed on the absence of strategies to address the priority areas for action and health inequities recommended by the NHHRC – namely, rural and remote communities, indigenous populations, dental health and mental health.
6. Mental health is now a major political issue in Australia. Although largely focusing on an increased provision of beds, rather than a comprehensive community and packaged care based response, the Coalition Motion on Mental Health passed by both the Senate and the House of Representatives in October and November 2010 with the support of the Independents in both chambers is indicative of this political engagement. The results of the Kings College London survey[8] of eight nations showing that Australians rated mental health as the third most significant concern (behind only the economy and global warming) is further evidence of the community engagement on this issue. The Government has recognised it must respond and has appointed the first ever Minister for Mental Health at a Federal level, however, awarding the portfolio to a junior minister does risk marginalising mental health in terms of not having a spokesperson in Cabinet. Moreover, the experience of states that have made similar appointments (notably NSW) is that little, if any, real change has resulted.
7. The other response of the Government was the announcement during the 2010 Federal Election Campaign of $277 million (over four years) for suicide prevention and mental health. Almost all the funding will be spent in years 3 and 4 and only $8.1 million will be spent in the 2010-11 financial year. Almost all the funds will go to existing programs (such as the Personal Helpers and Mentors program, respite, Day to Day Living and prevention programs in schools). In the programs for people with severe and persistent mental illnesses, the expansion of the program will (when fully rolled out) be less than a 10% increase on current allocations. Some of the innovative elements of the

[8] Kings College (2010). *Global Survey of Concerns*. London

commitment (new funds for suicide hotspots, new program for men's health) are too small to make the initiative viable.

8. The extent of the problems caused by inadequate investment and poor policy on mental health are now becoming increasingly understood and appreciated by the Australian community. Mental health problems are now costing Australian businesses over $20 billion per annum. This is in addition to the cost of health, welfare and other social services provided by all Australian governments estimated to be over $10 billion[9]. Payments by the Commonwealth for people with mental illness receiving the Disability Support Pension are now estimated at $4 billion per annum.
9. The introduction of new structures, namely the Local Hospital Networks and Medicare Locals, will consume considerable resources – both political and bureaucratic - and run the risk of taking attention off front line services over the coming years.

Key Issues for the Mental Health Sector in relation to the Overall Reform Package[10]

1. The NHHRC made 12 specific recommendations to the Federal Government for immediate action to tackle the pressing issues in mental health. The Government's response has been to provide a minimum of new funding for just two of the twelve recommendations – namely an additional $78 million for expanding the *headspace* program and $25.5 million for EPPIC.
2. Funding for the two early intervention programs has been labelled grossly inadequate by many advocates. The *headspace* model, agreed to by the Howard Government in 2004 and commenced in 2006, requires recurrent funding of $1 million per headspace site/centre to provide collaborative care that is affordable and accessible to young Australians. The present funding, provided by the Rudd Government in 2008, provides only around 40% of that recurrent cost. This has forced many *headspace* services to charge through the Medicare payments system for services and hence become unaffordable for consumers and inoperable for the providers. In short, the model is now a 'cardboard cut out' of the original design.
3. There is presently only one EPPIC service in Australia – at the Orygen Youth Health Service in Parkville Melbourne. It has a recurrent budget of $13 million per annum and provides services to around 800-1,000 young Australians each year. The Federal Government has committed funding for the EPPIC program of $25.5 million over four years. This is less than half the annual recurrent cost for just one EPPIC service.
4. The only other funding commitment of the Government in 2010 was the removal of the Social Workers and Occupational Therapists (OTs) from the right to provide services under the (Medicare) Better Access program. The Government effectively moved the savings (estimated at $58.5 million over four years) to the new FCPs component of the ATAPS program which will be administered by the Divisions of General Practice, and then Medicare Locals. The claims by the Government that this would "provide services through General Practice for 25,000 people with severe and persistent mental illness" have been shown to be baseless. Providers of ATAPS programs also indicated that they were not staffed with the appropriately skilled professionals for working with this population.

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[9] This an estimate based on recent announcements by all Australian governments in and analysis by Dr Lesley Russell from the Menzies Centre for Health Policy, University of Sydney, June 2010.

[10] Note: the specific issues arising from the major initiatives – Sub-acute Care Initiative, Medicare Locals and Local Hospital Networks – are outlined in the MHCA Position Papers pertaining to each issue.

5. In November 2010 the Government reversed the decision to remove Social Workers and OTs from Better Access but did not clarify where other funds will be found to cover the ATAPS FCP program.
6. There is little or no alignment between the National Mental Health Policy and Fourth National Mental Health Plan and the NHHN Agreement. The Fourth Plan has no resource allocation so it is unclear what the future is for any of the priority action areas under the Plan. The 'recovery' emphasis in the National Plan and Policy are at odds with much of the NHHN Agreement initiatives.

> *Mental health is fundamental to the future of the countries of Europe. Mental health underpins the social and intellectual skills that will be needed to meet the new challenges of the 21st century. It is also becoming increasingly clear, notably in campaigns on the environment and sustainable development, that communities across Europe place a high value on wellbeing. The limitations of consumerism are being more widely reflected upon, especially in relation to children and family life and the basis of civic society. We will have to face up to the fact that individual and collective mental health and wellbeing will depend on reducing the gap between rich and poor. At the same time, reducing inequality is not a sufficient policy response, important as that is. What is also needed is a shift in consciousness and a recognition that mental health is a precious resource to be promoted and protected at all levels of policy and practice.*
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> **WHO, European Office, 2009**

A Mental Health Sector-wide Position on the NHHN Reforms

These issues or principles are proposed to underpin a whole of sector advocacy position in relation to the NHHN Reforms.

The Reform Package

Position: ***The NHHN Agreement and the reform process has failed to take account of the urgency for direct action outlined in the NHHRC Final Report in relation to mental health, dental health, indigenous health and rural and remote health.***

- The NHHN Agreement and the commitment made by the Federal Government in 2010 to mental health are woefully inadequate and continue to marginalise Australians experiencing mental illness.
- The decision to defer consideration by COAG on arrangements for mental health services to mid 2011, after the commencement of all LHNs and a large number of Medicare Locals, reinforces the marginalisation of mental health services and clients. The decision fails to recognise that good health is dependent on good mental health.
- The NHHN Agreement fails to take account of the massive shortfall in funding for mental health services – now at just 6.5% of all health care spending and falling for the first time since the 1990s.

Position: The reform process must be underpinned by independent and transparent accountability.

- The reforms are complex and involve major changes to structures over the next 4-5 years. It is imperative that an independent and appropriately resourced organisation can report to the community on progress.
- There are significant risks to 'patient' safety and well being in the transition period.

Position: The boundaries for Medicare Locals, Local Hospital Networks and Local Government Areas should align to the maximum extent possible.

- Boundaries for Medicare Locals and Local Hospital Networks should align. They should also align with Local Government Areas and other state or regional boundaries to the maximum extent possible to assist in planning and reporting.
- From a preliminary analysis of the boundaries released late on 23 December 2010, there appear to be anomalies; most notable are the boundaries in the Brisbane South/Ipswich area.
- Any realignment should seek to avoid significant realignment of boundaries that will have significance for bed flow arrangements and may result in inter-Local Hospital Networks negotiations about services.

Position: There must be significant new investment in community mental health services. By 2013-14, 15% of all mental health funding must be directed to the community-managed mental health sector, 30% by 2020.

- The evidence to support increased investment in community mental health services, (both clinical, and recovery and support services) is compelling while the evidence to support greater investment in acute inpatient care is weak.
- Unmet demand for services for people with moderate to severe mental illness continues to be massive. In New Zealand, funding to the community managed mental health sector is now over 30%. These services provide community-based recovery and support. The most recent National Mental Health Report shows the Australian average is just 8.3% and most of the increase since 1992 has occurred in the last four years.
- By 2020 30% of all mental health expenditure in Australia should be directed to the community managed mental health sector as is the case in New Zealand. This will require a balanced process of purposive investment of both new and existing resources.
- While increased investment in community mental health services will likely lead to decreased pressure on acute and continuing care provided by the specialist mental health system, this investment in community managed mental health services must not happen at the expense of specialist mental health services.

Position: There must be significant new investment in prevention and early intervention mental health services. By 2015, 10% of all mental health funding must be directed to prevention and early intervention services.

- The evidence to support investment in early intervention is strong. The evidence to support investment in prevention is growing.
- Australia needs to build a 21st century mental health care system based on early identification and early intervention for the 1 million younger Australians who need access to services and the 20,000 people who develop or show signs of developing psychosis each year.
- Investment in early intervention and prevention initiatives must address the needs of all Australians across their lifespan, from children through to the elderly.

- The economics to underpin this investment in future working generations is compelling.
- The Government must commit to the full implementation of a national youth primary care service (*headspace* or similar), a national network of EPPIC programs and other evidence based prevention and early intervention mental health services. This can be achieved by 2015.

Priorities outside the NHHN reforms

Position: Consumer and carer engagement, participation and representation must be integrated into the design, implementation and evaluation of all relevant programs and reforms that may impact on them.

- Australia continues to have inadequate structures and supports to enable genuine and meaningful consumer and carer engagement, participation and representation. Resources must be committed to support both a national mental health consumer peak body and a national mental health carer peak body.
- Appropriate benchmarks must be set for both performance and monitoring of consumer and carer participation in mental health from the service level to the national policy development level.
- There must be appropriate funding and effective monitoring of initiatives outlined in the Fourth National Mental Health Plan, including:
    - the establishment of an effective peer workforce and expansion of opportunities for meaningful involvement of consumers and carers[11]
    - increased consumer and carer employment in clinical and community support settings[12]
    - accountability of service delivery including public reporting[13]
    - establishment of a culture of continuous quality improvement within service delivery systems that revolve around benchmarking and consumer and carer involvement.[14]
- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

Position: Cross-sector[15] service systems must be integrated, collaborative and flexible in order to address the unique needs of mental health consumers within a social determinants of health framework.

- Working collaboratively to improve the social, economic and environmental determinants of poor health at both the systemic and individual levels will lead to greater equity in mental health outcomes amongst Australians.

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[11] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

[12] Ibid p51.

[13] Ibid p61.

[14] Ibid.

[15] Including, but not limited to, the mental health, aged care, disability, AOD, housing, employment and education sectors.

- Data collection standards need to be introduced at all levels of Government and service delivery in order to inform and support targeted and innovative service delivery models that will meet the needs of disadvantaged and marginalised mental health consumers and carers.
- More research and monitoring of the nature and scale of mental health inequity and its relationship with social determinants is urgently required at all levels of Government and service delivery.
- Service funding formulas that mix performance based and activity based incentives are likely to support responsiveness to service demand and the development of innovative service models that target hard-to-reach client groups.

Position: Systemic issues relating to housing, including housing affordability, housing insecurity and homelessness must be addressed in conjunction with mental health reforms.

- Thirty percent of public housing stock must be set aside for people living with a mental illness.
- Properly resourced and monitored discharge planning must be implemented across Australia, with zero tolerance for discharge from hospitals to homelessness or unstable housing. This goal must be independently monitored and publicly reported.
- Home and community must become the preferred treatment sites with the number and scope of peer, carer, allied health and community options being significantly increased.
- A whole-of-government homelessness strategy that includes appropriate recognition of the relationship between mental health and homelessness should be developed in consultation with stakeholders, and then appropriately resourced.
- More research and monitoring of the nature and scale of homelessness and housing insecurity amongst people living with a mental illness is urgently required.

Position: Systemic issues relating to employment of mental health consumers and carers, including unemployment, underemployment, and inappropriate support services must be addressed in conjunction with mental health reforms.

- The employment rate for people with a mental illness needs to be increased from 29% to 53% — this is the rate for people with other forms of disability (physical and intellectual) and comparable to the rate of employment reported by the OECD in other developed economies for people with mental illness.
- Australian Government employment of people with a disability needs to increase from its current level of 3%[16] to at least the 1986 level of 6.6% of the of the total public service workforce.
- Support for innovative models of employment assistance for people with a mental illness including psychiatric-specialist employment service providers.
- There must be appropriate funding and effective monitoring of initiatives outlined in the Fourth National Mental Health Plan, including:

[16] In 2009, the number of employees in the APS was 4,566 or just 3% of total ongoing employees - the lowest recorded. Employment statistics of people with disability in the Australian Public Service can be found at http://www.apsc.gov.au/mac/disability6.htm#f61 and http://www.apsc.gov.au/stateoftheservice/0809/ataglance.html)

- The establishment of an effective peer workforce and expansion of opportunities for meaningful involvement of consumers and carers[17]

- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

Position: A life-course approach that recognises and addresses the social determinants of health must be employed across all early intervention mental health programs.

- The Australian mental health system is overwhelmingly skewed towards providing acute and continuing psychiatric care to adult Australians, and is ill-equipped to provide the targeted early intervention and support needed to improve the mental health outcomes of Australians outside the 26 – 64 age bracket, including children, youth and adolescence, and older people.
- Children's mental health outcomes, for example, are fundamentally influenced by their relationships with caregivers, other significant adults and their peers.[18] As a consequence of this, effective early intervention programs targeting children often employ a family and community focus, incorporating broad intersectoral partnerships between mental health, health, AOD, education, child care, child protection and judicial sectors. This model of service delivery is mostly unsupported within Australia's current mental health system.
- Early intervention programs must go beyond solely clinical interventions and address the full gamut of social and environmental factors that may negatively impact on the mental health of Australians.

Position: A national mental health promotion and anti-stigma campaign that addresses issues like stigma and discrimination, mental health illiteracy and help seeking behaviours must be undertaken as a matter of priority.

- State, territory and federal governments commit millions of dollars in highly visible campaigns promoting physical illnesses and injuries associated with smoking, alcohol consumption, obesity and road accidents, but have so far neglected to address mental health in such a comprehensive and systematic way.
- Anxiety and depression are the leading cause of burden of disease and injury in Australian women and the third cause for Australian men. Suicide and self-injury amongst Australian men ranks 8th in the leading cause of burden of disease and injury.[19]

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[17] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

[18] Further information in relation to the mental health needs of infants, children and adolescence can be accessed in the Australian Infant, Child, Adolescent and Family Mental Health Association's 2011 Position Paper entitled *Improving the mental health of infants, children and adolescents in Australia.* See http://www.aicafmha.net.au/resources/files/AICAFMHA_pos_paper_final.pdf

[19] Australian Institute of Health and Welfare (2007). *The burden of disease and injury in Australia 2003*, Cat No. PHE 82. AIHW, Canberra.

Position: A national mental health workforce strategy must define roles for clinical and non-clinical service providers and enhance opportunities to expand services in areas of need

- A National Mental Health Workforce Strategy will address workforce issues experienced by both clinical and non-clinical service providers working with Australians experiencing mental illness. It will also outline mechanisms for attracting mental health personnel to rural, remote and other areas of geographic and other need.
- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

Local Hospital Networks

Position: The integrity of funding streams needs to be retained

- LHN governance models need to retain control and quarantining of funding.
- Mental health funding needs to be controlled by mental health. This would ensure mental health core and project funding is not blocked or diverted to non-mental health expenditure.
- Further dividing up components of care will make the system vulnerable to agencies "cherry picking" mental health clients putting undue stress/cost on other parts of the system.

Position: Services need to be integrated

- There is a need to retain and build integration of hospital and community services. Any realignment should not separate community mental health or alcohol and other drug inpatient structures – one integrated 'whole' service: specialist services covering the continuum of care for appropriate management of patients/clients.

Position: Disruption to client flow must be avoided

- There is concern about the maintenance of existing acute referral pathways and how control of governance and funding can be maintained to ensure an organised patient flow.
- Cross border arrangements for best care need to be considered, e.g. networking Albury/Wodonga, Dareton with Mildura etc., for acute care conditions.

Medicare Locals

Position: There is a need for clarity in relation to what is covered by 'primary health'

- Primary health care is more than general practice.
- Primary health in the COAG Agreement is focussed on high prevalence disorders; it does not address the higher order more serious physical and medical conditions and the lower prevalence serious mental illnesses. This is problematic and simplistic. People with severe mental illness have multiple physical health needs which, in many cases, can best be addressed through integrated primary care that is effectively supported by specialist mental health services.
- It would be helpful to identify the scale of under-provision of service and funding for moderate and severe mental illness

Position: Services need to be integrated

- Separation of clients by illness is not helpful. Primary care, specialist community care and hospital care need to be seamless for all clients across the lifespan.
- Mental health services, both clinical and non-clinical, must also be integrated with other relevant services such as employment, housing, education, training etc.

Position: Community mental health services must have adequate representation in the governance structures, if they are not fully independent.

- Governance arrangements for the new Medicare Locals are critical. In line with contemporary governance practice, they should be fully independent and professional.
- Governance structures should ensure adequate representation of service providers, consumers, carers and community mental health organisations.

Sub-acute Care Initiative

Position: Providing funds for beds alone is inappropriate to support and promote recovery-oriented mental health service delivery. Packages of care that address both clinical and non-clinical needs of individuals moving into sub-acute care 'beds' must be available in both hospital and community settings.

- Multiple evaluations in Australia, and some overseas, show the value of investing in this type of packaged care. Stable and secure housing, access to timely and appropriate care based on need, and access to employment support can dramatically improve the health, social and economic outcomes for people with severe and persistent mental illness.
- Such approaches are cost effective when compared with either acute or sub-acute hospital based services.

Position: No less than 25% of the $1.6 billion allocation under the sub-acute initiative must be allocated to mental health and the total number of 'beds' allocated to mental health must not be less than 25% of the total 1,316 beds made available.

- It has been estimated that over the past two decades, the number of non-acute beds available for mental health consumers has declined by nearly 2,000. If the 1,316 beds allocated under this initiative were directed specifically to mental health alone,[20] this would only restore 80% of the 1993 capacity of non-acute beds.[21]
- The reduction in non-acute beds in mental health has increased pressure on acute services, significantly diminished service options, and negatively impacted on the quality of care and the ability of people with severe and persistent mental illness to recover.

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[20] See http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/ImplementationPlan-Stream1

[21] Department of Health and Ageing (2010). *National Mental Health Report 2010: Summary of 15 years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008.* Canberra: Commonwealth of Australia. p6.

Position: Models of care for the sub-acute 'beds' allocated to mental health should be based on evidence and agreed to with the mental health sector.

- A significant allocation of beds under this initiative has already been announced by the Federal Government. This has occurred with little scrutiny or consultation with the mental health sector.
- A number of the announcements, indeed all of those in NSW and Queensland, appear to place the sub-acute beds within the campuses of hospitals. The evidence to support the building of sub-acute beds for mental health within institutional settings does not exist.
- Both the international and Australian evidence is strong to support investment in supported accommodation for the prevention of acute care admission and recovery following acute care stays.
- More research is required into varying models of sub-acute mental health care to demonstrate good practice.
- Flexible care packages with both transitional and stable accommodation would represent a best buy in mental health for the sub-acute bed initiative. On the available evidence from existing programs in several Australian states, an allocation of $400 million would provide between 5,000-6,000 places. This is a compelling case for Government to consider.

Acknowledgements

This position paper has been prepared by the Mental Health Council of Australia with input from MHCA members and Board members, and in consultation with ConNetica Consulting. The MHCA thanks those members who contributed to the development of the paper.