

***Including, Connecting,
Contributing***

**A Blueprint to Transform
Mental Health and Social Participation
in Australia**

March 2011

Prepared by the Independent Mental Health Reform Group

Monsignor David Cappo Professor Patrick McGorry

Professor Ian Hickie Sebastian Rosenberg

John Moran Matthew Hamilton

Overview

This Blueprint details a four-year \$2.5bn program of strategic investment in 30 new services that have the capacity to transform the mental health in this country. Over five years, total proposed expenditure is \$3.5bn, serving to increase the current level of investment in mental health from 7% to 8% of the total health budget. Australia currently spends over \$100bn annually on health care, or around 10% of GDP.

Principles of this Blueprint

- The services presented here are ready for immediate implementation
- These services are in areas where autonomous Commonwealth activity is possible and desirable
- The services recommended must be genuinely transformational
- The Blueprint does not make specific recommendations regarding other key services which are currently within state/territory jurisdiction, such as community mental health services, judicial and police services etc.
- The Blueprint recommends services and programs which are grounded in evidence, demonstrated to have a positive impact on the lives of people with a mental illness.

The 30 transformational services are in eight priority areas:

1. Prevention and early intervention services for children, young people and emerging adults (i.e. 0-25 years), with specific emphasis on increased access to both better primary care and more specialised community-based services (\$988m);
2. New integrated community services that use innovative contracting systems to drive real social inclusion and enhanced economic participation (\$710m);
3. New collaborative health services that are consistent with national health reform and promote primary and specialized mental health care in community-based settings (\$203m);
4. Collaborative medical and psychiatric services for maintenance of the elderly in community settings and to promote healthy ageing (\$100m);
5. A National Mental Health Commission to report annually (\$50m);
6. Use of new technologies, particularly e-mental health services to increase access to services as well as support ongoing self-care and traditional clinical care (\$160m);

7. Strategic research, development and evaluation to promote health service reform, investigate new and enhanced treatments and trial new models of service provision (\$139m); and
8. Reform and develop the mental health workforce, with a specific emphasis on promotion of flexible and responsive team-based care (\$150m).

A summary of the expenditure recommended in this Blueprint across these eight priority areas is shown at Table 1 below. The complete list of the 30 transformational services is at Table 2.

Table 1 – Summary of Recommended Blueprint Expenditure

Priority Area	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
1. Services for Children and Young People	81	177	303	427	988	465	1453
2. New Integrated Community Services	135	155	190	230	710	230	940
3. New Collaborative Health Services	28	44	59	72	203	72	275
4. New Services for Healthy Ageing	17	20	27	36	100	36	136
5. Accountability	12.5	12.5	12.5	12.5	50	12.5	62.5
6. Use of New Technologies	20	34	46	60	160	60	220
7. Research and Development	24	29	39	47	139	47	186
8. Workforce development	27	36	39	48	150	48	198
Total Expenditure	344.5	507.5	715.5	932.5	2500	970.5	3470.5

Footnotes to Table 1:

- *The funding suggested in Table 1 is weighted towards maximum expenditure in years 4 and 5, allowing for the development of the relevant new programs in years 1-3 and the redeployment of staff, expenditures and infrastructure supports necessary for the successful delivery of the programs.*
- *The Blueprint described in Table 1 does not include funding already announced for 1300 sub-acute beds, some of which are to be allocated to mental health. As this separate initiative rolls out however, this Blueprint urges the Australian government to invest specifically in community-based models of sub-acute mental health care. These valuable new services cannot afford to become merely acute inpatient overflow wards (which would simply represent new money pouring into old and ineffective systems).*

Table 2 – The Top 30 Best Buys

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
Priority Area 1 – New Services for Children and Young People							
1. National rollout of 15 new EPPIC-style services	31	106	191	272	600	310	910
2. National expansion of Headspace 90 service sites	22	27	45	66	160	66	226
3. Development of National Autism Early Intervention	5	10	15	20	50	20	70
4. Services for Specialised Assessment of Child Behavioural Disorders	5	10	15	20	50	20	70
5. Development of National Services Model for ADHD	5	10	15	20	50	20	70
6. National roll-out of beyond blue perinatal program through enhanced Commonwealth funding	8	9	12	19	48	19	67
7. National roll-out of Triple P Parent Training	5	5	10	10	30	10	40
Priority Area 2 - New Integrated Community Services							
8. Expansion of community services to enhance social participation	30	40	50	60	180	60	240
9. Capacity Building for Employment Support Sector targeting people with a mental illness	30	40	50	60	180	60	240
10. Boost the Employment Pathway Fund	30	30	40	50	150	50	200
11. Housing Support Programs designed to knit into state-run housing services	25	35	40	50	150	50	200
12. Development of Provider-based Assessment Tool	15	5	5	5	30	5	35
13. Mental Health Promotion Campaign for the Unemployed	5	5	5	5	20	5	25
Priority Area 3 - New Collaborative Health Services							
14. Incorporate the 'medical home' model for those with recurrent and severe disorders, and related medical comorbidity	20	30	40	50	140	50	190
15. Programs that focus on detection and management of depressive disorders in a range of specific medical settings (heart disease, stroke, cancer and chronic pain)	3	5	7	9	24	9	33
16. Family intervention for schizophrenia	3	5	7	8	23	8	31
17. Evidence-based dialectical behavioural therapy services for people with borderline personality disorder	2	4	5	5	16	5	21
Priority Area 4 - Collaborative services for healthy ageing							
18. Collaborative geriatric medical teams, equipped for home visits and drawing on psychiatric assistance as necessary.	10	12	17	21	60	21	81

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
19. Activities aimed at increasing the social inclusion of older Australians, with an emphasis on building and maintaining strong social networks.	7	8	10	15	40	15	55
Priority Area 5 – New Accountability							
20. Establishment of the new mental health Commission	10	10	10	10	40	10	50
21. Development of national collation of Consumer and Family Experiences of Care	2.5	2.5	2.5	2.5	10	2.5	12.5
Priority Area 6 - Use of New Technologies							
22. Enhance clinical payments for use of technology alternatives to face to face care	10	20	30	40	100	40	140
23. Increase the access of young people to mental health services, through National E-Centre for youth	5	7	8	10	30	10	40
24. Enhance suicide prevention, through development of suicide prevention portal	5	7	8	10	30	10	40
Priority Area 7 - Strategic Research, Development and Evaluation							
25. Evaluate new health service models alongside headspace, EPPIC-style and collaborative care health services	10	12	15	20	57	20	77
26. Support national evaluative programs focused on evaluation of pre-emptive strategies and developments of novel treatment approaches in: autism, child abuse, anti-bullying, ADHD and conduct disorders	9	12	14	17	52	17	69
27. Targeted NHMRC-administered research funds for bi-national research programs in early psychosis and severe mood disorders	5	5	10	10	30	10	40
Priority Area 8 - Reform and develop the mental health workforce							
28. Coordinate mental health care in the community for those with severe and persisting illness	9	12	13	16	50	16	66
29. Develop integrated medical and psychological care for older persons residing in the community	9	12	13	16	50	16	66
30. Develop specific clinical training fellowships in child health, youth mental health aged care and health services and clinical research	9	12	13	16	50	16	66
Total Expenditure	344.5	503.5	715.5	932.5	2500	970.5	3470.5

Purpose of this Blueprint

There is overwhelming evidence of the extensive costs of mental illness to Australian social and economic life. Poor mental health is strongly associated with social and economic disadvantage and contributes to serious physical illnesses and premature death. The United Nation's International Labour Organisation now estimates that mental illnesses account for up to 4% of gross domestic product in developed countries. This equates to approximately \$40bn in the Australian economy.

Expected Outcomes from this Blueprint

- Reducing the potential impact of mental illness through evidence-based early intervention programs
- Increasing access to age-appropriate, quality services
- Creating new vehicles to drive effective collaboration between health, employment and social services
- Increasing both the number and capacity of organisations able to effectively manage both the health and other social needs of people with a mental illness
- Increasing the social participation of Australians with severe and persistent mental illnesses in family, work and community life
- Regular, independent and national reporting of progress towards reform

Currently our health and social services are not configured to support those with mental disorders overcome the impacts of their illness on economic and social participation. Mental health and community services need to provide new platforms for effective collaboration between health, social and employment agencies.

Collaboration will not be achieved by good will alone. This Blueprint outlines new approaches to deliver innovative purchasing through new lead agencies. These become the vehicle to drive improvements in social participation. The other important driver of service responsiveness outlined in this Blueprint is a new and robust mechanism of independent monitoring and accountability.

This Blueprint describes a set of 30 evidence-based best buys designed to deliver real social, health and economic benefits to people. These 30 services are described in Tables 3-10, with the total of \$2.5b of investment over the next four years and \$3.5 over the next five years.

As stated, the Blueprint is directed towards new services the Commonwealth can fund and set in place starting now. However, as a further step, this investment would provide the ideal starting point for a new COAG-led mental health agreement between all Governments from 2011-2016.

While this Blueprint has focused on the Commonwealth part of any such agreement, it would also clearly need the states and territories to fully participate by supporting key areas of service provision in areas for they are currently responsible. In that context, the expectation would be that the states and territories should then focus more narrowly on, and be held more accountable for:

- a) the development of high quality and more responsive acute care services within community settings;
- b) the provision of assertive community care to those with severe and debilitating disorders, particularly where treatment is being provided on a legally-sanctioned basis;
- c) the development and evaluation of new sub-acute models of care (including step-up and step-down care) utilising new Commonwealth funds available under the 2010/11 health reform package;
- d) prompt suicide follow-up in the community, subsequent to presentation to hospital emergency departments;
- e) preferential funding towards evidence-based models of supported housing, as part of an agreement with the Commonwealth which would also provide additional support services;
- f) the provision of high quality services within child protection, juvenile justice and ongoing adult justice health;
- g) the development of 21st century infrastructure and service models for inpatient care of adolescents and young adults; and
- h) the rapid enhancement of 21st century infrastructure and service models for inpatient care of those aged 25-70 years.

New Accountability Mechanisms

Australia is currently outcome blind in mental health, unable to assess the real impact of \$5.5bn of annual spending. A new and independent National Mental Health Commission should be established by an act of Australian Parliament to provide a more effective national mechanism to monitor, evaluate and advocate for the care provided to people with a mental illness and their families across Australia. The Commission should independently track and report the impact of our system of mental health care against a limited number of robust indicators that include health, employment, education and social participation outcome measures.

The five inter-related functions of the Commission should be to:

- a) submit an annual National Mental Health Report Card to the Australian Parliament;
- b) establish a National Mental Health Information Service to support those working with people with mental illness;

- c) establish a nationally-validated collection of the experience of mental health care for consumers and carers;
- d) identify priority areas for further mental health research, development and evaluation; and
- e) advocate for new strategic investments in those areas where key gaps in services are identified.

New Services Across the Lifespan

This Blueprint outlines the measures required to ensure that all Australians have access to quality mental health care that is appropriate to their stage of life and which effectively supports them to remain included and participating in Australian society. This Blueprint has identified two broad categories of age-related need and opportunity:

- The 0-25 age-range presents the optimal time for prevention and early intervention, including opportunities for children and young Australians to build strong networks of friends and family. These networks play a key role in protecting mental health.
- The 25+ age-range presents the optimal time to provide support for Australians with severe and persistent mental illnesses to participate in family, work and community life.

The life-stage approach to mental health endorsed by this Blueprint will see the goals, focus of intervention, service models, research and development priorities of Australian mental healthcare evolve with a person as they age.

Goals by life stage

- The goal of mental healthcare in early childhood (0-5) should be to support families with children under five to maximise opportunities for healthy child development.
- The goal of mental healthcare in early school years (5-12) should be to support children to establish the basic skills to adapt educationally and socially to primary school.
- The goal of intervention in adolescence and emerging adulthood (12-25) should increasingly be on the individual, but family, educational and employment environments will also be important. Young Australians should be able to select the type of mental health care that best meets their needs (including one stop shops, specialist youth mental health services, e-health portals and centres based in educational institutions or employment services).

- The goal of mental healthcare in middle years (25-65/70) should be to support mid-life Australians to effectively manage mental illnesses and to lead a productive life through a stable home, caring relationships and meaningful activity. These Australians should have a choice whether health, housing, social participation or employment agencies play the lead role in coordinating care.
- The goal of mental healthcare in later life (65/70+) should be to support older Australians to enjoy healthy ageing, including the prospect of living in their own homes.

30 'Best Buys' - The Blueprint in Detail

Tables 3-10 below now detail the 30 best buys – these are the essential new services identified across the eight program areas described in Table 1. Together, these 30 new services represent a Blueprint designed to deliver transformative care in the health, employment, education, housing and social services for people with a mental illness.

The majority of these areas have strong existing evidence of effect and feasibility. The major difficulties in Australia have been with our capacity to deliver consistent services across the country or with the transition from 'pilot' or demonstration projects to sustainable services.

In some instances, new purchasing and contracting systems which operate nationally but enable regional and local delivery of services need to be established and maintained. However, Australia now has considerable experience with these mechanisms in both the health and social services sector.

Priority Area 1 – New Services for Children and Young People

Table 3 – New Services for Children and Young People

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
1. National rollout of 20 new EPPIC-style services	31	106	191	272	600	310	910
2. National expansion of Headspace 90 service sites	22	27	45	66	160	66	226
3. Development of National Autism Early Intervention	5	10	15	20	50	20	70
4. Services for Specialised Assessment of Child Behavioural Disorders	5	10	15	20	50	20	70
5. Development of National Services Model for ADHD	5	10	15	20	50	20	70
6. National roll-out of beyond blue perinatal program through enhanced Commonwealth funding	8	9	12	19	48	19	67
7. National roll-out of Triple P Parent Training	5	5	10	10	30	10	40
Total Expenditure	81	177	303	427	988	465	1453

1. National rollout of 20 new EPPIC-style services

- These Australian developed service models have the largest international evidence base of any mental health model of care demonstrating not only their clinical effectiveness but also their return on financial and social return on investment.
- This is a mature model simply requiring implementation in Australia. Partial implementation failed in the late 1990s when support relied solely on sustainability through state-supported mechanisms.
- This is the most important mental health service development that will not only deliver return on investment but through its emphasis on community-based early intervention principles drive service change and major changes in work roles in the rest of the mental health care sector.
- Financial and services detailing of this proposal has already been supplied to the Minister and the Department of Health and Ageing through the National Advisory Council on Mental Health.

- A commitment of \$25m over 4 years was included in the Federal Budget 10-11.
- Rather than relying on state co-operation in service development or funding, the Commonwealth should proceed to establish initially the community-based arm of these key services.
- 20 new services would be established in two waves over four years, permitting national coverage and development of real national standards, bringing Australia back to the forefront of world's best practice.
- Within five years, the States would be expected to develop the relevant specialist acute care and inpatient services to complement these Commonwealth-supported services.
- The services should be developed under a national tender framework that permits development of the relevant new consortia capable of delivering such services and ensuring national coverage, including the provision of services to large regional centres.
- The development should be tied to a very specific research, development and evaluation agenda as specified in the specific research funding section.
- It is likely that e-mental health initiatives will assist the development of this national care program.

2. National expansion of Headspace 90 service sites

The Australian Government has already committed to expansion of this very successful and innovative program to 60 centres over the next four years. However, the company has already informed DoHA that insufficient funds have been allocated to either achieve this expansion or sustain the current centre program.

This program has the greatest chance of increasing earlier access to primary-care based assessment services for those with developing but already disabling mental health problems and related alcohol or other substance misuse.

The existing company structure can be utilized to achieve the expansion but there is strong need to tie this process to a rigorous research, development and evaluation program. Additional funds are identified in the research allocation to assist this process.

It is likely that relevant e-mental health initiatives will also be needed to complement this program. However, those services do not necessarily need to be developed by headspace and a variety of other processes, including those currently subject to competitive tender should be explored.

3. *National roll-out of beyond blue perinatal program through enhanced Commonwealth funding*

The initial roll-out of the national beyondblue-led perinatal depression program was a major achievement of the second phase of the beyondblue project.

The program was supported initially by the Rudd Government but then transferred major implementation to the states. Since that time the roll-out has fallen away and requires urgent re-focus and national leadership.

The key services developments are in the community and lie largely outside the States services environments. The current proposal would lead to this being reestablished as a national program led by Commonwealth funding.

4. *Services for Specialised Assessment of Child Behavioural Disorders*

The adverse impact of a wide range of behavioural disorders (including both internalizing disorders - like childhood-onset severe anxiety or obsessive-compulsive disorder - and externalizing disorders like oppositional defiant disorder or conduct disorder) on early educational and social outcomes is well recognized.

While universal parent training programs, as well as early childhood centre and primary school programs are essential, there is an increasing recognition of the key role of early specialist assessment and personalization of the treatment plan, as well as family and health monitoring of outcomes.

This proposal outlines the development of five national centres, operating with a hub and spoke model of services (covering major metro and large regional centres), to cover the states and territories (NSW/ACT, Vic/Tas, QLD, SA/NT, WA).

The centres will link with existing MBS and other Commonwealth-supported service initiatives (e.g. Better Access, ATAPS funding and fee for service) that maximize treatments by clinical psychologists and other appropriately trained practitioners. The program will also support additional education and training for pre-school and primary school staff to reinforce early identification and ongoing management of these disorders within early child care and primary school settings.

5. *Development of National Services Model for ADHD*

One of the most controversial areas of clinical service activity in child mental health remains the management of young children with moderate to severe attention deficit and hyperactivity syndromes.

The variation in region to region prescribing of stimulant medications remains unacceptably high, resulting in both under and likely over-treatment of different subpopulations.

This proposal outlines the development of five national centres, operating with a hub and spoke model of services (covering major metro and large regional centres), to cover the states and territories (NSW/ACT, Vic/Tas, QLD, SA/NT, WA).

The centres will link with existing MBS and other Commonwealth-supported service initiatives (e.g. Better Access ATAPS funding and fee for service) that maximize treatments by clinical psychologists and other appropriately trained practitioners. The national program will link with appropriate national monitoring systems (including PBS data and other professional databases) to monitor and report clinical practice and appropriateness of delivery of medications at the regional level.

The program will also support additional education and training for practitioners who are actively involved in management of these conditions in the health sector and the education sector.

The centres will promote research into the optimum indicators for commencement and cessation of relevant interventions.

6. Development of National Autism Early Intervention

Increasingly, the impact of childhood onset autistic spectrum disorders has been recognized in our community.

The Howard Government introduced some limited support for early intervention programs. Worldwide the need to improve the quality of early specialist assessment, evaluate the impacts of intensive early intervention programs and explore the value of new medical interventions (in combination with other relevant social, education and behavioural approaches) is now acknowledged.

Australia needs urgently a network of specialist assessment, research and evaluation centres to lead this process of relevant services development in Australia.

This proposal outlines the development of four national centres, Operating with a hub and spoke model of services (covering major metro and large regional centres), to cover the states (ACT/NSW, Vic/Tas, QLD, SA/WA/NT).

7. National roll-out of Triple P Parent Training

The Triple P Parenting Program has been developed in Australia and represents one of the world's most effective parent training programs for active management of a wide range of common behavioural symptoms in children. Not only has the program developed a very strong evidence base, it clearly articulates the need for early intervention and delivery by the relevant personnel (usually parents, assisted by other health or education personnel).

At various times over the last decade the Australian (including via beyondblue) and various State Governments have provided additional supports to the development or evaluation of this program.

However, Australia now needs to build the national capacity to make delivery of this program ongoing throughout the primary school years and ensure that it is delivered in partnership with other key providers in the primary care health sector.

The proposal devotes funding to the development of a national centre, with relevant satellite centres, for the maintenance of delivery of this program, training of relevant staff and ongoing development and evaluation.

Priority Area 2 - New Integrated Community Services

The transformational aspect of this Blueprint rests to a large extent on its capacity to drive new levels of integration between services. Strategies to achieve integration include the establishment of collaborative health services (EPPIC, headspace, collaborative care practices) that are described elsewhere in this Blueprint. These strategies can be further enhanced by additional, complimentary reforms in three key areas:

- Community services, particularly aimed at boosting social participation by people with a mental illness;
- Employment services because a core goal of this Blueprint is to achieve significantly enhanced employment outcomes for Australians with mental ill-health; and
- Housing support services – designed to knit into existing and new state and territory investment in evidence-based models of supported housing for people with a mental illness. The strong emphasis in these programs should be on providing alternatives to acute hospitalization for those with severe or persisting illness.

Table 4 – New Integrated Community Services

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
8. Expansion of community services to enhance social participation	30	40	50	60	180	60	240
9. Capacity Building for Employment Support Sector targeting people with a mental illness	30	40	50	60	180	60	240
10. Boost the Employment Pathway Fund	30	30	40	50	150	50	200
11. Housing Support Programs designed to knit into state-run housing services	25	35	40	50	150	50	200
12. Development of Provider-based Assessment Tool	15	5	5	5	30	5	35
13. Mental Health Promotion Campaign targeting the Unemployed	5	5	5	5	20	5	25
Total Expenditure	135	155	190	230	710	230	940

8. *Expansion of community services to enhance social participation*

Social participation, supportive relationships, involvement in group and community activity and networks are recognized as protective factors in maintaining good mental health. Isolation and exclusion are understood to act as risk factors.

Increasing the level of social participation in education, training, work, family life, good and stable housing, community networks, with friends and colleagues, neighbourhood groups and local organizations enhances the human dignity of people and builds a strong and resilient community that is able to care for its citizens. This is about social inclusion. People are brought more into the centre of community life.

There is a solid evidence base to support a range of programs and services. This Blueprint recommends programs in areas such as:

- Psycho-social rehabilitation programs, such as living skills, symptom management, relationship and family-focused programs, community integration, vocational skills etc.
- Mental health promotion (Act Belong Commit is evidence-based Australian example) and mental health literacy programs such as Mental Health First Aid
- Structured opportunities for participation in community activities
- Volunteering
- Physical activity
- Community building programs
- Community arts programs.

9. *Capacity Building for Employment Support Sector targeting people with a mental illness*

Returning to work is consistently named as the number one objective for people with mental illnesses, even above health objectives. Mental ill-health is a key driver or long term unemployment, accounting for about a third of those on Disability Support Pensions.

There is a real requirement to ensure staff in employment services are supported to deliver on the reforms described in this Blueprint. This Blueprint therefore calls for purposive investment in capacity building for the employment support sector to drive the development of innovations in regards to assisting job seekers into employment. New and expanded skills to be developed include those in care-coordination, recovery training, psycho-social practice and working with the new practitioner guidelines.

The investment described here also allows for employment services to have access to new funding to support collaboration in order to enable them to play a broader role in managing and coordinating the care of job-seekers with mental illnesses. Funding to support collaboration could become part of the servicing fee paid currently to agencies.

10. Boost the Employment Pathway Fund

This fund is the pool of money with which disability employment support staff arrange the services needed to get a job seeker ready for employment. A mix of clinical, psycho-social and other support services are often needed but the funds available to staff are critically poor. This Blueprint recommends increasing the amount of support the Employment Pathway Fund gives to evidence-based interventions for job-seekers with mental illnesses – for example the Intensive Placement Support Model or full time employment support workers located in mental health services.

11. Housing Support Programs designed to knit into state-run housing services

As stated earlier, the establishment of new models of supported housing for people with a mental illness is largely a state function which can be driven through appropriate inter-governmental agreements. There are proven models such as HASI, Opening Doors among others.

To this jurisdictional investment, the Blueprint proposes a new set of collaborative support services, designed specifically to provide alternatives to acute hospitalization for those with severe or persistent illness who have been hospitalized on more than three occasions in the last 12 months.

12. Development of Provider-based Assessment Tool

The current approach to job seeker classification is designed primarily to ensure DEEWR discharges its legislative obligations and has proven ineffective in meeting the needs of job-seekers with mental ill-health. In particular the 8 week duration of this process fritters away the optimal period to support Australians with mental illnesses to successfully pursue work opportunities. This Blueprint therefore proposes a new, provider-based assessment process that is speedier and better at identifying the needs of job seekers with mental ill-health.

13. Mental Health Promotion Campaign targeting the Unemployed

Mental health promotion campaign targeting the unemployed: People who are recently unemployed are very vulnerable to mental illness which can compound their situation and make re-employment less likely. Therefore a mental health promotion campaign should be designed and implemented to meet the needs of the newly unemployed, boost their mental health and help prevent the onset of illness.

Priority Area 3 - New Collaborative Health Services

It is a sad fact that too many people with mental illness cannot identify the health professional they feel is responsible for their care. Too many people are out of sight.

Health care reform, particularly with an emphasis on enhanced care for those with chronic illness, needs to pay particular attention to those with mental illness. The movement towards more meaningful management of long-term and complex conditions in enhanced primary care environments is long overdue.

While current Government policy directions such as GP Superclinics and the development of Medicare Locals are consistent with these needs, it is essential that relevant medical and psychological care components, as well as primary and more specialized mental health care components are not only well-integrated but preferentially co-located.

Another major consideration is the need to ensure that primary-care based systems actively track the broad health outcomes of those with chronic or recurrent mental disorders (as well as those with overt medical comorbidity or mental disorders that occur secondary to other medical conditions or treatments).

This requires a proactive attitude, underpinned by a focus on increased access to e-health records, proactive preventive stratifies (notably smoking cessation, weight reduction and management of cardiovascular risk), and regular health checks.

To achieve these enhanced medical and psychological outcomes, integrated health centres need to reflect key underlying philosophies such as the 'medical home' concept and actively promote a willingness to be the optimal point of initial or recurrent health care for people with recurrent or chronic mental disorders.

Table 5 - New Collaborative Health Services

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
14. Incorporate the 'medical home' model for those with recurrent and severe disorders, and related medical comorbidity	20	30	40	50	140	50	190
15. Programs that focus on detection and management of depressive disorders in a range of specific medical settings (heart disease, stroke, cancer and chronic pain)	3	5	7	9	24	9	33
16. Family intervention for schizophrenia	3	5	7	8	23	8	31
17. Evidence-based dialectical behavioural therapy services for people with borderline personality disorder	2	4	5	5	16	5	21
Total Expenditure	28	44	59	72	203	72	275

14. *Incorporate the 'medical home' model for those with recurrent and severe disorders, and related medical comorbidity*

Extensive work by the Commonwealth Fund of New York on the value of the 'medical home' in primary care (particularly for those with chronic ill-health), and the related work by the Institute of Medicine on enhancing quality of mental health care, indicate strongly the need to develop specific centres that focus on delivery of highly integrated medical and psychological care for those with recurrent or chronic mental disorders.

Such centres may develop from traditional multidisciplinary-based general practice or other primary care based health services or may develop out of existing specialist practice centres or adequately resourced community services programs that already have ongoing contact with the population in need.

This program proposes the development of such centres, which can be thought of as variations on the Superclinic model, providing grants of up to \$500,000 to establish multidisciplinary centres and then providing up to \$500,000/year to support enhanced care. The centres would be unlikely to be new practice sites, except in circumstances where no relevant service already exists.

The contractual arrangements relevant to each site would specify both the number of persons to be managed actively at each site as well as the annual reporting of relevant health indicators (e.g. smoking cessation rates, diabetes and cardiovascular risk screening, participation in other health checks, participation in enhanced mental health care programs).

The regular provision of services would proceed under normal MBS mechanisms with enhanced access to ATAPS style funding for provision of mental health services to more disadvantaged populations

15. *Programs that focus on detection and management of depressive disorders in a range of specific medical settings (heart disease, stroke, cancer and chronic pain)*

Psychological comorbidity in association with other major medical conditions contributes largely to a range of poor health outcomes and increased service usage costs – most notably in relation to increased use of public hospital bed days.

While a large range of programs have been developed and evaluated for psychological comorbidity (particularly depression) in relation to specific medical conditions (cardiac rehabilitation, cancer care, chronic pain, post-stroke etc), few are sustained outside specific research or local service funding.

This funding initiative invites development of best-practice models to be delivered in early-hospital discharge, post-hospital or community-based settings (up to \$500,000 grants to establish programs), with ongoing support to be met largely by use of existing MBS and related ATAPS style systems.

16. *Family intervention for schizophrenia*

Family interventions for those affected by schizophrenia have been demonstrated to reduce hospitalization and improve overall health and social outcomes. Access to this type of treatment is still extremely limited.

This proposal supports the development of relevant ATAPS style service and the development of mechanisms for providing family-based interventions to those who are currently unable to access this type of care. Where possible, group-based provision of this type of care should be actively supported.

17. *Evidence-based dialectical behavioural therapy services for people with borderline personality disorder*

- People diagnosed with borderline personality disorder are still frequently turned away from current public mental health systems despite their high illness-related burden and behavioural impacts on acute and emergency health care systems.
- The development of more effective behavioural strategies for care means that this style of intervention requires more active support under relevant ATAPS style service mechanisms.
- This proposal supports the development of relevant ATAPS style service mechanisms for providing this type of care to those who are currently denied access to effective treatments. Where possible, group-based provision of this type of care should be actively supported.

Priority Area 4 – New Services for Healthy Ageing

Table 6 – New Services for Healthy Ageing

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
18. Collaborative geriatric medical teams, equipped for home visits and drawing on psychiatric assistance as necessary.	10	12	17	21	60	21	81
19. Activities aimed at increasing the social inclusion of older Australians, with an emphasis on building and maintaining strong social networks.	7	8	10	15	40	15	55
Total Expenditure	17	20	27	36	100	36	136

18. *Collaborative geriatric medical teams, equipped for home visits and drawing on psychiatric assistance as necessary.*

- The delivery of effective and integrated medical and psychological care at home to older Australians with mental health and related cognitive and medical disorders can play a key role in reducing the chances of older persons moving into residential or other health care settings (acutely or in the longer-term)
- While various models of integrated home-based medical and psychological care are available in different parts of Australia, they are typically better organised and supported in wealthier communities
- The important potential role of specifically-trained and supported mental health nurses working in relevant medical and psychological teams is still under-rated
- The participation of specialist psychiatrists and neuropsychologists within such team-based models is still too limited by workforce and work role considerations
- This proposal seeks to enhance and expand access to relevant team-based models through relevant grant-based mechanisms. Integration with other relevant state-based models and other aged care models is essential.

19. *Activities aimed at increasing the social inclusion of older Australians, with an emphasis on building and maintaining strong social networks.*

These new services payments are designed for programs that reduce the social isolation commonly experienced by older person with severe, recurrent or persisting mental disorders. The emphasis is on contracting services that promote psychosocial rehabilitation and recovery and may well extend those new services being provided to younger persons (as described in Best Buy No. 8 above) to older persons.

Priority Area 5 – New Accountability

Table 7 – New Accountability

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
20. Establishment of the new mental health Commission	10	10	10	10	40	10	50
21. Development of national collation of Consumer and Family Experiences of Care	2.5	2.5	2.5	2.5	10	2.5	12.5
Total Expenditure	12.5	12.5	12.5	12.5	50	12.5	62.5

20. Establishment of a National Mental Health Commission

Over the last decade, the issue giving rise to the highest level of consensus among consumers, carers, independent academics and community advocates has been the need to establish a National Mental Health Commission. The establishment of a national Commission will reinforce the national focus on sustained improvement of this key area.

There are a variety of international and now state-based models for Commissions and considerable international evidence of the way in which their functions can drive more immediate reform of mental health services. The national accountability agenda, which lies at the heart of real structural changes in mental health, will be much advanced by the establishment of such a Commission.

The functions of a new national Commission should be limited initially to: development of annual National Mental Health Report Card, overseeing a National Mental Health Information Service to support those working with people with mental illness; establishing a nationally-validated collection of the experience of mental health care for consumers and carers; identifying priority areas for further mental health services research, development and evaluation; and, advocating for new strategic investments in those areas where key gaps in services are identified.

21. Development of national collation of Consumer and Family Experiences of Care

Over the last two decades, repeated enquiries into mental health services have collected large numbers of personal accounts of poor services, active discrimination or exclusion from health care, employment or housing. To replace these ad hoc processes, a permanent and ongoing emphasis on collection and collation of consumer and care experiences of care is proposed.

While this function can be overseen by the new national Commission for mental health, the program area needs to be separately described and funded. The process may well need to be enhanced by the holding of individual case enquiries or systematic investigations of various health or social service systems, where individual case reporting reveals systematic problems.

Priority Area 6 - Use of New Technologies

Australia has been a world leader in the development and evaluation of e-health strategies in mental health. To date, there have been many trials and partial implementation without developing this serious national capacity. Internet and other new technology-based services have the capacity to enhance greatly consumer participation in care and capacity to self-care. These are likely to also assist with enhanced safety of care.

Internet-based services are also the most likely solution to the problem of gross underservicing of many people with disorders who do not currently receive effective mental health interventions. These include young people, males, those with lower incomes, those residing in rural and regional Australia.

If skillfully deployed and strategically supported, these new service platforms may come to be an essential part of most new health care service systems. Developments in mental health care are likely to extend far beyond those currently envisioned in other aspects of physical health care.

Table 8 – Use of New Technologies

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
22. Enhance clinical payments for use of technology alternatives to face to face care	10	20	30	40	100	40	140
23. Increase the access of young people to mental health services, through National E-Centre for youth	5	7	8	10	30	10	40
24. Enhance suicide prevention, through development of suicide prevention portal	5	7	8	10	30	10	40
Total Expenditure	20	34	46	60	160	60	220

22. Enhance clinical payments for use of technology alternatives to face to face care

A wide range of programs now exist that can use digital technologies to replace low level face to face clinical contacts. These are particularly important alternatives for services such as reviews of treatments, outcomes of episodes of care, reviews after completion of other specific behavioural or psychological treatment programs, monitoring of medication side-effects, detection of early warning signs of treatment relapse.

Rather than trying to pick winners or develop specific programs for delivery by government-supported service providers, a better mechanism is to provide specific service payments.

To date an emphasis has been placed on enhancing services (largely through limited telepsychiatry frameworks) to those residing in rural and regional Australia. However, the wider implications of increased use of these services is much greater and likely to appeal particularly to young people, those who are in employment or education and those who are not easily able to attend traditional clinical appointments.

The goal here should not be to simply move existing models of clinical practice (such as specialized or detailed clinical assessment, or delivery of cognitive-behavioural or other specialized therapy on line) but to increase workforce capacity by decreasing clinic time spent on more minor clinical interactions.

The development of a cost-effective payment system will encourage providers to purchase new systems, develop better systems and rapidly integrate those systems into regular clinical care.

The payment mechanisms could operate in a novel number of ways including capitated systems, ATAPS style as well as limited fee for service. Specific rewards (practice incentive style) could operate for meeting the needs of designated population groups by severity, disability, demography, geography and/or socioeconomic need.

23. Increase the access of young people to mental health services, through National E-Centre for youth

This specific proposal is designed to improve greatly the access of young people to mental health services on-line and was developed by the Inspire Foundation and presented to the Australian Government.

The specific proposal establishes one national centre to maximize links with other Australian Government investments through the national broadband network as well as through the recently funded new CRC devoted to youth mental health. The proposal draws on the 15 year experience of the Inspire Foundation in developing the social networks and frameworks to maximize the engagement of young people in a pro-social fashion with new technologies.

24. Enhance suicide prevention, through development of suicide prevention portal

This specific proposal draws on the national capacity of the Centre for Mental Health Research at the ANU (directed by Professor Helen Christensen). It proposes the development and ongoing evaluation of a national e-health portal for suicide prevention.

To date, suicide prevention has grossly underutilized the capacity of the internet to connect with those who are most disconnected from other social systems and health care environments that assist with the reduction in suicide risk. There has been more than a decade of internationally recognized research and development behind this specific proposal.

Priority Area 7 – Strategic Research, Development and Evaluation

Australian mental health research is of high international regard but often not well utilized to support health service innovation or reform. The lack of overall capacity has meant that certain areas are better supported (such as investigator-initiated small clinical programs, fundamental neuroscience projects within larger university settings) while major population health initiatives and transformative health service programs are poorly supported. Too often, specific health service innovations financed by the Commonwealth have specifically excluded concurrent clinical research and evaluation.

While there have been new investments in clinical and basic neuroscience research through some increased State and University-based research, there is now an urgent need to link further developments with the style of health service transformation outlined in this document. This style of investment not only increases the knowledge base for further policy development but also markedly improves workforce training and development and continuous quality improvement.

A vibrant and internationally-ranked research sector has the capacity to recruit new local and international clinical leaders to our workforce. It also increases the chances for further international collaborations, workforce placements, technology and ideas transfers.

Table 9 – Strategic Research, Development and Evaluation

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
25. Evaluate new health service models alongside headspace, EPPIC-style and collaborative care health services	10	12	15	20	57	20	77
26. Support national evaluative programs focused on evaluation of pre-emptive strategies and developments of novel treatment approaches in: autism, child abuse, anti-bullying, ADHD and conduct disorders	9	12	14	17	52	17	69
27. Targeted NHMRC-administered research funds for bi-national research programs in early psychosis and severe mood disorders	5	5	10	10	30	10	40
Total Expenditure	24	29	39	47	139	47	186

25. Evaluate new health service models alongside headspace, EPPIC-style and collaborative care health services

- The current funding models for implementation of these new health service innovations do not link to significant clinical research funding mechanisms.
- The mechanisms for supporting these developments should operate through partnership-type agreements (similar to current NHMRC partnership grants) to ensure research rigor, national cooperation and sustained commitments over time.
- Clinical practitioner style fellowships, for both junior and more senior health practitioners should be developed in association with these programs.

26. *Support national evaluative programs focused on evaluation of pre-emptive strategies and developments of novel treatments autism, child abuse, anti-bullying, ADHD and conduct disorders.*

As national centres for enhanced services are developed for the range of child-onset mental disorders, a series of NHMRC-style partnership grants need to be developed to maximize the clinical research and training capacities of these centres.

Clinical practitioner style fellowships, for both junior and more senior health practitioners should be developed in association with these programs.

27. *Targeted NHMRC-administered research funds for bi-national research programs in early psychosis and severe mood disorders.*

There is currently a major opportunity to develop a bi-national research program in early psychosis and the early phases of major mood disorders with the national institutes of mental health in the USA.

This particular program would support Australian researchers to participate in this major series of bi-national arrangements with the specific focus of reducing the impact of these major disorders through enhanced early detection, provision of more intensive treatment and/or delivery of novel interventions.

The funding for the program should focus not only on program development but also specifically on support for clinical practitioner or other research fellowships tied to the program (including the possibility of placement at a participating US institution).

The program should also support for collection of relevant neuroimaging, neuropsychological or other biological specimens, and their development of the relevant analytical expertise in Australia.

Priority Area 8 - Reform and develop the mental health workforce

The capacity for mental health service development and innovation in Australia has often been constrained by an ageing mental health workforce, fierce demarcation issues between competing health professionals, an unwillingness to develop new work roles and a lack of support for development of relevant peer-based and self-care models.

While some health professionals have been drawn very effectively back into the health sector in recent years (largely registered psychologists through rapid expansion of the Better Access Scheme), other major areas – and most notably mental health nursing in community settings - are still seriously underdeveloped.

This proposal focuses mostly on those workforces who have the greatest capacity to work in a flexible and responsive manner with those with severe or persistent illness.

The development of new models of training, with great emphasis on working as part of new collaborative teams in child health, youth mental health, integrated medical and psychological health or aged care need to be prioritized (particularly over existing limited clinical training placements in institutional or other acute care settings).

Table 10 – Workforce Development

Best Buys	Expenditure Required (Fin Year) (\$m)						
	11-12	12-13	13-14	14-15	4 Yr Total	15-16	5 Yr Total
28. Coordinate mental health care in the community for those with severe and persisting illness	9	12	13	16	50	16	66
29. Develop integrated medical and psychological care for older persons residing in the community	9	12	13	16	50	16	66
30. Develop specific clinical training fellowships in child health, youth mental health aged care and health services and clinical research	9	12	13	16	50	16	66
Total Expenditure	27	36	39	48	150	48	198

28. Coordinate mental health care in the community for those with severe and persisting illness

There is an urgent need to develop workforces capable of integrating care and delivering a range of medical and/or psychological interventions to this subpopulation. The two groups most suited to rapid development and support are mental health nurses and peer-support workers. Relevant training and ongoing professional development programs need to be supported.

Reimbursement systems need to bring the levels of support for mental health nurses in line with those of other professionals in this field.

29. Develop integrated medical and psychological care for older persons residing in the community

There is an urgent need to develop medical and nursing workforces capable of integrating care and delivering the full range of medical and psychological assessments and interventions relevant to this subpopulation.

Relevant training and ongoing professional development programs need to be supported. Reimbursement systems need to bring the levels of support for mental health nurses in line with those of other professionals in this field. The increasing use of general practitioners with skills in this area need to be better utilized in a team framework.

30. Develop specific clinical training fellowships in child health, youth mental health aged care and health services and clinical research

Workforce development needs to be greatly enhanced through the provision of clinical training fellowships that are strongly tied to the major health services developments described throughout this blueprint.

Designated training fellowships that build clinical skills or encourage research and training, when provided at the key transition points in professional development, are a proven method for influencing long-term career direction. Currently, mental health has very few options for recruiting young and gifted clinicians compared with other high-profile health disciplines.