ACTIVITY BASED FUNDING AND MENTAL HEALTH ISSUES PAPER

MARCH 2012

Mental Health Council of Australia

CONTENTS

ABOUT THIS PAPER

The Mental Health Council of Australia (MHCA) and its Board have determined that Activity Based Funding (ABF) is one of the most significant policy reforms currently facing mental health in Australia and intend for this paper to contribute to a better understanding of the issues by the sector.

Health Outcomes International (HOI) and the Brain and Mind Research Institute (BMRI) University of Sydney agreed to collaborate in the preparation of this issues paper to facilitate an increased awareness of ABF and to encourage active interest and involvement of the mental health sector in the implementation of the national health funding reforms.

HOI is a consultancy service with a longstanding interest and expertise in casemix and ABF. The BMRI is a member of the MHCA.

The MHCA would like to acknowledge Sebastian Rosenberg, Senior Lecturer, BMRI and Lilian Lazarevic, Managing Director, HOI for their expertise and preparation of this paper.

GLOSSARY OF TERMS

ABF	Activity Based Funding – the means by which the Federal Government will pay for hospital services from 1 July 2012. The exact scope of which hospital-funded services are to be included is still up for debate but the principle is that ABF should be used wherever practicable.
AN-SNAP	Australian National Sub and Non-Acute Patient (AN-SNAP) casemix classification system developed for use in sub and non-acute care. SNAP defines four case types of subacute care (palliative care, rehabilitation, psychogeriatric care, and geriatric evaluation and management) and one case type of non-acute care (maintenance care), and classifies both overnight and ambulatory care.
AR-DRGs	Australian Refined Diagnosis Related Groups – the casemix classification developed for use in acute settings.
Casemix	A way of classifying 'patients' into groups with similar characteristics, treatment and costs. It is generally acknowledged that casemix systems in mental health require considerable further development before they can be regarded as robust.
IHPA	The Independent Hospital Pricing Authority – IHPA will set the national efficient price for public hospital services under ABF.
LHD/LHN	Local Health Districts/Local Health Networks – the new clusters of hospitals created by recent health reforms.
MH-CASC	Mental Health Classification and Service Costs – the casemix classification system developed specifically for mental health.
NHCDC	National Hospital Cost Data Collection – the annual collection of hospital costs for acute care services, emergency departments, subacute and outpatient services. This will be an important tool for the IHPA to set the national 'efficient' price to be paid across these services.
NHPA	National Health Performance Authority – the new body charged with monitoring and reporting health system performance.
NHRA	National Health Reform Agreement – signed by the Commonwealth and all states and territories in 2011.
NMDS	National Minimum Data Sets – the agreed definitions by which data is collected and reported.
NMHC	National Mental Health Commission – established in January 2012 to monitor and report on mental health reform.
URGs	Urgency Related Groups – the casemix classification developed for use in emergency departments

INTRODUCTION

This paper provides some background to the application of Activity Based Funding (ABF) to mental health in Australia that will be implemented on 1 July 2013. The key decisions around implementation will occur in 2012 and the sector needs to consider the issues and its preferences as to how ABF should apply to mental health services.

One of the key challenges to be faced is concurrent policy development across several different fronts in mental health. Federal health reforms are building two new service delivery structures: Medicare Locals, and the Hospital and Health Networks. ABF is the method by which the Federal Government has committed to disburse $175b of new funds for health over the period 2014–2030 and to fund growth in health services[1]. The only other major public source of funding is from increasingly tight jurisdictional health budget allocations. Mental health cannot afford to ignore ABF.

A further reform underway is the establishment of mental health commissions both state and federal. A key aspect of the National Mental Health Commission is the development of a new national Report Card for mental health. ABF and casemix methods offer a way of consistently classifying and reporting a range of mental health services nationally. Currently these services are reported differently across jurisdictions compromising their comparability. Consistent with the management maxim that "what gets measured gets done", there is a direct relationship between what can be reported in any Report Card (state or federal) and the design of the system for funding mental health care. At the same time, these arrangements need to fit into the work of the new National Health Performance Authority (NHPA), which is charged with national monitoring of the health system.

Finally, there is general interest in building community-based mental health services and avoiding continued over-reliance on acute hospital care. ABF needs to facilitate this.

This paper aims to assist consideration of these issues.

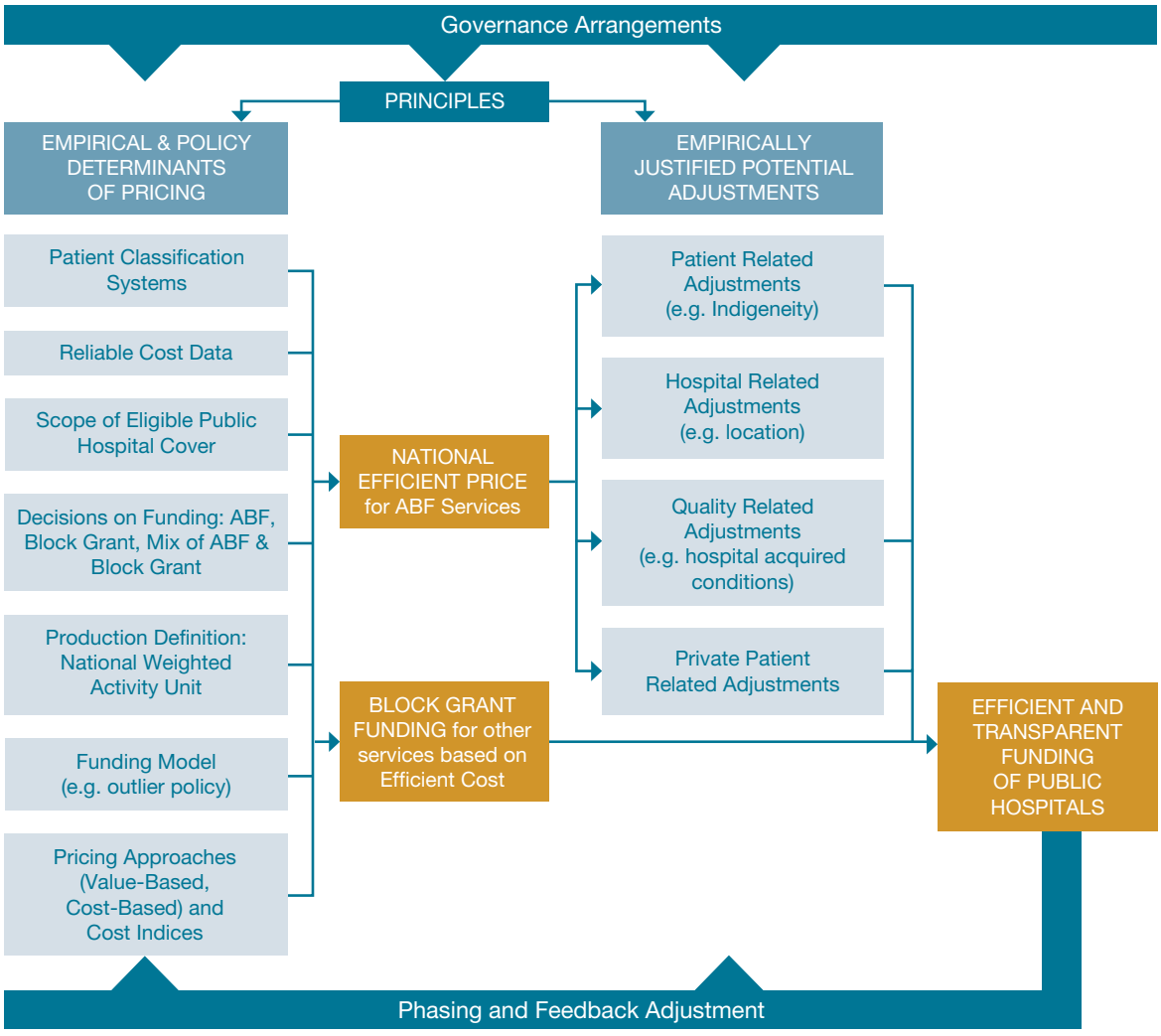
1. Financial Review "Gillard gave more on health deal: Baillieu" http://afr.com/p/national/gillard_gave_more_on_health_deal_V7GKEMTaHvDybbO2CUqrBO

ABF DEVELOPMENTS TO DATE

The Independent Hospital Pricing Authority (IHPA) has developed a draft ABF Pricing Framework[2] that will be used to inform the determination of the national efficient price for the implementation of in Australian public hospitals from 1 July 2012.

The components of the ABF Pricing Framework development process are described in Figure 1 below. The IHPA is now working through the key issues of which services are to be deemed in scope for funding under the new arrangements, which classification systems are to be used and the range of adjustments that will need to be in place to make the system function.

FIGURE 1: DRAFT ABF PRICING FRAMEWORK COMPONENTS



Source: IHPA "Activity based funding for Australian public hospitals: Towards a Pricing Framework"

2. Independent Hospital Pricing Authority (December 2011) "Activity based funding for Australian public hospitals: Towards a Pricing Framework" http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/EB8EFD07DF85BC70CA25798300033BE1/$File/IHPA%20Draft%20Pricing%20Framework_long%20version.pdf

1. **Implementation of ABF for mental health – 1 July 2013.** The National Health Reform Agreement signed by all jurisdictional Ministers of Health provides for the implementation of ABF for mental health services on 1 July 2013. The key issue to be determined are the details of the:

   – Mental health activity counting and business rules that will need to be applied consistently across jurisdictions;

   – Method for consistently classifying mental health services across the funding streams (acute care, subacute care, emergency departments, outpatients, hospital funded community services, and teaching, training and research);

   – Costing of mental health funding streams; and

   – Interim pricing model to be adopted.

   Some decisions have already been made in respect of specialist mental health services provided in the acute care, emergency department and outpatient settings. The IHPA has recently promulgated a report on hospital-funded community health services to jurisdictions for review and comment by jurisdictions; and two key consultancies will be commissioned for mental health and subacute care shortly.

2. **Limited input from broader mental health sector.** The decisions associated with the implementation of ABF have been driven largely by a working group comprised of jurisdictional policy representatives with little reference to the broader mental health sector, practitioners, consumers and carers. A number of jurisdictions have also established working groups.

   There is a pressing need for the mental health community to become more active to assist the IHPA meet its goals while ensuring determinations about the roll-out of ABF meet sector needs. It is reasonable to suggest two primary aims in this regard:

   – To capitalise on the opportunity offered by ABF to ensure that mental health can gain its fair share of new federal health funding offered as part of the national health reforms. The flip side of this is to ensure that mental health is not left to languish reliant for the majority of its funding from pressured state health budgets; and

   – To ensure the ABF system plays a role in promoting mental health reform and does not provide any perverse incentives for hospitalisation; stimulating the development of genuinely community-based mental health programs, creating new taxonomies by which to describe and compare services.

3. **Increased engagement of mental health sector with the IHPA and jurisdictions.** These goals can be prosecuted through increased engagement with both the IHPA and the individual jurisdictions. One key outcome would be to ensure the sector is appropriately represented on the jurisdictional and national mental health ABF working groups.

4. There are a number of opportunities that present themselves in this regard – all of them require the identification of champions; the rallying of effective jurisdictional support; increased dialogue with the IHPA (which is primarily focused on 1 July 2012); and the presentation of evidence to inform future funding decision making.

5. **Interim ABF arrangements – 1 July 2012.** The Draft ABF Pricing Framework proposes that from 1 July 2012 mental health services funded by public hospitals will be funded (interim approach) on the basis of activity for the following funding streams:

Acute care	AR-DRG (Australian Refined Diagnosis Related Group) efficient price
Emergency Care	Mental health services provided in emergency departments will be classified based on Urgency Related Groups (URGs)
Outpatient Care	Tier 2 classification for outpatient services based on one class "community mental health services" that will be used as the basis for counting eligible non-admitted mental health services.

6. There was an attempt in early 2011 by NSW, Victoria and Queensland to review alternative classification systems for mental health, however these efforts were stifled due to the imperative to implement the acute, emergency department and outpatient funding streams by 1 July 2012. Mental health is now in a very similar situation – there will be insufficient time to do anything that is meaningful so an interim solution will be implemented.

SUMMARY OF KEY IMPACTS

In summary the key impacts on Local Hospital Networks and service providers include:

1. **Refinement of proxy classification systems.** All three proxy classification systems in Table 1 above are not appropriate for funding mental health services and are considered to be an interim solution. Considerable investment of resources (and time) is required to ensure a robust classification system is implemented across Australia.

2. **Classification of mental health activity provided in Emergency Departments.** There are a number of limitations of the URG classification system for ABF funding of mental health services provided in emergency departments:

   – Although psychiatric illness is identified as a specific URG diagnosis block, the assignment of ED attendances with a mental health diagnosis is not adequate to capture the extent of mental health treatment provided in EDs. This is because mental health is often coded as a secondary/additional diagnosis.

   – It is essential that data is collected about mental illness as a secondary/additional diagnosis, along with other additional diagnoses that are likely to increase a patient's complexity (such as dementia).

   – The impact of consultation liaison and in-reach services into EDs needs to be fully assessed.

3. **AR-DRG classification system.** The extent to which acute mental health services are to be incorporated into ABF in 2012/13 has not been determined. However, the limited capacity of DRGs to group like patients and predict resource use is well known.

4. **Block funding.** It is unclear the extent to which block funding grants will be determined through bilateral agreements between the Commonwealth Department of Health and Ageing and states. It has been acknowledged that some mental health services will be able to be funded using ABF. Block funding and historical funding have generally delivered poor funding outcomes for mental health services. And while DRGs may be relatively poor predictors of mental health costs, they do provide some capacity for benchmarking that is not available through simple historical or block funding.

5. **Mental health costing data.** Currently the National Hospital Cost Data Collection (NHCDC)[3] is reported to the Commonwealth on an annual basis for acute care services, ED, subacute and outpatient services. This data collection includes mental health service costs. This issue will need to be addressed as part of the annual NHCDC costing process (Round 15 — scheduled to be submitted to the Commonwealth in June 2012; there is insufficient time for states to effect any changes in the costing process which will have an impact on determining efficient prices for ABF mental health funding).

3. For more information on the NHCDC: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-nhcdc-hrms

6. **AN-SNAP.** The current Australian National Sub and Non-Acute Patient (AN-SNAP) classification system has not undergone a comprehensive national review since the system was first developed in 1996; although NSW commissioned a review in 2005, this did not address subacute mental health services. Nationally, there is a need to consider:

   – A critical element of subacute care, ABF is being able to define, classify, count, cost and pay for activity in a consistent manner. The availability of consistent definitions for a range of clinical and service concepts is critical to being able to identify sub-acute cost drivers and in developing accurate costs of these services. Some of these definitions are currently in the National Health Data Dictionary (NHDD) however modifications are required for mental health such as psychogeriatric care; and

   – A review of cost drivers for mental health in consultation with clinicians and service providers.

7. **Hospital funded community services.** The IHPA commissioned a consultancy in November 2011. The report of this consultancy has been distributed to states and territories for review and comment. The national Mental Health Care Advisory Working Group (MHCAWG) participated in the discussions through which project deliverables are reviewed. The project was designed to contribute to the development of a nationally consistent approach to ABF for non-admitted community based health services. Specifically the objectives were to:

   – Gather relevant information to inform the development of a nationally consistent approach for identifying the hospital funded community health services in scope for ABF under the national health reform arrangements;

   – Identify documentation on, and where possible data from, relevant state/territory health authority data collection systems used in mental health community based services;

   – Prepare a national catalogue of hospital funded community based health services; and

   – Enable nationally consistent methods to be developed for classifying, counting and costing non-admitted community based health services for ABF purposes.

   New models of mental health services are emerging, such as step-up/ step-down services, which emphasise the need to ensure close links between acute and community-based services. Given that the findings of this consultancy will provide the basis for future funding of hospital funded mental health community services it is essential that providers and the mental health sector have an opportunity to fully assess the impact of the proposed recommendations.

8. **Impact assessment of ABF on mental health reform agenda and service delivery.** There is a need to assess the potential impact of implementing ABF for both the national mental health reform agenda and mental health service delivery. This requires empirical evidence to be submitted to the IHPA by jurisdictions to inform the decision making process. Issues to be addressed include:

   – The data used to determine ABF must include all mental health service activity provided and must be able to track clients across services if integrated care packages are to become the long term products for mental health funding;

- Currently national client based data cannot be linked across the client journey;
- Client outcome data is not linked to client activity data; and
- Intervention codes are not agreed.

9. **Strengthening governance arrangements for ABF mental health.** There is a need for mental health services to adopt a more proactive leadership role in order to influence ABF decision making. The current governance arrangements for ABF mental health need to be strengthened. For example the National ABF Mental Health Working Group meets infrequently — the jurisdictional representatives on this group are, on the most part, not technically attuned to contemporary funding model options. It is expected that the IHPA will commission work to commence in the next two months to assess mental health classification and funding options. From this perspective it is important for the mental health sector to actively participate in these debates.

10. **ABF mental health pricing model.** The ABF mental health pricing model needs to address a number of fundamental issues including management information requirements that are required to support the assessment of specific objectives (e.g. the current cost of service delivery; the extent to which unmet needs are being met; the efficacy of service models and interventions etc.).

11. **Collaborative working arrangements with the IHPA.** There is an opportunity for the mental health sector to influence the future collaborative approach to be adopted by the IHPA. To this end, strategies need to be developed to ensure that in the first instance all the issues that have been identified are discussed with the IHPA representatives and incorporated into a revised IHPA mental health work plan (which will be the blue print for the developmental activities to be undertaken to 30 June 2013.

ASSESSMENT OF MENTAL HEALTH CLASSIFICATION SYSTEM OPTIONS

A review of existing mental health datasets demonstrates that these datasets do not contain sufficient information on which to develop a patient-level mental health classification system.

1. **Admitted care.** For admitted services, while patient diagnoses and the patient's length of stay in hospital are captured in the Admitted Patient Care National Minimum Data Set (NMDS), the current health interventions framework (Australian College of Health Informatics — ACHI) that identifies what occurs during an admission is not well suited to specialised mental health care. It is likely this will be overcome with the proposed adoption of a Mental Health Interventions Classification and its incorporation in ACHI in 2014, but it will then be several years before this new code set yields sufficient data to allow the inclusion of such data in a future classification system.

2. **Mental Health Classification and Service Costs (MH-CASC).** MH-CASC is considered by some as being the classification system that should be implemented for ABF. However, there are some significant issues with MH-CASC, in particular:

   – This system was developed almost 15 years ago when the mental health service system was still largely institution-based, which means that many of the proposed classes and the associated costs are no longer relevant. There has been little subsequent national investment in MH-CASC refinement or development;

   – The proposed classes accounted for only a relatively low level of variation in observed costs;

   – The classification system reliance on clinician-rated clinical outcome scores on a relatively high-level scale, which is not particularly well-regarded by many clinicians, remains open to 'gaming'[4] and is liable to major revision;

   – The system does not allow for packages of care across settings; and

   – The system's extensive use of legal status as a splitting criterion.

3. **Outpatient care.** In the case of outpatient services, the number, date and duration of service contacts at the individual patient level are reported within the Community Mental Health Care (CMHC) NMDS. These are inadequate proxies for service classification. Other drivers of cost are required including number and profession of clinicians attending each contact, whether these contacts were facility-based or in the client's home, and whether the contact was in normal business hours or after hours.

4. **Assessment of mental health classification system options.** An evidence based approach is required investigate those classification systems that are actually already in place and

4. 'gaming' means decisions about treatment are made on the basis of getting the most from the casemix payment system rather than on the basis of patient care.

used for payment in other jurisdictions, such as the UK, Netherlands and Victorian funding systems.

The Health of the Nation Outcome Scales (HoNOS) and the other mental health outcome measures on which the MH-CASC classification was developed, have well documented measurement problems and despite being nationally mandated for use in specialised mental health services in Australia since the early 2000s, continue to be regarded with some scepticism by many professionals and consumers due to the broad nature of the scales. HoNOS was originally developed in the UK to provide a mechanism for recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'.

5. **Future ABF mental health development to be undertaken by the IHPA.** It is likely that the consultancy to be commissioned by the IHPA will seek to assess:

   – Classification system options that have been implemented in Australia and internationally; and

   – The suite of key performance indicators tailored to specialised mental health services that are the outcome of work that has been undertaken by a number of states and territories and by specialised mental health service organisations and clinicians.

ASSESSMENT OF ABF MENTAL HEALTH FUNDING OPTIONS

Another key issue that requires careful consideration relates to the design of future ABF mental health funding model options such as blended payment models.

The primary aim of ABF is to implement a national funding framework for mental health that describes the activity based funding infrastructure that will be developed by the IHPA in partnership with the states and territories. It should be designed to identify the key elements of a fully operational, nationally consistent activity based funding regime, addressing patient typology, classification, costing and funding of mental health services (funded through public hospital budget allocations). It also must address activities such as research and training, which are not directly related to the delivery of mental health services, for which an activity based funding approach may not be appropriate.

In the current climate it is important that incentives are provided for state managers and Local Health Districts/Networks (LHDs/LHNs) to be efficient and service focused in their delivery. To ensure that mental health funding is utilised well, it could be appropriate to require all funded agencies are able to demonstrate efficiency (in terms of the benchmark price).

BLENDED PAYMENT MODELS

In practice, most funding models are based on blending of inputs, outputs (ABF) and outcomes funding models. In the short term, it is likely that the mental health ABF model will balance the production efficiency incentives of an ABF approach with the practical effectiveness of an inputs-based approach. This balance will need to be struck whilst preserving incentives for quality services. A blended payment model would have a basic structure that ensured mental health services continue to be delivered, whilst being flexible enough to accommodate variations in cost of service delivery associated with activity demand and the range of service models across jurisdictions.

The performance based funding model (also known as payment for performance) warrants consideration as it creates incentives for maintenance or improvements in quality of care measures. This model allocates funding that is aligned with the achievement of specific thresholds on a set of pre-determined performance indicators. This model is often designed as a hybrid of the ABF model. The major challenge for these models is the development of valid and reliable measures of quality of care. An example of this model is the Payment by Results (PbR) funding model[4] that has been developed to fund health services in the United Kingdom.

5. UK Department of Health (2011) "Payment by Results Guidance for 2011–12" http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126157.pdf

UK PAYMENT BY RESULTS FUNDING MODEL

The "High Quality Care for All" report[6] recommended the development of mental health PbR in order to facilitate the comparison and benchmarking of mental health services, supporting effective purchasing of mental health services.

The UK PbR funding model comprises a set of 21 'care clusters' that together form 'currencies', or units for contracting and commissioning mental health services.

1. Each cluster defines a package of care for a group of service users who are relatively similar in their care needs and therefore resource requirements. A Clinical Decision Support Tool (CDST) has been derived based on an iterative process involving the "assessment of consumer needs, statistical cluster analysis of assessment scores and expert multidisciplinary opinion". Whilst the classification system is based on both clinical and non-clinical need, the 21 clusters are located within three clinical 'superclasses' that are the first step in the classification process: organic disease, psychotic disorders and non-psychotic disorder.

2. The Mental Health Clustering Tool (MHCT) has been developed incorporating the Summary Assessment of Risk and Need (SARN), and HoNOS PbR. Consumers are allocated to a cluster on the basis of 'need'.

3. The care clusters form the currencies that are used for purchasing mental health services. In addition, standardised care packages have been developed for each cluster known collectively as the 'Integrated Packages Approach to Care'. Each package describes the care activities required to meet the needs of people within a single cluster.

4. Currencies have been developed (focused on specialist inpatient, outpatient and community-based services for adults of working age and older people) and have been refined and tested at several sites in England.

5. In addition, costing of acute mental health services has been undertaken to assess the impact of the resource allocations of the currencies.

The intention of the UK Department of Health is to apply these currencies for purchasing mental health services and benchmarking, using local prices agreed between commissioners and providers by April 2012. However, a report of the Mental Health Payment by Results Readiness Review[7] published in November 2011 reported that notwithstanding the UK has been developing the PbR model for mental health for several years, the financial risks for service providers and the mental health system at large are too great and expose service providers to financial pressures. As a result, most areas plan to operate their 2012–13 contracts on a shadow funding basis with risk sharing mechanisms.

6. Darzi, A. (2008) "High Quality Care for All: NHS Next Stage Review Final Report" – Summary. London: Department of Health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

7. Mental Health Network NHS Confederation (2011) "Mental Health Payment by Results Readiness Review" http://www.nhsconfed.org/Publications/Documents/PbR_241111.pdf

FUTURE STRATEGIC DIRECTION FOR ABF MENTAL HEALTH

In Australia, ABF for mental health will be implemented over the coming three to five years. It is not going away. There is political will (on both sides of the political spectrum) to reduce the funding associated with block funding and, wherever possible, to implement an ABF model together with loadings (where required) for mental health. The system will drive greater transparency by creating a common language with which to describe and compare services and this is welcome.

It is timely for the MHCA as the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector to consider the formulation of strategies that will ensure the interests of the Australian mental health community are effectively addressed in terms of:

1. Ensuring the MHCA has input to the future mental health scoping study that will be commissioned by the IHPA in the coming months. Given the different mental health service models that are in existence across jurisdictions it is important that this project gain a greater understanding of the drivers of cost of these service models and the reasons for cost variations. The questions in ABF for mental health that still need answering should include an examination of:

   – Existing service definitions applied across jurisdictions;

   – Activity reporting and costing practices;

   – Reporting clinical and non-clinical outcomes measures;

   – Existing service agreements and funding arrangements across jurisdictions;

   – Existing mental health funding models that have been implemented in Australia and internationally;

   – The extent to which an appropriate infrastructure is available at LHD/LHN level across jurisdictions to support the implementation of ABF mental health (across funding streams particularly for sub-acute, outpatients, emergency departments and community services);

   Depending on the outcome of further work in this area, action will need to be taken to address unacceptable cost variances before an ABF system is fit for purpose to minimise the financial risk of system implementation.

2. Ensuring that the MHCA has an opportunity to review and comment on the findings of the hospital funded community services consultancy report.

3. Representation on the National ABF Mental Health Working Group. This Working Group currently has been established by the IHPA to inform future classification and funding options. ABF for mental health will of necessity be an iterative process as experiences in Australia and overseas have shown that funding reform of this nature requires significant lead time. This is particularly the case in Australia as a national mental health classification system is still to be implemented, and the quality of current activity and cost reporting needs to be improved for funding purposes.

4. Of paramount importance is the collection of patient level activity and cost data from a representative sample of service models and service providers that will be used for the purposes of developing the classification system, pricing arrangements and testing the sensitivity of funding model options. This requires a focus on data quality and information systems, which should lead to wider benefits for clinical management and improved consumer outcomes. It will be essential that clinicians are engaged in the review of patient-level data, classification and funding model options. Based on the preliminary planning work undertaken by a number of jurisdictions, strategies need to be developed to address mental health data collection under-counting, including introducing systematic solutions to prevent recurrence of the problems.

5. ABF model options for mental health need to be reviewed to assess the extent to which these options link clinical needs, activity, quality and outcomes in the resource allocation process. The focus on benchmarking will become more prominent over the coming years as the ABF mental health funding model is refined. Whilst this may be a concern for some providers, it has the potential to create an opportunity for best practice to be more visible and rewarded. Best practice, however, can only develop with appropriately funded research.

6. To achieve nationally consistent mental health funding reform, there is a need for clear leadership and strategic direction together with the adoption of a collaborative approach with funders and service providers. Currently many LHDs/LHNs are not engaged in the process. For example, there is a need for a strategic approach to increase the level of communication with mental health service providers and the NGO sector; and a change management strategy to support the implementation of ABF. This will in turn provide increased opportunities for information sharing and will support future ABF implementation and refinement.

CONCLUSION

Activity based funding is a reality for mental health in Australia and there can be no delay in the sector joining the debate about how implementation should occur. Hospital-funded mental health services are eligible for ABF, which is a deeper pool of federal health funding than tight state budgets. ABF offers the chance to develop new taxonomies by which to describe and compare care and outcomes. This infrastructure is sadly lacking in mental health in Australia, particularly for community mental health services. There is an urgent need for mental health sector leaders to outline their preferred approach to the systematic development of the required ABF infrastructure across acute, outpatient, emergency department and community services.

A first step might be to conduct a full, national readiness review of mental health services and data across these settings. Such a review would result in the identification of strengths and weaknesses, involve detailed and ongoing communication with the sector to dispel myths and create understanding.

An action plan and implementation timetable would be key final products of such a review and would take around six months to complete. It would be critical to partner with providers and the community in this work, and also with the jurisdictions currently responsible for funding and reporting mental health services.

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