NSW mental health services in context

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The organisation, funding and delivery of mental health care in New South Wales is complex and often confusing for both providers and consumers. The purpose of this paper is to provide some background to explain the context in which mental health care is delivered and to provide an overview of new funding arrangements for mental health that are currently being introduced.

Australia is a federation

Australia is one of the oldest countries in the world and it was not until the last few hundred years that the rest of the world discovered our existence. What is now white Australia did not begin until 1788 when NSW was established as a British penal colony.

In 1901 (and over 100 years after the colony of NSW was established) Australia became a federation. In the intervening period, health care was delivered by charities and religious orders and the colonies began to build (and continue to own) what are now public hospitals.

As a federation, Australia was established as a union of partially self-governing states that agreed to come together under the central (federal) government of Australia. A century later, Australia remains a federation with the responsibility of the two levels of government specified in the Australian Constitution of 1901.

Under the Australian Constitution, health care delivery remains the responsibility of what are now the states and territories. Any change to this would require a national referendum. However, because the Commonwealth government has the power to raise taxes, the Commonwealth now has an important role in the financing of health care, including mental health.

An important development occurred in 1949. The 1949 National Health Service Act gave the Commonwealth a formal role in health care for the first time. This Act did not give the Commonwealth a mandate to provide health care. But it did give the Commonwealth the ability to provide financial subsidies to other parties for the delivery of health care. In the early years after this act was introduced, the Commonwealth used it to introduce Commonwealth subsidies for fee-for-service health care (such as private GPs and medical specialists), prescribed medicines and health insurance. All of these subsidies involve payments to the private sector. Decades later, all of these services remain as important elements of a comprehensive approach to mental health care.

It is less than 40 years ago that the Commonwealth first began to provide subsidies to the states and territories for the delivery of public health care, including public mental health care. The introduction of what was originally Medibank (now Medicare) in 1975 included an agreement that the Commonwealth would provide financial assistance to the states and territories for the cost of running public hospitals. In 2013, approximately 38% of the cost of...
running public hospitals in NSW is met by the Commonwealth. This figure includes outpatient and outreach services provided by public hospitals. The Commonwealth also introduced funding for community health centres in the mid 1970s, another service that is a critical element in mental health care. The Commonwealth no longer provides funding for community health centres, with all costs now met by NSW.

Complex political, structural and financial relations between the Commonwealth and NSW governments have evolved in the last 40 years that continue to have a significant impact on the way that mental health care is organised and financed. While many commentators, clinicians and consumers have argued that only one level of government should be responsible for all mental health funding / delivery, it is important to recognise that this is not a realistic option under our current federated arrangements.

The reality is that mental health services cannot exist in isolation, whether they are provided or subsidised by the Commonwealth, NSW, or both. Mental health consumers need high-quality and coordinated access to other Commonwealth subsidised services such as primary health care, prescribed medicines and aged care. Equally, mental health consumers need high-quality and coordinated access to other state funded services such as schools, disability services, housing and education.

A realistic starting point is to recognise that the Commonwealth and NSW each have distinct as well as overlapping responsibilities for mental health care and to the accept that these arrangements are unlikely to change (at least in the foreseeable future). What is critically important is that the two levels of government work closely together to meet the needs of all mental health consumers. Mental health advocates have an important role in ensuring that this occurs.

The following sections of this chapter describe the management and funding arrangements for the major elements of a comprehensive mental health service. The discussion below is limited to health services only. It does not include other services that people often require such as education, housing, employment and social support and engagement. The intention is not to describe every possible service a consumer may need. The purpose is simply to illustrate the broader context within which mental health care is delivered.

To place this discussion into context, Figure 1 below shows national spending on mental health in 2011-12 (the most recent year for which figures are available). Across Australia, states and territories fund 61% of all mental health services, with the Commonwealth providing 35% and private health insurance 4%. The picture in NSW is similar.
Figure 1  National spending on mental health 2010-11

Table 1 below gives more detail about the Commonwealth share of funding. Over two thirds of Commonwealth funding is spent on mental health payments under the MBS and PBS. Three Commonwealth departments (Health, Veterans Affairs and Social Services) fund various mental health services and programs that together represent 25% of Commonwealth mental health payments and 8.3% of all mental health funding.

Table 1  Commonwealth spending on mental health 2010-11

<table>
<thead>
<tr>
<th>Commonwealth program</th>
<th>$millions</th>
<th>% of C’wealth MH funding</th>
<th>% of all MH funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Benefits Schedule</td>
<td>852</td>
<td>35.2%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Pharmaceutical Benefits Scheme</td>
<td>809</td>
<td>33.4%</td>
<td>11.8%</td>
</tr>
<tr>
<td>National programs (Dept of Health)</td>
<td>265</td>
<td>11.0%</td>
<td>3.9%</td>
</tr>
<tr>
<td>National programs (Dept. of Veterans Affairs)</td>
<td>161</td>
<td>6.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>National programs (Dept. of Social Services)</td>
<td>145</td>
<td>6.0%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Private health insurance rebates</td>
<td>99</td>
<td>4.1%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Research</td>
<td>58</td>
<td>2.4%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>1.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total Commonwealth spending</td>
<td>2420</td>
<td>100.0%</td>
<td>35.1%</td>
</tr>
</tbody>
</table>

Table 2 provides a variety of indicators to profile mental health services funded by the NSW government. Relative to Australia as a whole, NSW has more inpatient beds and less ambulatory care. Per capita spending on NGOs and residential services in NSW is also below the national average.

**Table 2  Indicators of the NSW mental health system 2010-12 and comparisons with Australia as a whole**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NSW 2010-11</th>
<th>Australia 2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total hospital beds</td>
<td>2,650</td>
<td>6,755</td>
</tr>
<tr>
<td>Per capita expenditure on inpatient care ($)</td>
<td>97</td>
<td>81</td>
</tr>
<tr>
<td>Inpatient beds per 100,000</td>
<td>36</td>
<td>30</td>
</tr>
<tr>
<td>Acute inpatient beds per 100,000</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Non acute inpatient beds per 100,000</td>
<td>13</td>
<td>9.7</td>
</tr>
<tr>
<td>Stand-alone psychiatric hospitals as % of total beds</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>Average cost per patient day ($)</td>
<td>845</td>
<td>842</td>
</tr>
<tr>
<td>Ambulatory care - % total service expenditure</td>
<td>37</td>
<td>41</td>
</tr>
<tr>
<td>Ambulatory care - per capita expenditure ($)</td>
<td>65</td>
<td>74</td>
</tr>
<tr>
<td>NGOs - % total service expenditure</td>
<td>6</td>
<td>9.3</td>
</tr>
<tr>
<td>NGOs - per capita expenditure ($)</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Residential services - % total service expenditure</td>
<td>0.9</td>
<td>6</td>
</tr>
<tr>
<td>Residential services - per capita expenditure ($)</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Residential services - adult beds per 100,000 - 24 hour staffed</td>
<td>2.3</td>
<td>6</td>
</tr>
<tr>
<td>Residential services - adult beds per 100,000 - non-24 hour staffed</td>
<td>0.5</td>
<td>5</td>
</tr>
<tr>
<td>Residential services - older persons' beds per 100,000 - 24 hour staffed</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>Residential services - older persons' beds per 100,000 - non-24 hour staffed</td>
<td>1.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Supported public housing places per 100,000</td>
<td>22</td>
<td>22</td>
</tr>
</tbody>
</table>


**The Commonwealth Medicare Benefits Schedule (MBS)**

The MBS is a Commonwealth program that financially subsidises patients seen by private GPs and specialists. In recent years the MBS has been expanded to include a range of allied health and nursing services. Under the MBS scheme, the Commonwealth provides a subsidy to the patient which is a financial contribution toward the cost of their care. If the provider bulk-bills the patient, the patient has no other costs to pay. Providers can charge more than the MBS subsidy, in which case the patient has to pay a ‘co-payment’. The MBS covers private patients (including those treated in public hospitals). It does not apply to public patients. There is a financial “Safety Net” to help patients with high medical expenses. Once an individual or a family reach the Safety Net threshold, they qualify for higher MBS subsidies for the rest of the year.
The Commonwealth Pharmaceutical Benefits Scheme (PBS)

The PBS is a Commonwealth program that subsidises the cost of prescribed medicines. Patients are charged a co-payment, with the amount that the patient has to pay dependent on whether or not they have a health care card. The PBS only covers prescribed medicines provided for private patients. It does not cover medicines provided by public hospitals. As with the MBS, there is also a financial “Safety Net” to help patients with high pharmaceutical bills. Once an individual or a family reach the Safety Net threshold, they qualify for a PBS Safety Net card that makes medicines cheaper, or free, for the rest of the year.

Commonwealth mental health programs

As noted above, the Commonwealth runs a variety of mental health programs through three Commonwealth departments. The Department of Health provides funding for a broad range of initiatives. These include (but are not limited to) youth mental health services such as headspace, early intervention programs and support services for carers. The Department of Social Services funds selective community mental health services through its Targeted Community Care (Mental Health) Program. The Department of Veterans Affairs funds a range of mental health services for veterans and their families including a well-established program in post-traumatic stress disorder.

While the nature of specific programmes may change from time to time, it can be expected that the Commonwealth will continue to fund a range of mental health initiatives through the NGO sector. NSW NGOs need to be positioned to make best use of these opportunities when they present.

The National Disability Insurance Scheme

A National Disability Insurance Scheme (NDIS) is being progressively implemented across Australia, with the Hunter region being the pilot site for NSW. The scheme is being designed for people who have lifelong disabilities as defined in the NDIS Act. A person meets the disability requirements of the Act if:

“(a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments, or to one or more impairments attributable to a psychiatric condition; and

(b) the person’s impairment or impairments are, or are likely to be, permanent; and

(c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities: communication, social interaction, learning, mobility, self-care, self-management; and

(d) the impairment or impairments affect the person’s capacity for social and economic participation; and
the person is likely to require support under the NDIS for the person’s lifetime.”¹

The full implications for people with a mental illness are yet to be understood. A person is only eligible for the scheme if he or she has a permanent impairment that impacts on their capacity to socially and economically participate. However, the Act recognises that an impairment may be permanent notwithstanding “that the severity of its impact on the functional capacity of the person may fluctuate or there are prospects that the severity of the impact of the impairment on the person’s functional capacity, including their psychosocial functioning, may improve”.

The focus of the NDIS is on individualised funding and care planning. Once accepted into the scheme, consumers are linked up with a ‘DisabilityCare Australia’ planner who will work with them to develop an individualised plan that meets their needs. There is a stated commitment to giving consumers maximum choice both in the services they receive and in the service provider who will deliver those services (public, NGO and private sectors). Each consumer will be allocated their own funding and will use this funding to pay for the services they receive.

In relation to mental health, the rules specify that the NDIS will be responsible for “supports that are not clinical in nature and that focus on a person’s functional ability, including supports that enable a person with a mental illness or psychiatric condition to undertake activities of daily living and participate in the community and social and economic life.”

The rules also specify the range of mental health services that the NDIS will not cover:

“(a) supports related to mental health that are clinical in nature, including acute, ambulatory and continuing care, rehabilitation/recovery; or

(b) early intervention supports related to mental health that are clinical in nature, including supports that are clinical in nature and that are for child and adolescent developmental needs; or

(c) any residential care where the primary purpose is for inpatient treatment or clinical rehabilitation, or where the services model primarily employs clinical staff; or

(d) supports relating to a co-morbidity with a psychiatric condition where the co-morbidity is clearly the responsibility of another service system (eg treatment for a drug or alcohol issue).”²

While it is too early to know how the definition of “permanent impairment” will be interpreted once the scheme is fully operational, it is clear that the scheme will be available only to the small proportion of mental health consumers who are assessed as having a “permanent impairment”. The exact number is not known but the Productivity Commission estimated that

only 12% of adults with severe mental disorders will be eligible. For NSW, this equates to less than 20,000 people.³

Funding for the NDIS includes both growth funding and funding offset against existing programs. In relation to mental health, the Productivity Commission (Chapter 16) estimated offsets of $616 million for community support programs currently provided to people with “significant and enduring psychiatric disability.. The $616 million includes expenditure on Australian Government programs such as the Support for Day to Day Living in the Community program and the Personal Helpers and Mentors service as well as recent budget initiatives for coordinated care. Offsets also encompass state and territory funded supports delivered by the not-for-profit sector.”⁴

One obvious implication is that some consumers will have access to a range of support services via the NDIS while others will not. For those that do, the NDIS represents a further funding stream for the public, private and NGO sectors.

Another implication is that NDIS participants will continue to require clinical treatment and rehabilitation from the mental health sector while at the same time receiving a range of non-health services via the NDIS scheme.

There are a range of other unresolved issues at this point. This includes how the NDIS will interface with mental health services and with the mental health legal system, how potential overlaps with existing intensive support services will be resolved and systems for substitute decision-making when a person is unwell. There is also the risk that, as eligibility for the NDIS is based on a person having a “permanent impairment”, the scheme may work against a focus on recovery.

That said, the establishment of the NDIS presents significant opportunities to improve the lives of those who are eligible and to give participants far greater choices than they currently have available. At the system level, the NDIS presents opportunities to learn more about individualised service planning and funding and better ways to measure need and outcomes.

**Public hospital services**

Public hospitals are owned and managed by each state and territory, with each state having its own legislation that governs the management and delivery of public hospitals and related services. Mental health care in public hospitals is typically delivered under one of three models:

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³ Productivity Commission, *Disability Care and Support* page 755.  

⁴ Productivity Commission, *Disability Care and Support* page 755.  
1. Most large public hospitals have designated mental health inpatient units as well as specialist outpatient and outreach services. This may include (but is not limited to) acute mental health units, rehabilitation units, community teams, child and adolescent services and aged mental health.

2. Mental health patients may receive public hospital care in non-designated units. For example, a mother with acute postnatal depression may be cared for in the maternity unit rather than the mental health unit. Likewise, a child requiring mental health care may receive it from a general paediatric unit rather than the mental health unit. Emergency departments are another example of a non-designated unit that frequently provides mental health care.

3. While most freestanding mental health hospitals have now closed, there remain a small number of specialist mental health hospitals that typically include a range of services including forensic mental health care.

In 2011 all Australian states and territories joined with the Commonwealth in signing the National Health Reform Agreement (NHRA). This agreement applies to all public hospital services. This includes all three models of public mental health care as described above.

The NHRA confirmed that the states and territories are to continue to be responsible for managing the public health system, including public hospitals and community health centres. It committed all governments to collecting and providing comparable and transparent data and to nationally consistent standards for healthcare and performance reporting. It also committed all governments to introduce local hospital networks (what are now Local Health Districts and speciality networks in NSW) and to a common funding model. This funding model is described in the next section.

The 2011 agreement committed the Commonwealth to continue contributing to the cost of public hospitals but it specifies that community health centres and public primary care are fully the responsibility of each state and territory, with the Commonwealth making no funding or contribution for these services. The agreement defined in broad terms the ‘hospital’ services that the Commonwealth will contribute to and included an agreement to establish a national Independent Hospital Pricing Authority (IHPA), whose role now includes:

1. Defining in detail the scope of a public hospital for the purposes of determining the Commonwealth funding share
2. Determining the price that the Commonwealth will pay
3. Designing the Commonwealth Activity Based Funding (ABF) model – see below.

In reviewing the above three points, it should be noted that the IHPA mandate is limited to determining the Commonwealth funding contribution and related matters. However, NSW and other states and territories have committed to moving towards a more common approach

where it proves practical and have already adopted much of the approach that the IHPA has developed to date.

As noted above, all governments agreed in the 2011 agreement to fund public hospital services using a funding model called Activity Based Funding (ABF) where practicable, with block funding to be used where ABF is not practical. The implication is that NSW and the Commonwealth will continue to jointly fund NSW public hospitals (as they have in the past), but both will do so by using a common approach (ABF). In 2014, each Local Health District in NSW is being funded through a mix of ABF and block grants, with the percentage funded via ABF being progressively increased and the percentage that is block funded being progressively decreased.

Importantly, the NHRA covers all health care delivered by and from public hospitals and makes no special provision for mental health care. For NSW mental health services, the introduction of a new approach to funding represents a significant change, the details of which are explained below.

**Scope of public hospitals for the purposes of the NHRA**

A key task for the IHPA is to define the scope of activity to be funded by the Commonwealth using the IHPA ABF model. Attachment 1 summarises the IHPA determination about the scope of public hospital mental health services to be funded by the Commonwealth under the NHPA.

The IHPA has determined that it is agnostic about where public hospital services are provided and about who provides those services. A public hospital service may be provided within the grounds of a hospital but can equally be provided in another setting such as a person’s home. Equally, a public hospital service may be provided by hospital staff or may be contracted to a third party such as an NGO.

The scope of mental health services as set out in Attachment 1 is quite broad, with all but four mental health activities being in scope. The four out of scope activities are general counselling, primary health care, psychosocial rehabilitation programs and prevention and early intervention services. These services are not eligible for Commonwealth funding, with the full costs to be met by the State. The IHPA has also determined that it does not recognise Consultation-Liaison Mental Health as a separate activity for ABF purposes.

**Activity Based Funding**

**Definition of ABF**

Historically, mental health services have been block funded, with each service usually receiving last year’s funding plus or minus a little. This historic way of funding public hospital services is being progressively phased out and is being replaced by Activity Based Funding or ABF. ABF means exactly what it says – hospitals are funded based on the volume and type of activities that they undertake. Because most hospital activity involves treating patients – or cases – the term ‘casemix funding’ is also used.
A critical element of ABF is that each ‘activity’ needs to be defined, classified, counted and costed in a consistent matter. If it is not possible to do all of these, the funding authority cannot pay for each activity in a consistent manner. Given the paucity of current mental health information systems, these basic requirements pose considerable challenges.

**The IHPA ABF classification model**

The NHRA initially recognised four different streams of “activities” to be funded under ABF:

- Acute inpatient admissions such as surgery, medical admissions, maternity and paediatrics
- Emergency department activity
- Sub-acute care (both inpatient and outpatient) such as rehabilitation and palliative care
- Outpatient services, including hospital outreach and community-based services.

Under the approach subsequently adopted by the IHPA, there is a different casemix classification for each of the above streams of care, with one national price that is calibrated across the various streams. The IHPA also recognises “Teaching, training and research” as a distinct activity that needs to be separately funded.

A comprehensive mental health service includes each of these activities and the IHPA resolved in 2013 to develop a separate classification and funding model for mental health care. The IHPA has a Mental Health Working Group to guide it in this work. Work to develop this classification and funding model is due to begin in early 2014 with the goal of having a new system ready for trialling in 2015-16.

In the interim, each component of mental health care is being classified and funded according to the existing activity streams. For example, acute mental health inpatient care is being classified by AR-DRG (the acute care casemix classification) and outpatient and ambulatory care by the IHPA Tier 2 outpatient list until such time as the new mental health classification is developed.

**The IHPA ABF funding model**

Under the NHRA, public hospitals receive funding from both the Commonwealth and from NSW, with the IHPA determining the scope of activity that the Commonwealth will fund and for determining the price that the Commonwealth will pay.

All states and territories have agreed to also introduce ABF. However, they are not bound to adopt the IHPA model or price.

**The NSW ABF funding model**

NSW has largely adopted the IHPA model at this stage although it has set its own state price. Under the NSW model, the Ministry of Health determines the total quantum of activity units to be funded at each Local Health District (LHD) and specialty network. Activity targets are set for each stream (acute, subacute, ED and outpatients). Mental health is not separately specified at
present, nor is there a separate mental health price. However, mental health activity could be specified separately in the future once there is a mental health classification in place.

It is important to understand that both the Commonwealth and the NSW Ministry of Health allocate funding to each LHD and specialty network. They do not fund each hospital or mental health service separately. It is then a decision of each LHD and network as to whether they fund their hospitals and services using the same formula or by using a different approach. This issue will become more strategically important once a separate classification and funding model is developed for mental health.

**Implications**

As shown in Figure 1, over 60% of mental health funding is provided by states and territories. The great majority of this is now in scope for ABF funding. This will progressively represent a significant change to the way public mental health care is counted, costed and funded. Implementation will need to occur over several years because the required counting, classification and costing systems are not yet in place. This gives the sector some time to develop the required expertise and skills to adapt to the new arrangements.

For the foreseeable future, public mental health services will continue to be funded by each LHD, with NSW Health (that is, the Ministry, LHDs and specialty networks) remaining responsible for planning and delivering mental health care in partnership with the Mental Health Commission and other relevant agencies.

The Commonwealth has committed to maintaining its current level of funding and to progressively increasing its share of funding for new services. From 2014, the Commonwealth will fund 45% of the ‘efficient price’ of new services, with this percentage increasing to 50% from 2017. However, in practice, services can only be expanded if the relevant state or territory contributes the other half.

A risk in introducing ABF approaches is that it incorrectly creates the perception that fee for service funding is being introduced and, in doing so, raises hopes that mental health funding will no longer be capped. This is not the case. States and territories have no choice but to live within a capped budget and NSW is no exception. This is an important consideration when developing a strategy for the delivery of mental health care into the future.

**Mental health services provided by Non-Government Organisations**

NGOs that deliver mental health care receive funding from the NSW and/or Commonwealth Governments. Commonwealth funded NGO services (such as, for example, the Targeted Community Care (Mental Health) Program) are not in scope for ABF. But, as noted above, under the new funding arrangements, the Commonwealth will contribute funding on an ABF basis if the service that the NGO provides is a substitute for one that would otherwise be provided by an LHD/public hospital.
There is no intention that the Commonwealth will fund the NGO sector directly for these services. Instead, as services that substitute for hospital services, the Commonwealth contribution would be no different to that for any other public hospital service, with the funding being allocated to the state and from there to the LHD. State government block funding will continue for other services for the foreseeable future.

The implication is that NGOs into the future will have four potential sources of funds. First, and as noted in Figure 1, NGOs can receive funding from the Commonwealth via three separate departments. Second, NGOs can receive funding directly from NSW Health and other government departments such as housing. Third, NGOs will be able to receive funding from the NDIS. Finally, NGOs in the future will be able to receive funding from LHDs/hospitals if they provide services that substitute for hospital care.

**Strategic opportunities**

The brief discussion above suggests some strategic opportunities for the development of mental health services in NSW. These include:

- Over two thirds of Commonwealth funding is spent on mental health payments under the MBS and the PBS. This reinforces the importance of promoting effective working relationships between the private and public mental health services and maximising the value of these two schemes for mental health consumers.

- Around 25% of Commonwealth mental health funding goes to the NGO sector. This reinforces the importance of up-skilling and supporting the NGO sector to enable NGOs services in NSW to tap into, and maximise funding from, Commonwealth mental health program money available from the Health, Veterans Affairs and Social Service departments.

- As shown in Table 2, NSW has, relative to other states, over-invested in inpatient care and under-invested in ambulatory care, NGO support services and residential care. This suggests that there would be value in working with the NSW health system on a longer term strategy to progressively achieve a better balance of investment between inpatient, ambulatory, NGO and residential care. It also suggests the ongoing need for a whole of state government approach that includes housing, education, employment and social opportunities as key components of a comprehensive mental health system.

- One key principle espoused by the IHPA is that its classification and funding models should be agnostic in regard to both setting of care and provider of care. Given this, it will be important for NSW to work with the IHPA to ensure that the mental health classification and ABF model is genuinely neutral. Specifically, the new funding model should not work against a recovery approach and should not work against the development of ambulatory models of care, including early intervention.

- As the new ABF classification and funding model is developed, it will be important for mental health stakeholders in NSW to understand the new model and to work together to establish the required information systems to ensure that mental health services receive their fair share of funding. NSW also has an important role in working on how to progressively improve the model over time.
Given the importance of the NDIS for the small group of consumers who will be eligible (that is, those with severe mental disorder and permanent impairment), it will be important for mental health stakeholders to work closely with the NDIS as the scheme is further developed and implemented. Mental health providers and advocates need to develop strategic partnerships with NDIS planners to ensure that the support needs of NDIS participants are met. It will be equally important for the NGO sector to develop the knowledge and expertise necessary to effectively tap into NDIS resources.

**Summary and conclusion**

The purpose of this paper has been to position mental health services in NSW in the context of broader national developments. Key among these developments is the progressive roll-out of the National Health Reform Agreement, including the introduction of ABF funding for the public hospital system, and the National Disability Insurance Scheme.

NSW needs to take an active role in the development of these new approaches at the national level, as well as play a key leadership role in ensuring that the mental health sector within NSW is fully engaged, educated and consulted about these developments. It is critical that NSW take these changes and opportunities into account in finalising a new “Strategic Plan for Mental Health in New South Wales”.
Attachment 1

Scope of Mental Health for Commonwealth ABF purposes

Mental health services deemed by the IHPA to be in scope for Commonwealth funding

All admitted programs, including hospital in the home programs. Forensic mental health inpatient services are included if they were included in the 2010 Public Hospital Establishments Collection.

All Emergency Department services provided by an Emergency Department and Non-admitted services including:

- Adult Integrated Community Mental Health Service
- Crisis Assessment and Treatment (including telephone-based services)
- Dual diagnosis services for patients with co-morbid conditions
- Home and community-based eating disorders programs
- Mental Health Hospital Avoidance Programs
- Mobile Support and Treatment services
- Perinatal Infant Mental Health services
- Step-Up Step-Down Services
- Telephone Triage Services

Mental health services deemed out of scope for Commonwealth funding by the IHPA

- General Counselling
- Primary Health Care
- Psychosocial rehabilitation programs (including long term supported accommodation, vocational training programs) where the primary purpose is to meet the social needs of consumers living in the community rather than hospital avoidance.
- Prevention and early intervention services.