# National mental health reform: less talk, more action

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## ABSTRACT

- The Council of Australian Governments revitalised national mental health reform in 2006. Unfortunately, evidence-based models of collaborative care have not yet been supported.
- Previous attempts at national reform have lacked a strategic vision. We continue to rely on arrangements that are fragmented between different levels of government, poorly resourced community services, and an embattled public hospital sector.
- Our persisting unwillingness to record or publicly report key measures of health, social or economic outcomes undermines community confidence in the mental health system.
- Six priority areas for urgent national action are proposed and linked to key measures of improved health system performance.
- In Australia, we recognise special groups (such as war veterans) and organise and fund services to meet their specific health needs. Such systems could be readily adapted to meet the needs of people with psychosis.


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> Purchasers and quality oversight organizations can create incentives for providers . . . through their funding and accountability mechanisms and by exercising leadership within their spheres of influence.[1]

The need to invest new money into new programs lay at the heart of the 2006 Council of Australian Governments (COAG) National Action Plan on Mental Health. Reports by the Mental Health Council of Australia[2] and the Senate Select Committee on Mental Health[3] demonstrated clearly that the mental health system was in crisis. Major constraints on access to care and affordability of services were evident.

The process of deinstitutionalisation has never been properly funded, leaving the needs of people with chronic mental illness, including housing and community support, unmet. New initiatives focusing on early intervention[4] struggled to find systemic support because of constant pressure on acute services, and there was no access under Medicare to essential psychological services for high-prevalence disorders such as depression.

The 2006 National Action Plan on Mental Health was inspired not merely by health concerns but also by economic factors. Numerous reports have detailed the negative impact on the Australian economy wrought by mental illness.[5-7] In April 2006, the then Prime Minister announced a unilateral package of federal mental health programs totalling $1.9 billion over 5 years. The major feature of the package was the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule program,[8] which committed over $500 million to new psychological services under traditional fee-for-service arrangements.

Sadly, this program abandoned the structures of the earlier Better Outcomes in Mental Health Care initiative,[9] which had placed a high priority on models of collaborative care and on GP education and training, while also providing preferential access for people with socioeconomic, demographic or geographical barriers to accessing care.

Under the Better Access program, nearly one million Australians now have a GP Mental Health Plan and have collectively received about three million sessions of psychological service. However, the program has all the inherent inequities common to other simplistic medical specialist systems supported by Medicare.[10] Clinical psychologists are overwhelmingly located in urban areas, charge significant out-of-pocket expenses (on average, $30 per consultation), and have the same low bulk-billing rates (30%) as psychiatrists. Moreover, young people are not using the new psychology services, despite 75% of all mental illness emerging by the age of 25 years.[11] The 2008 Federal Budget increased the estimated expenditure for the Better Access program by 40%, from $538 to $773.5 million over the 5 years to 2010–11. The program relies largely on referrals between GPs and psychologists.

> Not surprisingly, available evidence indicates that referrals alone do not lead to collaboration or coordinated care . . . Stronger approaches are needed to establish effective linkages among primary care, specialty mental health and substance-use treatment services.[1]

Another Australian Government initiative, the Mental Health Nurse Incentive Program ($191.6 million),[12] introduced in 2007, has stalled. Overall, and putting aside the new mental health Medicare Benefits Schedule items, the federal government has only managed to spend $87.3 million of the $1.9 billion allocated in full under the COAG Action Plan, or 4.6% of the total to be spent.[13]

In its first budget, the recently elected federal government cut $290 million from planned mental health expenditure. While cutting poorly planned or executed programs may be sound financial management, the reduction undermines serious attempts to develop novel initiatives and reinforces the dominance of the dysfunctional state systems.

In our view, urgent action is required in six key areas (Box 1). These are based directly on national and international reviews of what constitute "best buys" in mental health, including the work of the United States Institute of Medicine, the Australian Senate Select Committee on Mental Health and the Research Committee of the Mental Health Council of Australia.[1,3-5]

**1 Six key areas requiring urgent action for reform**

1. Preferential national funding for new organisational models of collaborative practice
2. National and state funding for early intervention services, with particular emphasis on youth services
3. Preferential national funding for employment of people with mental disorders
4. Specific national and state funding initiatives that link accommodation support with clinical services
5. New national funding methods for sustained e-health information and related clinical services
6. Independent national reporting of agreed health and social outcomes and health service performance ◆

### 1. Preferential national funding for new organisational models of collaborative practice

There is now clear evidence that the best quality mental health services are delivered through collaborative care.[1,14-16] We need appropriate and explicit incentives to encourage health professionals not just to co-locate but to work together effectively across a range of health, educational, employment, housing and other social services. Simplistic fee-for-service or cross-referral models fail to deliver the longer-term impacts that can be achieved through well organised and proactive collaborative or "stepped" care.

Collaborative care systems are characterised by their commitment to longer-term outcomes through their use of appropriate information technology platforms, patient tracking and recall systems, and consumer education and empowerment.[1] The financial model for such services can be simple and competitive,[16] and can include immediate modification of current fee-for-service systems.[17]

Ideally, we need governments to fund new organisations rather than more and more individual practitioners. New organisations can deliver sustainable care to communities that can be described geographically (eg, a series of local government areas), demographically (eg, people aged 12–25 years), or according to specific needs (eg, people with chronic mental illness). Already in Australia, we recognise special groups (such as war veterans) and organise and fund services to meet their specific health needs. Such models could be readily adapted to meet the needs of people with first-onset or enduring psychosis. Population-based and service-oriented organisations would progressively replace the current system in which services are funded on the basis of where private practitioners decide to practise or where state governments decide to draw the boundaries of area health services. New "superclinics" may fit some aspects of this new, more flexible model of service.

### 2. National and state funding for early intervention services, with particular emphasis on youth services

Evidence to support the effectiveness of genuine primary prevention in mental health is modest. By contrast, there is substantive evidence for both the short- and long-term benefits that accrue from early intervention.[4] As most mental disorders have their onset during adolescence and young adulthood, such services need to give priority to 12–25-year-olds. The *headspace* model (http://www.headspace.org.au), currently being developed around Australia, is a reasonable start.[18] To thrive, it now requires substantial commitments to recurrent funding and a move away from the previous federal government model that assumed significant out-of-pocket payments by young people or their families.

### 3. Preferential national funding for employment of people with mental disorders

Our national employment rate for people with a mental illness is 29%, roughly half that of comparable countries in the Organisation for Economic Co-operation and Development.[19] The newly elected federal government has started work on a National Mental Health and Disability Employment Strategy,[20] and this must ensure that appropriate support options are available for a sustained period to make a real difference to employment outcomes.[7]

### 4. Specific national and state funding initiatives that link accommodation support with clinical services

Despite its original intention, the 2006 COAG mental health package contained no new commitments to support housing. Homelessness is now back on the political agenda, but people will not be able to take advantage of new models of housing support if their mental illnesses go untreated. There are Australian models of housing with clinical and non-clinical support worth replicating — for example, the Housing and Supported Accommodation Initiative in New South Wales and Project 300 in Queensland.

### 5. New national funding methods for sustained e-health information and related clinical services

Australia has been at the forefront of international innovations in its use of e-health platforms to promote better mental health and deliver enhanced mental health care.[21,22] Given the overwhelming workforce shortages in mental health, the geographical and cost barriers to effective service provision, and the reluctance of key groups (such as young people and men) to use formal clinical services, e-health innovations will be central to real reforms.

### 6. Independent national reporting of agreed health and social outcomes and health service performance

Overall, the mental health system needs to set targets and implement a new, independent system of accountability. This will only occur through establishment of robust, transparent, properly funded and independent mechanisms. The first progress report of the COAG National Action Plan on Mental Health[13] could report on only five of its 12 indicators and relied largely on 1997 survey data.

Based on extensive community and professional consultation, we previously described a range of targets for a new system.[23] These focused on reducing premature death and disability due to mental disorders, particularly in young people. An updated set of performance measures for the health care system can now be added (Box 2). These new measures correspond to several of the key reforms suggested in Box 1. There is also some overlap with the COAG National Action Plan on Mental Health[13] and with the new whole-of-health-system indicators proposed by the National Health and Hospitals Reform Commission.[24]

**2 Key measures of performance in mental health care**

- Death rates (and causes of death) at 3 months and 12 months after discharge from a mental health facility
- Proportion of people with psychosis seen by a community-based mental health professional within 7 days after discharge from a mental health facility
- Waiting time for admission to a supported mental health place in the community
- Waiting time for admission to a supported drug and alcohol place in the community
- Waiting time for mental health emergency community support
- Consumer experience of being treated with dignity, based on agreed criteria
- Employment rates of working-age people with mental illness
- Proportion of people using mental health services who have access to stable housing ◆

A common theme is that new measures must focus not only on health but also on broader markers of social participation, functioning, and concepts such as patient dignity.[24] The key here must be regular, validated recording of the experiences of care of consumers and their families.

We need less talk and more action. The 1997 Australian Bureau of Statistics survey of mental health and wellbeing[25] showed that only 38% of people with a mental illness received any mental health care. It was a stunning disappointment that the corresponding survey a decade later[26] found that the rate of access to mental health care had in fact fallen to 35%.

At both federal and state levels, a profound reluctance to invest in new programs, while overspending on outmoded forms of practice, is both inept policy and poor practice. The past 15 years have seen piecemeal activity and political expediency. With 65% of Australians now missing out on care, the challenge is for the Australian Government to continue to drive the states and territories towards reform.

## Competing interests

None identified.

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