publichealth research&practice

July 2017; Vol. 27(3):e2731723
https://doi.org/10.17061/phrp2731723
www.phrp.com.au

Perspective

Shangri-La and the integration of mental health care in Australia

Sebastian Rosenberg[a,b]

[a] Brain and Mind Centre, University of Sydney, NSW, Australia
[b] Corresponding author: sebastian.rosenberg@sydney.edu.au

Article history

Publication date: July 2017
Citation: Rosenberg S. Shangri-La and the integration of mental health care in Australia. Public Health Res Pract. 2017;27(3):e2731723. https://doi.org/10.17061/phrp2731723

Key points

- The evidence for integrated care in mental health is strong, and current mental health reforms purport to foster integrated care; however, a range of problems are emerging
- Priority must be given to secondary mental health services, both clinical and nonclinical, as glue to bind primary and acute systems, and create a more durable continuum of care
- The move to decentralise responsibility for mental health service planning, funding and delivery should in no way diminish the need for strong accountability and benchmarking

Abstract

We wanted the best, but it turned out like always. (Viktor Chernomyrdin)[1]

According to literary legend, Shangri-La is an idyllic and harmonious place. Mental health is aspiring to its own Shangri-La in the shape of better integrated care. But do current reforms make integrated practice more or less likely? And what can be done to increase the chances of success?

The aim of this article is to review the current state of mental health reforms in Australia now under way across Primary Health Networks, the National Disability Insurance Scheme, psychosocial support services and elsewhere. What are these changes and what are the implications for the future of integrated mental health care? Is Shangri-La just over the horizon, or have we embarked instead on a fool's errand?

Introduction

The trajectory of 25 years of Australian mental health reform appears in doubt. The 1992 National Mental Health Strategy[2] set the nation on a path towards closure of the asylums and the development of a network of community mental health services designed to help people with a mental illness live well in the community. This was to be backed up by a new and robust approach to accountability that would enable the Australian community to determine whether what was being done was actually helping. Although it is possible to critique this strategy, its intent was clear, and its role as a rallying flagship undeniable. We had a map to paradise.

The central theme of the current round of mental health reforms seems far harder to identify. Multiple reforms are occurring simultaneously, with different origins and purposes. Spending on mental health has stalled.[3] Access rates remain a massive problem, particularly among certain demographic groups[4], and the number and rate of suicides in Australia are climbing.[5]

This article reviews emerging policy issues that are likely to have significant impact on mental health practice. It first considers evidence concerning the applicability of integrated care to mental health: what are the key components of such an approach, and the suggested characteristics and benefits? The article then surveys the contemporary policy landscape to assess whether the most recent raft of mental health reforms makes it more or less likely that the goal of

more integrated care will be achieved. Analysis includes a review of key policy changes and funding decisions that have affected programs, services and providers. Concepts such as integration, person-centred care and stepped care are explored in this context.

The immediacy of these important shifts requires consideration of material from a wide range of sources. Changes are occurring before or without formal research. This article therefore draws on a wide range of contemporary sources to demonstrate emerging views and concerns, in addition to traditional, more formal sources. The article concludes by suggesting three practical steps that could clarify the direction of mental health reform and provide new impetus towards better integrated care.

What do we mean by integrated mental health care?

The working premise behind integration is that, to provide more effective and efficient mental health care, it is important to improve integration between the primary, secondary and tertiary sectors, and across mental, physical and social services. Key factors that can drive integration of mental health care (Box 1) include the need for 'horizontal' integration within primary care, to bring physical and mental health services together, as well as 'vertical' integration in the health system to enable effective partnership between primary, secondary and tertiary mental health services.[6] There is clearly also a need to establish integration with sectors outside health, particularly housing, employment, education and community services.[7] Effective integration of mental health care depends on the extent to which some key factors are addressed. Done well, these factors are enablers of integration. Done poorly, they become barriers.

Box 1. Key factors in integration of mental health care[7]

- Taking local context into account
- Engaging key stakeholders in informal or formal partnerships
- Articulating governance procedures and identifying leaders
- Financing reforms sustainably
- Establishing appropriate infrastructure and resources (including considering colocation of services)
- Accounting for organisational culture
- Encouraging respectful communication
- Providing interprofessional education
- Reducing stigmatisation and discrimination
- Collecting adequate data that assess quality of care

Current reforms

To drive a more integrated approach, the Australian Government has placed pivotal importance on the role to be played by the 31 Primary Health Networks (PHNs). Australian Government spending on mental health was $3 billion in 2014–15[8], with about 35% of this going to services provided under Medicare. A further 30% went to a variety of mental health–related programs provided by the Australian Government (such as mental health nurses and suicide prevention). Some of this parcel of funding has now been distributed to the PHNs to 'commission' related services. In announcing the reforms, [then] Minister for Health Sussan Ley said:

> *… in response to the National Mental Health Commission's Review of Mental Health Programmes and Services we committed to changing the 'one size fits all' approach to mental health services. We want to be absolutely sure people would receive the right support at the right time, and not fall through the cracks.*[9]

This is ambitious, particularly when the gist of repeated major inquiries characterises the mental health 'system' as mostly cracks.[10,11] Strong evidence indicates that many face a large gap in life expectancy, as well as the impact of metabolic syndrome and the general health problems associated with poor lifestyle[12], the bread and butter of good primary care.

The advent of the National Disability Insurance Scheme (NDIS) is another key change with important ramifications for mental health. The Australian Government has allocated other existing mental health expenditure to the NDIS from programs previously managed by the Department of Health, as well as from other agencies (such as Partners in Recovery, Personal Helpers and Mentors, and Day to Day Living in the Community). State and territory governments are also transferring funding previously allocated to psychosocial support services to the NDIS. Although largely anecdotal, experience so far from NDIS trial sites is of profound disruption and uncertainty for these organisations and their clients.[13]

The NDIS is not permitted to fund anything that might otherwise be funded in the health sector (state or national). PHNs cannot 'commission' nonclinical services. This will emasculate Australia's already peripheral community mental health sector.[14] There is concern that large numbers of people currently receiving community mental health services will miss out and the vital psychosocial support workforce will vanish.[15] Modelling conducted using the National Mental Health Service Planning Framework indicates that 290 000 Australians will experience a severe mental illness that needs community support[16], but the NDIS anticipates providing packages of care for only 57 000 people with a mental illness.[17]

There is fundamental tension between the usual determination of 'permanence' with respect to disability and the concept of recovery.[18] Both the episodic nature

of much of mental illness and the philosophy that underpins recovery mean that the usual criteria that drive compensation payments are difficult to apply. Our current capacity to predict the course of mental illness over the long term is limited. The task of integrating mental health care is made more challenging by the highly individualised and fluctuating nature of the course of illness.

This raises the apparent clash between the current rhetoric of individualised, person-centred care (dominant in the NDIS) and traditional approaches to population health planning (as more evident in state health planning). The review by the National Mental Health Commission[19] also promoted regional and local autonomy in responding to mental illness. Planning for the successful integration of mental health care would benefit from a clearer understanding of whether this integration is to occur at the level of the jurisdiction, the region or the individual.

The current reforms also promise new integration through the implementation of 'stepped care' – an accurate and appropriate titration of the mental health response based on regular and rigorous monitoring of the patient's health status.[20] In relation to mental health reform in Australia, it seems that a much looser definition is being applied – along the lines of 'the right service at the right time'.[9]

On this basis, 31 PHNs have each developed their own conceptualisation of 'stepped care'. Across these versions, there are different ideas about how many steps there are or should be. Do the steps start with mental health promotion, proceed to acute admission and then move back down some scale of acuity to home? Or are we focusing only on stepped primary mental health care? And do the steps only relate to health services, or are there important steps also in relation to housing, education and employment services? The extent to which state and territory governments buy into the model of 'stepped care' is dubious. 'Horizontal' links between state-funded mental health services and other critical state-funded services, such as those provided by community services and housing departments, are typically tenuous.

The NDIS is not mentioned as part of stepped care. Its inclusion would permit further consideration of how best to marry the population-type planning being undertaken by the PHNs and Local Health Districts (LHDs) with the individualised planning approach inherent in the NDIS.

Large numbers of people are missing out on services of unknown quality while the key to hospital avoidance – the community mental health sector – is being asset-stripped before an NDIS takeover. It is increasingly difficult to find a mental health service between the general practitioner/psychologist and the front door of the emergency department of the local public hospital. The bar for admission to acute inpatient care is becoming insurmountable to all but the sickest.

This has created a phenomenon described as the 'missing middle' – a large cohort of people with mental health conditions too complex for primary care but not severe enough to qualify for hospital admission or an NDIS package of care. The alarming paucity of secondary mental health care available in Australia leaves this large population particularly vulnerable. It is clearly a complicated environment for mental health reform, seemingly driven more by concern for who pays than what works.

Three steps forward

With large and poorly connected reforms such as the PHNs and the NDIS in full swing, what should be done to start to better join things up? There are three key tasks.

1. Clarify the theory of change

Implementation has been a traditional weakness in mental health reform.[21] PHNs, LHDs, NDIS providers and other community sector organisations will not come together by magic to deliver integrated care, particularly when there are real reasons justifying their ongoing separation. The importance of understanding regional context in effective change processes is well understood and needs support.[22]

Developing a sustained method of change has been recognised overseas as a critical element of successful reform.[23] This is much less so in Australia. The NSW Agency for Clinical Innovation has set out a process for developing and implementing effective new models of care.[24] To be clear, this reform task is not about mental health. This is about the application of specific technologies and processes designed to make change happen.

2. Funding for reform

Change costs money. Genuine processes of codesign are deep and offer rich insight, but take considerable time and resources to engineer. International studies have found that project success rates are much higher when there is specific funding to support change in areas such as planning, training, communications, sustainability and monitoring.[25]

PHNs are struggling to maintain existing services with the limited funds they have been allocated. There is little, if any, new funding for change.

Funding rules also need to match intentions around flexibility. In the same way the NDIS cannot fund health services, current rules make it difficult, if not impossible, for PHNs to fund nonclinical services for mental health clients.[26] It is well understood that these kinds of psychosocial support services are critical to keeping people living well in the community.[27] Leaving aside the small number of NDIS package recipients, if PHNs are not funding these services, who is?

3. Strong accountability

Accountability has been at the heart of mental health reform from the very first national mental health plan. Yet despite repeated commitments, accountability remains very weak and inappropriately focused on inputs (dollars spent) and outputs (numbers of occasions of service, beds,

etc.).[28] There is no validated collection of the experience of care for consumers and carers. We do not have a good understanding about the housing or employment status of people with a mental illness, nor their quality of life. There is a risk that the reporting process will revert to template-driven nonsense. Although ostensibly independent, the PHNs are already subject to ongoing missives from the Department of Health about services, data, reporting and so on.[29]

There is, of course, a tension between the regional independence that underpins the reforms and the need to nationally promulgate good practice. Accountability can assist here and should be a priority. Measuring the quality of care provided by individuals and organisations, and reporting the results, is linked both conceptually and empirically to reductions in variations in care and increases in the delivery of effective care.[30] In short, accountability can drive quality improvement. Some state-based PHNs have come together to look at opportunities for shared learning and benchmarking. This type of activity must become the norm.

Conclusion

Integrated mental health practice is difficult. Many PHNs and LHDs are operating to meet their related but separate goals, and the NDIS is working independently. Disparate approaches risk perpetuation of systemic cracks. The rationale for more integrated mental health care does not seem as obvious as proponents of the reforms may have hoped.

It is critical in addressing this issue that priority be given to secondary mental health services, both clinical and nonclinical, as glue to bind primary and acute systems, and create a more durable continuum of care.

Change costs money and is a complex, time-consuming process. It must be emphasised that the move to decentralise responsibility for mental health service planning, funding and delivery should in no way diminish the need for strong accountability and benchmarking.

Consumers, carers, service providers and the general community want to know how their mental health system is performing in comparison with others, and that an effective system of quality improvement is in operation. Current mental health reforms are ambitious. Key ingredients in successful change cannot be missed, or we risk things turning out as always.

Competing interests

SR has previously provided paid consultancy services to the NDIS and is currently working with one PHN.

Author contributions

SR is the sole author.

References

1. The Economist. London: The Economist Newspaper Limited; 2017. Viktor Chernomyrdin; 2010 Nov 4 [cited 2017 Jul 28]; [about 4 screens]. Available from: www.economist.com/node/17414237
2. Australian Government Department of Health. Canberra: Commonwealth of Australia. National mental health strategy; 2014 Apr 17 [cited 2017 Jul 28]; [about 2 screens]. Available from: www.health.gov.au/internet/main/publishing.nsf/content/mental-strat
3. Rosenberg S, Salvador-Carulla L. Accountability for mental health: the Australian experience. J Ment Health Policy Econ. 2017;20(1):37–54.
4. Australian Bureau of Statistics. National survey of mental health and wellbeing: summary of results. Canberra: Commonwealth of Australia; 2007. Available from: www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf
5. Australian Bureau of Statistics. Causes of death, Australia, 2013. Canberra: Commonwealth of Australia; 2015. Available from: www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Leading%20Causes%20of%20Death~10001
6. Bywood PT, Brown L, Raven M. Improving the integration of mental health services in primary health care at the macro level. PHCRIS Policy Issue Review. Adelaide: Primary Health Care Research and Information Service; 2015 [cited 2017 Jul 18]. Available from: www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8443.pdf
7. Oliver-Baxter J, Bywood P, Brown L. Integrated care: what policies support and influence integration in health care across New Zealand, England, Canada and the United States? PHCRIS Policy Issue Review. Adelaide: Primary Health Care Research and Information Service; 2013. Available from: www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8414.pdf
8. Mental Health Services in Australia. Canberra: Australian Institute of Health and Welfare; 2016. Australian Government expenditure on mental health-related services; 2016 [cited 2017 Jul 7]; [about 4 screens]. Available from: mhsa.aihw.gov.au/resources/expenditure/aus-govt-mh-services
9. The Hon. Sussan Ley MP: Member for Farrer. Albury, NSW: The Hon Sussan Ley MP; 2017. Boost to mental health services underway; 2016 Oct 10 [cited 2017 Jul 7]; [about 2 screens]. Available from: sussanley.com/boost-to-mental-health-services-underway
10. The Senate Select Committee on Mental Health. A national approach to mental health – from crisis to community. Canberra: Commonwealth of Australia; 2006 [cited 2017 Jul 7]. Available from: www.aph.gov.au/binaries/senate/committee/mentalhealth_ctte/report/report.pdf

11. Mendoza J, Bresnan A, Rosenberg S, Elson A, Gilbert Y, Long P, et al. Obsessive hope disorder: reflections on 30 years of mental health reform in Australia and visions for the future. Summary report. Caloundra, QLD: ConNetica; 2013 [cited 2017 Jul 7]. Available from: cairns.health.qld.libguides.com/ld.php?content_id=8809934

12. Rosenbaum S, Samaras K, Teasdale S. Physical health ignored in people with mental illness. The Conversation. 2017 Jan 19. Available from: theconversation.com/physical-health-ignored-in-people-with-mental-illness-69040

13. Naufal R. Shitstorm: a short history of NDIS implementation. Disability Services Consulting. 2016 Aug 16 [cited 2017 Jul 18]. Available from: www.disabilityservicesconsulting.com.au/resources/shitstorm

14. Crowther L. Roadmap for reform in community mental health. Croakey. 2017 Feb 20 [cited 2017 Jul 18]. Available from: croakey.org/roadmap-for-reform-in-community-mental-health

15. Williams T, Smith G. Can the National Disability Insurance Scheme work for mental health? Aust N Z J Psychiatry. 2014;48(5):391–4.

16. McGrath D. Mental Health Australia Submission to the Joint Standing Committee on the National Disability Insurance Scheme into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition: attachment 1. Canberra: Mental Health Australia; 2017 [cited 2017 Jul 7]. Available from: www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Submissions

17. NDIS. Canberra: National Disability Insurance Scheme Launch Transition Agency; 2013. Nearly 700 people with psychosocial disability are part of the NDIS: media release; 2014 Oct 10 [cited 2017 Jul 7]; [about 3 screens]. Available from: www.ndis.gov.au/document/nearly-700-people-psychosocial-dis.html

18. Nicholas A, Reifels L. Mental health and the NDIS: a literature review. Melbourne: Mind Australia; 2014 [cited 2017 Jul 7]. Available from: www.ndis.gov.au/html/sites/default/files/files/Mental-health-and-the-NDIS-Literature-Review.pdf

19. National Mental Health Commission. Contributing lives, thriving communities: report of the national review of mental health programmes and services. Volume 1. Canberra: NMHC; 2014 [cited 2017 Jul 7]. Available from: www.mentalhealthcommission.gov.au/media/119905/Vol%201%20-%20Main%20Paper%20-%20Final.pdf

20. Bower P, Gilbody S. Stepped care in psychological therapies: access, effectiveness and efficiency. Narrative literature review. Br J Psychiatry. 2005;186:11–7.

21. Hickie IB. Time to implement national mental health reform. Med J Aust. 2015;202(10):515–7.

22. Bate P. Context is everything. London: The Health Foundation; 2014 [cited 2017 Jul 7]. Available from: www.health.org.uk/sites/health/files/PerspectivesOnContextBateContextIsEverything.pdf

23. Weiss CH. Nothing as practical as good theory: exploring theory-based evaluation for comprehensive community initiatives for children and families. In: Connell JP, Kubisch AC, Schorr LB, Weiss CH, editors. New approaches to evaluating community initiatives. Washington, DC: Aspen Institute; 1995. p. 65–92.

24. Agency for Clinical Innovation. Understanding the process to develop a model of care: an ACI framework. Sydney: Agency for Clinical Innovation; 2013 [cited 2017 Jul 7]. Available from: www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

25. IBM. Making change work. Somers, NY: IBM Corporation; 2008 [cited 2017 Jul 7]. Available from: www-07.ibm.com/au/pdf/making_change_work.pdf

26. Australian Government Department of Health. Annexure A1 – primary mental health care. Canberra: Commonwealth of Australia; [cited 2017 Jul 7]. Available from: www.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/$File/Annexure%20A1%20-%20Primary%20Mental%20Health%20Care.pdf

27. Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. Br J Psychiatry. 2004;185:283–90.

28. Rosenberg S, Hickie IB, McGorry PD, Salvador-Carulla L, Burns J, Christensen H, et al. Using accountability for mental health to drive reform. Med J Aust. 2015;203(8):328–30.

29. Australian Government Department of Health, Primary Health Networks. Primary Health Networks primary mental health care funding: mental health activity work plan. Canberra: Commonwealth of Australia [cited 2017 Jul 7]. Available from: www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/Mental%20Health%20Activity%20Work%20Plan%202016-17%20template.docx

30. Institute of Medicine. Improving the quality of health care for mental and substance-abuse conditions. Washington, DC: National Academies Press (US); 2006.