Paper 1: Learning from history

Ours is not the first review of a country's mental health system, and it is important to learn from the work that has gone before us. We therefore examined and analysed a wide range of Australian and international mental health review reports, and found a high level of commonality of themes among the recommendations of 34 reports. These themes are briefly outlined here, along with a short history of Australian mental health reform.

Mental health reform in Australia

Like most industrialised nations, the history of care for people experiencing mental health problems in Australia is characterised by a long phase of incarceration followed by (more recent) efforts to support the vast majority of people to live in the community. In the early 1960s, a process of deinstitutionalisation began which saw the number of psychiatric beds across Australia decrease rapidly from 30,000 in 1965 to approximately 8,000 in 1993. At the same time, there was only a limited development of the community services required to compensate for the closure of long-stay hospitals.[1]

By the 1980s there was increasing concern that the situation was unacceptable, and that the mental health system (in particular the supports available to people living in the community) had been largely neglected in planning, policy and funding.

The impetus for the development of a national approach to mental health strategy and policy was the Burdekin Report in 1993. This was a national inquiry by the Australian Human Rights and Equal Opportunity Commission into the human rights of people with a mental illness.

The report took into account evidence from other inquiries and concluded that people affected by mental illness were among the most vulnerable and disadvantaged in our society. It also recommended providing Aboriginal and Torres Strait Islander peoples with the training, power and resources needed to determine and deliver mental health strategies within culturally based understandings of mental health.[1]

The Burdekin report outlined that:

- the human rights of individuals affected by mental illness were being ignored or seriously violated
- ignorance and discrimination were widespread
- the problematic consequences of deinstitutionalisation were apparent, with a lack of available community-based supports including accommodation.[1]

A national approach to mental health strategy

The National Mental Health Strategy has guided mental health reform in Australia since 1992 and is articulated through the following documents:

- the 2008 National Mental Health Policy (which provides an overarching framework for the Strategy)[2]
- the National Mental Health Plans through which the National Mental Health Policy is put into action (the current plan, the fourth, runs from 2009 to 2014)[3]
- the Mental Health Statement of Rights and Responsibilities.[4]

While the first plan (1992–1997) emphasised structural changes in where and how mental health services were delivered, subsequent plans have broadened the approach to focus on partnerships between different sectors, the inclusion of promotion, prevention and early intervention, and a greater emphasis on the roles of consumers and carers.

However, these plans, as Federal Health Ministers' documents, have difficulty in getting traction with non-health agencies and sectors, and state/territory governments. There are, however, two further mechanisms for helping to set a unified direction for mental health policy—the National Mental Health Commission and the Council of Australian Governments (COAG).

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The National Mental Health Commission was established by the Government in 2012 as an independent executive agency. It reports to the Health Minister, to increase transparency and accountability in the mental health system and provide advice to the Government on achieving better whole-of-life outcomes for people experiencing mental illness and their supporters.

Figure 1 Timeline showing recent history of mental health reform in Australia
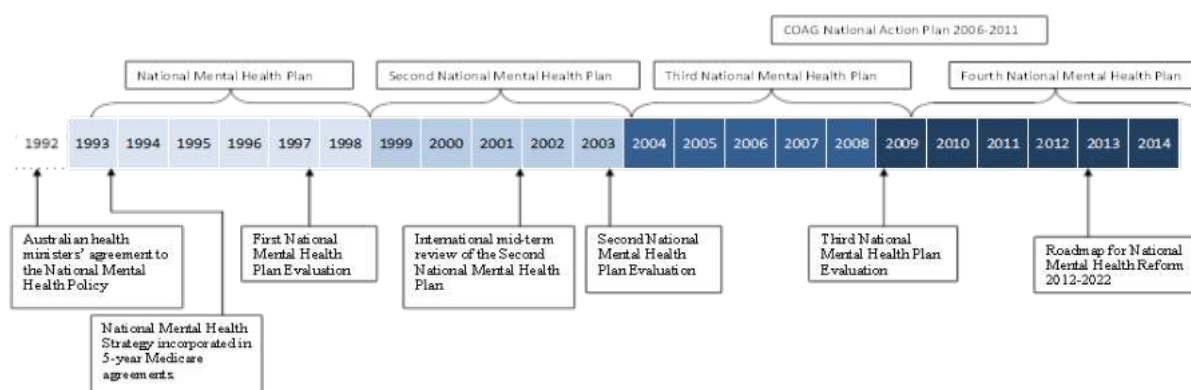
COAG is the principal forum for bringing Commonwealth and state/territory governments to the same table, and therefore plays a vital role in gaining meaningful nationwide agreement on policy directions.

In 2006 COAG responded to the growing recognition of the significance of mental health issues and the importance of housing, employment, justice, community and disability to maximise treatment outcomes and recovery from mental illness. Through the National Action Plan, across all jurisdictions, 145 measures or modifications to existing programmes were introduced.

COAG released The Roadmap for National Mental Health Reform 2012–2022 on 7 December 2012. This established five broad principles for reform: promote a person-centred approach; improve the mental health and social and emotional wellbeing of all Australians; prevent mental illness; focus on early detection and intervention; and improve access to high-quality services and supports.[2, 3]

The Standing Council on Health (ScoH) reports to COAG and is responsible for the implementation of COAG decisions on mental health reform in recognition of the broad impact that mental health issues have on Australian society.[5]

Milestones of Aboriginal and Torres Strait Islander mental health policy include the 1989 *National Aboriginal Health Strategy,* which defined health for Aboriginal and Torres Strait Islander peoples as 'not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life'.[6]

Also important was the 1991 report of the *Royal Commission into Aboriginal Deaths in Custody*—which drew national attention to the growing problem of suicide and the removal of children from their families.[7]

Perhaps the most significant single advance was the 1995 *Ways Forward* report. This provided the first national analysis of Aboriginal and Torres Strait Islander mental health and emphasised the importance of social and emotional wellbeing.[8] In 1996 the Australian

Government responded with the *Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996–2000)*.[9]

In 2004 the first *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009* was released. It signaled the growing recognition and legitimacy of the social and emotional wellbeing concept for policy-makers.[10] Action 7 of the *Fourth National Mental Health Plan* (2009–2014) calls for the renewal of the 2004 Framework,[3] and this is currently under way.

International and Australian mental health system reviews

The Commission undertook a brief web-based search and analysis of mental health system reviews in the international and Australian grey literature. Documents included in the analysis were published by government departments, universities, nongovernment organisations, think-tanks and private consultancies. Based on our web search we selected 17 key Australian reports and 17 reports from other countries for further analysis. Themes commonly emerging in the recommendations of these documents are summarised in the following table.

Themes	Priorities
Governance	Collaborative governance mechanisms must be developed at all levels (from national policy making to local delivery level), to span traditional departmental silos and to incorporate the interests of public, private and NGO providers as well as people with lived experience and their supporters
	Leadership must be taken at the level above individual sector and departmental interests
	Local ownership of reform principles, especially by clinicians and community groups, is vital. (This means real thought about how these apply to local circumstances and could be monitored and benchmarked locally)
	Clearer demarcation of responsibilities (delivery, funding) is required between state and federal levels of government
Policy	Alignment of policies across departmental and jurisdictional boundaries
	Alignment of incentives to keep people out of hospital
	A 'mental health in all policies' approach to be taken across all sectors and levels of government
	Key policy choices which need to be made by governments include:
	Balancing development of low intensity services for large numbers of people with anxiety/depression with the development of high intensity services for small numbers of people with severe and persistent problems
	Balancing investment in youth (where there is greater potential for lifetime benefits) against older people (whose mental capital is substantially under-utilised)

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Themes	Priorities
Service delivery	Existing variability of service quality and availability must be tackled through improved access in primary care and other community-based settings
	Co-ordination of care pathways means using a stepped care model across sectors
	Integration of services is needed: between primary and secondary care; between physical and mental health care; between specialist community and crisis/inpatient services
	Many people with chronic mental health difficulties could be successfully managed at a lower level of service intensity and using a greater variety of social interventions
	Alternatives to inpatient admission must urgently be developed and evaluated, such as crisis resolution teams and crisis houses
	Successful examples of service delivery are offered in many reports from different perspectives. For governments, successful initiatives are described as those that have good clinical outcomes, improved quality of life, cost outcomes, and perform against social outcomes such as reducing poverty and homelessness. For carers and people with lived experience, access to professional care, being treated with dignity and respect and responding to individual needs are important aspects of service provision.
Consumer orientation and human rights	Reduction in inequality of access to support, levels of disadvantage and health outcomes must be a central driver of all mental health initiatives and evaluations
	Respect, dignity and human rights including reduced involuntary incarceration, unnecessary hospitalisation and use of seclusion and restraint
	Specific anti-discrimination legislation for mental health problems needs to apply across sectors
	Consumer needs and values-focused outcome measurement
	Empowerment to be involved in decision-making, policy development, service delivery and design
Tackling disadvantage	In Australia there is insufficient focus in programme evaluation on how successfully interventions are reaching (or appropriate to) disadvantaged groups
	Disadvantage and its persistence needs to be longitudinally tracked nationally
Resources	Pool funding for mental health support and wellbeing promotion to avoid difficulty of costs and benefits accruing to different sectors

Themes	Priorities
	Above mechanism would allow funding of outcomes and pathway-focused whole-of-life support packages
	Rebalance towards community and primary care, early intervention, prevention and alternatives to inpatient hospital admission
Workforce	Up-skilling primary care and a generalist workforce for brief interventions
	Sustainability will require much greater use of the peer and consumer workforce
	Focusing on the wellbeing and morale of mental health professionals
	Role redesign may be required if resources are redirected 'upstream'—for example, specialist mental health professionals may have a dual role as clinicians and as advisers to generalists within an integrated primary/secondary care system
Data/evidence	A crucial barrier to reform in all countries is the absence of routinely collected outcomes data—or any means of collecting it. Urgent development is required globally, based both on clinical outcomes and on what people with lived experience and supporters find valuable and life-enriching
	Data infrastructure must be developed nationally around electronic care records
	This should provide nationally consistent, fine-grained data on health determinants, prevalence and service utilisation by postcode
	National prevalence studies should determine the extent of each problem and inform policy directions
	There is a lot we don't know about Australian service use and cost, including how much is spent on mental health services, how much is spent on each condition overall and on severe mental illnesses. The true cost of mental illness cannot truly be known or estimated[11, 12]
	There are limited studies into the cost-effectiveness of whole-of life programs or mental health-related programmes and treatments that are inclusive of areas such as housing, education, employment and justice
	What works in terms of policy interventions and reform is not known on a wide scale, and there are few examples of successful whole-system reform
Research	Prioritisation of translational research in mental health
	Increase funding levels commensurate with burden of disease
	Randomised controlled trials urgently needed to assess effectiveness, especially of social interventions

Themes	Priorities
	Cross-sector collaboration needed on research
	Develop evidence base for workplace mental health improvement
Productivity	Increasing the productivity of the population is the principal economic argument for investing in appropriate and timely support for mental health difficulties and promotion of resilience in the general population. The benefits far outweigh any costs of intervention—the costs of lost productivity amount to twice the costs of direct provision of health and social care
	Productivity refers both to the potential to improve the productivity (improved outcomes for reduced cost) of the mental health system and to getting people with mental illness back into work to support meaningful lives and reduce benefit costs, absenteeism, presenteeism and early retirement
	Educating employers and prioritising wellbeing in the workplace to tackle persistent labour market exclusion of people with mental illness
	The productivity of the mental health system itself can be enhanced through investment in early intervention at all stages of the life course

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