

## MENTAL HEALTH INITIATIVES IN THE 2011 BUDGET: A GOOD START OR JUST MORE DISCONNECTED SILOS?

<http://blogs.crikey.com.au/croakey/2011/05/11/more-comprehensive-analysis-on-mental-health-and-the-budget/>

Alan Rosen, 11 May 2011.

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Of course we should be grateful for any increase in targeted mental health funding, however delayed, and yes this budget allocation looks like real money, though Mr Swan certainly did not come up with enough to do the job. I strongly support some of the initiatives funded, but my concerns in a recent piece (link to last croakey piece attached) on the “independent blueprint group” recommendations, some mysterious variations of which are partially funded here, have not yet been assuaged. Over time, this budget commitment will begin to enhance some very well-researched or promising programmes: youth mental health “headspace” and early intervention, early childhood programmes, suicide prevention, and e-health strategies, more housing with regular support for adults with longer-term conditions, and more integrated mental health care for the elderly. In primary care, it is hoped that the blow-out in Better Access counselling can be more effectively contained and targeted to those with defined mild to moderate mental health conditions, and that ATAPs funding and CoAG support worker programs will be expanded to reach and coordinate the care for people with more complex conditions. This is supposed to include Aboriginal communities and those in rural and remote areas. However, it is notoriously difficult for inexperienced non-professional or sessional staff to herd seasoned clinical cats. Fee-for-service professionals consider that they are not paid sufficiently for the time it takes to do so, so many won't prioritize these functions. Basing these support and coordination services with “medicare-locals” may allow better linking in with physical care, but could tempt primary care centres to go up-market, to direct these support resources to people with milder conditions, and to favour sedentary clinic-based medical over psycho-social interventions for mental disorders severely affected by social conditions.

Tendering out the proposed “flexible care” packages and coordination teams for extended mental health care to Medicare Locals, NGO's or private interests provides a fascinating exercise in contestability, and may end up being a good idea, but they are largely untested in effectiveness, and will need extensive trialling over a longish period before we should consider wider implementation. However they have already been given a very substantial allocation in the budget (\$343.8 million) for a national roll-out, with no stated prior requirement for evaluation and rigorous research. Compare this to the considerable research evidence-base for modules of public community mental health services which will remain as abandoned orphans, sinking still in the wake of this budget. So what will be left of sound mental health services to coordinate?

Maybe “putting new money into old systems” doesn't work where the systems have been shown to be ineffective, like institutionally based care, but provision of well tested 7 day and night mobile mental health teams, with adaptations for regional populations, has not yet been tried consistently and equitably across this country. One state, Victoria, is an

exception, and even the resourcing there is now fraying. These teams only don't work where they have never been tried. Or when their resources are withdrawn due to managerial expediency or loss of a clinically informed culture. However, there is little encouragement for public mental health services in this budget, except a pious hope that at the next CoAG meeting, the Commonwealth will be able to convince the states to match this investment. But, as ever, funding signals shape practice, and there are no clear funding signals from the feds to the states for public community mental health services,, We need these to concentrate their minds on meeting their obligations to restore evidence-based services like mobile crisis and assertive community care teams. Such public community mental health services should be complementary to and the backbone of all the important NGO support services. The former should be available to reach out to all in need of mental health care and to support NGO facilities too, around the clock, largely with on-duty staff in urban settings, and on an on-call basis elsewhere. But many have been allowed to shrivel. There is very little in this budget that can be used as real leverage or incentives to the states to reinvest in public evidence-based community mental health services. These have been so eroded since the end of the 1st National Mental Health Plan in 1997 when incoming Howard government stopped the virtually contractual funding signals to the states. Consequently both the national strategy and state efforts became diluted, too thinly spread, and lost their momentum and focus. These signals need bringing back for services to become effective again.

This budget allocation will only keep mental health's head barely above water by still struggling to stop a decline below the habitual 7% of health expenditure, even when funding eventually fully kicks in towards the end of 5 years. If there was any justice for our clientele, it should have moved up in stages by then to 13% of the national health spend to more closely match the proportion of health burden due to mental illness, and to bring us into line with comparable OECD countries. Government has only just started to show some leadership, and yes the providers and the consumer and carer movements do need to get behind this belated encouragement, uniting to make these initial steps work, with a willingness to test new delivery systems, as well as to continue to pressure government to develop their commitment further.

That is why the Mental Health Commission as recommended to government by many stakeholders over many years, and most recently by the mental health minister's expert advisory panel and the "independent blueprint group", is the key to the fuller realization of the national reform agenda. It should ensure that evidence based care is equitably implemented, integrated and systematised, and that accountability mechanisms are much more arm's-length and transparent (links to my piece in croakey archives on MHC and our international review attached). Only then, if the Commission is allowed to be sufficiently expert, well-informed, independent, and continuous in tenure, will it be able to ensure that services actually do reach those in need consistently, and make a real difference in their lives, particularly to individuals with severe and persistent mental illness and their families. So far, the good news about the National Mental Health Commission, is:

1. that it is tripartisan, now being integral to the mental health policies of the Labor government, the federal Coalition and the Greens;

2. that it will complement in some way yet to be defined, the state mental health commissions which are now developing in Western Australia and New South Wales, and hopefully other states in the future, which may also function as or devolve integrative regional funding/commissioning authorities.
3. that it will be located within the prime minister's portfolio, which should provide for added independence from the Commonwealth health bureaucracy, and making it explicit that mental health should be an all-of-government enterprise. It must however report not only to the prime minister as stated, but to parliament and the public if it is to fulfil its promise of transparency.

So all this could either be a good start towards a happier ending, or an uncontrolled descent into more disconnected fragments of service, unless more balanced investments and strong monetary signals to the states to deliver evidence-based care for all age-groups and phases of care can be made to follow this up in the next chapter.