The mental health crisis needs more than increased investment in the mental health system

In a recent open letter to psychiatrists,[1] Andrew Leech, a general practitioner (GP) from Western Australia, eloquently describes the challenges GPs face and the frustration they experience when their referrals to psychiatrists are (all too often) rejected. He concludes the letter with his wish to work together to make the lives of patients easier. In response, a psychiatrist from New South Wales, Angelo Virgona, acknowledges Leech's frustration and describes the potential causes and possible solutions for the mental health crisis.[2] In particular, Virgona explains that one of the main drivers for the fragmented mental health care stems from a broken system, which leads to the patient experience of navigating a myriad of disconnected threads in seeking and receiving mental health support and care.[2] Virgona argues that multidisciplinary care and access to the right help at the right time is critical, with prevention and early intervention being the most cost-efficient and clinically effective forms of mental health intervention at a population level. Virgona acknowledges that the patients will not receive such care with an insufficient workforce and fragmented system. He calls for immediate and sustained investment in the mental health workforce, including psychiatrists.[2] In a perspective article published in the *Medical Journal of Australia*, McGorry and colleagues[3] similarly proposed four potential solutions for the mental health crisis among young people. First, prevention by gaining clarity on the modifiable risk factors driving young people's decline in mental health. Second, early intervention through integrated primary youth mental health care services. Third, more specialised multidisciplinary team-based care for young people with severe and persistent illnesses. Finally, they recommended redesigning the National Disability Insurance Scheme to augment the fully integrated care model, allowing health and social care to be integrated under one governance structure.

Although we largely agree with these recommendations, we would like to expand the discussion and argue that mending a broken system will require much more than increasing resources. We face a global mental health crisis — the rising incidence and prevalence of mental illnesses and associated unmet needs for care are not unique to Australia. The insufficient mental health workforce and inadequate investment have often been blamed for perpetuating such crises. Interestingly, however, it is not clear if the most obvious solution — more investment in the mental health workforce — has the expected outcome of improving the mental wellbeing of the nation. Patel and colleagues[4] recently highlighted the need for a shift towards a truly biopsychosocial framework across the lifespan to tackle the mental health crisis. To do so, they propose five key principles: (i) targeting harmful social environments across the life course; (ii) care determined by a person's needs, not their diagnosis; (iii) empowering front line (non-mental health) workers to deliver evidence-based psychosocial interventions; (iv) embracing a rights-based perspective for mental health care; and (v) placing people with lived experience at the centre of the care system. To achieve these, they propose four policy actions: (i) a whole-of-society approach to prevention and care; (ii) redesigning the architecture of care; (iii) investing more and wisely; and (iv) ensuring accountability. Patel and colleagues[4] also state that to pour more investment into the existing mental health workforce without addressing the key drivers of failure can lead to even greater inefficiency. This has already been demonstrated by over 30 years of mental health plans and policies in Australia.[5]

The GLOCAL (Global and Local Observation and Mapping of Care Levels) project conducted an extensive analysis of the mental health provision in Australia, in comparison to other mental health systems in Europe and the Americas.[6] The project's findings indicate significant gaps in the provision of community care in Australia compared with benchmark regions in north and south Europe as well as in the workforce capacity. These deficiencies compound the lack of highly qualified professionals in the public mental health sector with a continuous drift of these professionals (eg, psychiatrists, nurses and psychologists) to the private sector.[6] The traditional medical model of care — much as the process typically seen in the private psychiatry sector in Australia — for people with mental health conditions usually flows like this: an individual presents with a cluster of symptoms, a GP or a psychiatrist formulates them into a mental disorder diagnosis, and offers treatment mainly in the forms of pharmacotherapy or psychotherapy. In other words, we narrowly dichotomise mental health difficulties into a diagnosed mental disorder or no diagnosis.[4] This reductionist approach puts disproportional emphasis on specialists over generalists, medication over psychosocial support, and hospital care over community care despite no evidence that a higher density of mental health professionals reduces the prevalence of mental disorders.[4] Even though social determinants of health and social justice issues are often the root causes of many mental health difficulties, little complementary efforts are made to address these in the current system.[7]

The immediate and sustained investment to solve the mental health crisis should go well beyond the traditional mental health workforce by addressing the macro-level issues of the mental health ecosystem.[8] Better integration of acute and community care as

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well as mental health and drug and alcohol care systems is urgently needed. Public and population health approaches such as mental wellbeing and resilience promotion should be encouraged to reduce the incidence of mental health difficulties in the long term.[9] We also need to address the socio-economic and structural determinants of mental health and focus on the antecedents and consequences of mental health difficulties.[4,8] There are many strategies for primary prevention of mental disorders, such as actions to address inequalities, poverty and food security; parental interventions; preschool social and emotional learning interventions; school-based interventions; child adversity prevention; social isolation prevention; employment-related stress and mental disorder prevention; and health risk behaviour cessation and reduction.[9] Given that most people experience the first onset of mental disorders in the first two decades of their lives,[10] it makes sense to have a developmentally informed approach for young people, but we must also ensure that what is provided for young people at the front end is sustained adequately throughout their lifespan.[9] To increase potentially life-changing early detection at a population level, building a workforce for mental health care consisting of non-specialist providers is also critical.[4] For example, teachers and social service providers could effectively detect mental health difficulties (as opposed to diagnosing mental disorders) and deliver psychosocial support in partnership with mental health specialists who provide supervision, support and referral pathways as indicated. Improving the system where young people are transitioning in, out and between mental health services requires particular attention, as many have multiple attempts at different service providers with varying outcomes. Upskilling the teaching workforce should place an emphasis on strength-based psychosocial approaches as a main priority. This is important, as universal school-based mental health interventions may sometimes increase levels of anxiety for people without mental health difficulties. Although we acknowledge that such upskilling and increased capacity will only come with adequate training, recognition and remuneration with efficient payment mechanisms, we speculate that such an investment would potentially have a much broader impact on mental wellbeing at a population level than merely training more mental health professionals. Extending the concept further, for people with mental illness at any age, the systems thinking approach involving many sectors other than health, such as social welfare, education, employment, housing, justice and environment, is required.[8] We need whole-of-society interventions to address social determinants of health with adequate funding and goodwill from multiple government departments. In terms of the psychiatry workforce, more training needs to be provided to care for people with mental health difficulties in primary health settings. For this, psychiatry trainees should have more training positions and experience in GP liaison settings where they have exposure to high prevalence mental disorders in a supervised environment while building relationships with primary health colleagues.[11] Further, the psychiatry training curriculum should emphasise the social justice and human rights frameworks and put more focus on acquiring skills in leadership and public advocacy.[7,8]

The mental health crisis cannot be solved by psychiatry alone. The crisis is not driven by psychiatric disorders that can be diagnosed, treated and cured. To tackle the crisis, we need a societal response to address the social determinants of mental health and a whole-of-system approach to this problem. We must be able to provide psychosocial interventions in settings beyond GP surgeries and mental health clinics. We must shift from the reductionist medical approach for mental disorders to a holistic societal perspective on mental wellbeing. Without such fundamental transformation, we cannot mend the broken system. Of course, GPs and psychiatrists need to continue working together to make the lives of our patients easier, but we need much more help from everyone else in society.

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1 Leech A. "To my respected psychiatry colleagues". *newsGP* 2023, 23 Aug. https://www1.racgp.org.au/newsgp/gp-opinion/to-my-respected-psychiatry-colleagues (viewed Mar 2024).

2 Virgona A. Psychiatrist responds to GP's open letter. *newsGP* 2023, 30 Aug. https://www1.racgp.org.au/newsgp/clinical/psychiatrist-responds-to-gp-s-open-letter (viewed Mar 2024).

3 McGorry PD, Coghill D, Berk M. Mental health of young Australians: dealing with a public health crisis. *Med J Aust* 2023; 219: 246-249. https://www.mja.com.au/journal/2023/219/6/mental-health-young-australians-dealing-public-health-crisis

4 Patel V, Saxena S, Lund C, et al. Transforming mental health systems globally: principles and policy recommendations. *Lancet* 2023; 402: 656-666.

5 Rosenberg S, Salvador-Carulla L. Australia. Good intentions — reviewing 30 years of mental health policy reform. In: Hudson CG, editor. Research handbook on mental health policy. Cheltenham (UK): Edward Elgar Publishing, 2022; pp. 190-205.

6 University of Canberra. GLOCAL: Global and Local Observation and Mapping of Care Levels. https://www.canberra.edu.au/research/centres/hri/research-projects/glocal (viewed Mar 2024).

7 Sartorius N, Gill N, Virani S, Salvador-Carulla L. Fighting for human rights and social justice and the promotion of mental health: complementary efforts. *World Social Psychiatry* 2023; 5: 97-100.

8 Rosen A, Gill NS, Salvador-Carulla L. The future of community psychiatry and community mental health services. *Curr Opin Psychiatry* 2020; 33: 375-390.

9 Campion J, Javed A, Sartorius N, Marmot M. Addressing the public mental health challenge of COVID-19. *Lancet Psychiatry* 2020; 7: 657-659.

10 McGrath JJ, Al-Hamzawi A, Alonso J, et al. Age of onset and cumulative risk of mental disorders: a cross-national analysis of population surveys from 29 countries. *Lancet Psychiatry* 2023; 10: 668-681.

11 Suetani S, Sardinha S, Gill N. Improving the mental health of Australians: a renewed call for primary care psychiatry. *Australas Psychiatry* 2022; 30: 637-639. ■