

The crisis in mental health: the chariot needs one horseman

Better coordination costs no more and improves the lot of patients

How is it that Australia's mental health services are in disarray? A Senate inquiry is mooted, and the press run stories of concern almost every week. Most of the stories are about failures in public-sector acute-care services that are the responsibility of the state and territory governments. Christopher Pyne, the Australian Government's Parliamentary Secretary for Health said that "Australia's states and territories stand condemned for their failure to deliver adequate mental health services. . . perhaps it is time for them to cede their responsibility for mental health to the Commonwealth".¹

Part of this rhetoric should be viewed in the light of federal–state relationships. However, part does reflect the uncoordinated way we fund our health systems — Medicare and Pharmaceutical Benefits at the federal level, private health insurance, the state and territory provision of public-sector services, and rising out-of-pocket expenses at the individual level. A coordinated funding system would be preferable.

There are six contributors to Australia's mental health service — general practitioners, private psychiatrists, private psychologists, private hospitals, state inpatient and community services, and non-government charitable organisations. The work of these contributors is poorly coordinated. It is like a six-horse chariot with six horsemen who seldom communicate.

Coordination of health care is vital. In Canada, when Saskatoon, Edmonton and Calgary realised that a wave of influenza was coming, they had GPs give antiviral injections in nursing homes, made room in hospital intensive care units and had ambulances check their oxygen units. The wave of influenza came, there was no crisis and there were no unnecessary deaths. In Toronto, there was no such coordination — nursing homes closed, emergency rooms and intensive care units became full, ambulances circled the block and many people died unnecessarily.² Coordinating the elements of a health system is important. The chariot needs a single horseman.

In this issue of the Journal (*page 396*), Whiteford and Buckingham detail the achievements of the Australian Health Ministers' Advisory Council's National Mental Health Strategy 1993–2003, an attempt at federal–state coordination to which they contributed.³ The achievements have been considerable,⁴ but there are some reservations:

- While expenditure on mental health has increased, it has only increased in line with expenditure on other health services.
- Acute public-sector inpatient beds are at a satisfactory 18 per 100 000, but hospitals often are unable to admit critically ill patients because the number of rehabilitation beds and beds in the community is one quarter of the 50 per 100 000 recommended.⁵ Services that can't discharge can't admit.
- Community mental health services have grown as the number of hospital places has decreased. However, the absence of rehabilitation and community beds means that staff are being asked to care for people in the community who should be in supervised residential places.

- There have been few area-wide attempts to integrate the work of GPs, private psychiatrists and psychologists with the work of state inpatient and community services.

Also in this issue of the Journal (*page 401*), Hickie and colleagues provide a manifesto for change, asking for money to establish national targets for mental health outcomes, to promote early intervention in the young, provide effective treatment in primary care, maximise rehabilitation opportunities, and invest in sustainable innovation.⁶ These are good aims, but won't necessarily solve the present crisis. They do not address the issue of governance, how to enable the six contributors to work together, and how to remedy the deficiency in supervised accommodation.

How did this crisis come about? Australia's burden of mental illness (anxiety, depression, substance misuse and psychosis) is

similar to that of other developed countries. Our coverage (proportion of people with a current mental disorder who seek treatment) is better than in most such countries. Our trained workforce is good. We have a strong consumer and carer movement and a powerful lobby in the Mental Health Services Conference <<http://www.themhs.org>>.

We have very good data and know who is treated in each care sector.⁷ We have calculated that optimal care at current coverage would cost no more, but would be twice as effective as current care.⁸ So, while more money might make things easier, lack of money is not the cause of the crisis.

The current crisis is most evident in the inability of the acute-care units to admit emergency cases, but there is a much more worrying problem looming — psychiatrists and nurses do not want to work in public-sector inpatient and community services.³ Psychiatrists in training, who staff state hospital and community services, find it uncongenial and resolve to leave the public system; and nurses who are no longer trained within the system resolve not to enter it. Information from new brain-imaging strategies and from the human genome project is changing our understanding of mental disorders. One would think that this impending avalanche of information would produce clinicians eager to be involved. In much of medicine, any physician hoping for an appointment at a teaching hospital will be doing a research doctorate. This is not happening in psychiatry. Patients deserve better.

What to do? Is there any evidence that integrating the elements can improve services? There is. Projects in three health areas were funded by the federal government in 1999 to improve linkages between disparate parts of the mental health system. In each area, patient care improved, there was no increase in expenditure, and provider collaboration continued after the trial was over.⁹

Is Christopher Pyne right? Would things be better if there was a single payer and a single source of governance? Tony Abbott, Minister for Health and Ageing said "speculation about structural change is likely to dominate this year's health debate",¹⁰ which at least suggests that the matter is still on the table. The Constitution probably precludes the federal government forcibly taking over the states' responsibility for health, but a way around this impasse has

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EDITORIALS

been suggested, arguing for an “Australian Health Commission” that could take responsibility for all health services and provide a patient-focused health care system which would be to everyone’s benefit.¹¹ If something like this happens, the chariot would have one horseman, and the recurring crises in mental health might gradually ease.

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- 4 National mental health report 2004. Eighth report — summary of changes in Australia’s mental health services under the National Mental Health Strategy 1993–2002. Canberra: Australian Government Department of Health and Ageing, 2004. Available at: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pq-mental-pubs.htm> (accessed Jan 2005).
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- 7 Issakidis C, Andrews G. Who treats whom: an application of the pathways to care model in Australia. *Aust N Z J Psychiatry* 2005. In press.
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