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Brain and Mind
Centre

On the Right Track from the Start

A Discussion Paper – May 2023



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Expert, highly-personalised triage, assessment, and measurement-based care for the delivery of better primary mental health services.

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Executive Summary

Australia's approach to the provision of primary mental health care is sclerotic, a rigid and unresponsive system, delivering uneven and unfair services. Federal Budget 2023 has recognised this and begun investing in the process of reform.

This discussion paper provides a map of a new primary mental health care landscape.

It focuses on the development of two new central features:

1. **PHN Coordinated Consumer Triage and Tracking** – providing personalised measurement using technology to help people find the right clinical or psychosocial service, assess the impact of those various interventions and determine next steps; and
2. **A new specialised initial assessment and review function** – aiming to better coordinate the professional response to a person's mental health and psychosocial needs.

The effective delivery of these two functions is dependent on the development of a third key element, namely, a **new national digital infrastructure** to underpin rapid assessment, smart triage to appropriate levels of clinical and psychosocial care and ongoing coordination of care.

This digital approach will also empower consumers to be proactive in their own health care journey, prevent the loss of key information over time and drive the health care system towards greater accountability for the provision of evidence-based and recording of actual outcomes achieved by various service models.

These two new functions, backed by necessary technology, fundamentally shift the focus of care delivery away from Australia's two dominant entry points to mental health care: the general-practice based 'gate-keeper' to specialist care; and an Emergency Department-based access to acute care and specialist assessment.

These shifts will permit both those two key service elements to focus on their core functions. For General Practice, that means a key role in the coordination and delivery of more complex care to those with comorbid physical health difficulties and for Emergency Departments the urgent assessment and delivery of responding to life-threatening situations.

The emphasis on using digitally-enabled, client-reported assessments, coordinated regionally through PHNs, opens up the power of new technologies to facilitate the direction of care in the appropriate directions (clinically or psychosocially, and to relevant levels of self or professionally-delivered care) from the outset.

These new arrangements have the capacity to deliver a new national capacity to organise and coordinate the delivery of effective, timely and high quality primary-care initiated mental health services to Australians, wherever they live. This will have benefits not only for consumers and their families, but also for the communities in which they live and the broader economy.

While not enough Australians can access mental health care, those who can often spend too much time being directed to the wrong care. Precious opportunities to identify and respond to complex mental disorders early in the course of illness are lost. Existing technological capacity to triage and monitor individual progress has not been implemented at scale. People cannot tell the difference between the roles of different professionals, both clinical and psychosocial. People receiving inappropriate, general health care, without ever receiving specialist, personalised assessment often lose hope. Often those in need of psychosocial care and support are inappropriately directed back to MBS-reimbursed clinical systems.

Simply training more health professionals to work in this disorganised way will not be enough. Australia's mental health care and psychosocial support systems need to be radically re-organised. We need to help people get on the right clinical or psychosocial tracks as quickly and as easily as possible.

Recent evaluation of the Better Access Program clarified the urgency of primary mental health care reform. In its 2023 Federal Budget, the Albanese Government has already provisioned funding for this reform, arising from the Better Access evaluation (p.140 of Budget Paper 2). Our modelling has already demonstrated the need to avoid simplistic solutions purporting to provide direct access to services and instead demonstrated the need for carefully designed, system-level reforms that balance the provision of primary care-based and more specialist services, reduce the likelihood of unintended consequences and deliver optimal improvements in population mental health outcomes [1].

The map of primary mental health care presented here describes how we can get Australians back on track right now towards more equitable and accessible quality mental health care.

Aim

To describe a new and comprehensive primary mental health service ecosystem for Australia.

Background

Recent inquiries by the Productivity Commission [2], the Victorian Royal Commission [3] and the Australian Parliament [4] have highlighted the need for major reforms in mental health, particularly in relation to regional organization of primary care-based and more specialized mental health care.

Pressure to develop primary mental health care reform increased again following the release of the evaluation of the [Better Access Program](#) in late 2022. The Federal Labor government announced some modifications to the Program, which is currently costing around \$30m weekly, placing new caps on some services. This was done to address the Program's documented inequities reported both in the evaluation and [elsewhere](#).

These changes aside however, a broader picture of options and alternatives for primary mental health reform has yet to emerge, obscured too often by the many [competing](#) claims of the relevant professional [groups](#).

Thus far, Australia's efforts in primary mental health care have focused on lifting the rates of psychological treatments and improving public access to these services. There is some evidence this has been successful [5] though with rapidly increasing costs being borne [6] by individual consumers at both the GP and specialist psychology level. Consequently, many of those in greatest need have been locked out of any psychological care.

Table 1 Mental Health Medicare Activity 2021-2022

Type	No. Services	Medicare Benefit \$
GP Mental Health Care	2,889,999	250,549,903
Clinical Psychology	1,575,990	213,667,384
Registered Psychology	2,532,615	234,872,617
Psychiatry	1,653,291	267,201,226
Totals	8,651,895	966,291,130

*N.B. Face to Face Services only (does not include 1.6m Telehealth services)
Source: Medicare Statistics.*

Australia has been aware of a paradox in mental health care, whereby increasing access to care has not resulted in any apparent reduction in the prevalence of mental disorder [7]. Our recent modelling has found that this paradox is not a consequence of ineffective treatments, but that there is a genuine increase in rates of mental disorders, while access to effective treatments remains grossly insufficient. [8].

Further analysis indicates that, under certain conditions, an increase in the appropriate mix of primary care and specialist services capacity can precipitate an abrupt, step-like transition from a state of persistently high unmet need to an alternative, stable state in which people presenting for care receive timely and effective treatment. This qualitative shift in services system functioning results from a 'virtuous cycle' in which increasing treatment-dependent recovery among patients with mild to moderate disorders reduces the number of severely ill patients requiring intensive and/or prolonged treatment, effectively 'releasing' services capacity that can be used to further reduce the disease progression rate [9].

The challenge for mental health policy now is to shift from a simple focus on access, to broader considerations about most effective system design and increased emphasis on providing quality care.

Federal Budget 2023 recognised the need for urgent, broad reform of primary health care. Several important measures were funded, addressing issues in fee for service and bulkbilling, bolstering the role of Primary Health Networks and the mental health workforce. A platform has been set. This discussion paper aims to set out how Australia can build on this platform.

Discussion

This paper proposes fundamental redesign of Australia's primary mental health care system. This means a major shift in positions on key issues, including:

- Moving to a staged model of clinical service delivery, calibrating the professional response to more effectively respond to people's needs, with a strong emphasis on multidisciplinary teamwork for those with more complex needs
- Diversifying the way clinical and psychosocial services are funded, moving well beyond individual fee for service
- Properly describing the triage, delivery and outcome monitoring roles to be played by digital mental health services
- Considering the role of technology in the coordination of care and increased accountability for service provision
- Reconsidering professional roles as part of major workforce design
- Creating multiple entry points for consumers and their families to find the care they need and reduce the opportunity for people to become 'lost' in the system
- Properly designing the role to be played by non-government organisations as partners to clinical/medical services, through social prescribing among other means. One aspect of this should be reconsideration of the role of Tier 2 services under the NDIS, which have been permitted to develop unchecked as sole trader services, without regard for their psychosocial expertise and connections.

These issues are described in more detail below.

The Way Things Are

Figure 1 shows how Australians find mental health care now. There are multiple points of entry, but no really coordinated system of care. People typically arrive into mental health care in a disorganised fashion, often at times of crisis and via digital, phone and human services. GPs have been promoted as the first point of call, and gate-keepers, for many adults seeking mental health care. In responding to their clients' mental health needs, GP service responses are often reduced to just four specific mental health interventions:

- Prescribing medication
- Referring to a psychiatrist for another medical opinion
- Referring to another non-medical professional (overwhelmingly a psychologist) for a specific psychological intervention
- Conducting psychological treatments themselves. Based on the Medicare numbers reported, this option remains very rare. Of the 2.9m GP Medicare services reported (see Table 1 above), only 25,000 were for delivery of 'focussed psychological strategies'.

Some clients may obtain the help they need this way. However, many others may not, having a level of complexity or severity that requires more specialised, team-based or complex clinical and psychosocial interventions. The absence of ready access to more

specialised and expert responses is one cause of the 'cracks' through which Australians regularly fall in our current mental health system.

The other defining characteristic of the 'system' at Figure 1 is the overall absence of clear connections (or agreed pathways) between the service providers. We know that only around a quarter of all mental health plans written by GPs are reviewed (according to the use of the Medicare Item Number). There is clearly a lack of coordination, monitoring and accountability between different service providers. More cracks.

By contrast, Figure 2 represents a new design for Australian primary mental health care. It is based on some key principles. Regional planning and coordination of mental health services can promote more coordination, and accountability, across entry points.

In addition to existing concerns for access and the more recent focus on equity, Figure 2 aims to assert a new emphasis on quality. Australia's current approach to delivering primary mental health reflects historical patterns and pathways to care.

It fails to align with contemporary understanding about how best to deploy resources, both human and virtual, to best meet people's needs. The goal here is to explicitly deliver the right clinical care a person needs, at the clinical stage they are at, when they first present to care.

Consistent with the centrality of measurement-based care to improving individual outcomes, as a person's mental health improves or declines, the organised, professional response shifts accordingly.

A key principle underpinning Figure 2 is the role to be played by skilled professional assessment. A key reason people get lost in the system is that they are not subject to an appropriate level of initial professional assessment. Psychiatrists, clinical psychologists and mental health nurses have a new and central role to play here. Locations such as the new head to health hubs could be deployed here.

This timely and specialised assessment is particularly important for young people, making it less likely they are sent on a tour of unhelpful, disconnected services.

Figure 1 – The Current System

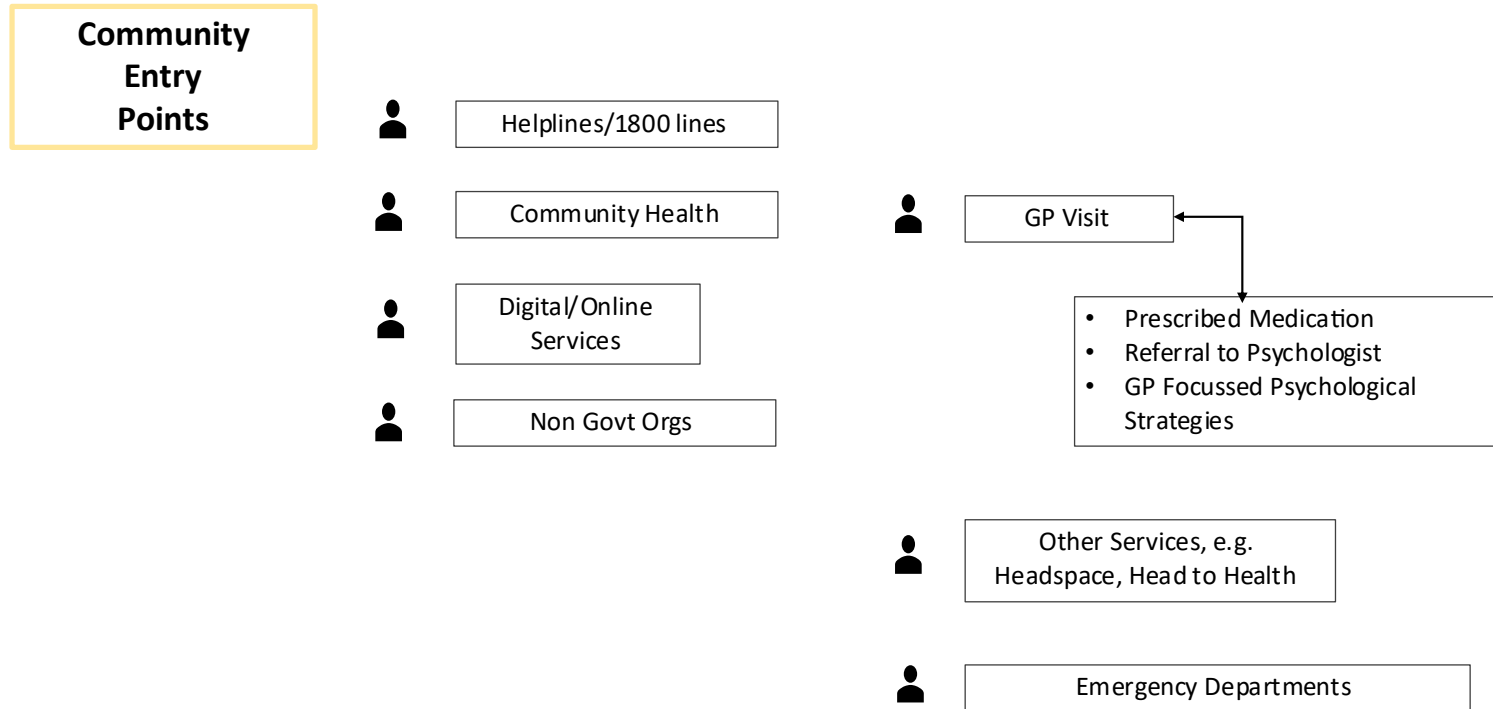


Figure 2 – A New Primary Mental Health Care Ecosystem

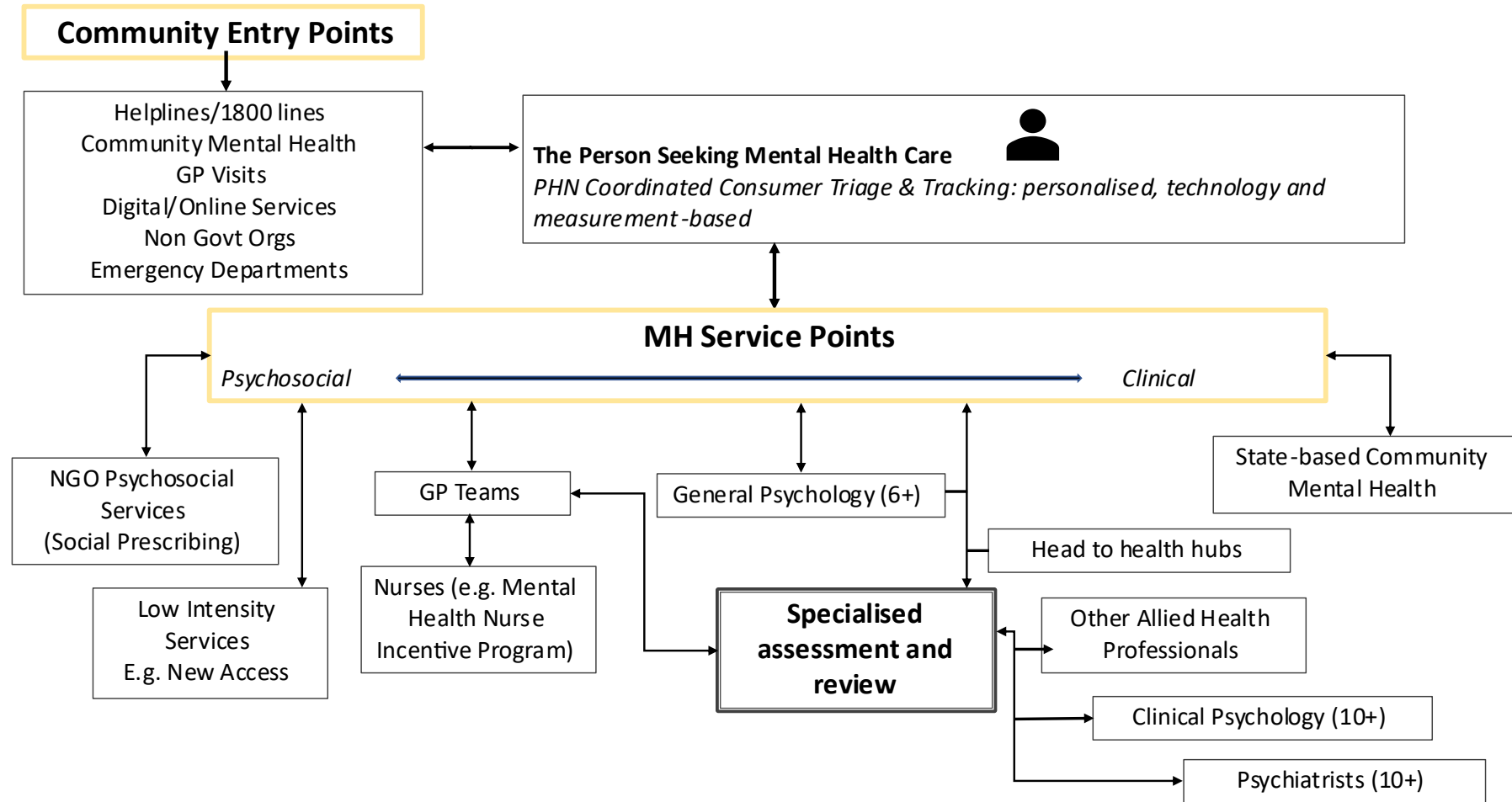


Figure 2 in Detail

Figure 2 aims to augment and diversify these options for both access and range of interventions available. This will require workforce redesign, role definition, funding and service challenges. It may seem complex, but this kind of fundamental reorganisation is urgently required to address the fragmented, ineffective mental health system currently provided to Australians.

Figure 2 describes general functions rather than specific 'branded' organisations. There is recurring concern for workforce design and role delineation, to better clarify who does what in the mental health service system. This is a matter for the new [National Mental Health Workforce Strategy](#).

From Stepped to Staged Care

In recent years, Australia's mental health reforms have been guided by the concept of '[stepped care](#)'. This has some benefits, particularly the notion of organising the service response to the right level of individual consumer need. But it is not enough [10].

The reform outlined in Figure 2 are predicated instead on 'staged care' [11], an approach developed in Australia over the past decade. In staged care, people are matched with either low- or higher-intensity clinical treatments based on specialist assessment. This kind of staged approach has been commonly used as an adjunct to formal diagnosis, prognostic statements and treatment planning in clinical medicine. Stage care fits well with a rebalancing of Australia's mental health treatments, away from 'post-vention' and towards targeted earlier intervention, both in life and in the course of illness.

Staged care places psychiatrists, clinical psychologists and mental health nurses at the forefront of this more comprehensive assessment process, using their expertise to determine the most appropriate mental health service response for each person from the start.

This specialist role must continue beyond initial assessment to ensure ongoing monitoring of consumer progress, redirecting the mental health service response depending on whether the person's mental health improves or declines.

Community Entry Points

The top half of Figure 2 describes the myriad entry points into primary mental health care currently available to Australians. It is a wide net involving phone, digital, face to face and other services, typically unstructured, without coordination, prioritisation or monitoring. As stated, this lack of structure partly explains the ‘cracks’ commonly ascribed to Australia’s mental health system.

PHN Coordinated Consumer Triage and Tracking

Figure 2 addresses this fragmentation by establishing a new explicit function for PHNs to triage and track primary mental health consumers. This is seen in the middle of the diagram. Using personalised approaches and technology, PHNs would be responsible for establishing and directing individual primary mental health care journeys and monitoring the impact of the care provided. People would be connected to the most appropriate **clinical or psychosocial services**, reflecting the mix and trajectory of their changing needs. This extends well beyond the limited introduction of a clinician-administered Initial Assessment and Referral (IAR) Process or the application of a linked Decision-Support Tool. It could harness the direct power, and scalability, of client-completed and more comprehensive assessment tools.

Mental Health Service Points

The bottom half of Figure 2 describes multiple mental health services that can be arrayed to best meet consumer needs and operating across the spectrum of psychosocial and clinical elements of care.

Psychosocial Services

Evidence is growing to support **social prescribing**. Australia has already had experience here, with evaluations of former programs such as Personal Helpers and Mentors [12] and Partners in Recovery [13] both found to offer positive outcomes for clients, including those in harder to reach cohorts. **HASI** is another example, begun in NSW but now with similar programs operating in other states, is another example of a program combining clinical and psychosocial aspects, particularly for clients with more complex needs. This combination lies at the heart of successful community living for people with more complex mental health issues, including in relation to the management of their primary care needs.

Figure 2 proposes a much more significant role for psychosocial services provided by non-government organisations. To date, NGO funding from the States and Territories has always been a peripheral element of the Australian mental health service landscape. It is currently less than 6% of total spending.

With some exceptions, this has been the case since the first national mental health plan. The prospects for evolution and growth of the psychosocial sector have been further imperiled by the advent of the NDIS [14].

All governments gave up their NGO resources to the NDIS on its commencement, and while considerable new funds have been provided to NDIS clients, there is little evidence these funds are helping psychosocial specialist organisations to thrive. Indeed, many have shrunk or even disappeared.

The absence of a vibrant psychosocial sector, despite good evidence [15] for its role, places unsustainable pressure on medical/clinical mental health services and leaves the mental health system unbalanced [16]. Development of the psychosocial sector could lead a broader process of community mental health service planning, aiming to finally bridge the gap between federally-funded primary care and state-funded hospital-based care.

Another innovation to augment Australia's primary mental health response would be to expand the BHP Foundation's Right Care, First Time, Where You Live Program. Currently operating across just 8 communities, this program works with local regions to develop decision-support tools based on systems modelling, to guide investments in sustained, coordinated and digitally enhanced youth mental health care.

Lower Intensity Services

For people needing the lowest intensity care, Figure 2 shows PHNs able to direct consumers to appropriate services, such as [New Access](#). Available already in just a few locations across Australia, New Access is a mental health early intervention program, offering low-intensity behavioural therapy, a form of evidence-based psychotherapy that uses trained coaches to guide clients through a series of structured resources to address mental health issues identified by the person. The evolution of a new cadre of coaches helps build depth and breadth of the mental health workforce.

Mental Health Professional Providers

As the need for more mental health clinical support becomes apparent, consumers begin to access different mental health professionals. Australia has recently built a primary care psychology workforce, to the point where it has overtaken nursing as the largest component of our national workforce.

How professionals work together is critical. For straightforward and short-term mental health care, the existing fee for service payment system will continue to play a central role. However, for other types of team-based and multidisciplinary care, other employment, funding and payment systems are necessary. Fixed and capitated models, together with funds pooling have already been canvassed by the [Productivity Commission](#).

And while competitive tendering may be suitable in some circumstances, longer term block or contract funding may be necessary in other circumstances, especially when attempting to address important, identifiable workforce and service gaps in communities.

For example, the Mental Health Nurse Incentive Program (MHNIP) operated previously, albeit on a limited budget and was evaluated as an important positive addition [17] to GP primary mental health care service options. This is an example of the evolution of more team-based general practice, providing a deeper set of service options for GPs than the three basic services responses which currently dominate: prescribe, refer or treat.

Other allied health service providers, such as social workers and occupational therapists which currently account for a very small fraction of total primary mental health services under Medicare, should become more prominent service providers, including operating as part of GP teams.

Specialised Assessment and Review

Where the aforementioned mental health services have not been able to address consumer needs, and at the heart of the reforms described in Figure 2, is a new role for psychiatry, clinical psychology and mental health nurses in the provision of specialised assessment and review.

Psychiatry and clinical psychology largely provide fee for service treatments, just like other medical specialists under Medicare. This role must be expanded so that where consumer needs fail to be met, these professionals take responsibility for the design of tailored service pathways to better meet these needs. These pathways could include longer or more sessions of professional care.

These professionals would also be responsible for monitoring the consumer progress, to ensure that devised pathways are followed and leading to improved consumer mental health.

PHNs should be able to access this specialised assessment capacity directly, as required.

Feedback Loops

Figure 2 makes it clear that services provided are tracked and monitored by the PHN. Consumers return for reassessment as required and progress in their recovery is tracked. The impact of professional care is also monitored as part of the specialist assessment process.

Technology as essential scaffolding

Australia leads the world in the development of a range of digital mental health services. Recent experience with COVID-19, when face to face care was impossible, has reinforced the public acceptability of these services. For particular groups, such as young people, accessing mental health care digitally may often be preferable to trying to organise face to face care.

However, as these services have developed apace, the overall environment for digital mental health care has been largely unregulated and organic. Digital services can be disconnected from each other and also from other face to face services.

Ironically, without this coordination, new digital technologies have perpetuated the fragmentation and disorganisation which characterises Australia's response to mental illness.

The development of appropriate regulation of digital services, including in mental health, has been identified as a priority by the World Economic Forum. The Government has already issued standards but these relate to the safety of applications, and appropriate models of care, rather than their connectivity. The reforms suggested here draw on experience and necessitate the development of a new platform to connect and manage mental health care in this complex service environment [18]. This could finally link these services in a planned and organised way, both to each other, and more broadly to the mental health and suicide prevention plans being developed in each region by PHNs and their state/territory counterparts.

New standards must be built, supporting an open Application Program Interface capacity between programs and services.

The Government could then apply these standards to its own purchasing and contracting decisions, creating an environment for new, interoperable digital mental health programs to flourish.

New digital technologies can also drive more effective and accurate assessment, tracking and calibration of individual consumer needs [19].

Fashioned in this way, technology can provide the system scaffolding that is necessary to counteract fragmentation, surmounting traditional stumbling blocks such as the lack of a Unique Patient Identifier.

Conclusion

The evaluation of the Better Access Program laid bare the limitations, inequities and waste arising from the current disorganisation of our mental health system. Getting primary mental health care right will have benefits right across the system, including into secondary and hospital-based services.

These are reforms that have been canvassed over many years, in successive inquiries, reports and recommendations. The focus here is on workforce design role delineation and individual planning and monitoring, making it more likely that a person will get the right help from the right professional at the right time. The necessarily involves both the clinical and psychosocial aspects of care.

This paper has outlined the properties of a new mental health service system, reflecting the real-world complexities of access and care and establish a new, more stable response to mental illness across Australian communities. A key part of this is how to capitalise on the skills of our precious mental health professional workforce. We must also consider how best to ensure they are funded and paid to work and succeed under this service model.

Australia is a wealthy country which has shown its willingness to invest in improving the lives of people with a mental illness. The development of the new service ecosystem described here will help make the most of these investments, assist our workforce to thrive, and organise new spending to be directed clearly to where it can be most effective.

References

- 1 Vacher C, Skinner A, Occhipinti JA, Rosenberg S, Ho N, Song YJ, Hickie IB. Improving access to mental health care: a system dynamics model of direct access to specialist care and accelerated specialist service capacity growth. *Medical journal of Australia*. 2023.
- 2 Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
- 3 State of Victoria. Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations, Parl Paper No. 202, Session 2018–21, 2021.
- 4 Australian Senate (2006). *From Crisis to Community*, Select Committee on Mental Health, March 2006
- 5 Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, Barendregt JJ et al. Estimating treatment rates for mental disorders in Australia. *Australian Health Review*. 2013 Dec 6;38(1):80-5.
- 6 Rosenberg S, Park SH, Hickie I. Paying the price—out-of-pocket payments for mental health care in Australia. *Australian Health Review*. 2022 Oct 27;46(6):660-6.
- 7 Jorm AF. Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Australian & New Zealand Journal of Psychiatry*. 2018 Nov;52(11):1057-62.
- 8 Skinner A, Occhipinti JA, Song YJ, Hickie IB. Population mental health improves with increasing access to treatment: evidence from a dynamic modelling analysis. *BMC psychiatry*. 2022 Dec;22(1):1-1.
- 9 Skinner A, Occhipinti JA, Prodan A, Song YJ, Hickie IB. Bi-stability and critical transitions in mental health care systems: a model-based analysis. *International Journal of Mental Health Systems*. 2023 Dec;17(1):1-2.
- 10 Rosenberg S, Salvador-Carulla L, Hickie I, Mendoza J. Stepped mental health care model leading Australia astray. *Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists*. 2020 Oct;28(5):597.
- 11 Hickie IB, Scott EM, Hermens DF, Naismith SL, Guastella AJ, Kaur M, Sidis A, Whitwell B, Glozier N, Davenport T, Pantelis C. Applying clinical staging to young people who present for mental health care. *Early intervention in psychiatry*. 2013 Feb;7(1):31-43.
- 12 Dunstan DA, Todd AK, Kennedy LM, Anderson DL. Impact and outcomes of a rural Personal Helpers and Mentors service. *Australian Journal of Rural Health*. 2014 Apr;22(2):50-5.
- 13 Hancock N, Scanlan JN, Gillespie JA, Smith-Merry J, Yen I. Partners in Recovery program evaluation: changes in unmet needs and recovery. *Australian Health Review*. 2017 Jul 11;42(4):445-52.
- 14 Smith-Merry J, Hancock N, Gilroy J, Llewellyn G, Yen I. Mind the gap: the national disability insurance scheme and psychosocial disability.

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- 15 Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington (DC): National Academies Press (US); 2001. PMID: 25057539.
 - 16 Thornicroft G, Tansella M. The balanced care model for global mental health. *Psychological medicine*. 2013 Apr;43(4):849-63.
 - 17 Happell B, Platania-Phung C. Review and analysis of the mental health nurse incentive program. *Australian Health Review*. 2017 Sep 4;43(1):111-9.
 - 18 Iorfino, F., et al., The impact of technology-enabled care coordination in a complex mental health system:a local system dynamics model. *Journal of Medical Internet Research*, 2021. **23**(6).
 - 19 LaMonica HM, Iorfino F, Lee GY, Piper S, Occhipinti JA, Davenport TA, Cross S, Milton A, Ospina-Pinillos L, Whittle L, Rowe SC. Informing the future of integrated digital and clinical mental health care: synthesis of the outcomes from project synergy. *JMIR Mental Health*. 2022 Mar 9;9(3):e33060.