THE UNIVERSITY OF SYDNEY
Brain and Mind Centre

Rethinking Mental Health in Australia

Adapting to the challenges of COVID-19 and planning for a brighter future

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About this Report

This report reflects the engagement of many mental health leaders in a series of events over recent months. In late 2019, in parallel with the enquiry of the Productivity Commission, the Brain and Mind Centre (BMC) and the Sydney Policy Lab (University of Sydney) and the Centre for Mental Health Research (CMHR) (Australian National University) jointly hosted a two-day forum to consider urgent reform priorities. In November 2019, as part of project undertaken with the Australian College of Mental Health Nurses, the CMHR hosted a national meeting to evaluate the current state of mental health planning.

During March and April 2020, the CMHR and ConNetica Consulting held a series of eight international webinars to understand the impact of COVID-19 on mental health care and build a rapid understanding of opportunities arising for reform. Over this same period, the BMC also held international #FliptheClinic webinars, designed to explore key issues, such as ending waiting lists, the role of digihealth and how technology can assist to improve the access and quality of care, with a specific emphasis on youth mental health and suicide prevention.

Hundreds of mental health leaders have participated in these events, most from Australia, including policymakers, funders, service providers, professionals, consumers, carers, researchers and others.

Sadly, the summer of 2019-20 has had a huge impact on the mental health of Australia, with fires, storms and now a pandemic. Although Australia's health system is frequently lauded as one of the best in the world[1], such assessments do not include mental health, where Australia's performance is far from world class[2]. Mental health was typically characterised as in crisis before COVID-19[3] [4]. The pandemic has now increased the community's risk of suicidality and mental illness associated with anxiety, depression, social isolation, financial distress, unemployment and educational dislocation[5].

This report has been prepared because there is widespread recognition that Australia's mental health system is palpably inadequate for the challenges ahead. As evidenced by repeated reports and inquiries, including the 2015 National Review[6], the 2019 draft Productivity Commission report[7] and the 2020 interim report of the Victorian Royal Commission[8] , even before COVID-19 Australia's mental health system was providing a level of care far below what could be expected.

Given the funding, given the resources, given the population demand, Australia's mental health system could be summarised thus: there are services providing mental health care that is awful, even dangerous; there are many places providing care that is at best adequate and typically short-term; and there are isolated pockets of well-intentioned and/or quality mental health care. Mediocrity shouldn't be the benchmark. There is now real and urgent enthusiasm for a radical shift in the way we plan for and respond to mental ill-health in Australia.

The National Mental Health Commission is currently working on a 'Vision 2030' for mental health. Governments in Australia are excellent at requesting new commissions, inquiries, responses, reports and roadmaps. Sadly, to date, these have largely advised further investment in 20th century models of mental health care, applying the philosophy "do as before, but more"[9] . This approach, fails to meet our national needs currently, takes no account of the new COVID-19-induced challenges and does not support active investment in growing Australia's Mental Wealth.

The pandemic has provided a definitive message. Business as usual approaches that prioritise traditional, very centralised, top-down, mental health planning mechanisms just will not work and are not good strategies. Repurposing the past is not an option. Consequently, there is an urgent need to design a contemporary, responsive and effective mental health system, that learns from the past but is fit for Australia in the 21st century not the 20th.

Drawing on the views of a broad cross-section of Australia's mental health leaders, including consumers and their families, this report starts to outline the fundamental changes which should underpin the trajectory of mental health care in Australia.

Summary of Key Action Areas

By way of summary, systemic, meaningful mental health reform depends on actions taken in the following areas:

1. Sophisticated health, data, telecommunications, digital and corporate infrastructure to support regionally based systems of mental health care. Regions represent those social, cultural, geographic and economic communities in which people live their lives. The composite of those regions captures the collective 'mental wealth' of Australia;

2. Counting (by service and by region) the number of people who recover from mental ill-health because of receiving optimised care, the time to recovery, the experience of care and the cost of that care to the individual and the community. This incorporates the key concepts of highly personalised and measurement-based care being delivered in real time;

3. Recovery from mental ill-health is not simply a reduction in symptoms. Rather it is a personal journey that focuses on articulating and supporting the maximal social and economic participation of the individual and their family and carers;

4. Funding models that support the provision of appropriate and evidence-informed multidisciplinary and team-based care for those with complex conditions including multi-morbidity and reward directly those activities that promote functional recovery. This is about organising an intelligent response to 'cumulative complexity'[10]. A key idea here is the mental health care home;

5. Effective, affordable, accessible, acceptable, evidence-based and accountable early intervention services for both the mental and physical health problems that are experienced by those with mental ill-health at any stage of life. The needs of children, young people and older persons are the most neglected historically.

Whatever is done in mental health from now on should be assessed against its contribution to these priority areas, described in more detail as 'domains' later in this paper.

Challenges for our System

Few issues galvanise support among Australians like public hospitals, emergency departments and Medicare. They evoke strong shared support for sentiments around issues such as universal access, timely responses in a crisis, equity and fairness. However, the reality of Medicare-funded services for care outside hospitals, is that while everyone is covered and it is notionally free for all, your access to care varies greatly on your social, economic, geographic and cultural circumstances. Do you live close to the health services you need? Are they available? Is there an out of pocket cost on top of the Medicare payment that individuals must pay? Are they culturally appropriate? Do you feel safe?

Beyond simple and immediate issues of access, there are major questions about quality. Concerning data from Australia's national mental health surveys in 1997 and 2007 focused our attention on lifting the rate of community access to mental health care. But this has distracted us from also considering the important multi-dimensional aspects of quality, including issues such as efficiency, effectiveness and acceptability.

Australia's universal Medicare system and guaranteed hospital access has given an illusion of service availability that masks significant problems across these dimensions of quality.

> The report states that without correction of defects in health care quality….. universal health coverage….will give many people access to care that will not help them and may even be harmful…. Equity and quality of care will arrive together, or not at all.
>
> *Berwick D, Snair M, Nishtar S. Crossing the Global Health Care Quality Chasm: A Key Component of Universal Health Coverage. JAMA. 2018;320(13):1317-1318.*

In the last 15 years, the Federal Government has generally focused its mental health reform around the instrument closest to hand – Medicare. The inclusion of psychological and social interventions under Medicare has been by far the most significant and expensive change made to the mental health service landscape. The numbers are staggering. Since 1 November 2006 (until 30 June 2019):

- General Practitioners have written 31m mental health care plans (or related services) costing $2.75bn
- Clinical psychologists have provided 19.5m sessions of therapy costing $2.45bn
- Registered psychologists have provided 30.3m sessions of therapy costing $2.6bn.

These services are skewed to those locations most able to afford the co-payments associated with care[11]. And while there is some evidence to suggest this effort has indeed resulted in an increase in the access to care among the overall population[12] , there is no evidence it has decreased the prevalence of mental illness[13] despite spending around $20m weekly.

Perhaps surprisingly, this colossal expansion in face to face care has had only minimal impact on the rate of prescribing of anti-depressant medications. Additionally, the rate of access to state and territory mental health services, typically focusing on the most severely unwell, has barely shifted – it was 1.6% in 2008-09 and 1.9% in 2017-18[14]. In 2004-05, there were 69.2 mental health-related emergency department presentations in public hospitals per 10,000 people. By 2017-18, there were 115.9.

Since 2006, the lack of financial support for alternatives to public or private hospitalisation, especially for people with more complex or comorbid conditions (e.g. with alcohol and other drugs), has meant that after Medicare services, there are few options but to seek hospital care. This is expensive for the taxpayer and often traumatic for consumers.

Medicare, along with our very stretched public mental health services, is delivering an undesirable kind of universality – disorganised, unaccountable and often inequitable.

Effective, co-designed, system-level planning of mental health in the 21st century must incorporate social context. This context typically operates at a regional level, reflecting defined geography, social and economic structures. This means good mental health planning necessarily spans drug and alcohol services, regional health, housing, community services, education, employment, justice and urban design among other areas (see here for example https://letsgethealthy.ca.gov/sdoh/). This context is missing from existing narrow and health-focused approaches to mental health planning, for example the 5th National Mental Health and Suicide Prevention Plan.

The overarching conceptual framework of 'stepped care' may well be unsuitable for Australia conditions[15], leaving a range of unhelpful, competing paradigms in place, such as 'acute, sub-acute and non-acute'. Similarly, simplistic notions of primary, secondary and tertiary care, aligned with diagnostic pseudo-specificity (mild, moderate and severe or anxiety-depression vs psychotic disorders), do not capture the degree of individual variability in needs or the complex and ongoing nature of most mental disorders.

There are workforce shortages but the health professions themselves have generally shown little real interest in driving reform. Much time and effort are wasted while the debate concentrates on Medicare sessions and rebates, ED presentations, bed numbers and waiting lists. Services and funding fail to reflect variation in need, by population or geography.

There is confusion regarding the role of the National Disability Insurance Scheme and widespread concern about the number of people with complex conditions who may never qualify for either NDIS support or hospital admission. More generally, the role of psychosocial support in mental health care has been neither defined nor supported financially in Australia. Peer support is rare. Consumer and carer organisations struggle to influence change.

The role of e-mental health services and telehealth (i.e. digital mental health care) has occurred organically, without structure. Longer term, holistic mental health care is sabotaged by the absence of integrated governance, funding, planning and accountability.

The proportion of national funding for mental health has not advanced since the first national mental health strategy in 1992. Structural discrimination ensures that funding for both services and research does not reflect mental illness's contribution to the overall burden of disease.

Systemic infrastructure for planning and accountability is not fit for purpose. State and territory mental health services annually report their success in meeting nationally agreed quality standards for service, yet evidence of poor care or even human rights abuse are frequent. The Health of the Nation Outcome Scales (HONOS) reported as part of National Outcomes and Casemix Collection[16] (NOCC) system fails to adequately link to any national process of systemic quality improvement and does not reflect consumer or carer views. The Your Experience of Service (YES) survey is new, rarely collected and yet to influence change. The National Mental Health Service Planning Framework is a commercial-in-confidence modelling product. Its underlying goals and assumptions are unclear. But we know it draws on 20th century epidemiological data to drive care towards some 'average' (per capita) requirements. The Framework fails to reflect the individual characteristics of both people and place, meaning its suitability for regional application is uncertain.

As well as problems with planning, systems of mental health funding and payments are also mired in old thinking, based on fee for service systems or a mirage of 'choice', which militate against collaborative care, and reward hospital stays over community care, post-vention over earlier intervention.

Current role delineation between levels of governments, service providers and professional organisations perpetuates this issue, with one result being what has become known as the 'missing middle'.

Regardless of the setting, existing systems of funding perpetuate debilitating fragmentation and competition rather than collaboration and quality care.

It is into this environment that COVID-19 arrived. In curtailing the way mental health care normally happens in Australia (or doesn't), the pandemic has prompted a new opportunity for fundamental reform in mental health.

Key Domains for Change

Building on the summary provided earlier in this paper, the following domains are where mental health reform should focus now.

1. Mental Wealth

Key to reform is to see mental health as more than just a health issue. Australia's mental health system should contribute to and capitalise on the Mental Wealth of people and communities. The Mental Wealth of a nation is defined as the combined cognitive and emotional resources of all its peoples[17]. This means building the social fabric and economic prosperity of communities by developing and using new tools to measure, monitor and forecast the national and regional dynamics of Mental Wealth[18]. This capability will drive improved understanding and communication of the social and economic value of population mental health and wellbeing.

Economics has long failed to properly account for mental health. The costs associated with poor mental health for individuals, families, workplaces, and the economy are enormous. The 2019 draft report of the Productivity Commission states that the cost to the Australian economy of mental ill-health and suicide is, conservatively, in the order of $43 to $51 billion per year. Additional to this is an approximately $130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health.

The case for investing in population mental health and wellbeing is not only morally and socially compelling, it is economically fundamental. There is an often-overlooked vital link between the mental wellbeing of Australians and our economic performance as a nation. This means recognising the importance of properly accounting for the broader whole-of-economy impacts of the social determinants of mental ill health, like housing, employment, and education to provide a holistic assessment of the economic impact of diminished mental health and wellbeing. We also recognise the need for significant investment in bringing together economic, clinical, psychosocial and mental health services research, and policy reform expertise, to integrate broader macroeconomic factors into our models that drive, and are driven by, a nation's mental health and wellbeing, particularly among young people.

Australia's mental health reform should be driven by its contribution to the Mental Wealth of the nation. There is an urgent requirement to develop the resources and infrastructure required for measuring, tracking, and reporting holistic indicators of our national Mental Wealth that are currently non-existent in Australia.

Right now, this is vital if we are to determine the extent to which Australia's Mental Wealth will be undermined by the rising tide of mental health issues resulting from the COVID-19 pandemic and subsequent recession. This kind of detailed planning requires development of interactive, regional modelling to allow scenario testing of a range of potential mitigation strategies including: active labour market programs, family support and housing programs, mental health system strengthening to improve the provision of quality and equitable access to care (with particular emphasis on new digital mental health systems), programs to prevent and manage chronic debt, and education support programs. Beyond COVID-19, a new national system of dynamic modelling will permit detailed planning, mapping the interrelationships between the economy, mental health and policy responses.

Quality and the Quadruple Aim

The concept of Mental Wealth fits well with the Quadruple Aim[19] (see Figure 1), which aims to improve health care by driving better outcomes across four dimensions of health care. The domains which follow can all be seen to support these four aims too. Again, mental health and wellbeing extends beyond the health system, and necessarily needs to refer to other things which matter to people, like social connectedness, housing, education, employment, community services, the justice system and beyond.

Figure 1

It has usefully been suggested that quality care has seven dimensions[20]:

1. efficacy: the ability of care, at its best, to improve health;
2. effectiveness: the degree to which attainable health improvements are realized;
3. efficiency: the ability to obtain the greatest health improvement at the lowest cost;
4. optimality: the most advantageous balancing of costs and benefits;

5. acceptability: conformity to patient preferences regarding accessibility, the patient-practitioner relation, the amenities, the effects of care, and the cost of care. It is perhaps this dimension that represents a crucial bridge across this quality 'journey' and provides a place to meaningfully capitalise on exploit the lived experience of consumers and their families;
6. legitimacy: conformity to social preferences concerning all of the above; and
7. equity: fairness in the distribution of care and its effects on health.

Under this multi-dimensional view of quality, health care professionals and service providers are obliged to take into account patient preferences as well as social preferences in assessing and assuring quality. Where these preferences disagree, establishing quality care depends on reconciling them. Practically, quality mental health care means that:

- people who need mental health care should get highly personalised and well-integrated services, regardless of where they live or capacity to pay;
- the process of providing care respects people's innate dignity; and that
- the aim of care is help people flourish.

People in need should receive definitive care without delay, designed not only to relieve symptoms but to deliver to a more complete state of mental health and well-being. The 'complete state' model captures both the medical and psychosocial complexity of people and the broader social context faced by consumers and carers, including the social determinants listed earlier (social connectedness etc).

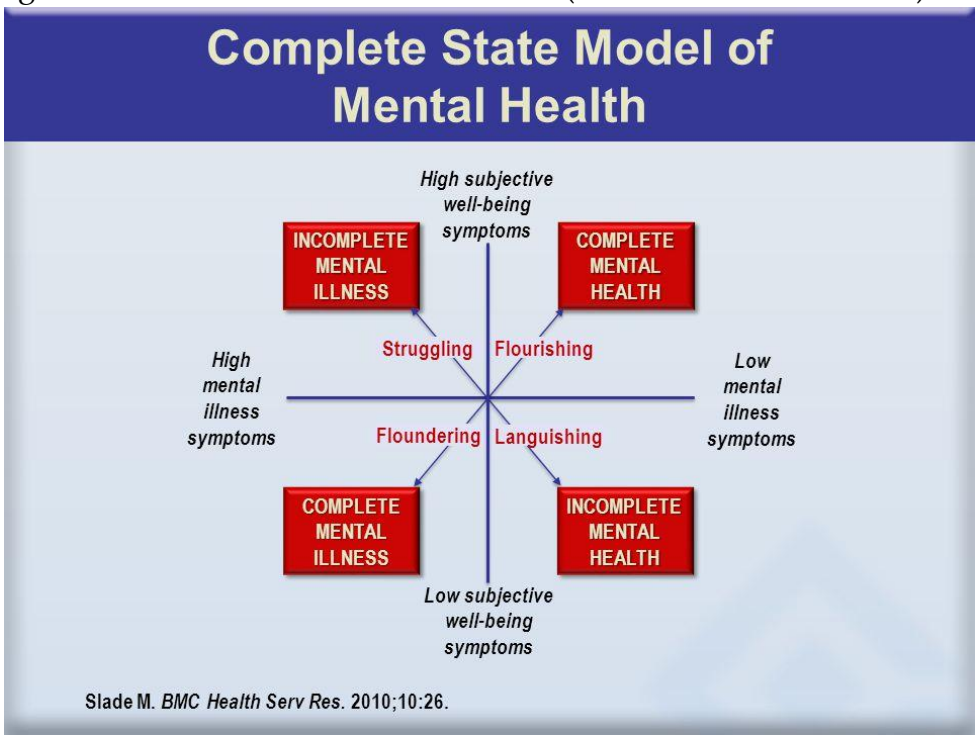

Figure 2

Later this paper discusses Australia's inability to develop meaningful accountability for mental health. There must be transparent and agreed metrics for the benefits to be gained from investment and that agreement includes policy makers, providers and consumers and carers. These metrics must be mapped into the Complete State, reflecting issues beyond traditional health administrative data sets.

The data which serves this purpose must be parsimonious, and collected and distributed in a time frame that's meaningful for providers, people and their families.

2. Personalised Care

> Positive consumer outcomes are the first priority in mental health policy and service delivery.
> *National Mental Health Policy 1992*
>
> There will also need to be consideration of funding models and how these can be adapted to promote more flexible and person-centred responses.
> *4th National Mental Health Plan*

Putting consumers at the centre of mental health care has been ubiquitous rhetoric across multiple state and federal plans and policies. It is time to consider what this really means.

Effective mental health care means that things need to work for individual people. If they don't, they don't work. Aiming for some population average is not an appropriate goal. Nor is it tenable for mental health services to continue to use opaque processes to determine who gets care, how long they wait, how much they pay and who misses out. All the power in our 'system' rests with funders and providers who decide when the door to care opens and shuts. The bar for entry has inexorably risen to unreasonable and unsafe levels. Consumer views about about the extent to which their mental health needs were understood and metaffects their quality of life[21].

Building on the existing top down commitment to universality, the system must be centred on the person and his or her family where they live. The informal elements (e.g. family support, out of pocket costs and social infrastructure) of the system of care must be recognised and valued.

Our interpretation of personalised care is derived particularly from our experience working with young people, where a highly personalised approach enhances stepped-care models by incorporating clinical staging and a person's current and multidimensional needs.

It explicitly aims to prevent progression to more complex and severe forms of illness, aligned to contemporary models of the patterns of emergence of psychopathology[22].

This model of personalised care is not simply an initial assessment and then allocation of service based on type and intensity of symptoms. In addition, it includes real-time clinical decision making based on continuous feedback on the effectiveness of interventions, or intensity of service, provided. Hence, it also includes measurement-based care.

Real-time tracking of actions by consumers is the preferred method to track progress against self-determined goals and enable routine outcome monitoring. This kind of real time feedback is now common across the human services and other sectors (see Figure 3).

Smartphones can link with powerful technology to track and monitor geographic, personal and social information, sensor data can be used individually or triangulated to track user activities and wellbeing.

This highly personalised and measurement-based model of care, linked to relevant service structures, has the potential to better match treatment type and intensity (defined by cost, time and risk). The clear goals are to prevent illness progression and promote recovery.

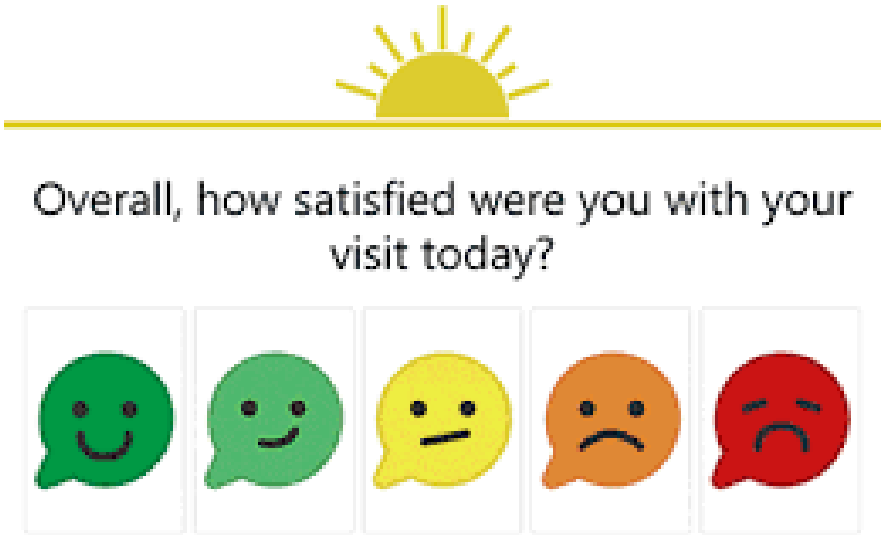

Figure 3

Personalised care like this, assembles individual components of care up to the right level of response to meet a person's mental health needs. People monitor and report their progress. This monitoring is the responsibility of the person, not the service provider. Both can get feedback on progress. The trajectory of individual journeys can be mapped and tracked. Changes are made along the way to optimise opportunities for recovery.

This is far from the current application of the concept of equity, where everyone is entitled to same care, or the same poor care. It also questions the reflex to just add more services to Medicare, as recently proposed by a psychologist-led review[23]. Personalised care would address this 'endless therapy' which leaves patients (and providers) stuck relationships which may even elicit harm rather than therapy[24].

3. Staging of Care

Reform to mental health in Australia should build on the principle of clinical staging. Existing approaches to stepped care leave more gaps than steps, a deficiency pointed out by the Productivity Commission[25]. Clinical staging is a refinement to traditional diagnostic practice which allows health professionals to provide earlier, more personalised and responsive care for consumers who present with mild, sub-threshold or full-threshold severe disorders[26].

We must identify and build a set of agreed or preferred steps or stages, to meet the needs of individuals across the whole clinical and psychosocial service spectrum, from early intervention to acute care.

This is detailed, evidence-informed planning. This work should include consideration of the role of GPs in providing referrals and evaluation of progress of mental health care, particularly within designated early intervention or continuing care services (e.g. *headspace*) that already provides those relevant medical, nursing or other equivalent services internally.

Accompanying this more intelligent staging of care must be steps to identify and respond to those people particularly at risk. This is a normal part of the way health and community services respond in areas other than mental health. People with cardiac or diabetes risk, or children in at risk families, are identified and steps taken to mitigate these risks. Modelling can help here too, identifying areas within regions more likely to need targeted assistance. No such processes exist in mental health, leaving Accident and Emergency Departments the front door, the only door often, to complex care.

The Commonwealth could assist here by supporting mental health training positions (medical and allied health) specifically and preferentially to community-based early intervention and multidisciplinary teams, working in ambulatory care settings matched to local and community needs. This training should stimulate diversity in the workforce.

As stated earlier, a critical element currently missing in Australia's response to mental illness is the adoption of active monitoring, to ensure we move to real-time 'measurement-based' care. Not only are the steps largely missing in stepped care, but so is the capacity to work out what step a person should be on and when they need to shift. We must focus timely attention on those who do not recover or deteriorate in care. Proper staging of organised mental health care depends on intelligence gathering, to ascertain regularly how a person is feeling, gauge their overall trajectory and re-orient care accordingly. This monitoring is not occurring now. The system is operating blind.

4. Digital Solutions

The World Economic Forum has highlighted the capacity for health information technologies to transform health care[27]. This has been reinforced by our recent COVID-19 experience, which saw the swift adoption of new telehealth services, including in mental health. Australia has led the world in development of these technologies in mental health, but this has occurred organically rather than as part of any system or plan. As a result, there are hundreds of different e-mental health applications and dozens of platforms. There are important issues to address, like privacy, trust and clinical governance and quality assurance[28].

The lack of specificity about how e-mental health services fit with face to face care raises issues for some health professionals, who continue to assert that large, non-specific benefits of treatment are dependent on empathic personal interactions - the therapeutic relationship[29]. While digital solutions may not suit everyone, there is now considerable evidence suggesting that the therapeutic relationship is maintained when comparing face-to-face with digitally enhanced treatments, such as immediate online assessment and dashboard of results[30 31 32].

No national workforce strategy, not even one that builds desirable new peer workforces, is likely to be able to meet demand for care[33]. Australia must now capitalise on its leadership in the development of e-mental health technologies by properly incorporating these services are part of the mental health service landscape. This means helping consumers and their families find the care they need on purpose, rather than by accident. This means enabling people to monitor and report on their progress and for this information to influence the shape of the care they receive.

5. Regional leadership with National Support

The key to effecting real change is not in the articulation of goals or tasks. It is in the doing. Regional decision-makers need to not only know what to do, but how to make real change occur. Regional skills and challenges vary.

But there is a need for new national expertise in implementation science as it pertains to mental health, setting out appropriate theories of change and supporting local leaders. This is not about mental health. It is about helping leaders do better.

Australian mental health plans have failed here, particularly at the national level, failing to properly support the implementation of change while reflecting and responding to local context. This kind of top-down, centralised, bureaucratic approach to planning is a relic of the 20th century.

A new and better approach to mental health planning must consider where people live, involve them meaningfully, be based on need in relation to the complete state concept and be modelled before implementation.

In relation to modelling, new skills and techniques are now available which permit greater levels of testing and insight[34 35]. These must become an everyday aspect of the way Australia plans to respond to mental illness and promote mental health. One part of this would include the mapping of service availability (what is already there) at a regional level. We need to know what is available and then address service and equity gaps, aiming to fairly improve access to and choice of mental health care across the nation.

In relation to governance, Australia now emphasises regional mental health leadership and planning, but this is proving difficult. Relationships between federally funded primary care planners and state funded regional planners are mixed at best, often distant. Fragmented funding means these parties do not recognise they have common clients. Despite the hopes of the 5th National Mental Health Plan, too often there is little real incentive for joined up planning across agencies, geographic boundaries or conflicting priorities. There are precious few examples of effective regional planning, or joint undertakings around issues such as avoiding unnecessary hospitalisation.

Also, local planners need the right skills and tools to undertake the holistic planning necessary to understand and respond to community mental health in the broad sense described here. How can we ensure local people can identify an appropriate theory of change and have the skills and resources to execute and monitor reforms as they evolve? And increasingly, there is awareness that effective regional mental health planning must engage not only health service providers but others, from other sectors, like housing, employment, education and beyond. This holistic planning is very rare.

These issues require considerable attention if the goal of regional leadership in mental health policy and planning is to be realised but key steps would include:

a) Detailed, open-source mapping and modelling of the full scope of mental health service availability and needs (i.e. beyond health services to include suicidality, housing, employment, education and other related social services). We need to know what is already available and needed at a regional (PHN-based) level. We need to be able to model, test and anticipate changes to make our mental health planning reflect changing economic and demographic circumstances. This information can help us identify and address service gaps to improve equitable access. There is confusion locally about which model or planning approach to use and the capacities necessary to sustain this effort.

b) The development of rural and population-specific models of mental health care that reflect demographic and geographic realities of inequitable access and foster local leadership in planning and delivery.

c) A nationally consistent suite of decision-support tools, about services, resources and finances to enable regional decision-making. This means moving beyond reliance on evidence-based medicine and randomised controlled trial approaches decision-making, to a more realistic, practical and timely response[36].

d) Promotion of models of complex assessment, multidisciplinary support, and consultation-liaison with mental health specialists in primary care settings (i.e. actively engages doctors, nurses, allied health professionals, peer support workers, psychiatrists, clinical psychologists, mental health nurses and others). This is key to managing complexity in community primary care.

e) Promotion of models of funding that foster organisational collaboration and multidisciplinary care, including funds pooling across multiple sources. One important concept here, already supported by the Commonwealth Government, could be the health care home[37]. These 'homes' could operate as either physical or digital entities. Evidence of their impact in chronic care is positive internationally[38]. Based on shared values and principles, a mental health care home could bring together groups of people with similar needs or in a defined catchment, pooling funds and services to create more efficient and effective care.

f) Building on the COVID-19 experience, regional models should include the private sector as well as public and NGO capacity. Mental health needs to bring together resources from across sectors in planning and service delivery. A more holistic approach to capitalising on existing mental health resources needs to address insurance-related impediments to cooperation and joint activity.

g) New capacity for regional benchmarking, so as to fairly compare performance, impel systemic quality improvement and reduce unwarranted variations in care. It should be noted that some regions may benefit from comparison with similar places in other countries, rather than locally (e.g. the Kimberley).

The achievement of these tasks is national infrastructure development, creating the frameworks of resources and capacities needed to enable regional leadership to flourish.

Effective regional governance will facilitate better accountability. Merely setting targets and reporting throughput is not enough. The Mental Health Principal Committee (MHPC) and its Mental Health Information Strategy Sub Committee (MHISSC) have been responsible for this kind of reporting for nearly 30 years. It has left us outcome blind, arguing about what qualifies as an admission, a seclusion event or a bed.

> A truth so incomplete it's worse than a lie.
> *Laurie Penny*

We need a new way of identifying and collecting the regional outcomes that permit useful benchmarking and inform the community about progress towards greater Mental Wealth.

6. Continuing to Build the Evidence about What Works

Inherent in the reforms suggested here is an honest appraisal of what we know works in mental health and what is desirable care. We know in Australia that there are some services which work well and help people recover from mental illness. These services are not usually supported to be implemented to adequate scale but should be.

However, there are also some services we know are undesirable and should cease. Services like this have created a situation in which some consumers and carers now associate mental health care with harm rather the therapy. Mental health services should be a desirable place to work, a place where people have an opportunity to learn, grow and see the positive impact they can have on the lives of others.

Finally, we must frankly recognise that much of what is done in the name of mental health care has a very limited evidence base – we just don't know if it is worthwhile or not. Funding for mental health is too scarce to waste on care of uncertain value.

Investment in evaluation and research is necessary to drive continued refinement of our 'armamentarium' – those techniques, services, equipment and medicines which are available and known to deliver the mental health care people need. These tools must include elements from all sectors, reflecting quality care across the social determinants of mental health.

One approach to building evidence is to establish a centralised, independent data repository or national observatory to propel a new focus on accountability and Mental Wealth. Existing data sets managed and reported by the Australian Institute of Health and Welfare or the Productivity Commission are not fit for purpose, focusing on health markers with restricted access and governance reflecting bureaucratic rather than community priorities.

This new observatory should offer an open-source, centralised and aggregated approach to the collection, analysis, interpretation, distribution and application of Mental Wealth data, necessary to inform local or regional decision-making, across sectors (health, including primary health care, private, NGOs etc, justice and law enforcement, community services, welfare) and domains (service activity, service quality, cost, outcomes, consumer and support person experiences, employment data, suicide data, disability payments, incarceration, child protection). An observatory could bring this information together to inform and drive quality improvement and accountability at the local and national level. There are already examples of this kind of observatory performing these functions elsewhere in the world, for example:

- The European Observatory on Health Systems and Policies
- The National Institute of Mental Health (USA)
- NHS in Scotland- Information Service Division

An Australian version of this kind of observatory or platform should link closely with existing related agencies (like the AIHW), provide open source access and utilise the latest in health information technologies for real time dashboard type presentation, as recently experienced during COVID-19[39].

Conclusion

COVID-19 has changed Australia's economic and social situation demanding a new level of responsiveness in our mental health services. It has already forced a rethink on homelessness. People long left on the streets were suddenly accommodated in hotels, a change permitting them to link to other services designed to improve the quality of their lives. This change is a template for how we can reengineer mental health more broadly.

Even when desired changes are carefully articulated, they can be elusive. A recent report from the WA Auditor General found not only a failure to make progress on published mental health reform goals, but that progress had been reversed[40]. For example, WA proposed rebalancing funding so that hospital spending declined from 42% in 2015 to 29% of total mental health spending by 2025. Unfortunately, the Auditor General reported that it rose to 47% by 2017-18. Community mental health support was supposed to rise from 8% to 22% but instead fell to 5% by 2017-18.

Mental health reform became a national priority in 1992, yet the prospect of substantive change now seems more remote not less. This paper reflects the views of people in the sector wrestling with how to provoke positive reform. Good mental health care is possible but our vision of it has been obscured by ineffective standards and accountability, poor service, and outdated approaches to planning.

Coordinated action against the key domains identified here seeks to end Australia's piecemeal approach to planning, policy, and incremental, opportunistic and small increases in real-terms funding which have characterised national and state-based mental health initiatives over past decades.

We need a new practical compact with consumers and their families, setting out the reasonable quality and service standards they should expect from their mental health services and who to call if they fall short. Consumer feedback should drive service improvement, as it does in so many other service areas. Clarifying these expectations and processes would help demystify mental health care.

This paper has attempted to outline some key principles and domains which should govern the next decade of mental health reform in Australia. These reforms would clearly contribute to the nation's Mental Wealth, meaning improved cognitive and emotional health in the community. This is vital if we are to not only address extant gaps in mental health care but turn reform into enduring productivity gains.

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