

# Beware of mental health commissions bearing gifts to primary care

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The National Mental Health Commission's (the Commission's) review of mental health services in early 2015 described them as fragmented and questioned the effectiveness of government spending in the area.<sup>1</sup> The review recommended changes that will have major implications for primary care.

One recommendation was the redirection of \$1 billion from hospitals to non-governmental providers of primary and community-based mental healthcare. Contracts would be administered by Primary Health Networks (PHNs). Another was the expansion of psychotherapy under the Medicare Benefits Schedule (MBS).

Although it is unclear how many of these recommendations will be implemented following a further governmental review, they potentially herald major changes for patients, general practitioners (GPs) and mental health services. This paper examines the methods that underpinned these recommendations.

The Commission's conclusions on existing mental health-related activity were largely based on a survey of 300 Commonwealth-funded, non-government organisations (NGOs), supplemented by secondary data from the Australian Institute of Health and Welfare (AIHW). However, of these, only 65 NGOs (21.7%) responded. Importantly, the Commission could not obtain timely information directly from the states and territories about what they funded and delivered. As a result, the

information available to the Commission was very limited:<sup>1</sup>

*This gap in evidence meant we largely were unable to gauge levels of unmet need or to compare service access and provision across regions. We do not know whether an apparent gap in Commonwealth programmes is in fact met elsewhere by state or territory-funded programmes.*

*The lack of a consistent national outcomes data collection framework made it difficult for us to assess the efficacy and cost-effectiveness of services and programmes. – Volume 2, page 34, paragraphs 1 and 2.*

Consequently, the Commission added the following caveat in the introduction to Volume 2:<sup>1</sup>

*This programme analysis in Volume 2 is not intended to be comprehensive or forensic—there was [sic] not adequate data made available to the Commission to undertake that level of work and the duration of the Review was limited.*

– Page 6, paragraph 1.

None of these issues is mentioned in the report summary, which will be the most widely read part. And, despite the lack of relevant data, the Commission still concluded that care was fragmented and required drastic change.

A further source of information was a three-week online survey of three groups:

- healthcare workers
- people with mental illness, their families, carers or the general public
- organisations.

In all three categories, findings were limited by response and selection bias. For example, only 861 healthcare professionals responded, of whom 63.5% were psychologists. The Commission received only 15 responses from doctors (1.8%) and 31 (3.6%) from nurses.

Only 621 people in the second group responded, a tiny minority of people with mental illness, their families or carers. In terms of organisations that responded, 68% of the care providers (n = 138) were not-for-profit or private, 21% were Medicare Locals and 11% were in the public sector. Of professional peak bodies, those representing psychologists made up 43% of submissions.

The submissions were thus largely from the non-governmental sector and/or one professional discipline. Furthermore, views of individuals were given equal prominence to those of large professional organisations.

Finally, the Commission engaged consultancies or appointed experts on areas including workforce, e-mental health and health service modelling. Some of these reports were informed by economic modelling or 'rapid' literature reviews of varying rigour, but others were based largely on opinions. One mentioned a confidential systematic review but gave no further details of either the paper or how the information was used. This is an important omission because rigorous systematic reviews may reach very different conclusions from other less robust methods.

As an example, government-commissioned reports on community treatment orders invariably find they are effective, whereas systematic reviews do not.<sup>2,3</sup>

In addition, issues identified in the expert reviews were selectively highlighted in the main report, while others were sidelined. For instance, the report stressed suicide prevention while ignoring the major killers of heart disease and cancer that cause 85% of the excess mortality in people with mental illness.<sup>4</sup>

Importantly for primary care, the Commission gave no consideration of the capacity and/or willingness of PHNs to undertake these greatly enhanced roles in mental health. There was also no mention of the possibility that

their recommendations could lead to a casualised, demoralised workforce dependent on the renewal of short-term contestable contracts for service provision. This is hardly good for continuity of care.

In conclusion, the Commission's recommendations for large-scale and potentially disruptive changes to psychiatric care are based on insufficient data that are subject to response, selection and reporting bias. People with mental illness deserve better than this.

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