Reviewer’s report

Title: An analysis of policy levers used to implement mental health reform in Australia 1992-2012

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Reviewer: Stephen Duckett

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Major essential revisions
There are three main weaknesses of this paper:
1. Failure to describe and properly take into account the nature of the Australian health care system;
2. Failure to describe adequately the policy process; and
3. Failure to distinguish word and deed.

These failures are related. The authors have the expertise to address them.

The Australian health care system is described very briefly in lines 46-49. Australia’s federal financial relations are described in lines 49-54. The health care system description is woefully inadequate.

There may be disagreement about who is responsible for what but my take is that in terms of mental health arrangements over the period covered by this paper:

• States (and territories) were responsible for public hospital inpatient mental health service delivery and associated public community mental health services. The Commonwealth financial support was variable but by and large the States were fully responsible for funding any on-going increase in these services
• Responsibility for community-based accommodation (and support) services for people with mental illness is shared, although states may be seen to have principal responsibility
• No government accepted responsibility for adequacy of private general practice, specialist psychiatry or allied health (e.g. psychologist) services
• The Commonwealth subsidised private medical services through Medicare
• The Commonwealth provided extensive subsidies for psychotropic drugs prescribed by private medical practitioners (or, more accurately, medical practitioners acting in a private capacity)
• The Commonwealth had responsibility for income support for people with mental illness.

The split (and no) responsibility for funding and service delivery has significant implications for policy development.

The paper reads as if all the mental health plans are Commonwealth government
plans. Although they were published by the Commonwealth government, it is more accurate to describe at least some of the plans as national. This is particularly important because it connotes that those plans represent the outcome of a negotiation between states and the Commonwealth about what is going to be published as the plan. The negotiation process involves two levels: the ‘mental health people’ in bureaucracies negotiating with their counterparts in other jurisdictions and the ‘mental health people’ negotiating with their colleagues in their own jurisdictions. To some extent the mental health plans are designed to change the balance of power (and resource allocation) within jurisdictions.

The negotiation process issue raises the question of what these documents are: to what extent are they lowest common denominator (what can we get all states to agree to do with their health system, or more accurately, say they are going to do with their health system), to what extent are they statements of where policy is already at, and to what extent are they articulations of what the Commonwealth will do and pay for (or some combination of all of the above). Mintzberg’s Strategy safari is a good resource for thinking through the different meanings of strategy and the same thinking can also be applied to policy.

The paper needs to be strengthened to take account of the quite different responsibilities for different aspects of mental health care and the different types of policy which is reflected in these documents.

The final major weakness is that there is no real evaluation of whether these policy documents had any impact on anything. Absent the documents, would (state) mental health reform muddled on in the same way, possible a bit slower, possible with some states lagging further? I’m not suggesting doubling the length of the paper to evaluate all aspects of the plans but some recognition that plans are just paper and what was attempted was a change in services (and whether that worked) is surely necessary. Perhaps the recently released National Mental Health Commission report could be drawn on to address this.

Discretionary revisions

In my conceptualisation of policy levers I use ‘hortatory policy’ or rhetoric as an additional lever. The mental health plans were strong on that and one of their uses was as crutches to support local activists in trying to achieve local (and jurisdictional) change. As a downside they also created a ‘cargo cult’ mentality that local or jurisdictional change was best facilitated by getting support from wise people in Canberra or in a national document.

Minor comments:

• A table with the plans as rows and the levers as columns (or vice versa) with the cells as policy initiatives (with or without a small indicator e.g. capital letter for priority area) may be a better presentation than the existing table 2. It would make it easier to look at changing emphasis over time. This would help to show whether there is a link between focus of a plan and levers used. Some thought might also be given to a table summarising the changed patterns in ‘priority areas’.

• The priority area of ‘community need’ might be better labelled as ‘responding to community need’
• In my presentation of levers I distinguish between providing additional services and the other levers. In the categorisation used in this paper additional services are embedded in the organisation lever (e.g. increased treatment rates) and in finance. The organisation lever is quite heterogeneous.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests