

Submission from the Public Health Association of Australia to the Senate Mental Health Inquiry

The following submission from the Public Health Association of Australia (PHAA) addresses particular Terms of Reference of the Senate Mental Health Inquiry (see bolded TOR):

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress

The PHAA contends that the National Mental Health Strategy set commendable new directions for mental health care in Australia. The Strategy endorsed the move to a modern, community-oriented system of care, with treatment to be provided in the community in the first instance, and hospital admission to act as a backup rather than a first option. Further, where possible, inpatient care should be provided through the general health system, with psychiatric inpatient units co-located with general hospitals rather than in separate psychiatric institutions. Importantly, over the life of the NMH Strategy, national directions have also been articulated for illness prevention and mental health promotion.

Under the First National Mental Health Plan, the provision of transition funding through NMH Reform and Incentive Grants enabled States such as Victoria to accelerate closing its psychiatric institutions and reinvest the savings in replacement services (Meadows & Singh 2003: 63 & 65). The institutions were replaced with comprehensive area-based mental health services encompassing both community-based and inpatient care, and managed by the general health system (Meadows & Singh 2003:65). However, successive National Mental Health Reports have shown that States and Territories have varied in the extent to which they have met the objectives of the NMH Strategy in achieving a more community-oriented system of mental health care.

Importantly, per capita expenditure by States and Territories on public mental health services continues to vary considerably. Inevitably this has an impact on what services are available and their accessibility, and the extent to which national objectives can be met. The latest NMH Report (Department of Health and Ageing 2003:3) notes that 'the gap between the highest spending jurisdiction and the lowest spending jurisdiction has decreased only marginally over the 1993-2002 period.' For instance, three jurisdictions, namely Queensland (\$84.83), the ACT (\$84.86) and NSW (\$85.13), continue to spend well below the national average expenditure of \$92.03 per capita (Department of Health and Ageing 2003:3). Furthermore, whilst particular jurisdictions may have higher levels of per capita expenditure, how this funding is spent may not match the objectives of the NMH strategy. To illustrate, whilst South Australia may have the third highest per capita expenditure, it spends the lowest proportion (1.9%) of mental health program funds on non government community support services (Department of Health and Ageing 2003:3 & 5). In addition, whilst Commonwealth expenditure on mental health care has risen, this mirrors the overall growth in health spending, so does not represent a significant increase in the proportion of Commonwealth expenditure on mental health (Department of Health and Ageing 2003:2).

A significant barrier to progress in meeting the national objectives is the capacity and readiness of State and Territory governments to resource and implement the needed changes. Clearly, given the size of the reform agenda, the implementation timeframe was too short for ensuring systemic change in all jurisdictions across Australia (Whiteford & Buckingham 2005:399). For instance, Whiteford and Buckingham (2005:399) note that: 'Consumers, carers and advocates point to persisting problems with access to acute care, continuity of care and the availability of rehabilitation services'. There is an urgent need to revitalise the NMH strategy, with the Commonwealth government providing national leadership, identifying specific targets to be met over a realistic timeframe, and providing extra funding to facilitate meeting those targets (Hickie et al. 2005:403).

b. the adequacy of various modes of care for people with a mental illness; in particular prevention, early intervention, acute care, community care, after hours crisis services and respite care

Australia has been in forefront of developing innovative models of care, including intensive home treatment of people with acute psychiatric conditions (Hoult 1986), early intervention for young people with psychosis (McGorry et al. 2002), and 24 hour residential community-based care (Whiteford & Buckingham 2005:397). However, what is lacking is sufficient resourcing and political will to ensure equitable access across Australia to the range of treatment and support known to be effective. As Hickie et al. (2005:403) note, access to the full spectrum of care is still required, in particular continuing care and rehabilitation and recovery programs for those with ongoing illness, which often receives less attention and resourcing than inpatient treatment for those with acute conditions. The range of treatments also needs to include psychosocial interventions whose efficacy is now well-established (for example, see Tarrier et al. 1998 & Pitschel-Walz et al.2001). The PHAA considers that through a renewed NMH strategy, the Commonwealth could set benchmarks for an adequate spectrum of care, taking account of the particular service needs of age groups across the lifespan.

c. opportunities for improving co-ordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care

As well as high quality clinical care, the recovery and wellbeing of people with a mental illness relies on ready access to a range of non-clinical services and resources, such as community support services funded by HACC and the Commonwealth/State Disability Agreement, and social housing funded through the Commonwealth/State Housing Agreement. It should be mandatory that these programs respond to the service needs of people with psychiatric disability, rather than seeing these as the responsibility of the mental health sector. Further, services funded by these programs should be distributed geographically to enhance consumer access. At the level of the individual consumer, ensuring access to the right range of services requires skilled and resourceful case managers with manageable caseloads so that consumers can be assured of individualised attention to their service needs.

d. the appropriate role of the private and non-government sectors

Both sectors have a major role to play which is currently underdeveloped. In regard to

the private sector, it has been noted in the latest NMH Report (Department of Health and Ageing 2003:36-37) that private psychiatrists are largely congregated in three capital cities, namely Melbourne, Adelaide and Sydney, and that there has been little change in this distribution since the NMH Strategy began. Access to private psychiatrists is thus limited or non-existent for those living in rural and remote parts of Australia and outer metropolitan areas. Services provided by private psychiatrists are heavily subsidised by taxpayers through the Medical Benefits Scheme. The Commonwealth could act to improve access, for instance, by increasing rebates for sessions delivered by private psychiatrists in under-serviced areas, particularly outer metropolitan suburbs and rural and remote regions, and/or by making provision of Medicare provider numbers conditional on private psychiatrists delivering a certain proportion of sessions to those areas.

Clinical psychologists in private practice are another key group of mental health professionals in the private sector. The Commonwealth's Better Outcomes initiative has improved access to clinical psychologists for some, as this program enables a GP to 'prescribe' up to six sessions with a clinical psychologist. However, for most people with mental disorders, clinical psychologists in private practice are only accessible to those with the ability to pay. This is therefore a greatly under-utilised resource, particularly as many of the newer psychological treatments are provided by this group of mental health professionals. The Commonwealth could increase access and improve service cover in under-resourced areas by allowing a number of appropriately qualified and experienced clinical psychologists to be accredited for Medicare rebates, with additional incentives for services delivered in rural and remote areas, and outer metropolitan areas.

General practitioners play a critical front-line role in mental health care. Most people seeking help for a mental health problem turn first to their GP, and it is general practitioners who provide the bulk of mental health care in Australia (Hickie et al. 2005: 401). Their contribution to mental health care could be supported further, for instance, by the Commonwealth under-writing the cost of courses run by universities and bodies such as the NSW Institute for Psychiatry which provide training GPs in primary care psychiatry. When these remain fee-paying courses, GPs are not encouraged to further their expertise in this area of practice.

Development of the non-government sector has been very uneven across the different States and Territories as shown in the latest NMH Report (Department of Health and Ageing 2003:5). For instance, the proportion of a State or Territory's mental health budget spent on the non-government sector varied from only 1.9% in SA and 2.4% in NSW, to 7% in Queensland and 9.3% in Victoria (Department of Health and Ageing 2003:5). The difference in funding has a major impact on the level and type of services provided. In jurisdictions with higher proportions of funding, the non government sector has become a key provider of community support services, which complement clinical treatment services. The range of services encompasses residential and non-residential rehabilitation, including vocational and pre-vocational programs; supported housing; consumer advocacy and support; respite care; and carer education and support. Again, the Commonwealth could provide leadership by increasing funding through the CSDA which was specifically targeted at services for people with psychiatry disability.

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes

The Mental Health Council of Australia Report called 'Out of Sight, Out of Mind' (Groom et al.2003:20) identifies the lack of stable and appropriate housing as a particular problem for consumers. The importance of vocational rehabilitation and access to paid work are also identified as key to achieving and maintaining mental health and wellbeing (Groom et al. 2003:21). Families and other primary carers reported insufficient support for the increasingly active role they are being expected to undertake in looking after relatives and friends with ongoing illness and disability (Groom et al. 2003:17). Clearly unmet need has a significant effect on mental health outcomes. Solutions involve different levels of government and also different departments across the same jurisdiction. A 'whole-of-government' approach is therefore required by both the Commonwealth in conjunction with States and Territories, and also State and Territory governments themselves.

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence

A major step forward has been the recognition that these groups do have particular needs that have been inadequately met in the past. Others making submissions to the Senate Inquiry will be better placed to identify the key issues for each of these groups. From a public health perspective, what is critical is that illness prevention and mental health promotion programs are included as fundamental components of the spectrum of interventions as well as clinical care.

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness

The 'Out of Sight, Out of Mind' Report (2003:17-18) records that primary carers reported a lack of recognition and support received from service providers. It was clear that service providers have been inadequately prepared for this change in the pattern of care. However, there is now abundant evidence of the key contribution made by families and other carers to the support and recovery of people with mental health problems, including those with major mental disorders (Pitschel-Walz et al. 2001).

h. the role of primary health care in promotion, prevention, early detection and chronic care management

General practitioners are a core component of the mental health care system, with 75% of mental health care being provided in the primary care sector (Hickie et al. 2005: 401). However, according to Hickie et al. (2005:401), 'almost 50% of people with mental disorders are not recognised by their general practitioner as having a psychological problem'. This highlights the importance of providing adequate pre-service and in-service training for general practitioners on the recognition and treatment of mental health problems, as well as ready access to specialist mental health professionals for consultation and referral as needed. Examples of programs which warrant expansion in this regard are primary mental health initiatives linking GPs to mental health services and the Commonwealth's Better Outcomes program which

enables participating GPs to refer patients to mental health professionals for specialist albeit time-limited treatment.

i. opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated

Consumers can and should play a core role in monitoring service quality and ensuring that services are responsive to consumer needs. This includes employing consumers as consultants within services as well as ensuring they contribute to pre-service and in-service training for mental health professionals. Statewide consumer advocacy organisations are another important component as they can identify and seek redress for systemic problems as well as resourcing and supporting consumers taking on consultancy roles in services.

j. the overrepresentation of people with a mental illness in the criminal justice system and in detention, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

k. the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimizing treatment refusal and coercion.

The use of detention and the involuntary treatment of people with mental disorder has long been the subject of concern by the legal profession and human rights practitioners. The NMH Strategy sought to introduce model mental health legislation so that comparable standards regarding these practices could be put in place across Australia. Importantly, critical scrutiny of the practice of seclusion has also begun to emerge in the professional literature (Morrall & Muir-Cochrane 2002). Seclusion and comparable practices which severely curtail the human rights of consumers should be made subject to the same evidential requirements of other mental health interventions. In particular, research is needed which identifies alternative non-coercive practices, and the training and other resources for their adoption.

l. the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers.

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness

Ongoing in-service training about the nature of mental illness, and appropriate ways of responding to people with a mental illness is clearly needed for staff of all human service agencies, including emergency services such as the police and ambulance officers.

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated.

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards

There is some duplication regarding data within national minimum datasets, which requires rationalisation. Outcome measurement was implemented in public mental health services from mid 2002, and it is still early days regarding the usefulness and appropriate interpretation of this information. Compliance with national standards for mental health is monitored through the annual National Survey of Mental Health services. Within the Information Development Plan funding of 2001/02, specific monies were provided to assist services in working towards meeting the national standards. Evaluation should be included within mental health core business activities, and appropriately resourced. Service funding options should be linked to the provision and quality of service information and data, including operational information on state-funded mental health services and through methods such as national surveys.

p. the potential for new modes of delivery of mental health care, including e-technology

Mental health services already make extensive use of video-conferencing and teleconferencing, which have particular value for rural and remote communities with limited access to mental health professionals. The use of email and other internet-based resources is important but is affected by the continuing uneven access to internet services across Australia, especially in rural and remote areas. Whilst it is essential that all have access to the facilities, equipment and training needed, e-technology should be used to complement not replace face-to-face clinical interventions.

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