MAXIMISING ACCESS

to Mental Health Services
LOOKING BEYOND HOSPITAL BEDS FOR MORE FLEXIBLE INTERVENTIONS

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At the beginning of 2013 – and not for the first time – there were very public debates expressing dismay about the growing use of practices which have mental health consumers in emergency departments restrained by handcuffing and other means, and isolating them in locked rooms through what is known as seclusion and restraint. South Australia (SA)’s Chief Psychiatrist Peter Tyliss acknowledged what appears to be an ‘upward trend’, suggesting this is in part due to SA now being one of only three states to collect data (ABC Radio: 2013).

In this same interview the South Australian Health Minister Jack Snelling suggests that demand for seclusion and restraint is a contributing factor to the current situation. The National Mental Health Commission calls for all jurisdictions to collect data on its use (NHMC: 2012).

The reality for many consumers (and their carers) of mental health services is that emergency departments continue to be the main source – and first point – of access to mental health services. This is coupled with police and emergency services also fulfilling a frontline and first responder role for mental health consumers. As a result, few alternative support or intervention options are available to them other than to take consumers to the Emergency Department.

After over two decades of reform, and after substantial federal and state government investments and initiatives, we continue to fail our community by not providing clear pathways, timely intervention, access to flexible and responsive acute care and recovery services to people confronted with mental health issues.

Stigma and mental health literacy, our personal understanding of mental illness, its signs and its impact, contribute to patterns of help-seeking (Smith and Shochet: 2011, 37-41). Many people are reluctant to seek assistance. Often, confronted by symptoms, spiralling distress and uncertainty about care responses, a consumer might delay or postpone seeking help. Many will first rely on family and informal supports, delaying help-seeking until circumstances result in the need for urgent intervention.

This delay is not about system navigation. Rather, it is about the dominance of service models. It is not sufficient to understand access merely as a stigma and literacy issue. To do so is to place the responsibility back on the consumer.

Stepped models of care include crisis respite services instead of emergency departments, recovery centres following acute admissions rather than extended hospitalisation before discharge, intensive home-based support rather than hospitalisation and recovery-orientated community support services. The dominant service, mind you, remains a hospital based in-patient model. Access to flexible acute care interventions remains an elusive alternative for consumers.

When most people think mental health and mental health services they think of hospital-based services and the stigma and uncertainty that go with it (CMHA: 2012).

Even if these barriers were resolved, consumers would still be confronted by the limited options for seeking assistance such as:

- Limited opportunities for consumers to access high quality, responsive, relevant community-setting acute care and recovery supports.
- Local services focused on recovery and stepped to meet the varying states of a consumer’s wellbeing.

The presence and availability of services need to be built up. While there is evidence that after decades of reform there is a shift in resources from standalone psychiatric resources and acute psychiatric beds to community-based services (Whiteford: 2002, 210–215), there remains a substantial belief in the delivery of services from an acute hospital-based perspective (Saraceno: 2007). This hegemony, or dominant narrative, is reflected in the ongoing public debate for an increase in funding for more acute beds.

Contra to this, there is ample practice and research evidence to support the position that mental health services are optimally delivered in community settings and in an integrated way (Saraceno: 2007). This goes beyond the concept of a step up and step down continuum of care, but embraces a model of care that seeks to deliver person-centred services concerned not only with a person’s psychological needs but with their social and physical wellbeing as well (COAG: 2012). This would be service that practices collaborative care.

A number of services’ models have been developed, funded and delivered by community and not-for-profit organisations such as the PARC (Prevention and Recovery Care) model to support short–term early intervention, Intensive Home Based Support, Headspace, EPPIC (Early Psychosis Prevention Intervention Centre; an integrated comprehensive service) and psycho-social rehabilitation and crisis respite services. But there are still too few of these outlets.

The community–managed mental health sector is central to the development of quantity, quality and accessible services such as the ones mentioned. The sector has been, and continues to be, a leader in the development of person-centred, recovery-orientated services promoting a narrative of care that is in opposition to that based on access to hospital beds.

Historically, this is a sector that has received little of the public spend on mental health and yet there is compelling evidence that investment in this sector will increase access to timely, effective and responsive services. With recent reforms, investment in the community mental health sector has increased from less than 2% of the investment to a little better than 5% (Whiteford: 2002, 210–215) but by international standards this remains low. New Zealand, for example, spends up to 30% of its mental health budget on dedicated community-managed services (Rosen, Goldbloom and McGeorge: 2010, 593–603).

Access will only be addressed by investment in a diversity of services that are relevant to the communities and target populations they seek to serve. Access will not be resolved with great investment in hospital-based beds.

Developing a political and community understanding of mental health needs that is more sophisticated than a plea for more beds is a fundamental step in this direction.
The drive to reform – and improve – the mental health service system in Australia began with the aspirations of mental health professionals, consumers, their families and carers. In 1991, the United Nations Declaration Principles for the Protection of Persons with Mental Illness was released, followed a year later by the report of the National Inquiry into the Human Rights of People with Mental Illness, which recorded the extent of mental illness and its treatment in Australia. Additionally, state inquiries highlighted abuse and violation of human rights.

First national mental health plan

Improving the rights of consumers, their families and carers was a pivotal theme of the first plan (1992–97). The commitment to empower the consumers, their families and carers of mental health services was a stark contrast to the neglect and gross human rights abuses that characterised mental health services over the past century. The 1997 evaluation of this, the First Plan, acknowledged that the mental health system was in poor shape at the start of the strategy (National Mental Health Strategy Evaluation Steering Committee: 1997), in particular, that ‘there was widespread dissatisfaction with services, consumers, their families and carers who all reported problems with access to services’.

The evaluation of the plan concluded that while significant gains had been made in mental health reform, reform had been uneven across, and within, jurisdictions, and that further action was required to maintain and build on the momentum generated under the plan. Major structural reform achieved during these five years was not necessarily accompanied by improved service quality (Whiteford, Buckingham and Mandescheid: 2002, 210–15) – and thus access.

Second national mental health plan

The second plan (1998–2003) built on the achievements to date and identified additional areas for national activity, such as:

• Promotion and prevention.
• Partnerships in service reform.
• Quality and effectiveness.

Consumers, their carers, mental health service providers and professional bodies were consulted and their views and recommendations helped identify priority areas of national activity.

The evaluation of the Second Plan acknowledged that the challenge to mental health service reform was to achieve a system of care that met the needs of individual consumers ‘across the entire course of their illness, across their multiple areas of need, and across the lifespan; however the complexity of the system reform required to deliver integrated care has become increasingly evident’. The evaluation concluded that Australia has continued to pursue and make progress towards implementing the objectives of the National Mental Health Strategy, including the three additional priority themes identified in the Second Plan. However, progress has been slower and less extensive than hoped. In particular, the national community consultations, where for the first time, consumers, their families and carers were part of the evaluation, revealed a high level of dissatisfaction.

It was while all this was going on that Australia became the first country in the world to develop a national strategy for the transformation of mental health services across the country. Twenty one years later, there have been:

• 1 national mental health report card.
• 2 national mental health policies.
• 11 national mental health reports.
• 4 national mental health plans.
• Several national strategies.
• Numerous national surveys of mental health.

There have also been state and territory mental health plans to meet local requirements.

In agreeing to a national mental health strategy, health ministers recognised, as in the 2010 National Mental Health Report’s summary of 15 years of reform, that it was important to monitor and publicly report on its progress (National Mental Health Report: 2010).

Part of this has been achieved through independent evaluations of each five-year national mental health plan.
The reports judged harshly the results of reforms over the previous decade. Now there is significantly more data but this does not extend to qualitative data from consumers, their families and carers at a national level nor does it collect recovery data from services delivering mental health programs.

When the National Mental Health Strategy began no information was available about the extent and impact of mental illness in Australia. Now there is significantly more data but this does not extend to qualitative data from consumers, their families and carers at a national level nor does it collect recovery data from services delivering mental health programs. As all plans have recognised the need for a change in the way governments respond to mental illness (2009) this is where the Australia could make vast improvements.

Outcome data from consumers and their families and carers must inform the evaluations of the national mental health plans, the Strategy and the way forward. Without this crucial data, the National Mental Health Strategy’s evaluations are incomplete and we will never truly know if access to timely, effective mental health services has improved for Australians currently experiencing a mental health difficulty.
such statements generally do not come with implementation objectives nor funding to support implementation of CALD community policy. Reporting of progress against CALD-related policy intent is also inadequate. Yet, to ensure that all Australian residents benefit from mental health reform, CALD-relevant mental health policy statements need to be translated into those very implementation objectives and resources allocated to meet them.

It is essential to evaluate and report on progress against CALD-relevant policy objectives—something that does not happen at the moment. Mental Health in Multicultural Australia (MHIMA) has designed and is trialling what is known as the Organisational Cultural Responsiveness Assessment Scale that will enable mental health services to track their own provision of culturally responsive services.

We know that many (but not all) immigrant and refugee communities access specialist mental health services far less than the Australian-born, and rates of service use vary enormously across country-of-birth groups. Yet the National Survey of Mental Health and Wellbeing (2007) found that the prevalence of common mental disorders in the overseas-born is not substantially different to that in the Australian-born, although the national survey sample was not sufficient to allow any specific conclusions about even the largest immigrant communities.

While we do not have population data on the...
Gaps in data collection

The general commitment to evidence-informed policy and mental health service design and delivery makes sense when the resources needed to gather, analyse and use the required evidence are procured. But there are major gaps in relation to CALD populations, in particular in our collection of data on national mental health outcomes. Because CALD variables are not included as part of such collected data, it is impossible to know whether treatment and care for immigrants and refugees have the same affect on them as on Australian-born. This makes it extremely difficult to plan effectively for the future. Ensuring that national outcomes data can be used to evaluate clinical and social outcomes for immigrants and refugees, consequently, is an urgent priority.

Routine data collections, generally, do not include sufficient CALD-relevant variables or, if they do, they are not systematically analysed and the findings are not reported. None of the National Mental Health Strategy reports, for instance, have included any CALD-relevant analysis, making it impossible to determine whether service standards are met, where the gaps are and whether our mental health system is moving towards equity.

MHIMA is collaborating with the National Mental Health Commission to develop strategies that will improve the quality of CALD-relevant evidence to inform the continuing mental health reform process and contribute to the Strategy’s equity objectives.

Cultural and linguistic diversity presents many challenges but also represents an opportunity to improve our understanding of health and illness determinants, and how we can develop more effective promotion, prevention and treatment programs. In the non-communicable diseases field, for instance, there has been an early study of the cardiovascular benefits of the Mediterranean diet.

The drive to develop more effective suicide prevention programs will illustrate the point in the mental health field where suicide rates vary widely among different country-of-birth groups in Australia, as they also do across countries. Systematic examination of this variation will contribute to a better understanding of both risk and protective factors and development of suicide prevention strategies that are designed and targeted for particular circumstances and population groups to make them more effective. By not already investigating these, we both limit our understanding of them and the development of new knowledge that can benefit all Australians.

Although these days we can respond better to the diverse mental health needs of a culturally and linguistically diverse population, much still needs to be done. Representatives of immigrant and refugee communities must be more effectively included in decision-making about all aspects of mental health policy and services, and within consumer and carer organisations themselves. In particular, the quality of evidence that informs such decisions needs to be improved, so that our mental health system fully reflects the diversity of the Australian population.

Most importantly, clear and consistent policy statements on cultural and linguistic diversity need to be implemented, and then that implementation must be monitored, evaluated and reported on. We must move from the rhetorical commitment of policy documents to go on to allocate resources that will create the necessary institutional arrangements to turn policy intent into action that will match the reality – and demands of Australian cultural and linguistic diversity.
H

Hennekens, CH; Hennekens, AR; Hollar, D and Casey, DE (2005), Schizophrenia and increased risks of cardiovascular disease, American Heart Journal, 150

Hillier, D; Fewell, F. Cann, W and Shephard, V (2005), Wellness at work: enhancing the quality of our working lives. International Review of Psychiatry, 17(5)

Hiljon, Michael (2004), Assessing the financial return-on-investment of good management strategies and the WORC Project. The University of Queensland


I


IndustriaALL Global Union (2012): The triangular trap: unions take action against agency labour Switzerland

J

Jacka, Felice; Reavley, Nicola; Jorm, Anthony; Tournbournou, John; Lewis Andrew; Berk, Michael. Prevention of mental health disorders: what can we learn from those who have gone before and where do we go next? Australian and New Zealand Journal of Psychiatry (in press)

K


MHCA (Mental Health Council of Australia) (2005). Not For Service: Experiences of Injustice and Dispari in Mental Health Care in Australia, MHCA, Canberra

MHCA and Human Rights and Equal Opportunity Commission (c. 2006), Time for service: solving Australia’s mental health crisis. MHCA, Canberra

MHCA (Mental Health Council of Australia) (2012), Recognition and Respect: Mental Health Carers Report 2012, Canberra, Australia


MHCC (2011), Care Coordination Literature Review and Discussion Paper


Morgan VA; Waterreus A; Jablensky A; Mackinnon A; McGrath J; Carr V, et al (2011). People living with psychotic illness Report on the second Australian national survey, Canberra: Commonwealth of Australia

Morley, B; Parkis, J; Sanderson, K; Burgess, P; Kohn, F; Naccarella, L and Haslak, G (2007), Better Outcomes in Mental Health Care: Impact of Different Models of Psychosocial Service Provision on Patient Outcomes, Australian and New Zealand Journal of Psychiatry, 41, 142-149, 4

Mowbray, Carol; Collins, Mary; Bellamy, Chytell; Mcgivern, Deborah; Bybee, Deborah and Silvagyi, Steve (2005), Supported education for adults with psychiatric disabilities: An innovation for social work and psychiatric rehabilitation practice. Social Work, 50


Munt, Chris (2009), Recovery DVD: Hertfordshire Partnership NHS Foundation Trust

L

Lambert, TJR, Velakoulis, D and Christos, Pantelis C (2009), Medical comorbidity in schizophrenia. Medical Journal of Australia, 178: S67–S70


NMHA (National Mental Health Association) (2012). National Report Card on Mental Health and Suicide Prevention, NMHC, Sydney


Pirkis, Jane; Harris, Meredith; Hall, Wayne and Funou, Maria (2011). Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: summative evaluation, Melbourne: Centre for Health Policy, Programs and Economics


Rinaudo, Ben and Ennals, Priscilla (2012). Mental illness, supported education, employment and recovery: Ben’s story, Work, 43


Roberts, Glenn and Wollson, Paul (2004). The rediscovery of recovery: open to all Advances in Treatment 10

Rosen, Alan; Goldbloom, David and M’George, Peter (2010). Mental Health Commissions: making the critical difference to the development and reform of mental health services. Current opinion in psychiatry, 23(6)


S

SANE Australia (2012). More Australians Calling for Help Australia


Shah , AJ; Veledar, E; Hong ,Y; Bremner, JD and Vaccarino, V (2011). Depression and history of attempted suicide as risk factors for heart disease mortality in young individuals, Archive of General Psychiatry, 68(11)

Smits, Filip, Willemsen, Godelief, Koopmanschap; Marc; Onrust, Simone; Cuypers, Pim and Beekman, Aartjan (2006). Cost-effectiveness of preventing depression in primary care patients: Randomised trial, British Journal of Psychiatry, 188

Smith, Coral L and Shochet, Ian M (2011). The Impact of Mental Health Literacy on Help-Seeking Intentions - Results of a Pilot Study with First Year Psychology Students: The Impact of Mental Health Literacy on Help-Seeking Intentions - Results of a Pilot Study with First Year Psychology Students


Stuart, Heather (2006). Media portrayal of mental illness and its treatments: What effect does it have on people with mental illness? CNS Drugs, 20(2)

Sullivan, William (1994). A long and winding road: the process of recovery form severe mental illness, Innovations and Research, III(3)

The Senate Select Committee on Mental Health, a National Approach to Mental Health – from Crisis to Community. Canberra: Commonwealth of Australia (2006)

Tooth, Barbara; Kalyanasundarm, Vi; Glover, Helen and Momenzadah, Sirous (2003), Factors consumers identify as important to recovery from schizophrenia, Australasian Psychiatry, XI


Vos, Theo; Barker, B; Stanley, L et al (2007), Measured in Disability Life Adjusted Years, 12% to mental health conditions, 4 per cent to suicide, and 6 per cent to alcohol and substance abuse. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003, School of Population Health, The University of Queensland, Brisbane


Waghorn, Geoff; Still, Megan; Chant, David and Whiteford, Harvey (2004), Specialised supported education for Australians with psychotic disorders, Australian Journal of Social Issues, 39

Watson J and Tully L (2008), Prevention and Early Intervention Update – Trends in Recent Research, Sydney: NSW Department of Community Services

Watson J, White A, Taplin S, Huntsman L (2005), Prevention and Early Intervention Literature Review, Sydney: NSW Department of Community Services


Zucconi, Alberto (2008), From Illness to health, wellbeing and empowerment: the person centred paradigm shift from patient to client, In Levitt, Brian E. (Ed.) Reflections on Human Potential: Bridging the person-centred approach and positive psychology, PCCS Books, Ross on Wye, Herefordshire, UK