Mercy Health

Submission to Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services

August 2011

Mercy Health welcomes this Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services. This document presents Mercy Health's comments and recommendations to the Inquiry.

Mercy Health is a Catholic community provider of care founded and wholly owned by the Sisters of Mercy Melbourne Congregation. We offer acute and sub acute hospital care, aged care, mental health programs, specialist women's health, early parenting, palliative, home and community care, and health worker training and development.

Our Mental Health services (Mercy Mental Health) provide high quality care and treatment of mental illness for the adult population of south west metropolitan Melbourne, together with a regional perinatal psychiatry mother baby service for western Victoria and metropolitan Melbourne. Our services include acute, sub-acute and community-based services including inpatient care. The community we care for includes the high growth municipality of Wyndham and the culturally and linguistically diverse municipality of Maribyrnong.

We also provide perinatal psychiatric services at our tertiary women's hospital, Mercy Hospital for Women, and support services to new mothers with mental health concerns at our early parenting centre, the O'Connell Family Centre.

Mercy Mental Health is experiencing unprecedented growth in demand for its services. Our employees work extremely hard to provide high quality mental health care to one of the fastest growing communities in Australia. There is a need to further expand our services in order to improve access to public mental health services in the south-west and we are working with the Department of Health to meet this need.

Mercy Health has made comments regarding those areas raised in the terms of reference and also recommendations for the areas that have specific relevance to the mental health services it provides.

Stephen Cornelissen
Chief Executive Officer
Mercy Health

Changes to the Better Access Initiative and funding

Many of the new funding proposals made in the 2011-12 budgets are to be delivered by making savings in the Better Access Program, therefore do not demonstrate a tangible commitment to the ever increasing mental health issue.

Many of the initiatives delivered through the Better Access Program are aimed to remove the stigmatisation of mental illness by moving to a more multidisciplinary model of care. The overall principles should not be destroyed through budget changes such as rationalisation of services.

Mercy Mental Health's experience is that there has been very limited uptake of general practitioner mental health services in the south west of Melbourne. This has been due in part to the small number of general practitioners who have completed Mental Health Skills Training, the feasibility of employing mental health practice nurses and the limited income it provides practitioners. Further rationalisation can only be seen to further discourage general practitioners involvement.

Reducing services provided within the primary health care setting, will inevitably flow over to greater demand for care in the acute setting, resulting in no cost savings.

Access to Allied Psychological Services Program

While the investment in primary mental health care services is to be commended, the effectiveness of the program's delivery through Medicare Locals, as indicated in the 2011-12 budget, is to be questioned. There continues to be confusion around the function of the new Medicare Locals and the placement of borders that have little regard for the existing service models and relationships.

Having the capacity for provision of up to 18 allied health treatment sessions for more complex problems has been of value adding to the provision of care. A reduction of this may be seen to have an adverse impact.

Mercy Mental Health's experience has been that while the services provided are valuable and of a good standard, the capacity of those on a low income to access services where the fee charged is above the bulk billing rate is limited, therefore the impact of the program in the south west of Melbourne is limited. This implies that the program's objective to improve access to mental health care for the more vulnerable and those at risk has not been achieved.

Services for people with severe mental illness

While Mercy Mental Health strongly supports improved early intervention and primary care initiatives, the reality is that there is a generation of our clients which have been missed at this stage and urgently require equitable access to inpatient and community based mental health services. Mercy Mental Health operates at 98% occupancy for its acute beds; in addition to this it has at any one time several outliers in other hospitals and numerous clients waiting for a bed in the two local Emergency Departments in its area.

Bed based mental health services are geared to acute presentations and clients with resistant psychosis requiring secure extended care. Current services do not provide well for clients with multiple disabilities or early degenerative or aquired brain conditions that require ongoing secure psychiatric nursing home care.

Workforce

Public mental health services in the south west of Melbourne continue to experience a high reliance on overseas trained medical officers and specialist shortages in nursing and occupational therapy staff, as well as psychologists willing to undertake the breadth of clinical work required in the field.

Alternative models of care need to be considered, thinking beyond psychology when considering the specialist workforce. Psychologists provide only limited services in public work; they are reluctant to undertake any case management duties other than psychotherapy and psychometric testing both of which have limited applicability in public treatment and support of public mental health clients. Nurses, social workers and occupational therapists on the other hand provide equal expertise and greater willingness to undertake the necessary breadth of clinical tasks.

Mental Health funding and services for disadvantaged groups

Mercy Health sees that there is a lack in the provision of funding for the training of personnel working with culturally and linguistically diverse client groups. Particular value could be added through greater support of bilingual professionals and this should be addressed in future funding models.

National mental health commission

Mercy Health is supportive of the establishment of a National Mental Health Commission. It is hopeful that its position within the Prime Minister's portfolio will raise the profile of mental health on the national agenda.

Impact of online services for people

Online services are a welcome addition to support rural and remote areas. They may also be valued and utilised in more affluent area. However they are limited in their applicability for severe illness and for diverse disadvantaged groups. Mercy Mental Health services a multi-lingual and disadvantaged community where access to internet is limited and where language proficiency and literacy are significant issues. For these communities person to person care proficient in dealing with disadvantage, trauma and trans-cultural issues, is still the best resource.

Perinatal Mental Health

Psychiatric illness is the one of the leading indirect causes of maternal morbidity and mortality in Australia. In addition, untreated maternal mental illness can be associated with poorer infant and child outcomes. Given these findings Perinatal Mental Health services should be integral to Maternity Services.

Perinatal Mental Health, under its broadest definition, covers mental illness from pre-conception planning through pregnancy, postpartum and infants until three years of age. As a sub-specialty area of mental health it requires specific assessment skills, knowledge of specific psychiatric disorders of the perinatal period, such as puerperal psychosis, the interaction of treatments with physiological changes in pregnancy, risks and responsiveness of treatments during the perinatal period and normal and abnormal development in the neonate, infant and toddler. The risks of pharmacological treatments in the perinatal period are both risks for the mother and also exposure of the infant to maternal treatments. However, any consideration of risk of treatments should also consider the risk for mother and child of untreated illness.

Mental Illness in Pregnancy and Postpartum

Antenatal and postnatal depression affects up to 20% of Australian women with potential long term health and mental health consequences for mother and child if undetected and/or untreated. Postnatal depression is one of the most common complications of child birth.

The prevalence of postnatal depression has been found to be higher in specific populations such as teenage mothers, low-income mothers, women with co-morbid substance abuse and indigenous women.

A number of risk factors have been identified for postnatal depression. The strong to moderate risk factors were found to be depression/anxiety during pregnancy and stressful life event during pregnancy. In addition, there were higher rates in very socially disadvantaged groups and in adolescent and older mothers. Poor marital relationship and poor social support, as well as adverse early life experiences such as childhood sexual abuse were also identified as risk factors. Hormonal changes associated with pregnancy and the postpartum may act as a “trigger” for depression in a “subgroup of women”.

Untreated maternal depression has been shown to be associated with higher rates of pregnancy complications such as pre-eclampsia, prematurity, impaired feto-placental functioning, low fetal growth. Untreated postnatal maternal depression has also been associated with poorer outcomes for offspring including lowered IQ in adolescence, impaired language development and developmental delay.

Although mental illnesses such as schizophrenia, bipolar disorder and borderline personality disorders are less prevalent, each has been found to be associated with quite significant antenatal and postnatal complications. Women with bipolar disorder and schizophrenia have an increased risk of complications in pregnancy from their illness and from the medications they are prescribed. They are also more vulnerable to challenges in the mother-infant relationship with observational studies showing lower sensitivity and higher intrusiveness particularly in those who remain symptomatic. Women with borderline personality disorders are particularly vulnerable at this time of their lives and personal development. Infants of women with borderline

personality disorders are at increased risk of developing disorganised attachment styles, the sequelae of which are an increased risk of adult psychopathology. Given the complexity and low prevalence of these three illnesses they often require expertise and experience in their antenatal care with multi-disciplinary teams with obstetric, paediatric and perinatal mental health clinicians with links to community services.

Recommendations for Perinatal Mental Health

Given that as many as 20% of women may suffer with a mental health issue in the perinatal period, and given the known psychosocial and developmental sequelae for her, her infant and her family, early intervention must be a focus of mental health policy and service development.

1) Services should be integrated and available in the public and private sector.

2) The recognition and development of Perinatal Mental Health as a subspecialty, requiring specific training and experience.

3) The development and appropriate funding of Perinatal Mental Health services as an integral part of maternity health care delivery.

4) The development of specific clinical practice guidelines for the assessment and management of women with perinatal anxiety, depression, schizophrenia, bipolar disorder, personality disorders and eating disorders for the perinatal period.

5) The development of specific services for women who have had a history of major obstetrical complications and or trauma.

6) The development of specific research opportunities and funding in order to further develop and evaluate safe treatments for women and their infants in the perinatal period.