Australian Psychiatry: From disparate state services to a National Mental Health Strategy and beyond.

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History and Demography

Australia, a vast continent of 7.7 million square km (including the Island State of Tasmania), is roughly the size of Europe or mainland USA, but with a sparse population of 20.2 million (2004 estimate) mainly concentrated in coastal areas.

First inhabitants were the Aborigines, who migrated here at least 40-60,000 years ago from Southeast Asia. Although sighted or visited by the Dutch, Portuguese, Spanish and British in the 1600s, it was not until Captain James Cook's voyage in 1770 that Britain claimed possession.

The history of Australian psychiatry is entwined with the impact of European (British) invasion and settlement, initially in 1788, to form penal colonies to alleviate the overcrowding of English jails, generating a masculine dominated individualistic culture (Quadrio, 2001) As European settlement in Australia expanded, the colonisers tried to come to terms with this remote vast landscape, and fought with the original Aboriginal inhabitants over land and resources. This resulted in fear and isolation for Europeans dissolved partially in rum, but faced often defiantly with a rebellious spirit, born in adversity. For Aboriginals it resulted in widespread, deadly epidemics and determined European attempts at extermination, seriously endangering the indigenous peoples (Rosen, 2005).

Australia's official language is English and its largest religion is Christianity (76.4%) with its population growth relying largely on migration from Britain, and to a lesser extent Ireland, until post World War II, then broadened by refugees and an additional influx encouraged from many parts of Europe, accompanied since the 1970's by more substantial migration from Asia. 92% of the current population are Caucasian,

7% Asian, and 1% other in origin including 350,000 who claim Aboriginal descent. Their population fell from ½ to 1 million before European contact to 60,000 and is now slowly climbing again. While refugees continue to be taken in and supported, Australia takes a tough stance on unauthorized arrivals (Infoplease, BBC country profiles, 2004).
Australia essentially came together as a Federation or collection of colonies which don't quite trust each other. This is expressed as intense rivalries in all things from football and cricket to perpetual argument over the proportion of the national tax base each State believes it deserves.

Consequently, we have a Commonwealth (national) government responsible for personal tax collection, unemployment and welfare benefits, and general policy directions in health, disability, education, employment, etc. The State Governments retain responsibility, through their State Health Departments, for organising all their own health services and facilities on the ground, including mental health services. Consequently, such provision is diverse, though influenced to some extent by policy directions driven by the Commonwealth Department of Health, particularly when attached to funding specifically tied to implementation of Federal programmes, eg the National Mental Health Strategy.

Mental Illness in Colonizers

People of European stock were seen as vulnerable to "bush madness", "moral insanity", "sunstroke" and "intemperance", the latter being due to binge drinking and adulterated alcohol.

It was some years before the first suicide was recorded: "When life is cheap suicide is rare" (Dax, 1989).

Initially, people with mental illness were confined in irons on ships (including grounded wrecked ship hulks) and in jails alongside troublesome convicts. No separate provision was made until 1811, with the first small institution for the "insane" opening in New South Wales, (NSW) accommodating 20 people. The first large asylum at Tarban Creek, NSW, was opened in 1838 (later named Gladesville Hospital, which finally ceased operating as an inpatient psychiatric facility in 1997). Further population expansion saw the emergence of many institutions over the next 100 years, and their story in Australia is similar to the chillingly consistent and familiar multinational experience throughout the Western world: overcrowding, loss of connection with families and the community, "institutionalisation", and oppressive practices countered by earnest but often thwarted attempts to improve conditions and reform practices (Dax, 1989).

Aboriginal "Mental Illness"

Aboriginal peoples have been subjected to dispossession and "spirit-breaking": largely undocumented emotional traumas through massacres, forced removal from their parents ("the stolen generations"), loss of traditional lands, culture and language, all contributing to a gradual genocide (Rosen, 1994, Wilson, 1997). This resulted in excessive drug and

alcohol disorders, violence and sexual abuse, high rates of incarceration in corrective and psychiatric institutions, and of deaths in custody.

Only in recent years have there been moves to adopt more functional approaches to Aboriginal Mental Illness, including integrating mental health services with whole of Aboriginal community building and with complimentary traditional healing practices, and providing specific training programmes for Aboriginal Mental Health Workers. (Swan et al 1994, Hunter, 1997)

From Non-Systematic to Systematic Deinstitutionalization

A non-systematic trend towards deinstitutionalisation picked up momentum from the 1950's or 1960's partly on the basis of renewed clinical optimism, availability of employment and changing social attitudes. But more often it appeared to be determined by economic and political imperatives, in response to scandals, inquiries, and the reluctance of governments to allocate funds to upgrade these facilities. Mental Health Services and resources, however, did not follow their patients into the community. In fact, by 1984, virtually 90% of people with severe mental illness in NSW were living in the community, whereas approximately 90% of public mental health staff and funding were retained in hospitals (Rosen, Parker et al, 1987).

The development of local general hospital psychiatric inpatient hospitals initially did not shift the concentration of work with inpatients with severe mental illness from the psychiatric hospitals. The general hospital units were initially highly selective, were not designated in some states to take involuntary patients and were reluctant to become so. Some of them used their resources and beds to favour academic interests and/or super specialty tertiary referral programmes. This is similar to the U.K. experience, as described by Baruch and Treacher (1977).

Compounding these trends, Australia has developed a substantial private medical sector, now funded nationally by taxpayers through our Health Insurance Commission, as well as via private health insurance schemes. This has promoted a parallel growth in private psychiatrist practices and psychiatric inpatient beds, concurrently moving "up market" to deal increasingly with less severe disorders and the demand for psychotherapy.

Working with involuntary patients those with fewer economic resources, and people not prepared to have their crises come in at convenient times to private clinics, was left largely to the public sector.

Meanwhile from the early 1970's some community health teams were put in place nationally through the Australian Assistance Plan, but they were often idealistically focussed on primary prevention, offering generic rather than specialist mental health services on a business hours, weekday basis.

In 1983 David Richmond was commissioned from outside the Mental Health field to report on these circumstances in the state of New South Wales (NSW). Consulting

widely, including via a publicised consumer and family phone-in, he was struck by the lack of provision of services and support for people with severe mental illness and their families in the community, and recommended a gradual shifting of resources to where most of these people now lived.
Richmond's Report (1983) endorsed the published results of a seminal randomised control study in Sydney (Hoult et al, 1984) of 24 hour community based psychiatric care as an alternative to hospital-centred acute care and office-hours only aftercare, replicating similar studies in North America (Stein & Test, 1980). From 1984 - 1987, The Richmond Implementation proceeded in NSW, demonstrating that with pump-priming funding, 24 hour mobile community mental health services in most localities could be established. These would prioritise the needs of individuals with severe mental illness and their families, and could be integrated with local general hospital psychiatric units, now increasingly under pressure to become gazetted to accommodate security risk acute in-patients, on an involuntary basis if necessary.

Transcultural Provision

As Australia has increasingly acknowledged and celebrated it's multicultural heritage, transcultural psychiatric service centres have developed in most capital cities, with specialised torture and trauma counselling services for refugees from persecution developing in some urban hubs.

Recent National Developments

The National Mental Health Policy was endorsed by all Australian Health Ministers and published in 1992, generalising this policy direction to all states and providing transitional funding in the national budget through the accompanying National Mental Health Strategy to shift services from institutions to local communities. This strategy has enjoyed bipartisan support as national government has passed from Labour to Conservative, although the federal funding has been wound back in recent years.

In the First National Mental Health Strategy these services were to be shifted from stand alone psychiatric hospitals to become largely community based, "mainstreamed", that is, integrated with and accessible via general health services, though remaining distinct as specialised mental health services. These included 7 day and night community mental health crisis intervention services, assertive community treatment teams, a range of supervised community residential facilities, community vocational rehabilitation and social recovery services, integrated with local psychiatric inpatient units based in general hospitals (Rosen et al, 2003). They were to develop strong links with groups of consumers, families, general practitioners, the non-government service organisations, and other non-health local services, like housing, general disability services, social security and employment. The rights and responsibilities of people with mental illnesses and their carers were to be amplified and upheld.

Initiatives included:

a) Promoting consumer and carer participation in policy and planning at every

level through the National Consumer Advisory Group (NCAG) with direct Ministerial Access relating to a network of state "CAG's". The present Commonwealth Government opted to disband the National CAG, however, and put in place a National peak body of non-government advocacy and service organisations (the Mental Health Council of Australia <http://www.mhca.com.au>).

b) Mental Health Category Classification and Costing Study (MHCASC) of whole episodes of psychiatric care, as an alternative or adjunct to hospital based casemix; community epidemiological studies to ascertain prevalence and needs, evaluating outcome measures for national use, promoting national networks and training.

c) Developing National Mental Health Standards (Gianfransesco et al, l996) which are now being used as the basis for service accreditation through independent hospital and community health national accreditation bodies.

Most Australian Mental Health Services have now been surveyed for accreditation with these standards at least once. The adoption of these standards by the Australian Council for Healthcare Standards (ACHS) the largest organisation for accreditation of health care services, public and private, has entailed the training and inclusion of paid consumer and family carer surveyors among the network of health professional surveyors.

Probably the most unexpected positive outcome of the whole National MHS Standards program, has been that this experience has been such a positive one for ACHS on the whole, that they are now considering: “why can’t we have consumer surveyors for all medical and surgical units?”

The Second National Mental Health Plan 1998 - 2003, focussed on the principles of Mental Health Promotion, Prevention and Partnerships with other (non-health) providers of services, and Quality, embodied in Accreditation of all services on the basis of the National Mental Health Standards, the development of a National Minimum Dataset with uniform outcome measures.

Initiatives include:

(a) Developing principles for workforce planning, professional competencies and university professional training, and more recently National Workforce Standards, defining core practical skills all mental health professionals should have and use, though practical provision has been left so far to the states and the professions involved (National Mental Health Strategy, 2002).

(b) A Community Awareness Mass Media Campaign and studies in community and staff attitudes to people with mental illness were developed under the first strategy. Later anti-stigma strategies have included the development and dissemination of media kits (now called Mindframe) to assist the press to put a more constructive "spin" on suicide and mental illness stories, a "Mind Matters"

program of mental health and illness education for all school students, and a manual for consumer advocates. Rotary International local branches have sponsored and organized Community Awareness workshops throughout Australia.

(c) Encouraging early prevention and improved detection, consumer access to services, and early intervention and shared mental health care with general practitioners in all age groups, but particularly for depression and psychosis in young people, and others at risk of suicide. Dedicated Early Intervention in Psychosis teams have developed throughout Australia following the lead of Pat McGorry's pioneering EPPIC team in the state of Victoria.

(d) National Mental Health and Wellbeing Community-wide Survey for both high and low prevalence psychiatric disorders. (Andrews et al, 2001, Meadows et al, 2002, Whiteford et al, 2005) which demonstrated that most care delivered by psychiatry is still inequitably distributed and is de facto shared care with general practitioners and other health professionals.

(e) Mandating a national suite of clinical functional and self-report Outcome Measures to be used in all public and private mental health services and facilities.

The achievements of the 1st and 2nd National Mental Health Plans are summarized in Table I.

The Third National Mental Health Plan 2003-8 has recently been adopted by all the Australian Federal and State Governments. It is to be guided by four priority themes: promoting mental health and preventing mental health problems and mental illness, increasing service responsiveness, strengthening quality and fostering research, innovation and sustainability.

Themhs Conference

There is a parallel development of a strong independent movement, The Mental Health Services Conference of Australia and New Zealand, http://www.themhs.org, (Andrew 2005) co-owned by all mental health professions and consumer/carer networks, which promotes joint conferences, binational forums and mental health service achievement awards in the areas of local integrated services, early intervention, dual diagnoses, rural and remote services, indigenous and transcultural mental health services, consumer and carer service initiatives, mass media representations of mental illness and services (print and electronic).

Workforce and training

Australian public mental health services are largely staffed by interdisciplinary teams of at least five fully professional disciplines: psychiatry, psychiatric nursing, psychology, (particularly clinical psychology) occupational therapy and social work. Variably, depending on location, teams also may include rehabilitation or vocational

counselors or instructors, indigenous and transcultural mental health workers. Increasingly, paid consumer and carer advocates, consultants or teams are being employed in such services. Case-management is generally shared between nursing and allied health professions, as Australian Standards and guidelines do not support the development of a generic case manager role, either by merging professions or on a non-professional basis (Rosen et al l995, 2001, 2005, National Mental Health Strategy 2003).

Following a medical course of 4 years (graduate) to 5 or 6 years (undergraduate) and 2-3 years of rotating hospital resident posts, trainee psychiatrists undergo a 5+ year training period combining apprenticeship and coursework. This now includes advanced training in a sub-specialty over the last 2 years, which may be child and adolescent psychiatry, adult psychiatry, age-care psychiatry, psychotherapy etc. and results in becoming a Fellow of the Australian and New Zealand College of Psychiatrists.

Nurses are trained in university general nursing courses for 3 years, and then may attain post-graduate certificates while working in their chosen specialty, eg mental health nursing.

Allied professionals usually have a bachelor degree often taking 4 years in their chosen profession, but are being increasingly encouraged to proceed to masters or doctorate level, particularly in psychology.

Of 2000 plus psychiatrists 20%+ are in public practice (Scott-Henderson 2000), although this proportion is growing (by 37% over the decade to 2002), while the private practice psychiatrist workforce has been shrinking by 2-3% pa since 1997 (Whiteford et al 2005).

The clinical staffing levels in public mental health services (National Mental Health Strategy 2004) totaled nearly 18,000 by 2002 having grown by 15% since 1992-3, and consisting of 62% nursing 22% allied health and 10% medical professionals. There is currently a shortage in psychiatry as in other Australian health disciplines, of registrars and nurses.

Mental Health Legislation

While each state and territory has its own Mental Health Act, a template model Mental Health Act upholding the rights and responsibilities of people with mental illness was developed during the First National Mental Health Strategy. A Rights Analysis Instrument was subsequently developed by the Federal Attorney-General's Department which is now used to calibrate all state and territory mental health legislation with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Whiteford et al 2005, United Nations 1991).

Research

Particular, sometimes outstanding contributions have been/are being made by Australians to psychiatric research in many areas, as listed by Henderson, 2000: The phenomenology and treatment of both the depressive and the anxiety disorders; abnormal illness behaviour and somatisation disorder; the prevention of mental disorders and the promotion of mental health; the epidemiology of the common and severe mental disorders and the social environment, the epidemiology of mental disorders in late life, the neurobiology of schizophrenia; early intervention in the psychoses; mental health service system research; mental health problems and services for indigenous Australians; alcohol and drug misuse; post-traumatic stress disorder; and psychiatry and ethics.

To these I would add or emphasize research in mental health literacy and mental health first aid, telepsychiatry and related strategies for rural/remote areas, classification phenomenology and treatment of depression, consultation-liaison issues and interfaces, psycho-social (including family) interventions and crisis and assertive community case management and residential alternatives to ini-patient care; interdisciplinary teams, outcome measurement and consumer and carer participation in services.

Conclusions

Firstly, we should acknowledge that there is common ground between all people of all cultural backgrounds in Australia – we have all had the experience of living on the margins at some stage, or in some generation of our family lives in Australia.

This requires supporting the struggle for full citizenship and rights for people who are still on the margins of society, including Aboriginal people, detained asylum seekers, and people living with mental illnesses.

Secondly, it is clear from this Australian example that sustained national mental health reform is achievable; that structural reform of mental health services is easier to achieve than improvements in service quality; and that the support of clinicians, consumers and carers is a critical factor in the success of mental health reforms (Singh, 2002, Whiteford et al 2005).

There is a lingering concern however that, although mental health reform in Australia looks good on paper, has been heading broadly in an appropriate direction, these reforms are already and has achieved international recognition, losing momentum; and core local mental health services are being eroded or have never adequately developed. Australia now lags behind similar Western Countries in terms of proportion of GDP and health budget spent on, and government funding of Mental Health Services (Rosen, 2005, Hickie et al 2005).

There is further concern that the closing of institutions in Australia has been half-hearted and incomplete; that it has not been accompanied by full transfer of real investment in Mental Health Services and facilities; and that under-resourced services are again being expected to be everything to everyone (Rosen 2003 and 2005, Hickie et al 2005).

Finally, there is a need for more coherent coordination of mental health services at one level of government (Andrews, 2005) and an independent National Mental Health Commission (Rosen et al, 2004, Hickie et al 2005) similar to the potent standing commission operating in New Zealand, and one recently implemented in Ireland, to externally monitor reforms; to cost the gaps in services; and to represent mental health service use needs directly to government.

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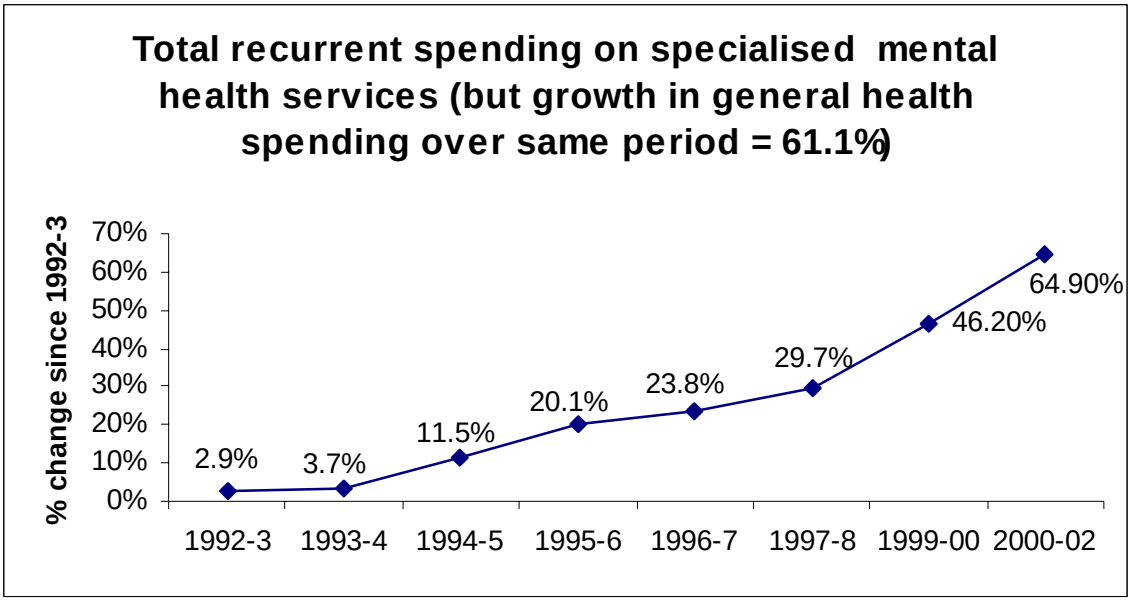
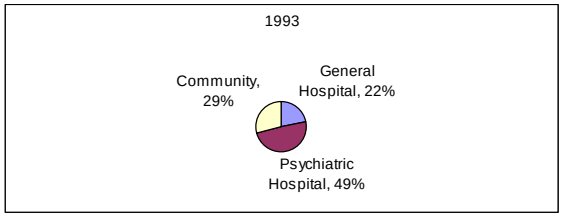
TABLE I

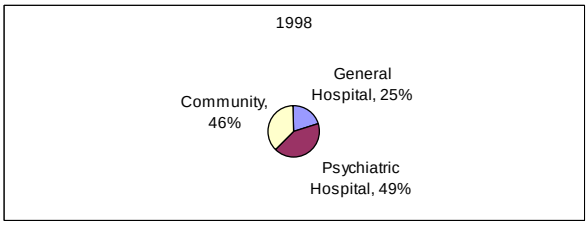
AUSTRALIAN NATIONAL MENTAL HEALTH STRATEGIES I AND II
SUMMARY OF ACHIEVEMENTS

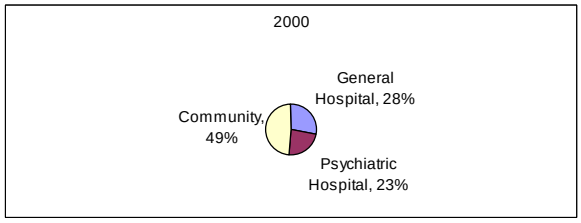
Source: National Mental Health Report, (2004) <http://wwww.mentalhealth.gov.au>

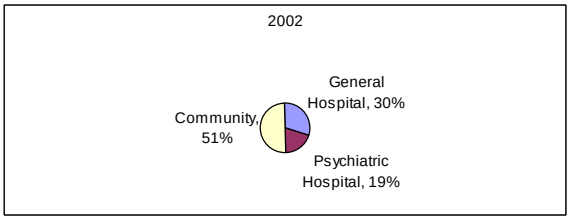
- Australian Population 20.2 million
- Australian Recurrent spending on mental health services (2001-2002) public and private, including pharmaceutical subsidies.
  $Aus 3.088 billion = $US 2.33 billion = Euros 1.79 billion or
  $Aus 154 per capita = $US 118 per capita = Euros 89 per capita









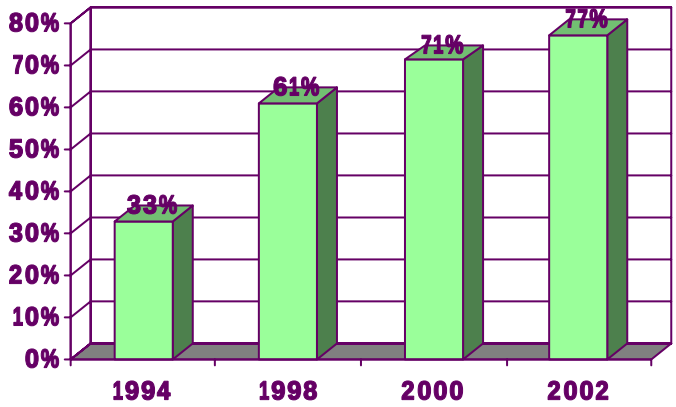


- Average State Spending
  $Aus 92.0 per capita = $US 70.8 per capita = Euros 53.36 per capita
  (62% increase l993-2002)

- Public Sector Psychiatric Beds
  - 1993: 45 beds/100,000
  - 1998: 33 beds/100,000 (26% decrease)
  - 2000: 31 beds/100,000 (31% decrease)
  - 2002 30.4 beds/100,000 (3% decrease)
- Psychiatric Beds in Stand-Alone public Hospitals % of total inpatient beds
  - 1993: 76%
  - 1998: 54% (30 % decrease)
  - 2000: 45% (38% decrease)
  - 2002 33% 43.4% decrease)

Increased consumer participation in decision making

Percent of mental health service organisations with formal participation mechanisms specific mental health consumer representation



Type of Consumer Participation	% of Mental Health Service Delivery Org.			
	1994	1998	2000	2002
Level 1: Appointment of person to represent the interests of mental health consumers and carers on management committee	17%	45%	57%	61%
Level 2: Specific mental health consumer/carer advisory group established	16%	16%	14%	15%
Level 3: Mental health consumers/carers invited to participate on broadly based committees	20%	13%	13%	13%
Level 4: Other arrangements or No arrangements	47%	26%	16%	11%

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