THE AUSTRALIAN EXPERIENCE OF DEINSTITUTIONALIZATION: INTERACTION OF AUSTRALIAN CULTURE WITH THE DEVELOPMENT AND REFORM OF ITS MENTAL HEALTH SERVICES

Submitted for publication in Acta Scandinavia Psychiatrica.

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Presented at 3rd Zurich International Conference on Social Psychiatry, Zurich, September 2003.

Keywords: Australia, Mental Health Service Reform, Deinstitutionalization, culture, National Strategy, History, Aboriginal, Colonial.

Objective: To describe the Australian experience of deinstitutionalization of the Australian National Mental Health Strategy in the context of the history of mental health services in Australia, and of Australian culture.

Method: The development of Australian Mental Health Services is described with reference to developments in both psychiatric intervention research and Australian culture. The effects and achievements of national mental health reforms are described and critically examined.

Results

The relationship in Australia between the development of mental health services and the development of Australian society includes the stories of colonisation, gold rushes, suppression of indigenous peoples' rights, incarceration of mentally ill people, and incompatible state service systems. Mental health services required reform to provide consistent services and support for full citizenship and rights for such individuals who are still on the margins of society.

Recent national developments in service models and service system research have been driven by the Australian National Mental Health Strategy. The translation of national policy into state/territory mental health service systems has led to a "natural" experiment between states. Differing funding and implementation strategies between states have developed services with particular strengths and limitations.

Conclusion

The effects of competition for limited resources between core mental health service delivery and the shift to a population-based public health approach (to prevention of mental illness and promotion of mental health), leaves our services vulnerable to doing neither particularly well. The recent loss of momentum of these reforms, due to failure of governments to continue to drive and fund them adequately, is causing the erosion of

their considerable achievements.

Historical Development of Mental Health Services in Australia
This history 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. 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.

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.[1, 2] 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.

Terra Nullius
White settlers believed they were occupying an empty ownerless land. They did not recognise Aboriginals as people in long continuous ownership of the land.

"The most puzzling thing to whites … was why these (Aboriginals) could display such a marked (even fierce) sense of territory, while having no apparent cult of private property". "What was it that bound them to the land?"… they carried their conception of the sacred, of mythic time and ancestral origins with them as they walked. These were embodied in the landscape, every hill and valley, each kind of animal and tree, had its place in a systemic but unwritten whole. Take this away and they were deprived, not of "property" (as if this) could be satisfied with another piece of land, but of their embodied history, their locus of myth, their "dreaming".[3]

Aboriginal reactions to this cultural oppression are often misinterpreted as mental illnesses, or applied sufficient stress to precipitate them. This resulted in a disproportionately high rate of incarceration of Aboriginal people in our mental and "corrective" institutions, in parallel up to the 1960's with indigenous people becoming the object of fascination as psychopathological exotica, during brief psychiatric safaris to remote Australia.[4] Only in recent years have there been moves to adopt more functional approaches to Aboriginal Mental Illness. These include integrating mental health services with a whole of community response, including primary health care, education, housing and meaningful work or activity (eg communal arts, custodianship over traditional lands etc.) encouraging complimentary traditional healing practices, and specific training programmes for Aboriginal Mental Health Workers.

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."[5]

Initially, people with mental illness were confined in irons on ships (including grounded wrecked ship hulks) and in jails alongside troublesome convicts. "To most Englishmen, this place seemed not just a mutant society but another planet - an exiled world, summed up in its popular name "Botany Bay". It was remote and anomalous to its white creators. It was strange but close, as the unconscious to the conscious mind". 3. No separate provision was made until 1811, with the first small institution for the "insane" opening in Castle Hill, New South Wales, (NSW) accommodating 20 people. Two small asylums were opened in Van Dieman's Land, now Tasmania, in 1824. 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). Gold Rushes from 1851 brought rapid population increase, "gold mania" and the building of 10 asylums, particularly in Victoria and Queensland, between 1860 and 1890. The first private provision in hospitals and "inebriates retreats" appeared in the 1880's. 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 [6]. countered by earnest but often thwarted attempts to improve conditions and reform practices. [5]

Gendered Practices

Quadrio (2001) [6] has demonstrated that the development of Australian Psychiatry and Psychiatric academia has represented "very much a boys club", arguably reflecting our slow emergence from all male-oriented frontier society. Practices are gendered in that male psychiatrists tend to see a less female, less affluent and older clientele for less psychotherapeutic based interventions. More male psychiatrists tend to sexualize their practices in that they represent 90% of the small but significant proportion of sexually offending psychiatrists. Psychiatric training has been conducted in a culture of masculinity, characterised at best by gender-based discrimination, and at worst by frank abuse. This "machoism", Quadrio argues, is manifest throughout Australian medicine and damages the practitioner by acculturation to high-clinical risk-taking associated with morbidity and mortality, and to devaluing of the relational self. Hofstede (l994)[7].reviews research demonstrating that Australia ranks 16th highest of 53 countries in indices of masculine culture (ambitious, individualistic, competitive etc.) whereas Scandinavian countries score lowest.

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.[8].

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 superspecialty tertiary referral programmes, similar to the British experience.[9]

Compounding these trends, Australia has developed a substantial private medical sector, 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 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 from psychiatric hospitals to where most of these people now lived.

Richmond's Report (1983) [10] endorsed the published results of a seminal randomised control study in Sydney[11] 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.[12] 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, by now increasingly under pressure to become gazetted to accommodate security risk acute in-patients, on an involuntary basis if necessary.

How Australian Culture has Shaped Its Mental Health Services.

Rivalries between Colonies
Being a wary federation of rivalrous colonies, every Australian major settlement developed a different railway gauge, from 2 foot 8 inches (80 cm) to 5 foot 6 inches (l65 cm). When the renowned American author Mark Twain (also known as Samuel Clements) visited the Australian colonies in 1895 and had to change train carriages and railway lines at the border between Victoria and NSW, he wrote: "Think of the paralysis that gave birth to that idea". He could have been talking about the American so-called health system.[13]

It was not until more than 60 years after Federation of the colonies to form the Commonwealth of Australia in 1901 that we could agree on and rebuild a railway line with one gauge that would take you from coast to coast, east to west.

Similarly each state has developed different mental health laws, with differing levels of mental health service and resourcing, until we began to bring this patchwork together into a National Mental Health Strategy.

Towards Federation
"Getting 6 independent colonies to give up their autonomy was a big ask" stated John Bannon, ex-Premier of South Australia.

Each colony had been independent in collecting taxes and duties on goods, and running its own army and navy. The huge task of getting them to give all this up for more consistency at a national level and more clout and leverage at an international level, has been vastly underestimated. Henry Parkes, known as the father of federation persuaded and badgered the colonies to do this by force of argument: "The colonial forces are like toy armies. For the defence of our shores, and in the event of war, should we not combine to form a Federal armed force?" Getting our toy colonial mental health services to join forces has taken a lot longer.

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 land cricket to 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. This leverage has been enhanced in recent years by seeking consensus about such programmes among all health ministers, State and Federal, through AHMAC (The Australian Health Ministers' Conference), and by formalised agreements between Commonwealth and States in return for transitional

implementation funds derived from the Medicare Levy raised nationally with personal taxation.

Recent National Developments
The National Mental Health Policy was endorsed by all Australian Health Ministers 1992,[14] 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 funding has been would back in recent years.

In **the First National Mental Health Strategy** [14] 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. 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 has 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).

b) Mental Health Category Classification and Costing Study (MHCASC) of whole episodes of psychiatric care, as an alternative or adjunct to hospital based casemix.

c) Developing National Mental Health Standards [15] which are now being used as the basis for service accreditation through independent hospital and community health national accreditation bodies by 2003.

The National (General) Health Strategy developed in parallel with an extensive issues paper on "continuity of care for people with chronic mental illness" [16], supporting a similar trajectory, particularly with respect to systematised alternatives to institutionally based services, and orderly transfer of services. A subsequent report on the status of Australian indigenous mental health services [17] recommended considerable changes to be applied with cultural sensitivity.

Vestiges of a Colonial Mentality: Differences in Implementation between the States
The Mental Health Directorates in some states have a high level of top-down control and

close regulation of regional services (eg Victoria), while in others, (eg NSW only policy direction can be advised from the Directorate, as administrative control of Mental Health Services has been devolved to the Area Health Services, which act as semi-independent quasi-corporate business units managing all health services for populations up to 1 million. In Australia, these differing relationships have been the subject of some instructive comparisons. At state level, the historical lack of a strong centralised mental health directorate in NSW allowed a bottom-up movement to develop a ground-swell for innovative change at the local level. Also NSW was the site of much of the initial seminal research informing the National Mental Health Strategies on the effectiveness of 24 hour crisis teams [11] Assertive Community Treatment teams [18, 19] and residential alternatives to psychiatric institutional care but NSW proved unable to distribute new service components consistently.[20, 21, 22].

The consequences in Victoria were that services remained institutionally based much longer, but when at last they were ready to change, it was in a much more systematic top-down manner, largely retaining central control of resources for mental health services.

So in Victoria all stand-alone psychiatric hospitals have been completely closed, and replaced much more consistently in every catchment "network" by 24 hour mobile crisis teams: community based mental health centres, assertive home-visiting case management teams; specialty dual disorder (with alcohol and drug abuse) personality disorder, brain injury and forensic services; 24 hour supervised residential cluster houses and a range of step-down less supervised households in suburban streets, plus acute and longterm admission facilities on general hospital sites. The latter are called Secure Extended Care Units, which are bright and airy with large outdoor gardens. The one good thing they have adopted from the old psychiatric hospitals is the need for space, both indoors and outdoors. Shifting the location of these facilities to general hospital sites however, gives residents the benefits of a less stigmatised treatment setting with much better access to general health care, which has been shown to be generally appalling for people with mental illnesses,[23] semi-supervised community residences, vocation and leisure enterprises are often run in contractual partnership with not-for-profit non-government organizations.

In spite of traditional rivalries between these two most populous states, they undoubtedly have needed each other as powerful complementary examples in this field.

The 2nd National Mental Health Plan 1998 - 2003,[24] has 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 some principles for workforce planning, professional competencies and university professional training, and more recently National Workforce

Standards, setting out core shared interdisciplinary skills, though practical provision has been left so far to the states and the professions involved.

(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 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 been popping up around Australia following the lead of Pat McGorry's pioneering "EPPIC" service in Victoria.

(d) National Mental Health and Wellbeing Community Survey for both high and low prevalence psychiatric disorders.

(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 proposal for a **third National Mental Health Plan 2003-2008**[25] has recently been adopted by all the Australian Federal and State Governments. It's activities will 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.

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

Themhs Conference

There is a parallel development of an independent movement The Mental Health Services Conference of Australia and New Zealand, co-owned by all mental health professions and consumer/carer networks, which promotes site visiting, parallel and joint conferences and binational mental health achievement award programmes 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, and excellence in electronic and print media portrayal of mental health issues. This is now the largest annual mental health conference in this region of the world.

The National Mental Health Standards

The Australian National Mental Health Standards[15] were conceived from the beginning as an essential plank of the National Mental Health Strategy platform. Nationwide consultations including all professional bodies, consumers, carers, managers and government resulted in a set of outcome oriented standards for all mental health services, whether public or private, hospital or community, with indicators for assessing whether services are meeting these standards, and an external accreditation system at least as rigorous as that for general health care. They surpass other healthcare standards in the degree of integration required of community with hospital, and acute with rehabilitation services at a local level, and the enshrining of the human rights of consumers and families throughout the standards. They also ensure that all services are involved in meaningful, quality improvement activities on a regular basis.

The greatest legacy of the National Standards project, has been the training and inclusion of paid consumer and family carer surveyors among the panels of surveyors. This adds to the expense of surveys, as does the fact that the surveyors now must spend significant time in mental health components of service.

The mental health consumer movement has been the strongest advocate, most supportive custodian, guardian and/or champion of the National Mental Health Standards. This is demonstrated by their dissemination of promotional materials and recent holding of a National Mental Health Standards festival.

However 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?"

Relating Inputs, Processes and Outcomes, at the Macro (National/State) Meso (Local) and Micro (Individual Service-User) levels, an application of the Mental Health Matrix Model of Thornicroft and Tansella (1999)[26], identifies the place of the National Mental Health Standards, in such service systems[27].

The tyranny of distance

Non-Aboriginal Australians often yearn for some distant homeland, as we or our ancestors came huge distances to get to Australia, and if often takes many years or several generations to go back to our lands of origin even to visit. Many Australians feel like voluntary or involuntary exiles, from some place in another hemisphere which seems like the centre of the universe, and often feel that we can't return to that land of origin unless we have made a huge material success of ourselves, sufficient to explain or excuse the long period of exile. So sometimes instead we send our children on expeditions of symbolic forgiveness or vicarious redemption.

There are some **upsides for mental health services** in this:
Since so many Australians catch a glimpse of our own reflections as marginal, out-of-place people, living "over there" rather than "here", we tend to cluster together for

comfort and out of common experience. So, although we have our own pockets of problems with stigma and red-neck prejudice, on the whole Australians are an easy-going, inclusive and tolerant lot, and have a fairly good record comparatively for community tolerance of people with mental illness.

While distance separates individuals and nuclear families from extended families as they spread out seeking work and cheaper housing, usually near our vast coastline, this makes us focus on the principles and technologies required to run rural/remote mental health services with innovations such as interactive television conferencing facilities, special care suites (apartments on a rural medical ward for local psychiatric inpatient admission) rooming-in schemes, joint shared care programmes with the Royal Flying Doctor Service etc.

Australian professionals also tend to choose discerningly what innovations they adopt from distant lands, so our psychiatric services tend to be seen as partway between North American system with its emphasis on private choice, and European systems with their emphasis of a broad public safety net of services.

Making virtues of our isolation, include "making do". Our service providers become inventive, drawing widely on skills and advice from elsewhere.

Our government mental health services often call on international outsiders to review services and give us a report card of how we measure up to international standards, unlike some countries who are averse to seeking the opinions of outsiders.

Australians travel a lot and make our own synthesis from what we perceive is the best of what the world offers (usually the Western world). Netherlands and Scandinavian mental health providers travel smarter and wider than we do - they tend to arrive in large fact-finding groups including practitioners and senior managers (and sometimes even their politicians with health portfolios) working together and spreading out - we tend to travel as "lone rangers", sampling more narrowly by consequence.

The downside of this is what we call the Australian "Cultural Cringe". The widely held assumption that all things cultural and professional are bigger and better in the Northern Hemisphere, and that the way they run things must be right, and we should slavishly follow their (your) lead.

This trend is tempered by a growing Australian Spirit of independence and confidence, and a long-ingrained spirit of defiance and adolescent rebellion
We are still not yet adept at learning to adopt and integrate lessons from traditional healing practices from our indigenous peoples and from the cultures of developing countries in our orbit, with Western scientific evidence based practices.

In the face of all our interstate rivalries and rough-hewn edges, there have been a few near-miracles: Eg "Multiculturalism", the attempt to integrate many ethnic immigrant groups into our national fabric by celebrating our cultural diversities, which replaced both an earlier British-o-centric "White Australia" policy. Though threatened by red-neck

political backlashes from time to time, Australia is self-identifying more and more as a multicultural democracy.

The new dilemma for services

With the advent of early prevention, detection and intervention programmes, with poorly defined prodromes, it is tempting for specialist services to offer a wide, unfocussed array of primary and early secondary prevention services and to again "try to be everything to everyone". With finite resources, this is much less a practical clinical strategy than a theological strategy. The dilemma is that the demand to provide these preventive services without new resources often can only be met through erosion of core acute and recovery clinical services[27]. This is occurring in our state among others, but should be resisted.

At the same time specialist services are scarce and should be focussed upon those individuals likely to have the most severe symptoms and greatest disability [26.]

Accordingly, more efforts are being made to support, retrain and supervise primary care clinicians to provide services for less severe disorders, and to do shared care with more severe disorders, and to detect, filter and refer those with a high risk of emerging severe disorder to specialist services.

As service providers we need to lift our heads out of our preoccupation with the pressure of current clinical casework, and switch our mindsets to a population-needs focus. Rather than just trying to cope with the next crisis or psychiatric emergency, we should be reorganising our services to go looking for people in dire need who have never yet appeared on our doorsteps, in keeping with the emerging evidence of better outcome with earlier detection and intervention eg of depression and psychosis. We should be taking responsibility not only for the next clinical encounter, but for the continuity of the whole episode of care, or even whole of life care if necessary, and for the encounter with the local community.

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.

To find common ground today between Australian society and Australian mental health services, we must move towards reconciliation for past and present wrongs and supporting the struggle for full citizenship and rights for people who are still on the margins of society, including Aboriginal people and detained asylum seekers.

Traditional healing practices from indigenous and developing country cultures in our orbit should not replace Western Scientific evidence based practices, but there is much we can learn from the former to compliment the latter, which would contribute to recovery. This includes a holistic quality of life approach to assessment and management,

attending to rites of passage throughout life, and re-inclusion in rather than exclusion from an extended kinship network.

We should also work together towards keeping alive this spirit of rebellion to help us overcome psychiatric disability, while not merely accepting the static role of a psychiatric "sufferer" or "survivor", but struggling towards optimal recovery and ongoing growth throughout life.

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[28].

There is a lingering concern however that, although mental health reform in Australia has been heading broadly in an appropriate direction these reforms are already 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 government funding of Mental Health Services, and the growth in recurrent spending in Australian mental health services is hardly more than the growth in general health services [29].

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.

We conclude that there is a need for an independent National Mental Health Commission similar to the potent one operating in New Zealand, to externally monitor reforms; to cost the gaps in services; and to represent mental health service resource needs directly to government.

Acknowledgements:

To Sylvia Hands for the typing and Karen Signorio for organizing the table. Also to the Australian National Mental Health Strategy, Professor Bruce Singh, Melbourne, Dr Georg Witte, Leiden, Dr Ken Thompson, Pittsburgh, Ms Viv Miller, Sydney and Professor Ron Diamond, Madison for assistance with the content and the table.

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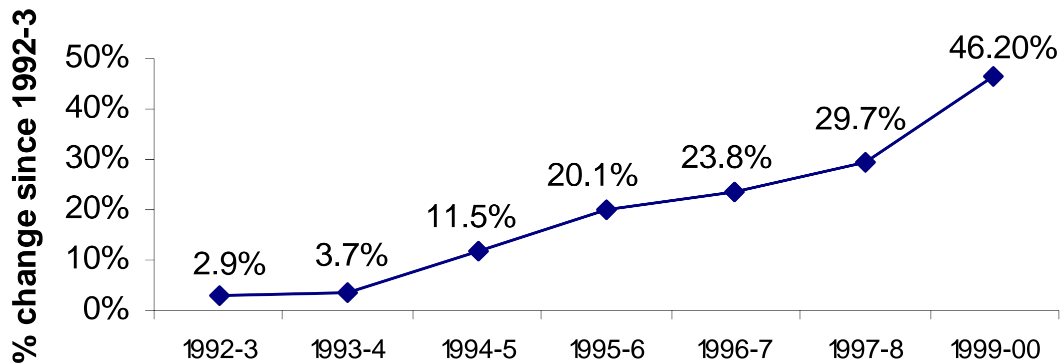
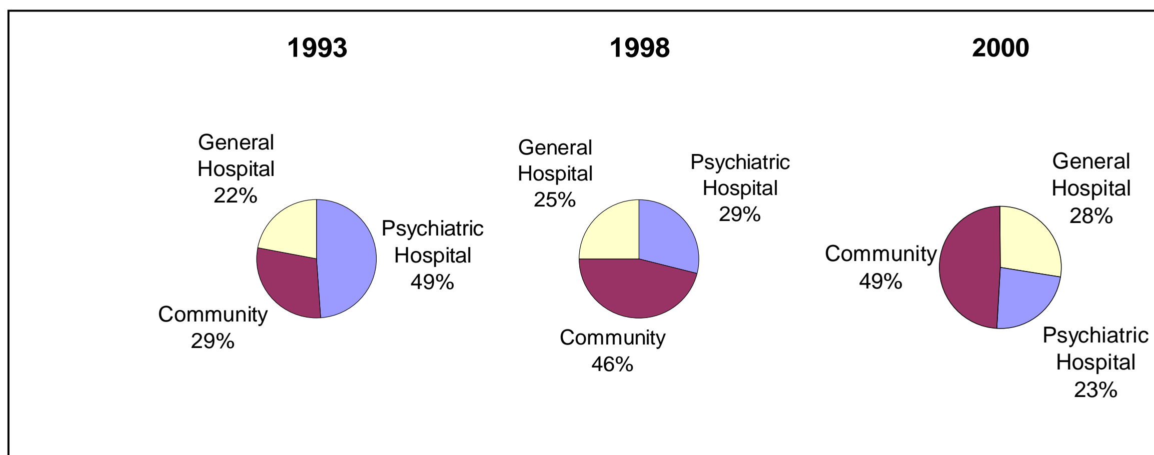
TABLE I
AUSTRALIAN NATIONAL MENTAL HEALTH STRATEGIES I AND II
SUMMARY OF ACHIEVEMENTS

Source: National Mental Health Report, 2002[29].

- Australian Population 20- million
- Australian Recurrent spending on mental health services (l999-2000) public and private
  $Aus 2.56 billion = $US 1.64 billion = Euros 1.48 billion or
  $Aus 130 per capita = $US 83.2 per capita = Euros 76 per capita

Total recurrent spending on specialised mental health services





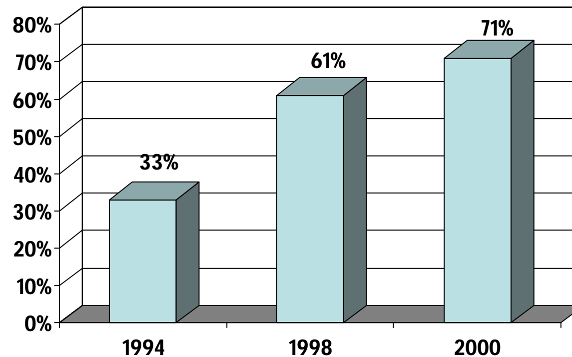
- Average State Spending
  $Aus 81.7 per capita = $US 52.3 per capita = Euros 47.4 per capita
  (I9% increase I993-2000)

- Public Sector Psychiatric Beds
  - 1993: 46 beds/100,000
  - 1998: 33 beds/100,000 (22% decrease)
  - 2000: 31 beds/100,000 (30% decrease)

- Psychiatric Beds in Stand-Alone public Hospitals % of total inpatient beds
  - 1993: 76%
  - 1998: 54% (30 % decrease)
  - 2000: 45% (38% 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**
Level 1 Appointment of person to represent the interests of mental health consumers and carers on management committee	17%	45%	57%
Level 2 Specific mental health consumer/ carer advisory group established	16%	16%	14%
Level 3 Mental health consumers/carers invited to participate on broadly based committees	20%	13%	13%
Level 4 Other arrangements No arrangements	47%	26%	16%