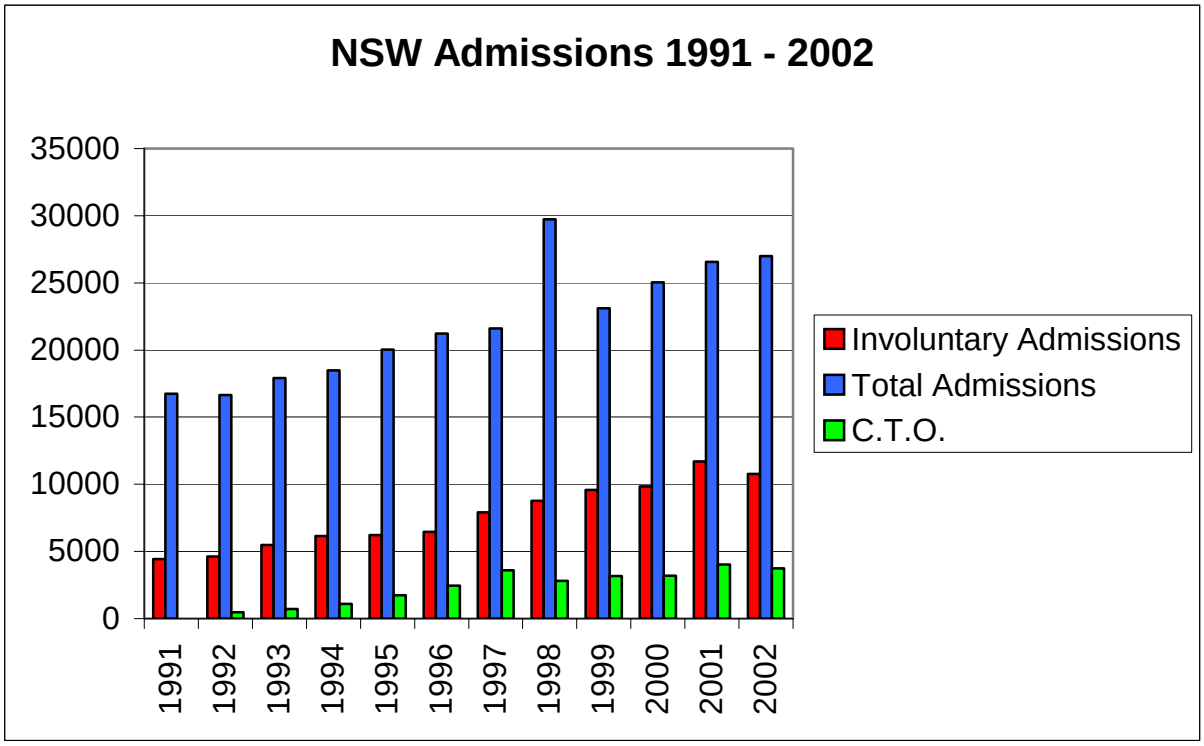
Drugs and Australian Government Policies Have Created a Crisis in Public Mental Health Services

This paper is a summary of material presented to the Mental Health Services Conference Summer Forum "Double Trouble" on February 20, 2004, by Dr Roger Gurr. Dr Gurr is currently Clinical Director of the Mental Health Unit and Clinical Director, Consultation Liaison Mental Health, Liverpool Health Service.

Public Mental Health Services in NSW are deteriorating and an analysis of the causes clearly points to the increased use of illicit drugs and Commonwealth and State Government policies and funding decisions.



The above graph shows that from 1993 there has been a rapid increase in the number of admissions to acute mental health units, from 16,000 to 27,000, with most of the growth being involuntary admissions. Before 1993 (10 years after the Richmond Report reforms began), the admission rate was only gently rising in line with population growth. This increase in demand correlates with the increase in the use of cannabis flower heads and the amphetamines/cocaine group of drugs (Paul Dillon, NDARC).

The number of admissions per available bed is now likely to stabilise, as maximum turnover has been reached and the growing excess is now accommodated in emergency departments and general hospital wards, and not captured statistically. The average length of stay is also likely to increase and stabilise, as people are taking longer to recover, as shown by the statistic that in 2000, 49% of involuntary admissions remained in hospital long enough to be presented to the Magistrate, but in 2002 it had risen to 77%. Those short-term admissions that used to reduce the average are now often not getting to the admission unit, being only offered

community care or being discharged after a stay in the emergency department or general ward, with increased levels of risk. Because it is hard to control illicit drug taking behaviour, some people appear to have more frequent relapses, which increases demand for beds.

Services have also had a major increase in the demand for assessments and so have had to put more resources into that activity. This has squeezed time for follow up and assistance with recovery, leading to increased rates of relapse and bed usage. When I was Director of the Blacktown City Mental Health Service, the data showed a reduction in the average time per occasion of service (incl. travel time) from 64.5 minutes in 1990/91 to 41.6 minutes in 1998/99 (last year for which I have data), a 35.5% reduction. During this period the increase in occasions of service was due to two age groups. The 10-24 age group increased from approximately 200 to 8,000 and the 25-44 age group increased from 10,000 to 20,000 occasions of service. The 45-64 and 65+ age groups were static. These statistics support the illicit drug hypothesis.

Those requiring admission have been more disturbed, more violent and difficult to manage, causing acute admission wards to be less pleasant places to work due to the aggression and rapid churning of patients to make room for those waiting. Staff spend more time processing admissions and discharges or dealing with challenging behaviours and thus have less time for making a rapport and for psychotherapeutic interactions with patients and families. The use of illicit drugs has increased the risks and reduced our ability to predict outcomes, making staff feel vulnerable to increased community expectations and legal accountability. These factors have affected recruitment and retention of medical and nursing staff, so the inpatient services are going through crises of numbers and skill-mix.

There has not been a sufficient increase in resources to match the increased demands on community and admission ward staff.

There is a major flow on effect on training the next generation of psychiatrists and mental health nurses. It is estimated that in NSW the percentage of nurses with specialist mental health nursing training, working in acute admission wards, has dropped to 20% (Sandra Hoot, College of Mental Health Nurses). Of those nurses working in any area of mental health in 2001 in NSW, only 36.6% had post basic qualifications in mental health nursing, community psychiatry/mental health or psychology (AIHW).

National Mental Health Nurses (RN & EN) Workforce

	1995	1997	1999	2001
Average Age	**39.7**	**40.7**	**42.5**	**43.7**
% Part Time (<35 Hrs)	**23.0**	**27.7**	**30.9**	**33.1**
Average Hours Per Week	**37.4**	**36.0**	**34.6**	**34.4**

Age	1995	1997	1999	2001	% Change
<25	493	481	354	264	-46.5
25-34	2,728	2,548	2,267	1,997	-26.8
35-44	4,766	5,121	4,466	3,988	-16.3
45-54	2,553	3,271	3,862	4,350	70.4
55+	707	873	1,224	1,479	109.1

Source: Australian Institute of Health & Welfare

These changes in the supply and the aging of the nursing workforce were predicted before the move to university based training, which gives little emphasis to mental health nursing. The number of university places for nurses, the curriculum and the practical experiences as part of the nursing courses are under the control of the Commonwealth. As there is no real financial incentive to return to university for post basic degree courses, and a cost to the student, those nurses that do take up mental health nursing then have to be trained on the job, pushing more of the training costs onto the State service budget.

There has been a growing vacancy rate in public psychiatrist positions, leading to the growth in the establishment of Area of Need positions, but that has not fixed the shortfall, as, of 38 currently established positions, 18 are vacant. Clearly the work and conditions are not seen as attractive! Public psychiatrists have found that their numbers have not kept pace with the increased workload, that they are mostly dealing with high risk dual diagnosis clients and they are being blamed for system failures they do not control. The public psychiatrists train the next generation, set the standards and do the research, so we need our best and brightest to join and provide for future needs. The deterioration in clinical leadership caused by the vacancies and a possible reduction in the quality of senior medical staff has severely affected the training program.

Registrars begin their training on acute admission wards, which has made many question their career choice. Over 50 doctors used to compete for training positions, but this down to around 25, with a high drop out rate, so there has been a growing vacancy rate in training positions (and career medical officer positions) in mental health. Of the currently established 37 Area Of Need non-specialist positions, 14 are vacant. Some parts of NSW also do not have enough positions to share the increased workload and stress (e.g SWSAHS needs about 15 more psychiatrists and 13 more Registrar positions to bring it up to parity with equivalent areas).

It is clear that the Area Of Need program is not an adequate solution. The Commonwealth controls the training and supply of doctors, and effectively their pay and conditions through the payments to private practitioners (uncapped budget). The competition between the public and private sectors for doctors ultimately determines

the pay and conditions for public sector doctors, to be paid for out of service provision budgets that are effectively capped.

NSW Area of Need Approvals and Recruitment

Specialist Psychiatrists

Year	Approved	Current	Vacant	Accum.
1997	5	1	0	1
1998	4	1	0	2
1999	12	5	2	7
2000	2	1	0	8
2001	10	9	2	17
2002	14	8	2	25
2003	13	13	12	38
		Vacant	18	

Non-Specialist in Psychiatry

Year	Approved	Current	Vacant	Accum.
1998	5	1	0	1
1999	8	6	0	7
2000	1	0	0	7
2001	5	4	0	11
2002	21	18	8	29
2003	8	8	6	37
		Vacant	14	

Source: NSW Health Department, February 2004

Accepted into Training		Left	Net
2000	36	5	31
2001	38	13	25
2002	38	10	28
2003	37	7	30
2004	22		22

Source: RANZCP NSW Branch 2004

How many vacancies can we expect with this trend?

If we use a spreadsheet, we find that to fill 243 positions with an average training period of 6 years (5 years is the minimum possible), then we need a net 41 people to enter training each year.

Net Entries Per Year	Average Years of Training	
41	5	6
Positions Filled	205	246
Positions Vacant	38	-3

If we take a figure close to the current net entry rate, say 27 net entries per year, then the spreadsheet shows that trainees will have to remain in training an average of 9 years to keep the positions filled. The important figures are the large vacancy factors we will have if we get our trainees over the College hurdles in reasonable time.

Net Entries Per Year	Average Years of Training Required				
27	5	6	7	8	9
Positions Filled	135	162	189	216	243
Positions Vacant	108	81	54	27	0

CONCLUSION

The trends illustrated in these data have been evident for many years and they have been brought to the attention of the Commonwealth and State Departments of Health. The lack of action to address these system issues has frustrated the managers of public mental health services, and so there are also growing vacancies in psychiatrist managerial positions. Some services may well collapse if present trends continue, and quality has already suffered, with real negative effects for consumers and families. Just building more admission units and providing more beds will not resolve the issues at the heart of our crisis. We need a careful review and a wide range of solutions, across levels of government and government departments.

It is now past time for the accountability to rest with those who control the levers of power and reform.