Australian Health Association
Submission
Senate Select Committee on Mental Health

About the Australian Healthcare Association

AHA's role

The Australian Healthcare Association is the national industry body for publicly funded hospitals and healthcare organisations, including aged and extended care, primary and community health. AHA has been a major contributor to Australia's health policy for over 50 years.

AHA's members include the governing bodies of Area and District Health Services, Regional Health Authorities, Community Health Services and Hospitals as well as a number of associate and individual members. AHA is governed by a National Council. Councillors are senior health care executives, clinicians, academics and industry leaders from across Australia.

AHA provides high-level advocacy and representation, publishes the Australian Health Review – a peer reviewed health policy journal and the Healthcare Brief newsletter. AHA also convenes an Annual Conference covering a broad range of health sector issues as well as other seminars and workshops on specific issues.

AHA's Vision

All Australians will have access to effective healthcare services that are appropriate and responsive to their needs in all settings, delivered safely by capable personnel providing continuity across the spectrum of healthcare settings (home, residential facility or hospital). Those services must be efficiently delivered and adequately resourced to ensure their sustainability.

AHA's Mission

- To advance excellence in Australian public healthcare services in all settings by promoting the development and implementation of well-resourced evidence-based policies;
- To support a national industry network of hospital and healthcare organisations and to provide high-level representation and information for members;
- To be an independent source of advice, input and analysis for government agencies, media, other industry groups and the community on issues affecting the delivery of healthcare;
- To create a stimulating environment for analysis, review and development of health policy and practice through strategic planning alliances with stakeholders.

Introduction

The World Health Organisation estimates that mental disorders account for 12% of the global burden of disease and will account for nearly 15% of disability-adjusted life-years lost to illness by 2020 [WHO 2003]. The total economic cost is substantial, with indirect costs attributable to mental disorders outweighing the direct treatment costs by two to six times in developed market economies. Addressing the economic and personal costs of mental illness are major issues for all modern Western societies[1].

Families bear a significant proportion of these economic costs because of the dearth of comprehensive publicly funded mental health service networks. They also incur significant social costs, including the emotional load of looking after a disabled family member, diminished quality of life, social exclusion, stigmatization and loss of opportunities. Sectors of society with adverse circumstances and the least resources are most vulnerable to mental disorders.

The relationship between physical and mental disorders is significant. Untreated mental disorders result in poor outcomes for co-morbid physical illnesses. People suffering from a mental disorder have an increased risk of physical illness resulting from diminished immune function, propensity for non-compliance with prescribed medical regimes and perceived barriers to obtaining treatment for physical disorders. Likewise, individuals with chronic physical illness are more likely than other people to suffer from mental disorders.

During the last five decades scientific advances have improved treatment options. Concurrently, there has been a growing awareness of the need to protect the human rights of people with mental disorders, both in institutional care settings and in the community. It is critical that available interventions are made accessible through reform of policy and legislation, service development, adequate financing and training of personnel [WHO 2003].

The designation of mental health by Commonwealth and State Governments as one of the five National Health Priority Areas recognises its public health importance for Australia[2]. The Human Rights and Equal Opportunity Commission (HREOC 1993) concluded that people with mental illness are among the most vulnerable and disadvantaged in our community; they may experience stigma and discrimination in many aspects of their lives.

The Senate Select Committee on Mental Health is to inquire into the provision of mental health services in Australia, and will publish a report by 6 October 2005. The following Australian Healthcare Association submission addresses 9 of the 16 Terms of Reference most relevant to the experience of its members.

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[1] In 1996, the World Health Organisation (WHO) predicted that depression was expected to be a leading contributor to the burden of disease in the 21st Century (Murray & Lopez 1996). Australia established a National Depression Initiative in 2000 to develop a strategic response to this growing problem.

[2] The 1997 National Survey of Mental Health and Wellbeing of Adults (ABS 1997) found that almost one in five of the adult population (17.7% or 2.4 million people) had a mental disorder at some time during the 12 months prior to the survey. By far the most common were anxiety or affective disorders and substance misuse. One in four of them suffered from more than one mental disorder (Andrews et al 1999).

a. The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress

Background

In 1992, all Australian Health Ministers agreed to a national mental health policy as a framework to guide mental health reform from an institutionally based mental health system to one that facilitates a consumer focused, community based service. Accordingly, the National Mental Health Strategy was agreed and implemented in 1992. It was reaffirmed in 1998 with the Second National Mental Health Plan and again in 2003 with the endorsement by all Health Ministers of the National Mental Health Plan 2003-2008. The policies have been implemented mainly through the Australian Healthcare Agreements.

These policies committed all Australian governments to:

- Increase funding;
- Reduce human rights abuses;
- Move the locus of care from hospitals to the community;
- Deliver quality mental health within the mainstream of Australian health and welfare services;
- Facilitate genuine participation for consumers and carers; and
- Implement a broader population-based health promotion and disease prevention approach.

The 2001 International Mid-term Review of the Second National Mental Health Plan, a precursor to the final evaluation of the Second National Mental Health Plan, provided an international perspective on the impact of the National Mental Health Strategy [Thornicroft G & Betts VT 2001]. The findings of this Report are still relevant.

It reported that the Strategy and its First and Second National Mental Health Plans were international exemplars. The main achievements were cited as the integration of mental health assessment and intervention in mainstream health delivery and the inclusion of mental health consumers and carers in policy development. The AHA also believes that considerable reform has been achieved through the implementation of policies arising from this national agenda. However, the Mid-term Review recommended issues where implementation was incomplete.

Consolidating reforms

In the view of AHA, many of the issues raised by the Mid-term review have still not been adequately dealt with and require critical attention. They are listed below.

Emergency and transition

- Make additional funding available to ensure nation-wide availability of expert 24-hour specialist services in emergency departments and in crisis/home treatment teams in order to balance the capacity of community-based and hospital-based alternatives and to guarantee support for people with mental health problems who are in crisis.
- Make additional funding available to increase the availability and capacity of transitional care services in order to provide a high level of support for

patients on discharge from hospital care. Many patients are extremely vulnerable at this point in their treatment. Transitional care not only eases their return to the community but serves to prevent relapse (relapse, when it occurs, contributes to re-admission to hospital of people with severe and recurrent mental illness).

Workforce

- Make additional funding available to address the immediate and serious workforce issues (in numbers, distribution, knowledge and training of mental health professionals, especially nurses) at both the Commonwealth and State and Territory levels. This includes both their education needs and the content of curricula for mental health professionals.
- Introduce item numbers and other financial incentives for private psychiatrists to i) consult with primary care staff with a focus on rural and remote practitioners; ii) routinely conduct initial and crisis assessments; iii) provide data relating to the outcomes of their interventions; and iv) act in collaboration with other components of the wider mental health service system.

Rural and remote

- Make additional funding available to i) improve services in rural and remote regions including enhancing the telehealth capacity; ii) establish additional centres for rural and remote mental health modelled on existing centres of excellence that have produced value, practical understanding, and effective services in non-metropolitan settings.

Quality Assurance

- Establish stronger lines of accountability for the implementation of service standards and the routine use of outcome measures.

Shared care

- Nurture and further develop shared care resources in primary mental health care including offering incentives to encourage psychiatrists to consult to primary care practitioners.

Treatment options

- Consider imaginative and innovative options needed for the longer-term stability of viable mental health services, such as a psychosocial rather than a medical model with enhanced roles for professionals who are not medical doctors, and fund them through Medicare.
- Increase services to those with disorders of high prevalence focusing especially on early intervention opportunities in schools, the workplace, and the community to promote mental health and quality of life, and decrease disability.
- Eliminate barriers between mental health and substance abuse agencies and services at Commonwealth, State, Territory and local levels with the goal of establishing full integration of these two health services.
- Build upon dual diagnosis integrated programming and include care for a variety of co-morbidities to build a seamless system for consumers.

Promotion and prevention

- Consolidate programming and funding for promotion and prevention across i) multiple mental health diagnoses and ii) a variety of sectors and programs. The lead role in mental health promotion should be with mainstream, generic health promotion agencies.

- Integrate prevention activities with service sectors to attain better utilisation of skilled mental health clinicians.

Rehabilitation

- Make additional funding available to ensure that vocational rehabilitation and other disability support services leading to recovery are provided to people with mental health problems in parity with other disabled groups.

Consumers and carers

- Provide additional resources to support an expanded consumer and carer network to ensure i) their ongoing involvement in policy and program planning; ii) respite care for carers and iii) training for consumers, carers, and mental health advocates.
- Implement measures to further reduce stigma in Australian society.

Specific groups

- Enhance services for children and adolescents.
- Improve services to Aboriginal and Torres Strait Islander populations.
- Produce a national strategy for the improvement of mental health services in forensic, prison and detention centre settings.

AHA Recommendation 1

The AHA urges the Committee to recommend action in respect of the issues listed above.

Resources vs demand

The National Mental Health Strategy assumed that the proportion of health expenditure devoted to mental health would increase. However, data produced by the AIHW show that overall expenditure on mental health has remained stable since 1993-04.

According to the AIHW Report, *Mental Health Services in Australia 2002-03*, total expenditure for mental health disorders in 2000–01 was 6.7% ($3,861 million) of recurrent health care expenditure compared to 6.6% ($2,697 million) of recurrent health care expenditure in 1993-94 [AIHW 2005].

The majority of expenditure in 2000-01 was for hospital services (31.0% of mental health care expenditure or $1,196 million), community mental health services (21.8% or $842 million) and pharmaceuticals (15.9% or $615 million). In the same period, expenditure on Alzheimer's disease and other dementias totalled $2,679 million and the majority of this expenditure occurred in aged care homes (87.3% or $2,339 million) [AIHW 2005].

AHA considers expenditure of 6.7% to be insufficient to meet the existing demand for services, much less future needs. The growing impact of mental illness within the Australian population has become increasingly apparent and this situation can only worsen as costs of providing mental health care are expected to rise substantially.

The 1997 *National Survey of Mental Health and Wellbeing* by the Australian Bureau of Statistics found that 18% of adults in the community had a mental disorder in the twelve months prior to the survey. The prevalence of mental health problems in children and adolescents in Australia was 14% of the population and 3% of Australian adults experience serious mental illness such as a psychotic disorder. The 1999 AIHW report titled *Burden of Disease and Injury in Australia* indicated that mental disorders constitute the leading cause of disability burden in Australia,

accounting for an estimated 27% of the total years lost due to disability. The 2001 *National Health Survey* reported increases in the rates of severe psychological distress among adults in the community from 8.2% in 1997 to 12.6% in 2001. Ten per cent of adults reported they had a long-term mental or behavioural problem and 9.5% of people had taken a pharmaceutical medication in the last two weeks for a mental health-related condition.

Factors recognised as contributing to increased costs for mental health services include:

- Increased utilisation by those who do not currently use services [estimated to be 62% of persons] and those who now receive grossly inadequate services;
- Increased expectations for early intervention, in more specialised forms and for longer periods, by those with disorders;
- Increased public, business and professional awareness of the total societal burden and economic costs of untreated mental disorders;
- Changing population patterns of illness; for example, as the rates of illness continue to increase in younger persons the costs of direct treatment and associated disability and unemployment support will also increase;
- The costs of purchasing new pharmaceuticals affecting the central nervous system (which need to be imported);
- Societal pressures such as urbanisation and experience of civil disturbance.

AHA Recommendation 2
AHA calls for a significant increase in funding for mental heatlh services.

Barriers to implementation
Successful implementation of the National Mental Health Strategy requires a collaborative effort between the Commonwealth Government and the governments of all States and Territories working with consumers, carers and mental health sector representatives, through the AHMAC National Mental Health Working Group. Under current arrangements, the Commonwealth's role in implementing the Strategy is to coordinate mental health system reform on a national basis, monitor the reform process, and disseminate information in annual reports on national progress in achieving the agreed outcomes. The States and Territories are responsible for implementing the public sector reform initiatives as part of their service delivery role.

In the view of the AHA, Australia's current system of funding and delivering health services is far from optimum. The fact that both levels of government are responsible for healthcare in Australia is a major impediment to any reform process, including in a specific area such as mental health. Problems that are reducing the efficiency and the effectiveness of all parts of our system include:

- Inefficiencies, due to cost-shifting and funding duplication between the Federal and State governments;
- A lack of accountability for health funding, due in part to the Federal/State division of responsibilities;
- Gaps in service provision due to cost-shifting and deficiencies in integration across jurisdictions;
- Not enough consumer and community involvement in priority setting within the health system; and
- A lack of coordination across health care settings and between health care professionals.

Many of these problems arise from deficiencies in the overall coordination of the health system. They relate to underlying structural problems and not simply

organisational or management issues. Therefore, addressing these problems will require structural changes, which should be the highest priority for health system reform. Superficial modifications to program delivery will not increase the effectiveness and the efficiency of the system over the long term and will just defer the need for structural reform. The AHA has developed seven principles to guide such a reform process. They are:

1. Clear political accountability for adequate funding of healthcare;
2. Clear accountability of healthcare providers to funders;
3. Incentives to ensure that care is provided in the most appropriate setting by the most appropriate provider;
4. Integrated planning across jurisdictions, healthcare settings and professional groups;
5. Consumer and community involvement in priority setting;
6. Removal of incentives for cost-shifting; and
7. Increased funding for areas of need.

Meeting these criteria would require major structural reform to our current system and there are a number of options that could be considered. These include having the Commonwealth take over responsibility for all public health services or, on the other hand, devolving responsibility for all health services to the states. Within these two extreme points of the reform spectrum there are a number of different degrees of change and variations on how reform could be achieved.

AHA Recommendation 3
The AHA recommends serious discussion among Health Ministers to consider reforming Australia's system of health financing including the option of the Commonwealth taking over full funding responsibility for the public system.

b. The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care

Deinstitutionalization and the balance between hospital and community services

A major objective of the National Mental Health Strategy was to shift the mental health service balance away from the historical reliance on separate psychiatric hospitals to i) mainstreaming care within general health services and ii) providing a significantly increased level of community based services.

In this respect, the Strategy seems to have triggered significant reform. In 2000-01 expenditure on hospital services was 31.0% of total mental health care expenditure, down from 40.5% in 1993–94. Furthermore, at the commencement of the Strategy, 55% of acute psychiatric beds were located in specialist mental health units in general hospitals. By June 1998, general hospitals housed 73% of acute psychiatric beds as a result of a reduction in stand-alone acute services, coupled with 34% growth in general hospital-based beds through the commissioning of new or expanded units.

While deinstitutionalization as a general policy thrust is viewed positively by stakeholders, inadequate resources directed to the community sector have limited adjustment to the transition, resulting in marginalization of mental health services and

the fragmentation and exclusion of services for people with mental disorders. Deinstitutionalization is a complex process which must be accompanied by the development of a comprehensive network of alternative services in the community. It is a mistake to believe that community treatment would enable governments to spread the cost of treatment to other providers or that it would be more cost-effective than the increasingly expensive institutional care of chronic inpatients [WHO 2003].

Inadequate funding for establishing infrastructure and human resources in community-based services, provided concurrently with the deinstitutionalization program, have resulted in existing services, both hospital and community care, becoming stretched beyond capacity.

Unmet need for services

As with general health care, mental health services in Australia are delivered through a mixed public and private delivery and financing system. Provision of services outside the health system necessary for optimal outcomes include housing, disability support, domiciliary care, income support, employment and training programs.

The majority of people with mental disorders still receive either no treatment or treatment that fails to meet current international standards for optimal care. According to the Mental Health Council of Australia (MHCA) report *Out Of Hospital, Out Of Mind!,* only 38% of persons with mental disorders access care and less than one in six persons with depression or anxiety are currently receiving evidence-based treatments [MHCA 2003].

The MHCA report also found that an overwhelming perception of those who currently use or provide mental health services was that those living with mental illness continue to be ignored. The *Out Of Hospital, Out Of Mind!*, Report says that, “after two 5-year National Mental Health Plans this does not represent a failure of policy, but rather a failure of implementation. This includes poor government administration and accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutions”.

Mechanisms for managing demand should include national agreement on the level and mix of mental health services.

Acute sector

Managing demand in the acute health sector, including in emergency settings, is critical. Despite growth in the number of beds (above), demand is growing and there are increasing problems due to lack of access to inpatient care. This leads to a process of hospital admission and discharge that is forced to prioritise only those who require acute care, resulting in many patients failing to receive suitable care and others being discharged inappropriately early without the support of transitional services. To ensure a proper functioning acute mental health service, provision must be made for:

- Improved 24-hour access to specialist mental health services through emergency departments, supported by consistent and effective triage;
- Improved 24-hour availability of ambulatory crisis teams as an alternative to hospital emergency assessment;
- Improved access to inpatient care;

- o Increases in the availability and capacity of transitional care services in order to provide a high level of support for patients on discharge from hospital care; and
- o Expanded consultation and liaison across mental health services.

Community sector

Expensive specialist services are not necessarily the answer to access. Even within the resource constraints of health services in nearly all countries, significant improvements in the delivery of mental health services can be achieved by redirecting resources towards services that are less expensive, have reasonably good outcomes and benefit larger proportions of populations.

According to the AIHW Report, *Mental Health Services in Australia 2002-03* [AIHW 2005], private medical services continue to be the main providers for people with mental health problems, with over 10 million GP consultations a year for mental health related conditions and around 2 million visits to private psychiatrists. This compares with 4.7 million service contacts between patients and community-based mental health services and hospital outpatient clinics.

However, the decline in bulk-billing is placing pressure on GP interventions. Furthermore, the number of psychiatrist attendances has been falling slightly each year for the last five years, perhaps because these services are grossly maldistributed and involve large out-of-pocket costs. This statistic underpins reports from GPs that they are poorly supported by specialist care services [MHCA 2003]]. The situation is further exacerbated because access to specialist psychology and other allied health services is restricted, largely by lack of government or private insurance support.

The decline in private psychiatric services was accompanied by an 11.4% increase in the number of medical officers employed in public mental health services between 1998–99 and 1999–2000. The total number of psychiatrists employed in both public and private sectors increased 9.9% between 1998 and 2002 [AIHW 2005]. Although this trend is encouraging, workforce shortages will limit the industry's ability to reach optimum staffing levels.

AHA Recommendation 4
The AHA recommends national agreement on the level and mix of mental health services in order to better manage demand at all levels of the system.

c. Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care

Continuity of care is a key challenge as yet unrealised in the provision of mental health services. Ideally, all services should be linked to form a single, integrated service system that emphasises continuity of care, both over time and across service boundaries, mainstreamed with the health system as a whole. Continuity of care can be achieved through the development of care pathways that are consistent with evidence-based practice and processes for measurement. Care pathways should enable a consumer to access and progress through various levels in the system in a timely way without 'falling into gaps'.

This progression requires the components of the system, whether primary, specialist, hospital or residential, to be identified and integrated into one sustainable service. Components include: early intervention, ambulatory assessment/treatment, crisis intervention, community treatment, inpatient treatment (acute and long-term), day-hospital care, rehabilitation and disability support and relapse prevention.

The responsibility for these different components spans Commonwealth, state and territory governments, as well including different departments within these governments. This division of responsibilities creates major barriers to continuity of care.

Difficulties in linking programs funded by different providers lead to a lack of communication between services. Consumers are unable to navigate their course between services and often fall 'between the gaps'. The impact of this is felt most noticeably at the boundary of Federal and State Government services and causes fundamental breaks in continuity of care at the hospital-community interface. For example, there is often a break-down in communication between crisis hospital and assessment teams (funded by State governments) and GPs (funded by the Federal Government), regarding notices of admissions and discharges, just at a time when patients are most vulnerable.

AHA recommendation 5
AHA would prefer a national system of Healthcare in which the Commonwealth Government had full funding responsibility and states/territories undertook to deliver services. In the meantime, there needs to be clearer accountabilities for each level of government including greater transparency in the use of funds tied to an agreed set performance indicators.

d. The appropriate role of the private and non-government sectors

Hospital care – public-private comparison

According to the AIHW Report, *Mental Health Services in Australia 2002-03*, although the total number of hospital admissions for mental health-related conditions remained fairly stable between 1998-99 and 2002-03 (with an overall increase of 5% over the 4 years), the number of admissions to public psychiatric hospitals in that time fell by 24% to 14,570 as a result of deinstitutionalization. Mental health-related admissions to public acute hospitals rose by more than 11% over the 4 years (to 140,435 admissions), and admissions to private hospitals fluctuated around 37,000 each year.

The same Report found that there were 2,926,670 patient-days attributed to non-ambulatory-equivalent mental health-related separations in 2002–03. The number of patient-days for public acute hospitals increased by 8.9% between 1998–99 and 2002–03, the number for private hospitals increased by 5.4% and the number for public psychiatric hospitals decreased by 28.7%. Private hospital separations had longer average lengths of stay (ALOS) than public acute hospital separations and increased to 16.3 days for 2002–03. In 2002–03, the median lengths of stay for public acute and private hospitals were 5 and 12 days, respectively.

Same-day care for a hospital admitted patient can be considered to be ambulatory-equivalent. The number ambulatory-equivalent mental health-related separations per 1,000 population increased in the private sector by 50.0% and decreased in the

public sector by 18.8%. Overall, the number of increased from 82,326 in 1998–99 to 108,946 in 2002–03, as a result of deinstitutionalization and mainstreaming policies [AIHW 2005].

The AHIW Report provides the following description of types of services provided in the public and private hospital sectors.

Types of services – public-private comparison

Of all public acute hospital separations with specialised psychiatric care, approximately 23% had a principal diagnosis in the s*chizophrenia* grouping, which also accounted for approximately 33% of reported public acute hospital patient-days and psychiatric care days. Approximately 14% had principal diagnoses of *depressive episode*, which accounted for about 11% of public acute hospital patient-days and psychiatric care days.

Separations with principal diagnoses of d*epressive episode* accounted for around 25% of all private hospital separations, patient-days and psychiatric care days. Separations with principal diagnoses of *recurrent depressive disorders* were the next largest group, accounting for approximately 18% of all private hospital separations and about 16% of patient days and psychiatric care days. The most common same-day separations with specialised psychiatric care in private hospitals were those with principal diagnoses of *depressive episode* (40.9%) and *recurrent depressive disorders* (37.2%). For overnight separations with specialised psychiatric care, the corresponding figures were 22.8% for *depressive episode,* 15.6% for *recurrent depressive disorders* and 10.7% for r*eaction to severe stress and adjustment disorders*.

Over 25% of all public psychiatric hospital separations with specialised psychiatric care and 51.5% of all psychiatric care days in public psychiatric hospitals were attributed to principal diagnoses of *schizophrenia*. Principal diagnoses of *Schizophrenia* also accounted for the largest proportion of specialised overnight separations and patient-days in public psychiatric hospitals (26.9% and 52.0% respectively).

Public-private partnerships

It is clear that, as with healthcare generally, there is a statistical difference in the types of services mainly provided in the two sectors. For many conditions requiring emergency admission or involving complex conditions and/or complications, and for people living away from metropolitan regions, private hospitals do not offer a substitute service for public hospitals.

The AHA supports more effective partnerships between the public and private hospital sectors including improved mechanisms for collaboration. Implementation of greater coordination and collaboration would require the involvement of health funding bodies and the health insurance industry. A revised system could incorporate mechanisms to fund private hospital mental health service providers to become more involved in crisis response and initial care and to facilitate greater consultation with primary care practitioners.

Additionally, it would be beneficial if private sector patients had improved access to public services such as allied health practitioners (eg. occupational therapy) and rehabilitation, for more inclusive and comprehensive care.

In addition, there is room for better linking of GPs and the public and private mental health sectors, including better discharge planning and improved access by GPs to psychiatrists and other mental health professionals. The expansion of programs that provide financial incentives for private psychiatrists to i) consult with primary care staff with a focus on rural and remote practitioners; ii) routinely conduct initial and crisis assessments; iii) provide data relating to the outcomes of their interventions; and iv) act in collaboration with other components of the wider mental health service system would encourage greater liaison.

AHA Recommendation 6

AHA recommends the consolidation and extension of partnerships between the public and private sectors in the acute and community sectors including the use of appropriate financial incentives.

g. The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness

Workforce re-alignment and re-training

AHA recognises the dedication and skills of providers. Any failings of the system derive principally from the manner in which the transition from institution to community-based mental health services has been managed. Institutional care services must be replaced with efficient, effective and reliable community services. Greater integration is required between programs that are fragmented across levels of government and among many agencies.

Workforce re-alignment and re-training is critical and has lagged behind the organisational reforms. New models of care resulting from the shift away from institutional care towards community care challenge the skills of those working in mental health. It is important that practitioners acquire and maintain new knowledge, skills and attitudes to provide quality services in this new service environment. It is particularly important that workers allow those with a mental illness and their carers to play an active role in decisions regarding their treatment.

Teams and partnerships

When a serious mental illness or a serious emotional disturbance is first diagnosed, the primary health care provider - in full partnership with consumers and families - should develop an individualized plan of care for managing the illness. This partnership of personalised care should be supported through a team approach which facilitates integrated services across sectors. A multi-disciplinary team approach to service delivery is an underpinning factor in the National Mental Health Strategy.

Incentives are required to encourage establishment of professional teams across the different professions and services. This is particularly crucial to ensure access as psychiatrists tend to work in the private sector. Barriers to a collaborative team structure include different values and approaches to working with clients, the need to maintain ownership of a particular area or department, fear of competition for funds and protecting confidentiality of clients.

The lack of standardisation of legislation and practices across States and Territories is also a major impediment, negatively impacting on the transfer of information

between sectors and States. Another barrier is the misunderstanding between professions and lack of awareness of roles. The different perceptions of each other's roles would be mitigated through joint educational training programs for professionals.

Consumers believe that, where GPs, psychologists and/or mental health nurses work together, services are more efficient and comprehensive and access is improved [MHCA 2003]. An expansion of incentives is needed to encourage psychiatrists to provide a 'consultant' service to GPs and other primary care providers[3] and to facilitate shared mental health care. The AHA believes that Divisions of General Practice should be encouraged to administer mental health shared-care arrangements as a permanent and natural component of their activities. Targeted and ongoing funding for Divisions to establish such projects should continue, taking into account results of projects already under-way or completed.

Workforce mal-distribution

The mal-distribution of the mental health workforce remains a serious issue. Consumers in urban fringe, rural and remote areas experience significant difficulties in accessing specialist care. In 2002, Australia had 12.1 psychiatrists per 100,000 population (including 1.0 non-clinician and 3.0 psychiatrists-in-training). Major cities had a relatively high number of psychiatrists per 100,000 population than remote and very remote areas [AIHW 2005].

In 2001, 12,094 nurses identified psychiatric and mental health nursing as their main area of nursing. They accounted for 6.0% of all employed clinical nurses. There were 62.2 mental health nurses per 100,000 population in 2001, a level consistent with previous years. Major cities and inner regional areas had relatively high number of mental health nurses per 100,000 population. Remote and very remote areas had fewer of these nurses per 100,000 population, but rates increased between 1997 and 2001 [AIHW 2005].

To overcome this shortage, an integrated and collaborative approach is needed to create effective workforce development strategies to recruit and maintain professionals in rural practice.

AHA Recommendation 7

AHA calls for an urgent Ministerial Summit from the health, education and vocational training sectors work to develop a common approach to planning for the mental health workforce including:

- ***Developing a consensus on the optimal number and ratio of health professionals necessary to meet the population's mental health care needs, taking into account changing demography, advances in technology and patterns of service delivery;***
- ***Determining the extent of funding required for undergraduate and postgraduate education of mental health professionals and other workers;***
- ***Developing strategies to ensure effective use of available infrastructure for clinical training including joint educational training programs for***

[3] As a consultant, the psychiatrist sees and assesses the patient and recommends ongoing treatment, either by the GP or the psychiatrist. The emphasis on 'consultation psychiatry' is expected to increase over the forthcoming decade (AMWAC 1999).

professionals to foster increased awareness of each others' roles and to advance a multi-disciplinary team approach to care;

- ***Coordinating a nationally funded incentive and scholarship program aimed at recruitment and retention of a skilled workforce in targeted areas;***
- ***Developing a strategy for rationalising professional registration and accreditation requirements;***
- ***Targeted and ongoing funding for Divisions of General Practice to establish mental health projects should continue, taking into account results of projects already under-way or completed; and***
- ***Development of workforce development strategies to recruit and maintain professionals in rural practice.***

h. The role of primary health care in promotion, prevention, early detection and chronic care management

Primary mental health care

By supporting a strong focus on primary care the following will be achieved:

- Improved access to, and enhanced quality of, primary mental health services in all practice settings or locations.
- A more integrated and responsive mental health service with greater focus on patient, carer and community needs, including:
  - improved services for high prevalence disorders (eg anxiety and depression);
  - timely response for people experiencing, or at risk of experiencing, crisis; and
  - early intervention for young people either experiencing first-episode mental disorder, early signs and symptoms of mental disorder, or at risk of mental disturbance[4].

AHA Recommendation 8

AHA recommends measures be taken to achieve greater role clarification between general practitioners, specialists, nurses and allied health professionals, including increased shared-care arrangements.

n. The current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated

Although mental health research has made great advances in the last 5 decades or so, it is often limited in its application because studies and clinical trials have been small and localised, restricting researchers from drawing valid general conclusions. In order to justify evidence based policy and practice reform, larger scale research is required involving multiple sites.

The UK Mental Health Research Network "provides an infrastructure across England with a range of demographic and cultural differences together with specific service configurations which enables it to host large scale research projects in mental health.

[4] A 1998 study of Australian child and adolescent mental health found that 14.1% of 4-17 year-olds experienced mental health problems in the previous 6 months to being interviewed (Rey J in MJA April 2001).

Researchers using the UK MHRN can access the valuable high-level expertise within the network and can benefit from a coordinated approach to patient recruitment." The UK model incorporates eight research hubs which have clinical, academic and service user components. The clinical component consists of primary, secondary and social care and the academic component is a mix of high quality multi-disciplinary researchers from universities and research consortia.

The Network is designed to provide a research infrastructure and supports large-scale research which will help to raise the standard of mental health research. In addition, it acts as a central point of information and reference, connecting service users and carers to researchers and mental health professionals.

Such a Network would improve integration of resources, experience and expertise and, consequently, attract support from the major funding bodies.

AHA recommendation 9
AHA recommends the establishment of a Research Network (similar to the UK Mental Health Research Network).

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;

Comprehensive performance and quality measures for monitoring and evaluating mental health services have yet to be developed. While, the Commonwealth, state and territory governments are committed to providing routine consumer measures in public services and to the pooling of data nationally, the quality agenda needs to focus more on service quality, safety and outcomes (rather than inputs and structure). This can be achieved through a culture of measurement including the establishment of measurement systems and national benchmarking. A critical underpinning of this approach will be national agreement on appropriate levels and mix of services, together with addressing governance and workforce issues.

AHA recommendation 10
AHA recommends that all Australian governments should adopt national standards for quality and safety in mental healthcare services. The standards will ensure:

- ***Sufficient funding for high level scientific research and evaluation on the measurement and improvement of patient care, health status and outcomes subject to regular reporting on national trends and disparities in quality;***
- ***The use of nationally standardized information to create effective linkages between sources of health information from state/territory, regional, and local levels;***
- ***Quarterly analysis, at the national level, of data on high-level adverse events;***
- ***Active consumer involvement and public access to an annual report of national adverse events;***
- ***Increased resourcing for safety and quality improvement in Australia's public services;***

- ***Workforce reform focused on a multi-disciplinary team approach to care underpinned with education and training programs that encourage a culture of safety and greater openness in the system;***
- ***Evidence-based practice as part of routine service delivery;***

A nationally standardized Information Framework would incorporate indicators to measure:

- ***Per capita utilisation of all services regardless of setting (acute, residential, community);***
- ***Timeliness and availability of access for each service type broken down by socio-economic status, location and ethnicity;***
- ***Whether services are appropriate and safe (free from avoidable harm), based on standards and are responsive to patient/client needs;***
- ***The degree of integration and coordination of services;***
- ***Effectiveness of outcomes;***
- ***The degree of efficiency in the use of resources;***
- ***The level of skills and knowledge of the providing individual or agency;***
- ***The capacity of the system to maintain a sustainable quality of care through its workforce, facilities and equipment and to be responsive to change and emerging needs; and***
- ***The identification and qualitative assessment of emergent causal factors and trends that have the potential to compromise optimal performance.***

- ***The Framework would require all providers and agencies to create a culture of learning and evidence-based decision-making.***

p. The potential for new modes of delivery of mental health care, including e-technology

Interactive telecommunication and information technologies make it possible for mental health providers to literally be in two places at once, extending scarce resources to individuals, and to entire regions, that are underserved. The range of mental health services provided to rural consumers over a telehealth network is virtually limitless and can involve all services not requiring direct physical contact with the client.

Telehealth applications also enhance continuity of care. A "virtual treatment team" can be formed between all professionals involved in the care of the patient facilitating continuity; for example, between hospital and community, and allowing family members to be more involved in treatment and discharge planning.

Telehealth networks may also be used for education and training for mental health staff, and to bring consumers and family members together for information and support.

Though outcome studies are limited to date, informal findings suggest that telehealth improves continuity of care, increases family and consumer involvement in treatment, and reduces length of stays and readmission rates. Participant satisfaction surveys reveal that consumers perceive telehealth services as worthwhile, of high quality, and worth continuing [MHCA 2003].

Start-up costs for a telehealth network are becoming more affordable due to decreasing equipment costs. However, the single biggest limitation on the use, expansion, and long term sustainability of telehealth systems is often the ongoing telecommunication costs. The more advanced the transmission technology, the greater the bandwidth a telecommunications system will have available (the information-carrying capacity of the telecommunications channel). At higher bandwidths, picture and sound are transmitted more quickly and with better quality. Lower bandwidth systems are more affordable, but they create noticeable lags in video and audio transmission that may negatively impact the service applications [Smith & Allison 1998].

AHA believes that telehealth, in particular in mental health services, have the potential to diminish location-based inequities in mental health care. However, ongoing expenses often prove to be a barrier to continued operation and funding is required to sustain services.

AHA recommendation 11
A national strategy and funding program to establish comprehensive telehealth services for mental health care.

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References

AIHW 2005. Australian Institute of Health and Welfare. *Mental health services in Australia 2002–03*. Canberra: AIHW (Mental Health Series no. 6).

MHCA 2003: Mental Health Council of Australia. O*ut of hospital, out of mind!* A Report Detailing Mental Health Services in Australia in 2002 and Community Priorities for National Mental Health Policy for 2003-2008 APRIL, 2003. Authors: Groom G, Hickie I & Davenport T

Smith HA & Allison RA 1998. *Telemental Health: Delivering Mental Health Care at a Distance* (A Summary Report). U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thornicroft G & Betts VT [2001]. *International mid-term review of the second national mental health plan for Australia*. Mental Health and Special Programs Branch, Department of Health and Ageing, Canberra.

WHO [2003]. The mental health policy and service guidance package: the mental health context

Terms of Reference

The Select Committee on Mental Health, was appointed on 8 March 2005 to inquire into and report by 6 October 2005 on the provision of mental health services in Australia, with particular reference to:

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

c. opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

d. the appropriate role of the private and non-government sectors;

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

h. the role of primary health care in promotion, prevention, early detection and chronic care management;

i. opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

k. the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

l. the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

p. the potential for new modes of delivery of mental health care, including e-technology.