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CENTRE FOR PSYCHIATRIC NURSING RESEARCH & PRACTICE

SUBMISSION: SENATE SELECT COMMITTEE ON MENTAL HEALTH

CPNRP Level 1, 723 Swanston Street CARLTON VIC 3053

Introduction

The Centre for Psychiatric Nursing Research and Practice is an initiative for psychiatric nurses and other stakeholders throughout Victoria, including clinicians, managers, academics and researchers from metropolitan and rural areas. The Centre works with psychiatric nurses, consumers, carers and other members of the multidisciplinary team to bring about the ongoing development and improvement of clinical practice.

The CPNRP has prepared a report which comments on specific terms of reference relevant to the Centre and have included an Executive Summary and Recommendations. Also included are additional attachments to provide further evidence of statements made throughout the report.

Aim

The primary aim of the Centre is to contribute to the ongoing development and advancement of psychiatric nursing practice in order to enhance the well-being of consumers of Mental Health Services. The CPNRP, therefore, recognizes practice as paramount. Research, education and professional development exist to support, be guided by and, where necessary, to challenge current clinical practice.

The CPNRP is committed to programs and other initiatives designed to bridge the gap between practice, research, education and professional development, to promote the unification of psychiatric nursing towards a common, consumer focused goal.

Development of the CPNRP

Funded by the Mental Health Branch of the Department of Human Services, Victoria, the CPNRP is located at the School of Nursing, The University of Melbourne, and is operated in partnership with North Western Mental Health, Melbourne Health. The CPNRP officially commenced operation in November 1999.

The CPNRP is funded to address education, professional development and research issues, particularly as they relate to psychiatric nursing practice, with the aim to facilitate and oversee changes in nursing practices in order to improve health outcomes for consumers of mental health services.

Executive Summary

1. Despite positive advances in the area of consumer perspective and focus in the National Mental Health Strategy, lack of genuine opportunities, and commitment of adequate resources for consumers to participate effectively in the planning, implementation and evaluation of service delivery hamper progress significantly.

2. Research undertaken by the CPNRP suggests that, despite increased contact with consumers experiencing mental health problems since mainstreaming, health professionals, particularly nurses, are not adequately prepared to provide optimum care for this population. Education and training to provide this level of care has not been provided.

3. Although 20% of the population experiences mental illness, only 7% of the health budget goes to mental health, leaving a 13% gap in expenditure, and therefore mental health care.

4. Increased Commonwealth expenditure on mental health has not been matched by Victoria; further, two thirds of the increased Commonwealth expenditure on mental health was simply increased pharmaceutical costs (402%).

5. Only 1.8% of recurrent expenditure on health was spent on public psychiatric hospitals. Only 1.6% of expenditure on health was spent on mental health research. Only 5.7% of health expenditure per person in Australia was spent on mental health.

6. Disablement is associated with poorer life satisfaction and a greater likelihood of not being in the labour force. Anxiety disorders, affective disorders and substance use disorders account for 5.9 million person days per month disablement.

7. Funding for mental health research is currently inadequate and fails to reflect the impact of mental health issues. Only 1.6% of expenditure on health was spent on mental health research.

8. The outcome assessments selected by the Federal Government do not assess domains of interest or aspects of mental health care and service provision that are important to service users and their carers.

9. Although National and State Mental Health Plans emphasise the importance of consumer participation, particularly in the planning, monitoring and review of mental health services, there is little evidence that consumers are meaningfully and substantially involved in the development of the methods and procedures used in the monitoring and review of services.

Recommendations

1. The implementation, evaluation, and adequate resourcing of strategies to ensure genuine consumer participation at a systemic level, for example:

- Competitive funding provided for the implementation of consumer academic positions.
- Creation of consumer held positions within each state mental health branch to co-ordinate and promote consumer perspective activities; develop consumer governance models; set up mechanisms where the needs of the consumer workforce can be addressed; mechanisms through which can be addressed the provision of funding for consumer initiated projects, research and other programs.
- The capacity for these consumer positions to have face to face meetings bi-annually and be a 'think tank' for the promotion of consumer perspective and its activities.
- The inclusion of 'consumer perspective' in future government thinking and documentation as an integral though distinctive practice and discipline in the mental health workforce.
- The implementation and evaluation of training packages to enhance knowledge, skill and positive attitude development in health professionals throughout the general health care system
- The creation of a Mental Health Commission to continually monitor the state of all matters pertaining to mental health nationally, including the capacity to perform a consumer and carer advocacy role; to initiate studies in aspects of mental health issues and issue recommendations and monitor the efficacy of current and future mental health plans.

2. The provision of funding for an exploration and evaluation of strategies currently employed in emergency departments to improve the quality of care for people experiencing mental health problems, with the view to identifying best practice.

3. The provision of funding to support initiatives designed to increase the detection of people receiving care and treatment within mental health services who also have a problem with drug and/or alcohol usage

4. A substantial increase in research monies, to fund initiatives aimed at improving the detection of and, enhance initiatives to address dual diagnosis problems.

5. The availability of funding to introduce new, or enhance existing services with the specific scope of addressing dual diagnosis issues

6. The training and resourcing of consumers so they can develop and occupy specialist non – employee consumer perspective roles such as advocacy, peer support, educator, researcher, supervision to mental health practitioners, project officers, complaints officers and so on within mental health services.

7. That consumer perspective education inform how the practioner can facilitate the self determination of the consumer and that consumer perspective be used to evaluate the effectiveness of strategies to support consumer self determination**.**

8. That funding be allocated to develop peer support programs, and consumer operated services in each state and territory, and that consumers define recovery and what approaches/resources should be used to facilitate recovery

9. That consumer perspective is seen to be a sixth discipline in mental health - requiring funding and resources to develop and deliver curricula materials to the mental health workforce.

10. That a consumer perspective curricula, research and training centre be established in each state and territory that can develop, deliver and evaluate consumer perspective curricula; support Consumer Educators and Consumer Researchers with their training needs; tender competitively; assist and evaluate such projects as peer support programs; consumer operated services and promote consumer perspective projects.

11. That a mechanism be established whereby a consumer initiated research agenda is then resourced and developed using the above networks and data gathered from the testimony of consumers.

12. That this research agenda is then funded to target enquiry into the experience of seclusion and detention; involuntary treatment in the community; the impact of this on wellbeing, and possible strategies to avoid iatrogenesis.

13. The implementation and evaluation of training packages to enhance knowledge, skill and positive attitude development in health professionals throughout the general health care system.

14. The provision of funding for an exploration and evaluation of strategies currently employed within the general health care system to improve the quality of care for people experiencing mental health problems, with the view to identifying best practice

15. That increased funding to be made available specifically targeting mental health research, and that research funding guidelines encourage multidisciplinary research teams.

16. Given that nurses make up the largest single professional grouping with the mental health sector, and that they have direct contact with consumers, it is imperative that not only mental health research spending be increased, but that it particularly be increased to fund research undertaken by, and including, mental health nurses.

17. Given that the National Mental Health Plan indicates a need for consumer perspective to be included within mental health services, mental health research should include the funding of consumer-focused research as well.

18. The development of outcome assessments which do assess domains of interest or aspects of mental health care and service provision, that are important to service users and their carers.

19. Increased and more appropriate use of information and data which is routinely gathered to enable improved outcomes for consumers and carers.

Term of Reference: 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.

Major Issues

A.1. "One of the most chronically disadvantaged groups in this country continues to be ignored. After two five-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" (Groom, Hickie, & Davenport, 2003, 'Out of Hospital, Out of Mind!', p.ii.).

A.2. The primary aim of the National Mental Health Strategy (NMHS) was to improve the lives of people experiencing a mental illness through the development of a more consumer focused and less institutionally based system of care. Despite positive advances in the area a number of barriers continue to exist, including:

- Lack of genuine opportunities and commitment of proper resources for consumers to participate effectively in the planning, implementation and evaluation of service delivery at either an individual or systemic level, or to deliver peer support and consumer operated services, or to provide education and training of the mental health workforce and in tertiary training.

- The mainstreaming of mental health services has substantially increased contact with consumers experiencing mental health problems by the general health care sector. Research undertaken by the CPNRP, (see Attachment One) demonstrates a high prevalence of significant mental health problems throughout the general health care system. Further research clearly indicates that health professionals, particularly nurses, are not adequately prepared to provide optimum care for this population. Education and training to provide this level of care has not been forthcoming. (see Attachments Two and Three).

Important Mental Health Figures

A.3. Australia spend approximately 7% (or $2.56 bn) of its health budget on mental health. However, research shows that 20% of the population experiences mental illness – leaving a considerable 13% gap in expenditure. Although international comparisons can only be

approximate, other first-world countries report spending 10-14% of total health expenditure on mental health.

A.4. Despite the increased expenditure in mental health over the last decade, there is no evidence that the proportion of total health expenditure devoted to mental health has increased. Increases in expenditure on mental health (46%) have simply mirrored increases in the costs of providing other forms of health care (42%).

A.5. The National Mental Health Strategy assumed that the proportion of health expenditure devoted to mental health would increase. While the Commonwealth did increase its contribution significantly (by 73% per capita), growth in State and Territory expenditure was only 19.8% per capita. Victoria recorded a very low increase of and 4.4% per capita.

A.6. Whilst growth in Commonwealth expenditure was significant, over two thirds of this was accounted for by the increase in pharmaceutical costs (402%) rather than planned or appropriate expansion of service systems, or support for non-pharmacological treatments.

(Figures taken from Groom et.al p.3)

Relevant figures from (Australian Institute of Health and Welfare, 2004) – Australia's health 2004

A.7. *Australia's health 2004* is the "nation's authoritative source of information on patterns of health and illness, determinants of health, the supply and use of health services, and health services expenditure".

- Total health expenditure in 2001-2002 was $66,582 million or 9.3% of national GDP (p. 229). Health expenditure per person was $3,292 in 2001-02.

- In 2001-02, recurrent expenditure on health was estimated at $62,693 million, or 94.2% of total expenditure on health. The largest component of recurrent expenditure in 2001.02 was for hospital services, totalling $22,236 million. This was made up of public (non-psychiatric) hospitals ($16,678 million), public (psychiatric) hospitals ($409 million) and private hospitals ($5,149 million). Only 1.8% of recurrent expenditure on health was spent on public psychiatric hospitals.

- In 2001-2002, 6.0% ($2,929 million) of the total health expenditure was spent on mental disorders (does not include $778 million spent on public community mental health services). The amount spent on each health system cost is outlined below. Of note, only $109 million is spent on research relevant to mental disorders. This constitutes 9.2% of the total amount spent on health research in 2001-2002. Only 0.16% of expenditure on health was spent on mental health research.

- According to the Australian Bureau of Statistics, Australia's estimated resident population at June 2002 was 19.7 million. Therefore, of the $3,292 of health expenditure per Australian in 2001-2002, only $188.17 was spent on mental health

care (this includes hospitals, aged care homes, out-of-hospital medical services, dental and other professional services, total pharmaceuticals, research and public mental health services).

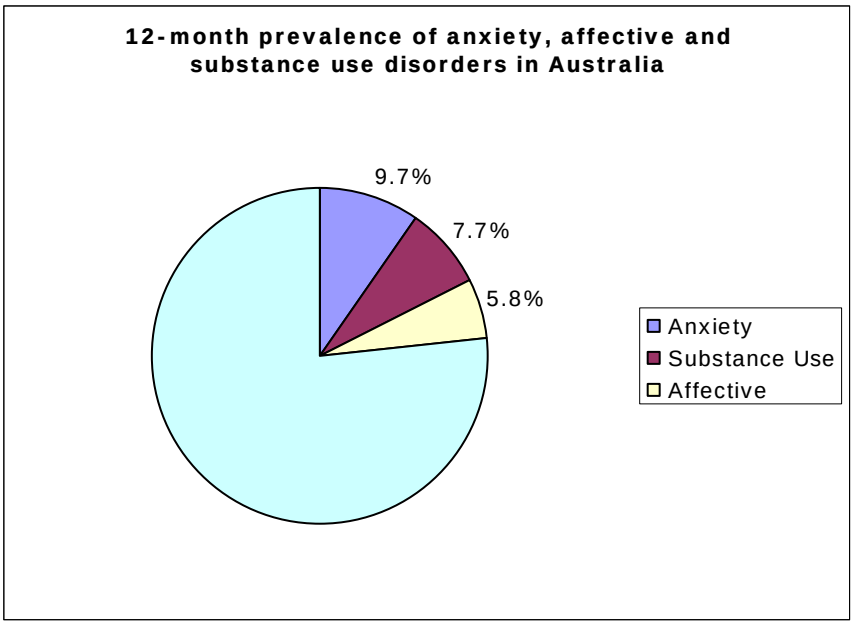
- In 2001-02, specialised mental health services (with residential facilities included) had a recurrent expenditure of $778 million and an average of 9,785 full time-equivalent staff (AIHW, 2004). Staff numbers increased by 12.8% over the 3 years from 1998-99.

- Schizophrenia, schizo typal and delusional disorders accounted for over 48% of service contacts for which a principal diagnosis was reported. Principal diagnoses of mood (affective) disorders and neurotic, stress-related and somatoform disorders accounted for 25% and 10% of these service contacts, respectively.

Relevant figures from the National Survey of Mental Health and Well Being (Andrews, Hall, Teesson, & Henderson, 1999; Dear, Henderson, & Korten, 2002; Henderson, Andrews, & Hall, 2000; Korten & Henderson, 2000)

A.8. The National Survey, conducted in 1997, was based on the responses of 10,641 Australians aged 18-99 years who were representative of the Australian adult population.

The rate of mental disorders in a 12-month period



A.9. A little less than one in five Australian adults (17.7%) had an anxiety, affective or substance use disorder (or more than one of these disorders) in the past 12 months. These prevalence rates mean that overall, approximately 2,383,000 Australian adults had a mental

disorder within the previous 12 months (this figure is based on the size of the Australian population in 1997; therefore, the figure would be greater now). (n.b., these rates most likely represent an underestimate as they do not include low-prevalence disorders – e.g., schizophrenia and responses from homeless people and the residents of nursing homes, hospitals and hostels, and prisons where higher rates of mental disorders are usually found).

A.10. Disablement is associated with poorer life satisfaction and a greater likelihood of not being in the labour force.

A.11. Overall, anxiety disorders account for some 2.7 million person days out of role per month among adults in Australia. The corresponding figure for affective disorders and substance use disorders are 2.1 million and 1.1 million person days per month respectively.

Service Access

A.12. For all persons who had one or more of the common mental disorders, 65% had not used any form of health service in the previous 12 months. This does not say much for prevention and early intervention if the overwhelming majority of people with high prevalence disorders that are very disabling do not access treatments – particularly when most of the high prevalence disorders are highly treatable.

A.13. Of the relatively smaller proportion of people who sought treatment, most sought treatment from a general practitioner (29.4%) rather than a specialist mental health professional (6%) such as a psychiatrist, psychologist or mental health worker. This stresses the importance to ensure GP's are adequately trained and resourced when it comes to mental health.

Recommendations

- The implementation and evaluation, and adequate resourcing of strategies to ensure genuine consumer participation at a systemic level, for example.
- Competitive funding provided for the implementation of consumer academic positions.
- Creation of consumer held positions within each state mental health branch to co-ordinate and promote consumer perspective activities; develop consumer governance models; set up mechanisms where the needs of the consumer workforce can be addressed; mechanisms through which can be addressed the provision of funding for consumer initiated projects, research and other programs.
- The capacity for these consumer positions to have face to face meetings bi-annually and be a 'think tank' for the promotion of consumer perspective and its activities.
- The inclusion of 'consumer perspective' in future government thinking and documentation as an integral though distinctive practice and discipline in the mental health workforce.

- The implementation and evaluation of training packages to enhance knowledge, skill and positive attitude development in health professionals throughout the general health care system.

- The creation of a Mental Health Commission to continually monitor the state of all matters pertaining to mental health nationally, including the capacity to perform a consumer and carer advocacy role; to initiate studies in aspects of mental health issues and issue recommendations and monitor the efficacy of current and future mental health plans.

- That the committee seek advice from consumer networks and groups around the nation about how best to hear testimony from those interested in speaking to the committee about their experience of detention and seclusion, and or their experience of care standards, in the context of their human and civil rights

Term of Reference: B

The adequacy of various models of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hour's crisis services and respite care.

Major Issues

B.1. The research and training activities of the CPNRP have clearly demonstrated the problematic nature of mental health care delivery through the Emergency Departments of public hospitals.(see Attachment Four). The research literature clearly demonstrates the inadequacies in skill and knowledge of health care professionals in providing care for people experiencing mental health problems. Nurses in particular have been shown to have negative attitudes. The impact of attitudes on care delivery has been addressed in the literature, with clear conclusions that negative attitudes will reduce the quality of care provided. (see Attachment Five).

B.2. Emergency Departments have adopted a number of strategies to improve the quality of care provided to people experiencing mental health related problems, including Psychiatric Consultation and Liaison Nursing (PCLN) and enhanced Crisis Assessment and Treatment Teams (ECATT). A small number of research studies suggest that the PCLN role has had impact in improving the quality of care provided. There are currently no documented evaluations of the ECATT role.

Recommendations

- The implementation and evaluation of training packages to enhance knowledge, skill and positive attitude development in health professionals throughout the general health care system.
- The provision of funding for an exploration and evaluation of strategies currently employed in emergency departments to improve the quality of care for people experiencing mental health problems, with the view to identifying best practice

Term of Reference: 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

Major Issues

F.1. The CPNRP has a particular interest in the special needs of people experiencing a dual diagnosis of a mental illness and a drug and/or alcohol dependence. Despite widespread recognizing of the high and increasing incidence of dual diagnosis within the health care system there is a significant lack of services specifically designed to provide appropriate care and treatment to meet the needs of these consumers. Research conducted by the CPNRP demonstrates the deficiencies of skill and knowledge in mental health practitioners employed in CATT teams throughout Victoria. However, it demonstrates the improvement that an educational program can produce in the areas of knowledge, skill and attitude. (see Attachments Two and Three).

F.2. In recognition of the magnitude of this problem, the CPNRP is leading the development of a multi-disciplinary project to examine the practice of screening for drug and alcohol use in in-patient mental health services in metropolitan Melbourne and Rural Victoria. It is intended that the findings from this study will be utilized to identify, implement and evaluate strategies to enhance nurses' preparedness and ability to routinely screen for drug and alcohol usage on admission to mental health services. It is expected that training programs will be developed to enhance the progress of this initiative.

Recommendations

- The provision of funding to support initiatives designed to increase the detection of people receiving care and treatment within mental health services who also have a problem with drug and/or alcohol usage.
- A substantial increase in research monies to fund initiatives aimed at improving the detection of and enhance initiatives to address, dual diagnosis problems
- The availability of funding to introduce new, or enhance existing services with the specific scope of addressing dual diagnosis issues

Term of Reference: H

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

Major Issues

Iatrogenesis

H.1. Iatrogenesis refers to the trauma acquired through using mental health services independent of whatever issues bring a person to the attention of those services in the first instance. Iatrogenesis is likely to occur when service use is not on a voluntary basis. Involuntary service use can be in an acute hospital where the issues are both detention and treatment, or in the community, where the major issue is treatment. Recent research with asylum seekers and refugees shows that detention has a negative consequence for mental health and well being. (McGorry). It is no different for those incarcerated due to psychiatric illness. Absconding from mental health services is a regular phenomenon. One reason consumers give for this is not wanting to be in hospital because of forced treatment.

Consumer involvement in service reform

H.2. Consumer involvement in service reform has come a long way since the first National Mental Health Plan. However, such activities have been continuously under funded, and are sadly, therefore, far from where they might be. It has been tantalizing to watch the rise of the consumer workforce within mental health services, to see how much has been achieved, but to know how much more could be accomplished with proper funding, and more salaried time. Many innovative roles could be played by consumer employees. Service based Consumer employees have to severely limit their priorities, especially if they are only working an average of 12 - 16 hours per week. During this time they are often having to cover aged, adult and youth services, plus be involved in each discrete service program, initiate projects, respond to policy, planning and maintain consumer networks. In addition to service based consultancy, there is much scope for other specialty roles, where consumers would not be service employees. Education and training, research, peer support and the supervision of staff using consumer perspective are other such roles.

Consumer involvement in treatment

H.3. As a right enshrined in mental health legislation, the extent to which consumers are involved in treatment is a major issue. There are signs of new thinking about how to ensure this right. However, it is consumers who are best placed to begin the education

process to mental health practitioners about how to facilitate this right, and how to place the consumer at the centre, not the periphery of their own welfare - these are practice issues that need to be taught using consumer perspective. Consumer perspective should underpin thinking about how best to facilitate consumer self-determination, and inform evaluative research regarding the effectiveness of different interventions aimed at self determination in treatment. (see Attachment Six).

Recovery centres

H.4. The Soteria houses set up by Dr Loren Mosher are an example of a recovery centre without forced treatments. There are other recovery centres in Europe and The US, where outcomes are at the least comparable, usually better, than for standard acute hospital care. As the current rhetoric moves toward the language of recovery, it is critical that it is consumers who define this most individual and personal journey. We need the resources to develop and articulate our own deepening and sophisticated thinking about what works best for us, in terms of service provision, and in terms of our own well being and self care. Nobody else can do that for us, and no service or government can be confident of success without that knowledge, and without then directing resources to it.

Consumer operated services

H.5. We know that peer support and peer operated services work. (ref) Australia lags far behind New Zealand, the United Kingdom, Europe and the United States when it comes to resourcing consumer operated peer support and recovery services, so that it is not surprising to find there are almost **no such services** in the whole of the country, and therefore almost no current evaluative data. In fact, the money spent on consumer initiated projects and services is negligible. This is a serious gap, when we already know that these types of services work. If our National mental health plans are to be more than mere rhetoric, proper resources must be devoted to consumer initiated projects and services.

Peer Support

H.6. There are some states in which consumers have developed local peer support programs. These desperately need funding and resources if they are to succeed. They will also need to develop their own evaluation processes that suit their aims and needs and this too requires networking and funding. It is still as though everybody but the consumer has a stake in what should be provided.

H.7. This does not address the fact that in many states, peer support programs are completely unfunded, or do not yet exist except in very basic forms. While ever these important activities remain invisible, they cannot be built upon, and risk folding through lack of resources. In addition, invisibility means that conventional research does not investigate their positive outcome for people and so therefore many activities are never promoted.

Consumer perspective and the education of the mental health workforce

H.8. The Commonwealth Ministers National Mental Health Plans have since their inception, consistently articulated the importance of consumer perspective in the education and training of mental health practitioners, but the thinking about how to do this effectively and subsequent funding of activities has been left languishing. It is disgraceful that consumer perspective is largely still a 'one session add-on' in most tertiary mental health courses. We have had ten years of guidelines in National and State documents regarding the importance of consumer perspective in the education and training of the mental health workforce. We can only imagine the kind of attitudinal and systemic change that might have been possible by now through the influence of consumer perspective in the education of the mental health workforce, had these guidelines been backed up by a series of substantive consumer perspective academic and research positions across the five disciplines in mental health.

Recommendations

- That consumers be trained, and resourced to develop and occupy specialist non – employee consumer perspective roles such as advocacy, peer support, educator, researcher, supervision to mental health practitioners, project officers, complaints officers etc.

- That consumer perspective education inform how the practioner can facilitate the self determination of the consumer and that consumer perspective be used to evaluate the effectiveness of strategies to support consumer self determination.

- That funding be allocated to develop peer support programs, and consumer operated services in each state and territory, and that consumers define recovery and what approaches/resources should be used to facilitate recovery

- That consumer perspective is seen to be a sixth discipline in mental health - requiring funding and resources to develop and deliver curricula materials to the mental health workforce.

- That a consumer perspective curricula, research and training centre be established in each state and territory that can develop, deliver and evaluate consumer perspective curricula; support Consumer Educators and Consumer Researchers with their training needs; tender competitively; assist and evaluate such projects as peer support programs; consumer operated services and promote consumer perspective projects.

Term of Reference: 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 minimizing treatment refusal and coercion

Major Issues

Testimony

K.1. It is not since the Burdekin enquiry in 1992 that consumers have had the opportunity to speak about their experience of using mental health services in any sustained, rigorous way. The issue facing the nation now, is neglect of people in need. It is every citizen's right to receive care that gives the opportunity to live a good life. It is testament to the growing dissatisfaction with access to and provision of mental health services that when the Human Rights and Equal Opportunities Commission undertook consultations in Victoria late last year, people had to be turned away because there was not enough room for them in the Town Hall venue. It is of the most utmost importance for the committee to honour the experience of the people for whom this enquiry has been established. There is very little in the non consumer literature about the relationship between seclusion, detention, involuntary treatment and consequent undermining of self-determination and wellbeing. We need to know.

Research Gap

K.2. An extremely conservative estimate places upwards of 7,000 individuals on Community Treatment Orders in Victoria last year. This represents a gross violation of civil rights, where individuals do not have the right to refuse treatment. Suicide post discharge is on the increase. Inability to access services has become a critical concern. The slogan for the National Mental Health Consumer Network is "Nothing about us without us". We will not have a true picture of whether mental health services are working unless it is based upon the testimony/experience of those using or unable to access these services. We will not know the extent to which some people have experienced the mental health service system itself as traumatizing and why/how, unless there are opportunities for this testimony to be heard. We cannot have an accurate picture of what is going on state wide and nationally unless there is a clear and transparent process where consumer testimony is sought. This process needs to be carefully planned and managed. It is only out of such qualitative research that we can begin to gain a picture of how people are currently experiencing the mental health system and therefore what needs to be done.

Recommendations

- That the committee seek advice from consumer networks and groups around the nation about how best to hear testimony from those interested in speaking to the committee about their experience of detention and seclusion, and or their experience of care standards, in the context of their human and civil rights

- That a mechanism be established whereby a consumer initiated research agenda is then resourced and developed using the above networks and data gathered from the testimony of consumers.

- That this research agenda is then funded to target enquiry into the experience of seclusion and detention; involuntary treatment in the community; the impact of this on wellbeing, and possible strategies to avoid iatrogenesis.

References

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Mary O'Hagan: Force in mental health services: international user/survivor perspectives**:** Mental Health Commission NZ **website:** force%20Paper%20Mary%20O%27Hagan%20August%202002

Roper, C (ed) Sight Unseen (2003) CPNRP, Melbourne

Term of Reference: 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.

Major Issues

M.1. Funding for mental health research is currently inadequate and fails to reflect the impact of mental health issues.

M.2. Despite methodological limitations, the available literature clearly demonstrates a high prevalence of mental illness within the general health care system. It is therefore imperative that health care professionals possess the skills and knowledge to meet the special needs of this consumer group. On the contrary available literature suggests that general health care professionals, most notably nurses, lack the required skills and knowledge to work effectively with people experience significant mental health problems. For example, recent media attention in Victoria strongly suggests that emergency departments tend not to be well equipped in dealing with mental health issues. This lack of confidence and competence will surely impact on the standard of care provided. Evaluations of the psychiatric consultation liaison nursing role (PCLN)

Recommendations

- The implementation and evaluation of training packages to enhance knowledge, skill and positive attitude development in health professionals throughout the general health care system.
- The provision of funding for an exploration and evaluation of strategies currently employed within the general health care system to improve the quality of care for people experiencing mental health problems, with the view to identifying best practice
- Increased funding to be made available specifically targeting mental health research. Research funding guidelines should encourage multidisciplinary research teams
- That increased funding to be made available specifically targeting mental health research, and that research funding guidelines encourage multidisciplinary research teams.

Term of Reference: N

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

Major Issues

N.1. Currently, there is inadequate funding available to undertake research specific to psychiatric / mental health nursing, even in priority areas identified by the state and federal governments (e.g., dual diagnosis; consumers rights, especially with respect to seclusion and restraint procedures; promotion and prevention; and the quality and effectiveness of service delivery).

N.2. Few researchers consult and/or collaborate with past and/or current consumers of mental health services when designing and implementing mental health research.

N.3. A myopic focus on shorter-term interventions (this appears to be related to the inability to attract funding to develop, evaluate and implement longer-term interventions, rather than being related to their relative effectiveness).

N.4. There is a paucity of larger-scale, longitudinal studies to evaluate the long-term effectiveness of mental health interventions, which may lead to certain priority areas being under-treated, but may also impact upon the capacity to deliver best-practice clinical services, and therefore improved outcomes, to consumers. The data below clearly demonstrates a lack of spending when it comes to mental health research.

Relevant figures from (Australian Institute of Health and Welfare, 2004) – Australia's health 2004

N.5. *Australia's health 2004* is the "nation's authoritative source of information on patterns of health and illness, determinants of health, the supply and use of health services, and health services expenditure".

- In 2001-2002, 6.0% ($2,929 million) of the total health expenditure was spent on mental disorders (does not include $778 million spent on public community mental health services). The amount spent on each health system cost is outlined below. Of note, only $109 million is spent on research relevant to mental disorders. This constitutes 9.2% of the total amount spent on health research in 2001-2002. **Only 0.16% of expenditure on health was spent on mental health research.**

Recommendations

- Given that nurses make up the largest single professional grouping with the mental health sector, and that they have direct contact with consumers, it is imperative that not only mental health research spending be increased, but that it particularly be increased to fund research undertaken by, and including, mental health nurses.

- Given that the National Mental Health Plan indicates a need for consumer perspective to be included within mental health services, mental health research should include the funding of consumer-focused research as well.

Term of Reference: 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

Major Issues

O.1. Whilst it is important to acknowledge the efforts of the state and federal governments with respect to the monitoring of outcomes, there is a range of problems associated with the standardised measures used to assess outcomes and the quality and use made of collected data.

Problems with measures used:

O.2. Currently, three standardised measures are used in routine clinical practice for monitoring the outcomes of individual consumers. These are the Health of the Nations Scale (HoNOS), the Life Skills Profile (LSP-16) and the Behavior and Symptom Identification Scale (BASIS-32). When evaluated against 12 principles broadly applicable to outcome assessment developed by a group of mental health consumer, professional, service and policy-making organisations (Smith, Manderscheid, Flynn, & Steinwachs, 1997), these measures perform very poorly (the tools only meet the requirements of three out of the twelve principles).

O.3. Most importantly, the outcome assessments selected by the government do not assess domains of interest or aspects of mental health care and service provision that are important to service users and their carers (Fossey & Harvey, 2001; Graham et al., 2001; Miller, Siggins, Kavanagh, & Donald, 2003; Noble & Douglas, 2004)

O.4. Services assume that changes in the outcomes assessed can be attributed to the services received, but is this a fair assumption? A number of other changes may occur in an individual's life at the same time that they are receiving services. "There are so many possible factors that may influence ratings that changes can rarely be attributed to any specific intervention" (Lakeman, 2004). Unless services specifically chart the events and circumstances of each individual consumer and map these against noted changes, they cannot state with any certainty the reasons for these changes.

O.5. Despite the implementation of routine outcome measures throughout Australian public and private mental health facilities, there are no acceptable, systematic means through which consumers can provide feedback on the services they receive. We acknowledge that some services do employ consumer satisfaction surveys to obtain consumer feedback; however, there are significant doubts regarding the validity and utility of such surveys. Specifically,

consumer satisfaction surveys consistently produce positive results irrespective of the quality of the service being rated (Gill, Pratt, & Librera, 1998; Oades, Viney, Malins, Strang, & Eman, 2005).

O.6. Although national and state policy documents (Commonwealth of Australia, 2003; Department of Human Services, 2002) emphasise the importance of consumer participation, particularly in the planning, monitoring and review of mental health services, to date, there is little evidence that consumers are meaningfully and substantially involved in the development or implementation of the methods and procedures used in the monitoring and review of services.

The quality of collected data

O.7. There are widespread problems with the rates of completion, i.e., response rates are poor for a number of these measures. Therefore, there would be significant issues associated with the interpretation of analyses performed on the available data, if that were to occur.

The use made of collected data

O.8. The information being gathered routinely is not being used appropriately and/or to its full extent. Simply measuring outcomes, in and of itself, does not assist with the improvement of consumer outcomes (Lakeman, 2004). The information gathered needs to be converted into a digestible format (clear, constructive feedback) before it is of any use to services and the consumers who they aim to assist. At present, the time and resources spent on assessing outcomes is wasteful and will continue to be so unless governments and/or services are actually prepared to facilitate the analysis and interpretation of routine outcome assessment data.

Recommendations

- The development of outcome assessments which do assess domains of interest or aspects of mental health care and service provision that are important to service users and their carers.

- Increased and more appropriate use of information and data which is routinely gathered to enable improved outcomes for consumers and carers.

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