St. Vincent's Health (Melbourne)

St.Vincent's Mental Health Service

Submission to Senate Select Committee on Mental Health

St.Vincent's Mental Health Service is a publicly funded area mental health service under the auspice of St. Vincent's Health, Melbourne. It is responsible for the management of an adult area mental health service including a 44 bed acute inpatient service, two community mental health centres each with approximately 350 registered consumers, a primary mental health and early intervention service and a 20 bed community residential rehabilitation service. It also provides consultation and liaison psychiatry services to the general hospital wards. There are approximately 222 EFT staff and a budget of $21.5 million provided by the Department of Human Services, Victoria. St.Vincent's Health also auspices the St.George's Aged Psychiatry Service.

The service also has responsibility for the following state-wide and regional mental health services: the Victorian Dual Disability Service (Intellectual Disability and Mental Health), The Victorian Transcultural Psychiatry Unit, the Northern Dual Diagnosis Service (Problematic substance use and mental health), and the Victorian Aboriginal Mental Health Inpatient Service.

The Mental Health Service works collaboratively with other programs of St.Vincent's Health, in particular the Drug and Alcohol Service and the Emergency Department.

Comments are arranged with reference to the terms of reference of committee in italics.

a. 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

There is considerable variation in implementation of the National Mental Health Strategy across Australia. Some states, such as Victoria, have made considerable progress in moving to community-based comprehensive care systems, whereas other states do not have comprehensive care across all geographic areas. Some areas do not have adequate community resources; others lack access to long-term secure beds.

The strategy has moved to a focus on prevention and public education, while there is still inadequate implementation of comprehensive services for those with the highest needs.

b. ***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;***

Since the development of the first national mental health plan, the prioritising of services for those most in need of mental health care, has been relatively successful in providing better services for those with the most severe mental health problems.

However, improved community knowledge of mental health problems, has led to a demand for services by a wider client group, and put additional strain on public mental health services which in most cases were only just meeting the need of its existing clients. Firstly, additional resources to provide easy access and a quick response to people making initial contact with public mental health services is important. Secondly, the needs of a wider client group, especially those with high prevalence disorders such as moderate depression, could be met by improving availability of counselling services in generic community health services working in conjunction with general practitioners, rather than treating all people in the public mental health system.

Improved resources and structural reform to improve early diagnosis and early identification of relapse, particularly for young people, are important, and need to be available across all areas.

Public mental health services need to be resourced and supported to rebalance their focus in order to give proper emphasis to the prevention of disability and relapse and the enhancement of recovery for people at all stages of mental health problems. Such a reorientation is likely to reduce the overall burden of mental health care on the community in the longer term.

Additional resources for community services need to be available. Community service provision is uneven across Australia. Even in Victoria where there is a comprehensive community-based service system, additional funds have been required to develop community services in the metropolitan growth corridors. Funds for community services need to keep in line with population growth.

Expanding the capacity of community-based services will decrease the need for acute hospital beds. If adequate resources are put into ongoing community care and rehabilitation, acute episodes requiring hospitalisation will be reduced. This is not only cost-efficient, but provides better quality of life for the consumer, and less disruption to the community as a whole.

Acute phase treatments and the containment of risk is currently a dominant focus, at the cost of providing a more wholistic approach incorporating psychological and social interventions. A specialist mental health system overly focussed on acute treatment misses opportunities to work with the person to foster recovery and prevent future relapse. Resources to provide leadership and training in best practice are needed.

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

The split between Commonwealth and State funding in relation to medicare fee for service funding, means that a substantial pool of funding for mental health is tied to private practitioners who provide services for people with lower mental health needs, and can afford the gap payment, than the public sector services. This creates a two tier system: with the decrease in bulk-billing access to private psychiatrists is limited. More programs aimed at linking public and private systems would be helpful. Some type of incentive program to increase the involvement of psychiatrists in the public sector would be helpful, plus funding to improve coordination of care between the public and private sectors.

d. Appropriate role of the private and non-government sectors

Non-government organisations (NGOs) play an important role in provision of psychiatric disability rehabilitation and support in Victoria but these services are not uniformly available across Australia or even Victoria. In addition their funding is limited and this impacts on their ability to employ experienced and skilled staff in providing this valuable rehabilitation work. A partnership model between NGOs and clinical mental health service offers an improved and cost-effective model for ongoing care.

Additional funding and expansion of services to improve focus on housing support and employment preparation, skills development and support is required.

Opportunities for all sectors providing mental health care to work more collaboratively to meet the needs of people with a mental health problem could be enhanced. The Victorian Public and Private Partnerships in Mental Health Project (a project of the National Mental Health Integration Program) demonstrated what could be achieved with some additional resources to enhance care coordination between the sectors. Ongoing dedicated resources to support collaborative activities and systems of care for patients who receive services across sectors would sustain these activities and reduce fragmentation.

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

Inadequate housing and social support and absence of meaningful occupation are well known to have a negative impact on mental health. The current support services available for people with a mental illness could be expanded to improve mental health outcomes. The availability of secure affordable housing with the appropriate support is crucial in alleviating the impact of mental illness. People with mental illness are over-represented in the homeless population.

In particular, the current limited range of accommodation options for people with mental illness impacts on their ability to sustain living in the community. Development of an increased range of accessible and affordable accommodation options with varying levels of support would improve the mental health outcomes for consumers. Too often people with mental illness relapse because of inadequate accommodation or supports to maintain accommodation. Inpatient stays are also prolonged due to the poor availability of suitable supported housing for discharge for some consumers. Accommodation options should include independent public housing with support, improved boarding house and residential care for those who need a high level of support, and some transitional residential rehabilitation services.

Where supported accommodation options exist they often are not set up to deal with the needs of people with complex conditions, in particular those with both substance use issues and mental illness and /or those with more challenging behaviour. Inclusion of some targeted support for those with complex needs within the range of supported accommodation options available would assist.

Similarly increasing the range of supports and programs to assist people with a mental illness to become work ready, develop work skills and sustain meaningful employment is critical to improving their mental health. Employment can provide improved self-esteem, social skills, and social support while improving the socio-economic situation of consumers, all contributing to improved mental health. There are many innovative pre-employment and supported employment programs in other countries that assist people with a mental illness. This is an area that has been significantly under developed in Australia. The Commonwealth employment programs are not accessible for many of the more disabled clients in state mental health services.

f. 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

More funds for aboriginal-controlled community services to provide mental health and substance use services, is essential. Partnership programs with generic mental health services, and targeted training programs to increase the participation of aboriginal health workers in mental health service provision. Scholarship programs to train aboriginal medical practitioners and nurses in mental health, as well as specialised training programs in mental health for aboriginal generic health workers would assist.

More supports are needed for the aged. Australia's aging population will stretch existing specialist resources for older people with mental health needs and new innovative systems of care are required to meet this emerging demand. Models providing in-home care and supported accommodation options are required.

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

Employment of carer consultants in public mental health services has been effective in improving focus on the role of primary carers. Other states would benefit from implementing programs such as the Victorian Government Carer Support Fund initiative, which provides funds to carers to relieve the burden created by caring for mentally ill family members.

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

At the Commonwealth level much attention has been given to supporting the role of General Practitioners (GPs) in mental health care. GPs have an important role in mental health promotion, prevention and early detection and also a role in chronic care as they do for all health conditions and the recent initiatives have improved support to GPs to carry out these roles.

The Primary Mental Health Initiative in Victoria has been an important development in providing increased support and improved skills for primary carers particularly GPs in the treatment, recovery and support of people with a mental illness. This model should be considered for expansion across Australia.

This initiative has added value alongside the Commonwealth "Better Outcomes in Mental Health" initiative. However many GPs do not have the time, skill or desire to provide all the psychosocial interventions and supports many people with mental illness require. Therefore some people with mental illness receive poor access to the treatment and support services they require when the GP is the main service provider. Enhancing the range of services available for people to be referred to by GPs, and making these easy for GPs to locate and refer to, is vital. Some aspects of the Commonwealth Better Outcomes in Mental Health initiative are very cumbersome and complex for GPs to utilise, and of somewhat limited benefits for consumers. Therefore some GPs have expressed the view that they are not utilising these because it is too much paper work for the money and/or too limited in benefits for patients. Reducing the complexity for GPs to refer patients to appropriate treatment and support service is important to ensuring consumers get access to services in a timely way.

Many GPs find that access to Primary Mental Health Services for secondary consultation, training and short-term psychological interventions more efficient than using the Better Outcome Medicare items. Expansion of resources in primary mental health teams to enable them to provide an increased range of secondary consultation and both short term to medium term psychological treatments would be a more efficient use of funding than paying private providers through the current "access to allied health" component of "Better Outcomes in Mental Health".

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;

Meaningful representation of consumers and carers in service planning, monitoring, evaluation and research is needed to ensure an appropriate focus on recovery. There are models where this operates at an impressive level but the involvement of consumers and carers is currently variable and often dependent on the individual skills and attitudes of staff and managers involved in service planning and delivery. More focus is needed on supporting consumers and carers to participate fully and meaningfully participate in service planning and related activities. Consumer, carers and the mental health workforce all require ongoing education and support to improve understanding and the ability to work together using their differing perspectives to achieve their common gaol of provision best practice care for people with a mental illness.

The establishment in each state of a central Consumer Education Unit could enable consumer educators to act as both mentors for consumers consultants involved in consumer participation activities at the individual service level but also provide training and education to the mental health workforce.

j. 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;

Better specialist mental health resources for diversion, post-release and ongoing care of people with mental illness who have been in the criminal justice system is important. While these services should augment the provision of services to ex-offenders by generic public mental health services, specialist forensic community mental health services can provide support and education to generic mental health staff, as well as managing a small group of clients with more challenging behavioural problems.

Improved mental health programs in prisons is essential, especially programs that also address substance abuse issues. Lack of counselling services combined with wide-spread use of pharmacotherapeutic medication, does not produce rehabilitation.

k. 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;

All human beings deserve dignified care and treatment when they are ill which protects their rights. Mental health has under gone significant reform over the last 20 years with the mental health legislation across all states reflecting the importance of protecting

consumer rights and ensuring treatment occurs in the least restrictive manner possible. Due to the nature of mental illness, involuntary detention and seclusion are at times necessary, to ensure an individual is safe from doing harm to themselves or others due to their illness. The majority of mental health clinicians are very mindful of the restrictive and intrusive nature of seclusion and involuntary detention and utilise these as treatment options of last resort and attempt to ensure a person's dignity and rights are protected during these processes. Statutory review and appeal mechanisms are important aspects of the legislation that protect individuals against inappropriate use of these practices.

The training and support of the specialised mental health workforce in skills to engage with severely mentally ill people requires ongoing development and attention to ensure best practice techniques are utilised.

The ability to conform to legislation depends on adequate resources to provide safe staffing levels. There are too many public acute inpatient wards that are routinely locked, because of staffing shortages.

l. 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;

People with mental illness continue to experience stigma in their dealing with agencies and service providers as well as the general community. This stigma is often based on ignorance and fear of the unknown. Improved education about mental illnesses and the needs of people with mental illness to support agencies could be enhanced to reduce stigma and improve understanding and service responses.

Education to improve understanding of ways to assist a person disabled by a mental illness, as well as to prevent discrimination is needed.

Increased attention needs to be paid to the physical health needs of people with mental illness. Examples from recent literature in Australia -

- the standardised mortality rate for people with mental illness is 2.5 times that of the general population;
- life expectancy for a woman with mental illness is 6 years less than average and for men it is 15 years earlier than average;
- 20-20% of people with schizophrenia have diabetes or impaired glucose tolerance;
- people with mental illness are 2-3 times more likely to be a smoker than the rest of the population and will therefore experience the health related impacts of smoking;

- cardiovascular disease is a bigger killer of people with mental illness than suicide but despite this people with mental illness are much less likely to have coronary artery surgery than the rest of the population.

This is evidence that the health system needs to find innovative ways to address both the mental health and physical health needs of people with a mental illness. Despite having mainstreamed most mental health services into general health services the current fragmentation of models of care for physical and mental health care, as well as the nature of mental illness itself, means that people with mental health problems may have poor access to quality physical health care even when they are receiving quality mental health care.

New innovative integrated models of care are needed to address these issues. For example: funding for GPs to work as part community mental health teams; additional resources and workforce training to enable mental health workforce to also manage physical health issues of consumers; a increased focus on health promotion and prevention program targeted to people with mental illness such as the QUIT South Australia Tobacco and mental illness project.

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

Funding of mental health research is inadequate, and public mental health services have limited capacity for research. Those services fortunate enough to be linked to tertiary educational institutions have a greater capacity. There is a great need for improved clinically based research. Links should be made between metropolitan and regional services to foster research in those areas with fewer academic and research links. Fostering of a learning culture through funding clinical leadership positions to lead research and implementation of evidence-based practice would be of great benefit.

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

Public mental health services require increased resources in data and quality management to enable them to effectively utilise the available data to report, monitor and improve service delivery in an optimal way at the local level. Benchmarking activities need enhancement to enable service to compare their performance against other like services and participate in quality improvement strategies.

There have been improvements is the monitoring and evaluation of mental health services over recent years with the introduction of routine outcome measurement data collection and standardisation of key performance indicators along with the introduction and monitoring of the National Standards for Mental Health. Mental health services require increased resources in data and quality management to enable them to effectively utilise

the available data to report, monitor and improve service delivery in an optimal way at the local level. Benchmarking activities need enhancement to enable service to compare their performance against other like services and participate in quality improvement strategies.

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

Technology is a valuable support in delivery mental health care in rural and remote parts of Australia. Mental health services require access to the latest technology for videoconferencing (Telepsychiatry) to deliver services as well as for remote service providers to have access to suitable supports for consultation, education and training.

Information technology also supports in electronic medical records and information systems with remote capacity have potential for enhancing delivery of outreach services and improving coordination of patient care. There has been insufficient investment into modern technologies to support mental health practice.

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