Submission to the Senate Select Committee on Mental Health – 21st of May 2005

A Picture of a Community Mental Health Service

This is a private submission from a community mental health worker. My intension is to give a picture, from my own experiences, of conditions and issues that affect the provision and outcomes of Community Services to people affected by mental health problems.

I am a registered nurse and psychologist with 20 years health work experience and I have worked in mental health for the past 12 years. Most of this time has been at the one community health centre (Sydney inner west) working for an acute mental health team (crisis work) and providing longer-term case management.

The Population

Community Mental Health Teams usually cover a specific geographical area and population. The service in this submission covers about 12 suburbs with 135,000 people from diverse cultural backgrounds. The majority of people come from Non English Speaking Backgrounds.

In terms of mental health problems, using the often-quoted estimate of 18%, there are some 24,000 people in the area who will experience a diagnosable illness in any given year. Within this group perhaps 3 to 4% of the population, more than 4000 people, will experience a Serious Mental Illness (SMI), such as Major Depression, Bipolar Disorder, Schizophrenia or Borderline Personality Disorder that will have long-term consequences. Much less than one half of these people would come to the attention of the service or receive ongoing case management.

The service regularly comes across people who have been unwell for years and not accessed services or have had previous brief contacts with the service but the service has not had the resources or commitment to maintaining an ongoing relationship with the client. (The ACT model – see below – is predicated on the idea that it is necessary for the service to actively engage and maintain many potential clients as their psychiatric disorder and social stigma mitigate directly against their seeking help.)

Using Health Department estimates, there is an area average of at least one completed suicided every fourteen days, and at least three suicide attempts per day. The majority of these events do not come to the attention of the service, and it is unknown what percentage of people have received some form of services before their death. This is despite the fact that most of these people also have a mental illness.

My own observation is that the service is unaware of most suicides in the area as there is no regular feedback from hospitals, the police or the Coroner, identifying the people living in the catchment area who might have suicided. I recall one Christmas Day, when I commented to a police officer that it was very quiet. She responded that she had already been to three completed suicides that day. Who those three people were, I never discovered.

The Community Mental Health Service

One of the important things to come out of the Richmond Report (1982) was a commitment to the *Assertive Community Treatment* model (ACT) originally developed by Test and Stein in Wisconsin in the 1970's. This model has proved to be highly robust. Thirty years later, the Cochrane Systematic Reviews on treatment efficacy identify it as the clinical and organisational model most suited to supporting and treating people with serious mental illness.

When I started in community health in the mid 90's the ACT model of practice was still clearly espoused. In particular there was a multidisciplinary team approach to service with 24-hour support for people within a specific geographical area and a commitment to keeping people out of hospital if at all possible. The service was demonstrably assertive and individual clients were viewed as the responsibility of the whole team, not just a single clinician.

At the time there were still staff on the team that had been provided training on the ACT model through the NSW Institute of Psychiatry (one of the recommendations of the Richmond Report) and there was a generally *proactive* approach to clients with the workload predominantly lying in longer-term case management. Acute or crisis work rarely exceeded 20 or so clients at any given time.

Over the years the understanding of the ACT model (and indeed a clear commitment to best practice) has largely evaporated. And, although staffing levels have only increased marginally, the workload has increased dramatically.

The dominant work demand is now crisis work with the acute client load routinely reaching 50 to 60 clients at any given time – these are generally people who have attempted suicide and/or are experiencing an acute episode SMI and/or have been recently discharged from a psychiatric hospital.

The service has changed, becoming increasingly *reactive,* as the staff-to-client ratio has decreased, as the knowledge base of the team has declined, and as staff have become more distressed (*burnt out*) by the volume and nature of the work they face. Despite the increased demand (with its associated decline in quality), there is still a very large unmet need in the community.

In terms of other services that the population can (and many do) access, there are many local GP's, and some private psychiatrists. The service uses these alternatives whenever possible but neither are assertive in follow-up (assertive follow-up is a crucial element of the ACT model). Further they are increasingly unlikely to bulk bill, and all private psychiatrists have their rooms outside of the catchment area (catch a bus and/or train).

The definition of a good outcome in mental health is not just a reduction in symptoms. It includes a reduction in *". . . disability, risk factors, and the social consequences of the disorder . . ." (WHO 2000)* GP's and private psychiatrists do not provide the necessary depth of service to achieve this. As a result some 4000 people with an SMI each year inadequately treated and competing for a specialised community mental health service that has, at most, 30 clinical staff (get your calculator out).

The service does not advertise its existence to the local community. Referrals come largely as a result of word of mouth, and from A&E departments, police and GPs. I've witnessed a growth in demand for the community service over the years that is driven by psychiatric bed closures and by the efforts of the Consumer Movement, NGO's and Federal Government to educate people, communities and community agencies, like the police and schools, about mental illness.

The corresponding lack of growth in resources means that clinicians are being pushed away from efforts to meet this demand towards attempts to gate-keep access to the service. The further lack of overt acknowledgement from management as to the resource short fall means that clinicians are increasingly compromised in this decision making process (who do we blame when things go wrong?).

Lack of Outcome Research and Quality

This description is subjective and an appeal to research is necessarily limited as an exploration of the Australian Community Mental Health Services is so far quite sparse – a point observed in commentaries such as the recent report *Out Of Sight Out Of Mind*. But I believe that the extent of problems can still be found in existing data, and by comparing this with demographic and epidemiological research.

As suggested above, statistics on national suicide rates and the population incidence of various psychiatric disorders predict something about a given catchment area. Rather than trying to collect further quantitative data on the performance of a service and the people they do see, much more could be made of qualitative questions directed to clients, potential clients and clinicians. Why for example are community health services not completely overwhelmed?

I regularly have contact with adjacent services and clearly there are some areas where service is significantly inadequate, has never been adequate, and the clinicians working there report the service was overwhelmed long ago. I like to think the service I work for is at least treading water but this is more about protecting my own sense of professional adequacy than anything else.

Working at the community level, a number of qualitative measures of functioning are available simple from observation – the starting point of any qualitative research. For example, there is a lack of any meaningful top down flow of information. There are many documents such as the *National Mental Health Standards*, *National Standards for Mental Health Workers*, *The Clinicians Tool Kit*, *The National Mental Health Strategy*, *the NSW policy on Open Disclosure*, and the *NSW Senate Inquiry into Mental Health* that mental health management have not promoted or even made available at the clinical level.

These publications are mentioned in this submission because I've gone looking for anything that might help make sense of what I see going on around me. Primarily I've been frustrated by the poor quality of client advocacy and disclosure within and by the service.

What appears clear is the lack of a grass roots clinician driven demand for change (something that matches the consumer movement). What quantity and quality of submissions were made to the NSW Inquiry and to this inquiry by the clinical staff currently employed in the community sector? I did not find out about this or the NSW Senate inquiry through my workplace or professional channels, and most staff appear unaware that it is currently in progress.

There are in fact Two to three hundred community mental health centres and around 10 to 11 thousand Community Mental Health staff (FTE) employed in the public sector across all of Australia. They are comprised mostly of Registered Nurses, Social Workers, Psychologists and Psychiatrists and Registrars. They see people and their families at their most distressed and deal with the full spectrum of personal crises that people can experience. It is not a particularly large number of clinicians and it is ideally suited for qualitative research. If governments want to know what is really going on in mental health, start asking these people (not the managers) directly.

Adverse Outcomes

Perhaps the most serious indicator that there is something seriously wrong is the service's failure to acknowledge and address adverse client outcomes. What is significant is the lack of reporting, the lack of data, the lack of quality improvement, and the lack of disclosure to the clients affected by adverse outcomes. In fact there has been a clear resistance to any discussion, at the clinical level, of adverse client outcomes.

To start with an obvious example, over a ten-year period there are only a handful of medication incident reports from community mental health teams in the area service. The number is I think less than ten and someone sitting on the Area's drug committee told me that the total for many years was only one incident report. There is a great deal of research on medication errors as they are an inevitable result of giving out medications to people yet the service has not attempted to identify the extent of the problem or why incidents are not reported.

My experience is that despite reporting many adverse client incidents to managers I have not been encouraged to put anything in writing – in fact, quite the reverse. And there is little if any feedback on the outcome of any investigation (assuming it occurs). The response from managers is consistently *reactive*, and there is no acknowledgement to clients that mistakes have been made in their particular case.

Often clients do not recognise that a mistake has been made. Where they do, they are unlikely to pursue the issue or have the capacity or energy to advocate on their own behalf. There are patient advocate systems in place but these wait for the client to complain. Mental illness is inherently isolating but advocacy services generally do not reach out to clients in the community, and where they do, clinicians usually mediate this process.

The Council of Social Service of NSW (2004) on consumers complaining to health services observes that "*. . .they are unlikely to complain directly to a health service because most consumers are unaware of how or where to complain . . . They fear the possible repercussions from service providers . . . [and] . . . feel that no one will* *take notice of their complaint, it will take too long to resolve or that it will not lead to any significant change."* The Council further observes that " . . . *the most vulnerable groups such as those with drug and alcohol issues, mental health problems, disabilities or the aged are the least likely to complain for fear of retribution."*

I can only affirm the Council's assertions. To give a simple example of this problem from the clinician side, the National Mental Health Standards require that clinicians give written information about *patient rights* to their clients when they access the service. This does not happen on the team described in this submission.

Consumer complaints about adverse outcomes of course require that the client understands how treatment and service provision should proceed. Imagine someone who is 20 years old, has schizoaffective disorder and lacks insight into the illness and the necessity for medication. A common solution is to make a Community Treatment Order under the NSW Mental Health Act at the time of the person's hospital discharge. This order requires that the community service ensure treatment over the next six months then to review and possibly renew the order through the NSW Mental Health Review Tribunal. The intension is to protect the person from relapse and rehospitalisation.

Now imagine that on discharge the community service fails to identify the person is on an order does not provide follow-up (in this case the person was phoned and advised that he should attend Drug Health for a dependency problem.) Two months later after no follow-up and no medication (a fortnightly antipsychotic injection), The person relapses in a psychotic state and is picked-up by the police in the street at night and scheduled back to a psychiatric hospital. The hospital does not liase with the community and is unaware of the preceding lack of follow-up. The problem might be identified when the person is discharged back to the community service. At this point does the community service disclose to the person and the parents the nature of the error that has been made?

For the client and family this is a very serious failure of service. It is not an isolated example. There are many cases of clients not appropriately followed up on discharge from hospital and actually more serious outcomes, but an appropriate discussion of these events (such as advocated by the Health Department's *Clinician's Toolkit)* does not occur.

(I note Professor Boettcher's submission to the Committee and the observation that *". . . There are many instances of death or injury that were easily attributed to not being admitted [to a psychiatric hospital]."* It should also be observed that there are equally many deaths and injuries that might be attributed to the quality or lack of community mental health follow-up. *". . . poor structures, inadequate resources and overworked staff [leading] to substandard patient care . . ."*)

There is some hope that the new Incident Information Management System (IIMS) introduced recently in New South Wales will contribute to change and improvement. However, it is still up against a culture in Mental Health that is reluctant to talk about problems let alone report. I have already listened to senior managers vacillating about what to report and who should report.

Government Responses

Perhaps one of the most disheartening things I've seen in recent years is the NSW Government's published response (2002) to it's own Senate inquiry into mental health (2001). Recommendations 6 and 7 pertain directly to the provision of Community Mental Health Services. It is worth re-considering the response in light of suicide rates, and the discernable unmet community need for services, and the fact that community mental health services are a key element in the National Mental Health Strategy – a key element in any mental health strategy.

> "*Recommendation 6: That the Minister for Health ensures additional resources are made available for community crisis teams and the adequate case management of people with a mental illness in the community.*
>
> "*Response: The community crisis team/case management model may not be the most appropriate for all people. NSW Health will continue to enhance appropriate and effective community mental health programs, tailored to the needs of the individual, in partnership with general practitioners and other service providers. This will involve a range of programs including emergency access response, rehabilitation, case management and community mental health programs.*
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> "*Recommendation 7: That NSW Health develop a program of assertive case management for the sustainable long-term management of people with a mental illness in the community and that the Minister for Health provide long-term recurrent funding to support such a program. Such a model should be based of the Assertive Community Treatment program developed in the USA and include:*
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> - *A multidisciplinary team of psychiatric inpatient staff, including case managers, a psychiatrist, several nurses, social workers, vocational specialists and substance abuse treatment specialists, operating a 24-hour, seven days per week service*
>
> - *Comprehensive treatment planning, ongoing responsibility, staff continuity and small case loads, most commonly with one staff member for every 10 clients*
>
> - *Targeting individuals with the greatest need to ensure cost efficiency, particularly those with multiple hospitalizations.*
>
> "*Response: The assertive case management model may not be most appropriate for all people, is not practical or sustainable in rural and remote areas, and is resource intensive. NSW Health will continue to increase resources for appropriate and effective community mental health programs, tailored to the needs of the individual, in partnership with general practitioners and other service providers, including Assertive Community Treatment for those patients for whom it is appropriate."*

Conclusion

This submission is in many ways circumspect. I still work in the place I am describing and having been educated in the public health system. It has taken many years for me to even admit to myself the injustice of what is happening and not happening. There are many other disturbing things I could have described – for example the submission from *insane Australia* at point 2 talks about “human rights violations”. Again I can only affirm everything they are saying.

The clinicians who work in mental health want to help people. The overwhelming problem for the community mental health service is lack of resources, not just in terms of number of staff or access to psychiatric hospital beds but also in terms of quality training and education, accountability, research and a commitment to openness. Once you have really listened to the stories of hardship and endurance that all people with a serious metal illness have to tell then some part of your heart will surely be broken.

Waiting for change
Yours faithfully

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