Submission to

Senate Select Committee on Mental Health

St Vincents & Mater Health Sydney Board
May 2005

Terms 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.

b. The adequacy of various modes 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.

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.

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

Introduction

St Vincents & Mater Health Sydney (SV&MHS) is part of the national Sisters of Charity Health Service and one of Australia's major providers of health care services in both the Public and Private (not-for-profit) sectors.

An in-depth analysis by the Catholic Health Australia is being undertaken to address the issues and concerns of its Australia-wide membership in relation to mental health services. This submission represents a contribution by the Board of St Vincents & Mater Health Sydney to the Enquiry, drawing on the Board's experience of providing mental health services, and the advice of our Director of Mental Health, Dr Peter McGeorge QSO. It examines each of the Terms of Reference and concludes with a set of general recommendations to help improve the care and treatment of people with mental illness and disability with particular reference to the issues SVMHS are dealing with.

The Board's submission draws on St Vincents & Mater Health experience in delivering mental health services, and particularly the experience of operating an inner city mental health service at St Vincent's Hospital.

St Vincent's Mental Health Service (SVMHS) comprises seven clinical units providing acute and community mental health services including a 27 bed inpatient unit, consultation liaison psychiatry and community based services covering crisis and intake, case management, community rehabilitation, early psychosis service and older persons mental health. The service also accommodates the Clinical Research Unit for Anxiety Disorders (CRUfAD). These services are all Public Hospital Services.

Located in the inner city of Sydney, St Vincent's provides services to the local government areas of Woollahra, Sydney and South Sydney, which forms one sector within the broader South East Sydney Illawarra Area Health Service. With a local catchment population of 102,000 it is an area of considerable socio-economic diversity, with a significant transient population, attracted for business and recreation. It is also noteworthy for having Australia's highest concentration of homeless people. As a consequence, the population is characterised by complex health and social needs, with higher than average prevalence of mental health disorders, drug and alcohol use, dual diagnoses and people living with HIV and AIDS.

Geographical mobility and episodic homelessness are recognised internationally as a challenge in mental health service planning, and local need has been complicated in recent years by the closure of several homeless shelters and hostels. It is also affected by demand on St Vincent's emergency department which, reflecting its close proximity to King's Cross and Oxford Street, is one of the busiest in NSW and manages a very high number of people with drug and alcohol related and other mental health problems.

a) The extent to which 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.

The model of care proposed in the National Mental Health Strategy has met with wide spread acceptance by those working in the mental health sector. For various reasons, some related to resource allocation, some related to issues of implementation which are inherent in the Mental Health field; the model has not been sufficiently implemented to see the anticipated gains made across the country as a whole. By comparison with international benchmarks spending on Mental Health Services has fallen significantly behind other countries as a percentage of total health spending[1].

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.

[1] Rosen Australasian Psychiatry Sept 2004

Prevention and Early Intervention

There are some innovative and internationally recognised prevention and early intervention programmes in Australia such as the Mental Health Promotion (VicHealth) and Early Psychosis (EPICC) programmes in Victoria. However systematically planned and adequately resourced mental health promotion, prevention and early intervention programmes need to be more widely implemented to fulfill the excellent National plans that have developed on a more systematic basis in other States.

Without a basic infrastructure and targeted funding for prevention and early intervention those with mental illness are forced into escalating their needs to receive attention. In such circumstances the possibility of serious public incident at one extreme and the violation of patient rights and stigmatisation at the other may continue to occur.

Acute Care

The lack of community resources and an organisational/contractual structure to ensure that services are directed in the early stages of illness to those most in need has resulted in an undue focus on acute care. Many Mental Health Services across the State now have considerable pressure on their acute beds. In some States there have been times when patients have had to be transported far away from their home areas to receive acute inpatient care. There have even been times when there are no acute beds available anywhere in their entire state.

This situation reflects an inadequate continuum of care[2] in terms of volume and functionality, across the spectrum of services that should include prevention, early intervention, acute and continuing care.

Contemporary, "best practice" models of mental health care which include the resources and systems needed to operate them, have been defined in a variety of countries throughout the world[3]. Well functioning systems of contemporary mental health care are being developed in a number of areas in various countries throughout the world.

In inner city areas demand for acute services is significantly greater than elsewhere. Many of those seeking services or more commonly those referred to acute services by agencies such as the Police, are either homeless or transient in terms of the daily migration of office worker into the city and the massive influx of people, especially the young during the course of a weekend.

For example 60% of patients admitted to St Vincent's Acute Inpatient Unit (Caritas) are of no fixed address, while many of the other 40% are either transiently homeless, are visitors to the area or live in hostel accommodation in the inner city. The inpatient service now operates at well over 98% occupancy and has seen an 11% increase over five years. Although inpatient separations have remained fairly constant at about 650 per year, the average length of stay is gradually rising and the service is under constant pressure.

The majority of patients are brought in by a law enforcement agency (37%) or admitted via the emergency department (30%). On average 83% of patients are scheduled involuntarily under the Mental Health Act.

The original model of care established in the wake of the Richmond Report envisaged a continuum of care involving crisis teams, community mental health centres for those with less acute needs and a network of mental health operated housing including supervised hostels and group houses for those needing accommodation and company over the longer term.

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[2] A continuum of care should involve ready access to acute and non-acute community based specialist assessment, treatment and rehabilitation services; acute, rehabilitation, forensic and extended care inpatient beds; and access to Government and non-government support services including income support, housing, social networking, mental health promotion, early intervention programmes and primary healthcare.

[3] A good example is the New Zealand Mental Health Blueprint (NZ Mental Health Commission 1998)

Anyone requiring longer term or more secure care could be transferred to the older institutions although in time it was expected that they would be replaced by community based accommodation programmes and service. The reduction of access to longer term more secure facilities and the lack of mental health operated community based programmes and services has created undue pressures on Acute Units throughout the State.

Community Care

There are a number of areas within Australia where staffing of mental health teams and the funding of NGO services is falling short of international benchmarks[4,5,6]. In some cases resource gaps in Australia may be as large as 50%. These gaps impact not only on the General Adult population, as referred to above, but also on young people and their families. In this context it is important to realise that mental illnesses are as affected by social conditions as much as or even to a greater extent by social conditions as the biological factors. Therefore the continuum of care referred to above should be seen as something that needs to cover the age range from the young to the elderly and not just the general adult population.

Given due attention to these matters and the continuum of care needed for maintaining the mental health of the community in an optimal state, a focus on community care over and above inpatient care is essential. Seminal studies show that consumers prefer it, more severe degrees of disability and recidivism are averted and ultimately family burden is minimised.

This said however it is the lack of a comprehensive properly resourced continuum that has led to the current situation and which remains a challenge in many areas throughout Australia.

Child, Adolescent and Aged Care Services

If General Adult services are under-funded these services are even more so. Given the high levels of youth suicide in Australia, alcohol and drug abuse, the numbers of young people who are developing persistent psychotic disorder (in some cases relating to drug misuse) and the numbers of young people whose parents have mental disorder who themselves need access to specialist services are extremely sparse. Rather than local services in many cases young people and their families have to travel well outside their localities to get psychiatric care.

The same applies to the elderly who are growing as a percentage of the population and whose psychiatric needs require specific attention. Staffing of community teams is below international benchmarks and there are insufficient inpatient beds. In regard to the latter elderly patients who do not have other age related disabilities are more often than not admitted to general acute units where they are mixed with younger patients who often have dual psychiatric and substance abuse disorders.

Initiatives to address the current situation

The system is severely strained across the age spectrum and particularly in the area of acute care. In NSW a number of recent Government initiatives will assist SVMHS in both the short and longer term to improve access to acute care, reduce risk and provide a basis upon which a more integrated service can be developed. The NSW Government has identified the development of a state of the art facility for St Vincent's Hospital to house all of its mental health services on the site of the main St Vincent's campus as a priority for development of a Public Private Partnership (PPP) model. The project will also collocate Drug and Alcohol Services, supporting better service linkages for caring for patients with dual diagnosis. It has also sponsored the development of a number of Psychiatric Emergency Care Centres (PECCs), including a Unit at St Vincent's, to be established throughout the State by the end of 2005.

[4] NZ Mental Health Blueprint recommends 49 FTE/100,000 General Adult community based clinicians.
[5] NZ MH Blueprint recommends 21 FTEs/100,000
[6] NZ MH Blueprint recommends 13 FTEs and 5 beds/100,000

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.

There are genuine efforts being made to improve coordination and the delivery of services in NSW. SVMHS has submitted a proposal to provide specific assistance for the homeless and has managed to secure funding for nurse liaison positions to improve the interface between SVMHS NGOs and Primary Healthcare. However these efforts are still limited by the lack of NGO funding earmarked for specific mental illness initiatives. There is also a need to develop a model of decision making which engages and builds on existing expertise and centres of interest within a framework which seeks to establish equity, best practice and outcomes for consumers.

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

The non-government sector (along with Primary Healthcare) is potentially one of the greatest assets that could be drawn upon to improve mental health care in Australia and yet by comparison with other countries the NGO sector is relatively undeveloped. It appears that a major reason for the lack of development within the sector relates to fears about the ability of non-clinicians to properly manage the needs of those with mental illness, a resistance on behalf of certain public service staff to partner with NGOs for fear of losing control of their livelihood and expectations of NGOs that Public Service MHS should continue to bear the majority of risk for patients. For example rather than learn about how to take on Case Manager roles there is a view expressed that this is the sole responsibility of the Public Service provider.

Notwithstanding the latter however it is clear that most of those working in the NGOs would welcome the opportunity to accept more responsibility for the mental health care of those with mental illnesses. In this respect it is worth noting that in countries where specific Mental Health NGOs have been established, they have shown themselves capable of providing a number of services beside residential care including drop-ins, work opportunities, income advice and social bonding however there does not appear to be any implementation plan to make initiatives happen on a systematic basis.

Potentially there are a number of ways in which the private sector could make a contribution to overall care of the seriously mentally ill. While in fact more is probably being done than is commonly recognised, the incentives to integrate private services with public services are perverse and mitigate against this happening in any coherent and mutually beneficial way. For example private psychiatrists are capable of earning a considerable amount more in private practice than in the public services and are able to gate-keep out patients with high and complex needs. Again even where they work in public services as VMOs their rates of pay are a disincentive to taking on much needed Staff Specialist positions.

Notwithstanding these considerations, there are potential benefits to developing integrated models of care between the public, not for profit and private sectors. In this respect, St Vincents & Mater Health is ideally placed to develop new models of partnership between the public and private sectors in mental health, and is currently investigating how this might be done within the funding constraints of the current system. Pilot funding for innovative models would help these initiatives.

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

As indicated above the lack of specified NGO supported accommodation is one of the major barriers to better mental health outcomes. Moreover if one was looking at one area to make significant gains it would be to increase access to supported accommodation. There is even the opportunity to "leap frog" the progress made in other countries in this area, notably New Zealand, which while it has a devoted a massive amount more funding to this aspect of the mental health continuum of care did not sufficiently align the NGO accommodation it funded to the needs of consumers utilising public (specialist) MHS.

While the problem in NZ is of a lesser order to that in NSW nevertheless the disjuncture at the interface between the public MHS and the NGOs has resulted in "bed blocking" which is inimical to recovery and optimal utilisation of resources.

While there are a number of NGOs providing general care for consumers with mental illnesses there is no transparent designated system to fund initiatives in the community to support their recovery. As a consequence funding is sought from a number of relatively unrelated sources and care despite the best efforts of providers to collaborate with one another is patchy at best and randomly targeted at worst. This applies across the board in terms of employment family and social support services resulting in a situation where positive outcomes are mitigated against. In New South Wales some initiatives are being developed with cooperation between Housing and Health portfolios with a view to targeting NGO accommodation for the mentally ill.

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

This is yet another area that has been woefully neglected by funders despite the importance of the family in supporting family members with mental illness when they are unwell and in their recovery. There are carer based NGOs such as ARAFMI who advocate for resources and attention to be given to the positive role the family might play in providing support and promoting recovery but nevertheless in terms of policy and funding support there is relatively little to see for their efforts.

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.

Comments have been made above about services for the young and elderly who have mental illnesses. Services for these groups should have an equivalent continuum of care as that cited for general adult consumers. For a variety of reasons, however, funders tend to give priority to the needs of the general adult population rather than those at either end of the age spectrum. This relates in a large part to the numbers of people between the ages of 17-65 and the fact that incidents involving this group are given more media attention than the young and the elderly. Greater priority must be given to them because of the change in the demographic profile which sees more young and especially more elderly than has been the case in the past.

While efforts are being made to profile and meet the needs of indigenous Australians and migrant non-English speaking people, at this stage developments are in a quite rudimentary state. Psychiatric models of care and treatment tend to emphasise the biological and psycho-social aspects of mental illness rather than giving due attention to the cultural world view of these groups. There is however a growing body of knowledge that indicates that transcultural services may be of specific value to specific ethnic groups.

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

This is one of the areas where major gains could be made with relatively little effort and expenditure. While not all General Practitioners are sympathetically inclined towards managing the needs of mentally ill, many are, while others might be more so if properly supported by specialists and those in Public MHS. Professor Ian Hickie has done a lot of work in this area as has Professor Graeme Meadows. They and others have defined systems for delivering better assessment, treatment and care to the mentally ill in primary healthcare. What is lacking is the practical translation of this work in to common practice. This requires education of GPs, the funding of liaison workers to operate at the interface between primary healthcare, the specialist sector and Public MHS and also project funding to better develop the systems of care and infrastructure necessary to enable GPs to look after the many consumers who no longer need specialist services.

SVMHS has recently had funding for a GP liaison worker approved by the NSW Minister of Health and has quite good linkages with primary healthcare. This is welcomed; however, to develop a fully functional system, further funding is required to develop a GP Liaison team that would have real impact on the population.

i: 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.

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.

These items are dealt with together given the inter-relationship between consumer participation, patient rights and citizenship.

The consumer movement in Australia is gathering momentum. This is evident in the growing participation in Australasian wide conferences such as the THEMHS conference and in the presence of consumers in management and service development meetings within the Public MHS. St Vincent's recently appointed a 0.5FTE Consumer Consultant and has begun a process of paying meeting fees and/transport costs of consumers participating in service development meetings. It is however early days and again support to ensure that all consumers of the services who wish to have contact with a Consumer Advocate is very limited at this point in time.

The de-institutionalisation of psychiatric hospitals has seen a shift of people who would otherwise have been cared for in them to prisons. There are different schools of thought about the degree of responsibility that a person with a mental illness can take for their behaviour when for example it is driven by a psychotic state. In Anglo-American countries and Australasia there is legal recognition of the impairment that mental illness can cause. Nevertheless in practice and in the general public all too often primitive and prejudicial attitudes to mental illness prevail.

This said, recovery is promoted by consumers being treated with respect, in the least restrictive conditions and where secure care is required in environments that meet health and safety standards and are as homely as possible. All too often custodial environments are drab and have furniture and fittings in a deteriorated state. Unfortunately this is still true for many inpatient facilities throughout Australia.

Despite the environments in which they work many staff continue to work to high professional standards and with the principles of recovery in mind. However it is a fact that where environments are bleak and inhospitable, practice has a tendency to degenerate from being therapeutic to being custodial. In such circumstances undue emphasis may be placed on the use of seclusion and medication as a "chemical straitjacket". This situation prolongs recovery and results in early readmission, absconding and violence.

In terms of mental health promotion and making the public aware of the potential positive outcomes of well treated mental illnesses there appears to be very few systematic attempts to educate the public and to destigmatise mental illness. This is of course impossible to do when services are constantly in crisis mode and the public is subject to the worst outcomes of poorly treated mental illness. Nevertheless a well planned and implemented destigmatisation campaign[7] can make a major contribution to the quality of life of those with mental illness who have been discriminated against because of their disability.

These comments are equally pertinent to the way in which other Human Service agencies deal with those that have mental illnesses.

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

Australia has an enviable reputation for research in the Mental Health field. There is still too little research however that is directed towards what services have been established and how they are working for consumers. Such information would be invaluable as far as informing funders about the implementation of the National Mental Health Strategy and how it should be modified to achieve more cost-effective results. With such information available it may be in some cases not so much a matter of the adequacy of funding as its targeting while in others it may simply be a matter of critical resource levels. In this regard, too often funding of services is piecemeal and appears to be done in a way that addresses immediate pressure points rather than achieve real and sustainable results.

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.

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

The enhanced utilisation of technology has huge value added potential. At St Vincent's Hospital there are some excellent innovations that have been put in place such as the OWL (on-line waiting list) which allows clinicians and administrators the opportunity to define accurately and in "real time" the bed state and significant needs to patients in hospital units. This facilitates better bed management and in particular helps to avert crises that lead to ill-feeling and loss of functionality between various hospital departments. It is planned to bring this system on line in St Vincent's and to extend it to the community team as a "virtual ward".

St Vincent's has recently also introduced a system of telephone triage which enables people needing information or who are in crisis to get help more immediately. It also will allow the prioritisation of cases so that those most in need will get access to care in a more timely manner while those whose needs are not so pressing can be connected with services more appropriate to their needs rather than all cases being treated as "acute".

[7] Such as the NZ "Like Minds Like Mine" campaign

The use of the internet is underdeveloped compared with elsewhere where an increasing number of consumers are going online to seek out information and help that is appropriate to their needs. It is possible to establish by this means an integrated system of credentialed providers, however given the St Vincent's demographics, reliance will be placed more on networking and the building up of "face to face" infrastructure in the short to medium term.

Summary

Many MHS in Australia are significantly under resourced and supported with the result that there is an undue focus on acute care rather than a continuum that includes mental health promotion, early intervention, relapse prevention, social support and recovery. Responsibility for this continuum straddles Federal, State, private and NGO sectors. While additional services for those with high and complex needs are urgently required, a shift in service delivery to NGOs and Primary Healthcare would have a major payoff.

There also needs to be greater attention and resources given to the translation of policies into service delivery and to the development of a culture which includes consumers as practical advisors in the process of implementation. This needs to take place vertically from the Commonwealth to the States and Area Health Services and horizontally across States and Area Health Services.

While the challenges ahead are significant it is important to know that there are many excellent and committed people working in the field of Mental Health who have their eyes on the future and their heads and hearts set on improving the mental health of the community and the quality of life for those with mental illnesses. Australia has an excellent plan to base this on. With this in mind much can be done to improve Mental health Services in Australia in the short, medium and for the long term.

Recommendations

1) That a more realistic National funding framework based on local and international benchmarks and weighted for acuity and disability is developed and implemented.

2) That priority is given to developing specific funding streams for consumers of MHS with special emphasis being given to the development of Mental Health NGOs and the expansion of Public Service Community Mental Health Teams and Liaison workers to support them and consumers seeking/needing specialist psychiatric help. In particular the development of supported accommodation and work opportunities for consumers is critical and must be aligned with Public MHS to achieve integrate care for them in an optimal manner.

3) That urgent attention is given to Primary Healthcare agencies to enable them to meet the immediate medical and psychiatric needs of consumers no longer needing frequent psychiatric support.

4) That Area Psychiatric Services develop models that allow for innovation and specialisation by particular services while ensuring that services are able to be monitored and meet National standards for service delivery and best practice.

5) That ways of integrating and synergising the Public and Private sectors are explored and implemented in the first instance by the establishment of Pilot Sites such as St Vincents & Mater Health.

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