Mental Health Crisis

Australia has a mental health crisis. Despite two national mental health plans and a decade of changes to public mental health services, individuals, patients, families, carers and support groups from all around Australia are saying that the care of mentally ill individuals is a disgrace. The experience of these groups is backed up by recent reports into the state of mental health nationwide (see recent “Not for Service” report). This primarily affects public mental health services.

In my opinion the problems in mental health stem from the following difficulties. First, there are not enough mental health services to meet the needs of patients. This leads to rationing. In the current situation resources are so limited that rationing has to be tightened to extreme degrees and as a result only the most severely ill patients may be offered treatment. Other patients who are very ill but fall under the rationing threshold may not get appropriate care. This rationing is most acutely felt when decisions are made to admit patients to psychiatric inpatient care from hospital emergency departments, when decisions are made to discharge patients from inpatient care, and when decisions are made to determine which patients are offered intensive case management by community mental health clinics. The severity of rationing nowadays means that patients who need hospital admission may not get it, that patients who need longer stays in hospital may be discharged too early, and those patients who need intensive community case management and follow-up may not get it. These flaws in the provision of treatment can have disastrous consequences; a recent article in The Australian newspaper (Kate Legge, July 19, 2005) drew attention to 42 suicide deaths in Victoria in young people under age 30 over a two year period where inadequate treatment was linked to the suicide. Lack of mental health beds for high risk patients, too rapid discharge, and lack of intensive treatment were problems identified.

Second, new revisions of state mental health acts have been introduced around Australia over the past two decades. These acts are often more enlightened than the ones they replace in that they give more weight to patient autonomy and to the least restrictive forms of treatment being used. However, these acts can be misused because of the pressures of rationing that apply at the moment and this can lead to patients being treated inappropriately. The mental health acts may be used as a 'fig leaf' to cover inadequate resources ("your son doesn't meet criteria for admission"), or mental health act provisions may be invoked for patients who do not need to be involuntary just in order to access community case management. Another article in The Australian (Clara Pirani, July 4, 2005) highlighted psychiatrists needing to use these practices in order to get appropriate care for their patients.

Third, over the past 20 years there has been a push by public mental health services to ‘mainstream’ the care of individuals suffering from mental illness. This means providing services for them within the general health system rather than a separate service for psychiatric illness. While this has emphasized the role of the general practitioner in providing treatment, and had some (limited) benefit of reducing stigma and curtailing the excesses of some treatment practices in the older, or more isolated stand alone psychiatric facilities, the policy more broadly has been a failure. The unique needs of individuals suffering mental illness have not been fully appreciated and provided for and this has led to a secondary marginalization of mentally ill

patients in general health services. One needs to look no further than the way patients with mental illness and substance abuse are treated in busy public hospital emergency departments to see evidence of this marginalization. Indeed, belatedly, there is now recognition that separate psychiatric emergency departments need to operate in public hospitals. But beyond the emergency department the mentally ill need inpatient units with plenty of space, sub acute and extended care treatment facilities, and properly supervised community residential accommodation – all features that are not usually offered or supported by general health services.

Having got to this 'mental health crisis' what can be done?

In my opinion the first action is to emphasize accountability at the point of the patient – clinician contact. The patient placing his/her care in the hands of a doctor, nurse or other mental health professional needs to know that that clinician has the patient's welfare at heart and that the treatment needs of the patient will not be inappropriately influenced by the demands of rationing applied by the mental health service. This form of accountability will lead to a profound change in the way public mental health services are provided and resourced. Substantial staffing and facility enhancements and additional funding will be required to support this change. As a method of enhancing accountability, the Gold Coast Institute of Mental Health has called for a standing coronial inquiry into all suicides to review each pathway to death and any contact the person had with treatment services in order to monitor the quality of mental health care.

The second action is to acknowledge that the 'mainstreaming' policy has its limitations and a move to another model is now needed. An alternate model would recognize the special needs of individuals with mental illness and build a system of care from there while utilizing the strengths and services that comes from close association with general health services. This change in direction would facilitate the development of community, emergency department, inpatient, sub acute, extended care, and residential supervised accommodation services that better meet the needs of the mentally ill. While a major investment of public resources is required to deal with the mental health crisis, the money will not be well spent unless issues of accountability and service direction are addressed.

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Bed crisis forces doctors to certify mental patients
Clara Pirani, Medical reporter (The Australian)
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DOCTORS are taking the drastic step of committing patients with mental health problems to ensure they receive treatment following the closure of thousands of public psychiatric beds in Australia.

Usually only patients who are an immediate threat to themselves or others should be committed, but NSW psychiatrist Brian Boettcher said it was the only way doctors could make sure their patients were treated.
"I was told ... that because of the lack of community centres to cope with people with mental health problems, they will only take people who are certified," Dr Boettcher told The Australian.

"You could probably treat a lot of these people without having them committed, but because of the shortage of public beds you have to kind of exaggerate their symptoms a bit in order to get them into the community centres.

"The patient has less of a say in their treatment when they are certified and they lose privacy because it can go on the public record."

According to the National Mental Health Report, released by the federal Government last year, the number of public-sector psychiatric beds fell by 25 per cent between 1993 and 2000.

Private hospitals accounted for 23 per cent of all psychiatric beds in 2001-02, up from 14per cent in 1992-93.

Lois Achimovich, a Fremantle psychiatrist with 30 years' experience, believes the lack of mental health services in the public system has led some patients to commit suicide.

"If they haven't got private cover they don't get treatment and my view is that in some cases that has been fatal," Dr Achimovich said.

A Queensland psychiatrist, who did not want to be named, agreed the use of mental health orders to commit patients was often the only way to get them treated.

"The reality is that in many services, the only way to ensure patients will be admitted to hospital, or receive any on-going case management on discharge, is through installing a mental health order of some kind, even when the patient can manage without it."

Dr Achimovich said hospitals usually won't admit patients unless they have harmed themselves or others, or are suffering hallucinations or delusions.

"I've had patients where all of that is true and still they haven't admitted

them because they don't have any beds," he said.

"We want proper assessment of what happens to these people when they don't get put in hospital."