A fork in the road

Metal Health Services in Australia have since the 1970'S embarked on a journey first taken 20 years before in the United States and the United Kingdom.

The first of these major reforms here in Australia was to social security legislation making it possible for patients in mental institutions to receive disability pensions.

When combined with the pharmaceutical break throughs of the late 1950's, Phenothiazine's (Chlorpromazine), Tricyclic Antidepressants (Imipramine), Lithium Carbonate in the early 1960's, Haloperidol and the in the early 1970's, the atypical agents, Risperidone and the SSRI's, Zoloft in the 1990's the psychopharmacological treatment of mental illness has been matched with changes in social policy.

Changes in social policy were also driven through a desire for social justice . Reforms to policy were reflected through the implementation of the recommendations from the 1983 NSW Inquiry into The Care and Treatment of the Mentally Ill otherwise know as the Richmond Report. The "Richmond" years heralded reports into services in other States and what followed was a decade of aggressive de-institutionalisation across Australia.

What was supposed to be a period of enlightened treatment in NSW (and other jurisdictions) also saw the a period of abuse and exploitation in the form of physical neglect, homelessness, incarceration, unregulated nursing homes boarding houses across metropolitan Sydney and in the Blue Mountains. (See NSW health CARE Complaints Commission Report 1994)

Mental Health Services have been subjected to countless inquiries and investigations even to the extent of Royal Commissions and Human Rights Commissions promising radical and sweeping reforms resulting in repeated failures of governments to action in a sustainable way the recommendations. The most recent example being the NSW Upper House Inquiry into mental health.

In all that time much has been promised for both the community and those that work in the field of mental health.

From the early 1990's there has been bi-partisan political support at both Commonwealth, State and Territory levels for a National Mental Health Strategy, Policy and three successive National Mental Plans to support the Strategy. These reforms have also been endorsed by consumer and carer groups and by community agencies as well.

These "reforms" have been funded by the Commonwealth under the Health Care Agreements and each year a National Mental Health report has been published to monitor the implementation of the strategy and the three mental health plans.

The strategy was evaluated mid term by Professor Sir David Goldberg who concluded that the reforms introduced saw Australia well placed to complete the process begun under the Strategy in 1992. So what if anything has gone wrong.

The strategy has achieved great social reforms in the areas of reduction in stigma and discrimination and there is no doubt that overall the lot of those with severe psychological conditions has moved immeasurably away from the social and legal control achieved through the use of the psychiatric institutions.

Much has been promised over the last 30 years however some would argue that the journey has faltered at a fork in the road. Many would argue that the opportunity presented by the reform agenda has been squandered not through a lack of good public policy in this vital area of health care but in terms of its implementation.

Even today and approaching 15 years since the National Mental Health Strategy little sustainable argument can mounted to suggest that the 38 Objectives contained in the policy are misguided in either their formulation or in their intent.

So why then do we find ourselves in a position where there is to be a new and now National Inquiry into Mental Health and why is there such a despondent and cynical mood in respect to the outcome.

Such inquiries are not restricted to this country with similar reports commissioned in similar numbers in the United States and the United Kingdom.

Two reports in the United States completed in recent years, the Surgeons Generals Report into mental health and the George Bush senior report into mental health are instructive in that they approach the issues from the point of view that they do not dwell on the basis of an organisational autopsy.

Many would tend to approach the question of "whats wrong with the mental health system" by identifying the resource base as being inadequate both in terms of the material and human resources allocated to meet need. Seldom do such reports seem to focus on what's wrong with individual service elements and their use of existing resources.

Successive budgets in all States and Territories have increased the base budget allocation to mental health and although per capita funding has increased the effect has been to underscore that it is grossly inadequate.

When the de-institutionalisation reforms of the 1980's took hold there was corresponding and rapid growth in the development and expansion of community mental health services. This also marks the period in which major reforms took hold in terms of the organisation and administration of health care generally and of mental health services.

At the same time that the large psychiatric asylums were dismantled so to were their administrative structures. Some would assess the journey as incomplete until the resources said to be locked in the institutions are released through their closure and only then will true reforms be complete.

At the same time the primary health care model gained ascendency in terms of the wider issues in health policy making and health planning. Within that model as it applies to mental health integration and mainstreaming of services are seen as central

planks. When combined with a social justice philosophy determined to confront discrimination through anti-discrimination laws as well as reforms to mental health legislation.

Along with the reforms to philosophy and policy came reforms to the legal system. The legal principle of the "least restrictive environment" also applied to the accessing services and the policy of constructing acute mental health units onsite at general hospitals through the mainstreaming principle became established as a planning norm.

In the ACT as elsewhere the number of longer stay beds were reduced in the mid 1990's with a corresponding growth in resources occurring in community based mental health services.

Community mental health services were originally based in hospitals and developed firstly to accommodate the discharge of ex-psychiatric adult inpatients. These domiciliary outpatient and community follow-up services primarily catered to younger adults.

Progressively services became community based and have been established in areas such as child and adolescent, older persons, eating disorders, dual disability, dual diagnosis, forensic mental health and personality disorders.

Front ends are built into these services in the form of Crisis Teams. These teams control much of the flow of new referrals as a means of screening inappropriate referrals and controlling resource use further along the system.

Assertive Case Management Teams are also a feature of mental health services with these teams (depending on how they are constituted) tending to concentrate on those who require consistent and assertive follow-up in order to for them to remain well.

For a period hospital based and community based mental health services co-existed under separate administrations. From the late 1980's the idea of separate administrations were largely abandoned in favour of main streaming. The disconnection between hospital and community care has however continued to remain a pervasive and unresolved legacy in many services. Resolved on paper but not in practice.

In terms of measures of success social justice has been seen to be done in that there are now a range of alternative less restrictive means of providing care to people with significant disabling psychological conditions.

Mental health legislation, nationally provides for community based "orders" requiring varying levels of compliance.

The complexities associated with providing and co-ordinating community based services eventually saw the adoption of "case management" as a means of creating a common approach to providing integrated care not only in mental health but elsewhere across the health care system.

Much has been done and much has been achieved and yet there is an all pervasive sense that the effectiveness of these reforms has not translated into a reduction in the burden of disease.

In terms of an institutional based system the objectives are clear. To ensure that a safe and humane standard of care is provided. Many inquiries have found against institution on both counts. The care provided has been unsafe and judged to be inhumane.

Similar inquiries have also found in the post institutional era that community based care has also failed. Most notably the NSW Health Care Complaints Commission inquiry into Boarding Houses and Hostels and the Human Rights and Equal Opportunity Commissioners Inquiry into Human Rights and Mental Illness otherwise known as the Burdekin Report.

Both conclude that for many of the mentally ill they continue to live at the margins in society, they are exploited and are actively discriminated against particularly in the areas of employment and housing. The care provided has also been criticised for being unsafe and inhumane.

When examining the nature of these inquiries be they into hospitals, community based services or now national inquires into the state of mental health care they tend not to readily address systems issues. Instead they tend to make recommendations that are reactive to the perceived causes.

In turn Governments tend to respond to recommendations in reports in a piecemeal manner. In the final analysis the need for another inquiry tends to occur before a third of the recommendations of the previous inquiry were implemented. If there is one certainty in life it is that there will be another enquiry somewhere into mental health services.

This said it begs the questions why are mental health services established and structured the way they are and why have they tended to remain unchanged?

In terms of an institutional or hospital based mental health system there is a familiarity in terms of how it organises itself around purpose. The objectives of the hospital in terms of institutional care are relatively self evident. The hospital is both a destination and a sanctuary as well as a source of security for a community that sees mental illness as something to be contained and yet managed humanely.

The intent and will of the community is clear in this model is clear and those charged with providing this type of care are readily able to interpret and translate this into action hence the relevance of the term “Benevolent Custodian

Much less familiarity exists in terms of the objectives of community based mental health services model or indeed the area integrated mental health services model.

Although the intent of the community is clear those charged with interpreting and translating that intent into action have struggled to do so effectively.

It is here that we must consider the role of service modelling. Planing for health services has as its centre piece the primary health care model. Promoting healthy communities and resilience through health promotion, prevention and early intervention is the dominant paradigm in health policy and planning today. Planning is based around a populations health approach requiring a whole of government, whole of life span approach to improving the health of the community.

This begs the question as to what is the purpose of a mental health, how should a mental health service be structured and in turn how it should be resourced.

In a given population the incidence and prevalence of psychiatric morbidity and psychiatric disability can be forecast through extrapolations provided by the Australian Institute of Health and Welfare. These figures can also be tested in terms of their accuracy the levels of morbidity actually experienced in a given community.

In turn it is then possible to identify the level and range of services to be provided to that group and to calculate and allocate resources the resources necessary. This approach seems eminently logical with the exception that in mental health a range of variables have remained ill-defined in terms of services to be provided, the type of service and level of service.

At this point it is worth examining this issue through an analysis of the relationship between psychiatry the law and society.

Psychiatry is that branch of medicine charged by the community with the treatment and care of the mentally ill. As a branch of medicine it is classed as a science, a medical science. The role of a science is to make sense of an environment and make that environment more predictable. In psychiatry the science is the study of the mind in all its facets and particularly its behavioural dimensions.

As the decision to act is accepted as having its origins in the brain psychiatry often finds itself looked ce that provides the understanding of such behaviour. When a persons behaviour is at odds with an ability to exercise self determination combined with an inability to articulate reason through accepted logic psychiatry is called upon to intervene both on behalf of the individual and on behalf of the society in \which the individual lives. This is done through provisions in the law chiefly in criminal law and the statute referred to as the Mental Health Act.

As a science modern psychiatry is a relative new comer in terms of being able to demonstrate its science. It is early days it was often called quackery and was without an ability to provide factual evidence for much of its practise. Psychiatry has had a long and enduring relationship with pharmacy. Behaviour and how to moderate it have produced two distinct camps. There is an organic school of psychiatry and a dynamic school of psychiatry. Each has achieved ascendancy at times and it must be said that they are not mutually exclusive.

What has tended to haunt psychiatry and its practise has been an agreed position arrived at through research as to how best to treat various conditions that constitute psychiatric morbidity. High prevalence conditions in particular have proved elusive in terms of the successful treatment of longitudinal cohorts.

The questions asked of psychiatry are no different to those asked in all branches of medicine. What is the evidence, what is the scientific evidence to suggest that a particular condition should be treated in particular manner.

Evidence based medicine has its origins in industrial quality control as practised by the Japanese in the 1950's. Statistical quality control seeks to eliminate the variables in production. When human variables are taken into account in terms of the processes required to achieve a net cost of production it is possible to benchmark services to determine best practices. This may be done nationally or internationally.

In terms of medicine those areas with the least variables are more amenable to these approaches. For example the replacement of joints using prosthetic devices. Although a complex procedure the variables by and large can be controlled and surgical practises adopted around the world for joint replacement are now well accepted.

This has not been the case in the practise of psychiatry until very recently. It is interesting to note that the great strides that have been made in general medicine and in psychiatry have been particularly evident after two world wars. With a considerable number of disabled service men and women needing care and treatment the usual conservatism associated with medical practise gave way to innovation and research by necessity. It must also be said funding was provided for that research and innovation.

Interestingly Edwards Demings work with Japanese industry in the 1950's and 1960's was based on work done on the production of aircraft in the US during war time. Once the war was over such production system controls were considered no longer necessary and these 'innovations" lapsed to the great cost of the US economy some 20 years later.

It is to the subject of cost that we now turn in this discussion. The cost of providing mental health services places a significant demand on Government. It is a much misunderstood motivation that de-institutionalisation was driven by economic imperatives. Institutional care is in fact less of a cost than the current area integrated model.

In terms of net cost of service Governments are increasingly looking for indicators that improvements are occurring on the basis of funding health programs and mental health is no exception. If a mental health service is expected to reduce the impact of mental illness on its community how does it do this within the resources that it has.

How does it know it organises its resources around purpose to best effect? This also begs the question of reach in terms of the capacity of that mental health service to sustain a level of activity that reduces the psychiatric morbidity of the community.