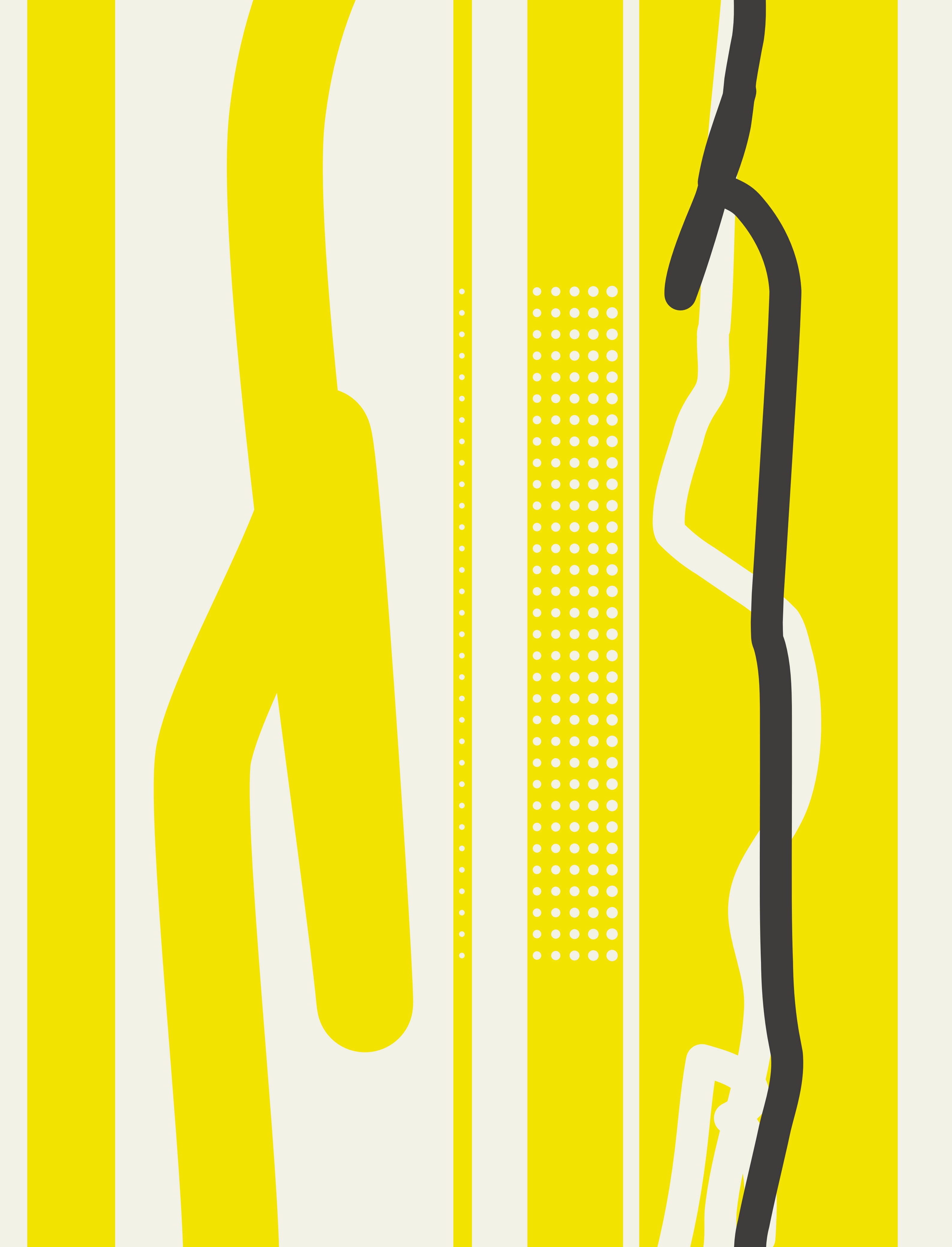
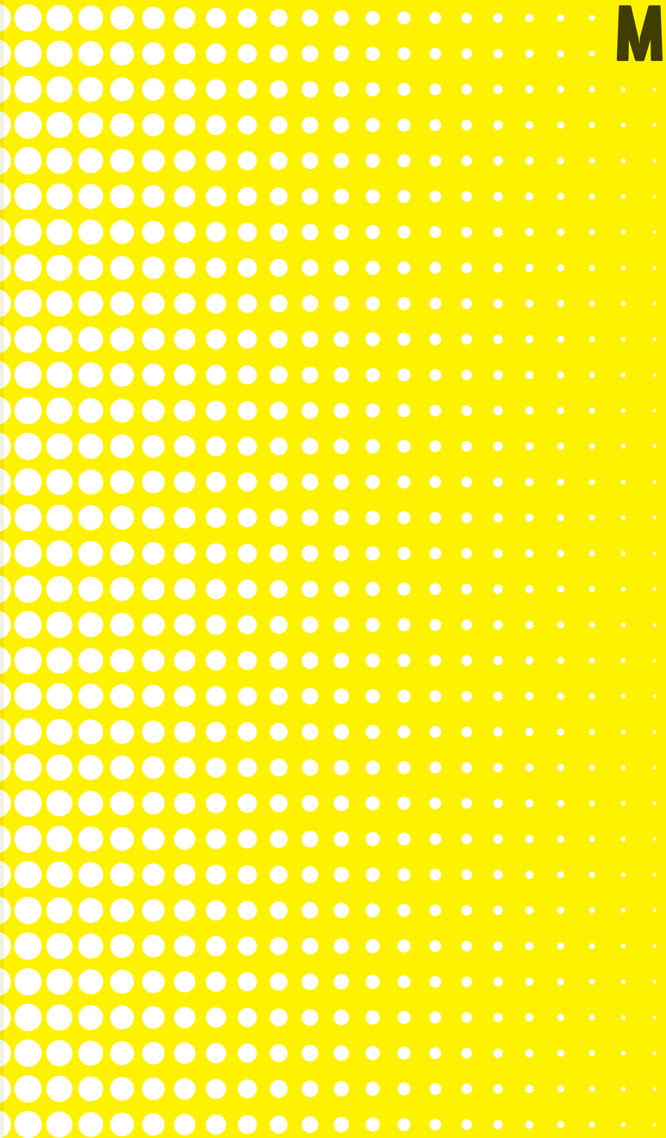


MAXIMISING ACCESS
to Mental Health Services



LOOKING BEYOND HOSPITAL BEDS FOR MORE FLEXIBLE INTERVENTIONS

by Paul Senior

Executive Manager,
Support Training & Intervention Services,
Centacare Catholic Family Services

At the beginning of 2013 – and not for the first time – there were very public debates expressing dismay about the growing use of practices which have mental health consumers in emergency departments restrained by handcuffing and other means, and isolating them in locked rooms through what is known as seclusion and restraint. South Australia (SA)'s Chief Psychiatrist Peter Tyliss acknowledged what appears to be an 'upward trend', suggesting this is in part due to SA now being one of only three states to collect data (ABC Radio: 2013).

In this same interview the South Australian Health Minister Jack Snelling suggests that demand for seclusion and restraint is a contributing factor to the current situation. The National Mental Health Commission calls for all jurisdictions to collect data on its use (NHMC: 2012).

The reality for many consumers (and their carers) of mental health services is that emergency departments continue to be the main source – and first point – of access to mental health services. This is coupled with police and emergency services also fulfilling a frontline and first responder role for mental health services. As a result, few alternative support or intervention options are available to them other than to take consumers to the Emergency Department.

After over two decades of reform, and after substantial federal and state government investments and initiatives, we continue to fail our community by not providing clear pathways, timely intervention, access to flexible and responsive acute care and recovery services to people confronted with mental health issues. Access to services is influenced by where the service is located and the stepped level of care that might or might not be available and the appropriateness of the services offered.

Stepped models of care include crisis respite services instead of emergency departments, recovery centres following acute admissions rather than extended hospitalisation before discharge, intensive home-based support rather than hospitalisation and recovery-orientated community support services. The dominant service, mind you, remains a hospital based in-patient model. Access to flexible acute care interventions remains an elusive alternative for consumers.

AFTER AT LEAST TWO DECADES OF REFORM, AND AFTER SUBSTANTIAL FEDERAL AND STATE GOVERNMENT INVESTMENTS AND INITIATIVES, WE CONTINUE TO FAIL OUR COMMUNITY BY NOT PROVIDING CLEAR PATHWAYS, TIMELY INTERVENTION, ACCESS TO FLEXIBLE AND RESPONSIVE ACUTE CARE AND RECOVERY SERVICES TO PEOPLE CONFRONTED WITH MENTAL HEALTH ISSUES.

Stigma and mental health literacy, our personal understanding of mental illness, its signs and its impact, contribute to patterns of help-seeking (Smith and Shochet: 2011, 37-41). Many people are reluctant to seek assistance. Often, confronted by symptoms, spiralling distress and uncertainty about care responses, a consumer might delay or postpone seeking help. Many will first rely on family and informal supports, delaying help-seeking until circumstances result in the need for urgent intervention.

This delay is not about system navigation. Rather, it is about the dominance of service models. It is not sufficient to understand access merely as a stigma and literacy issue. To do so is to place the responsibility back on the consumer.

When most people think mental health and mental health services they think of hospital-based services and the stigma and uncertainty that go with it (CMHA: 2012).

Even if these barriers were resolved, consumers would still be confronted by the limited options for seeking assistance such as:

- Limited opportunities for consumers to access high quality, responsive, relevant community-setting acute care and recovery supports.
- Local services focused on recovery and stepped to meet the varying states of a consumer's wellbeing.

The presence and availability of services need to be built up. While there is evidence that after decades of reform there is a shift in resources from standalone psychiatric resources and acute psychiatric beds to community-based services (Whiteford: 2002, 210–215), there remains a substantial belief in the delivery of services from an acute hospital-based perspective (Saraceno: 2007). This hegemony, or dominant narrative, is reflected in the ongoing public debate for an increase in funding for more acute beds.

Contra to this, there is ample practice and research evidence to support the position that mental health services are optimally delivered in community settings and in an integrated way (Saraceno: 2007). This goes beyond the concept of a step up and step down continuum of care, but embraces a model of care that seeks to deliver person-centred services concerned not only with a person's psychological needs but with their social and physical wellbeing as well (COAG: 2012). This would be service that practices collaborative care.

A number of services' models have been developed, funded and delivered by community and not-for-profit organisations such as the PARC (Prevention and Recovery Care) model to support short-term early intervention, Intensive Home Based Support, Headspace, EPPIC (Early Psychosis Prevention Intervention Centre; an integrated comprehensive service) and psycho-social rehabilitation and crisis respite services. But there are still too few of these outlets.

The community-managed mental health sector is central to the development of quantity, quality and accessible services such as the ones mentioned. The sector has been, and continues to be, a leader in the development of person-centred, recovery-orientated services promoting a narrative of care that is in opposition to that based on access to hospital beds.

Historically, this is a sector that has received little of the public spend on mental health and yet there is compelling evidence that investment in this sector will increase access to timely, effective and responsive services. With recent reforms, investment in the community mental health sector has increased from less than 2% of the investment to a little better than 5% (Whiteford: 2002, 210–215) but by international standards this remains low. New Zealand, for example, expends up to 30% of its mental health budget on dedicated community-managed services (Rosen, Goldbloom and McGeorge: 2010, 593–603).

Access will only be addressed by investment in a diversity of services that are relevant to the communities and target populations they seek to serve. Access will not be resolved with great investment in hospital-based beds. Developing a political and community understanding of mental health needs that is more sophisticated than a plea for more beds is a fundamental step in this direction.

IMPROVED

HAS THE HEALTH IMPROVED ACCESS

by Jackie Crowe

National Mental Health Commissioner

The drive to reform – and improve – the mental health service system in Australia began with the aspirations of mental health professionals, consumers, their families and carers. In 1991, the United Nations Declaration Principles for the Protection of Persons with Mental Illness was released, followed a year later by the report of the National Inquiry into the Human Rights of People with Mental Illness, which recorded the extent of mental illness and its treatment in Australia. Additionally, state inquiries highlighted abuse and violation of human rights.

It was while all this was going on that Australia became the first country in the world to develop a national strategy for the transformation of mental health services across the country. Twenty one years later, there have been:

- 1 national mental health report card.
- 2 national mental health policies.
- 11 national mental health reports.
- 4 national mental health plans.
- Several national strategies.
- Numerous national surveys of mental health.

There have also been state and territory mental health plans to meet local requirements.

In agreeing to a national mental health strategy, health ministers recognised, as in the 2010 National Mental Health Report's summary of 15 years of reform, that it was important to monitor and publicly report on its progress (National Mental Health Report: 2010). Part of this has been achieved through independent evaluations of each five-year national mental health plan.

01

First national mental health plan

Improving the rights of consumers, their families and carers was a pivotal theme of the first plan (1992-97). The commitment to empower the consumers, their families and carers of mental health services was a stark contrast to the neglect and gross human rights abuses that characterised mental health services over the past century.

The 1997 evaluation of this, the First Plan, acknowledged that the mental health system was in poor shape at the start of the strategy (National Mental Health Strategy Evaluation Steering Committee: 1997), in particular, that 'there was widespread dissatisfaction with services, consumers, their families and carers who all reported problems with access to services'.

The evaluation of the plan concluded that while significant gains had been made in mental health reform, reform had been uneven across, and within, jurisdictions, and that further action was required to maintain and build on the momentum generated under the plan. Major structural reform achieved during these five years was not necessarily accompanied by improved service quality (Whiteford, Buckingham and Mandescheid: 2002, 210-15) – and thus access.

02

Second national mental health plan

The second plan (1998-2003) built on the achievements to date and identified additional areas for national activity, such as:

- Promotion and prevention.
- Partnerships in service reform.
- Quality and effectiveness.

Consumers, their carers, mental health service providers and professional bodies were consulted and their views and recommendations helped identify priority areas of national activity.

The evaluation of the Second Plan acknowledged that the challenge to mental health service reform was to achieve a system of care that met the needs of individual consumers 'across the entire course of their illness, across their multiple areas of need, and across the lifespan; however the complexity of the system reform required to deliver integrated care has become increasingly evident'. The evaluation concluded that Australia has continued to pursue and make progress towards implementing the objectives of the National Mental Health Strategy, including the three additional priority themes identified in the Second Plan. However, progress has been slower and less extensive than hoped. In particular, the national community consultations, where for the first time, consumers, their families and carers were part of the evaluation, revealed a high level of dissatisfaction.

ACCESS?

STRATEGY TO SERVICES?

Third national mental health plan

The intent of the Third Plan (2003-08) was to unite the achievements of the First and Second Plans, address gaps identified in both, and to provide new directions for the National Mental Health Strategy. In evaluating the plan, many felt it had an aspirational quality and was thus too broad to achieve reform by trying to be all things to all people. In the evaluation, people indicated that they could not say if the key directions or outcomes had been fulfilled because the required actions were not clearly defined.

It was during the lifetime of this plan that reports from the Mental Health Council of Australia and the Senate Select Committee on Mental Health (2006) were published capturing the persisting, distressing and daily experiences of inadequate mental health and community care. The reports detailed personal stories of people with mental illness, their families and carers. They also stated that such stories were often excluded from other national reports. The reports judged harshly the results of reforms over the previous decade.

Fourth national mental health plan

The Fourth Plan (2009-14) had actions in five priority areas that had been developed to achieve the vision of 'a mental health system that enables recovery, which prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community … with an outcome to have improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services.'

An evaluation to the Fourth Plan is underway.

Future issues

Bringing together different governments and stakeholders, including consumers and their families and carers, to agree to a national approach to mental health is quite an achievement. And there seems to be consensus that national mental health plans are necessary to maintain and focus momentum for ensuring ongoing reform of mental healthcare throughout Australia (Currie and Thornicroft).

It is clear that the aims of the strategy and thus the plans themselves have not yet been fully translated into the expected benefits for consumers, their families and carers or the general population. This is especially when it comes to improved access to appropriate care. There is widespread dissatisfaction with the state of service, and a strong consensus that further change is needed, including the need for more resources in mental health and in the way that these resources are used.

Although it important to say that Australia has continued to pursue, and make progress in implementing the objectives of the national mental health plans, a quandary does arise. Disquiet about service delivery from consumers, their families, carers, advocates and communities indicates that there are continuing problems with access to timely and effective mental health services (Groom, Hickie and Davenport Tracey: 2003). Given this, have the national mental health plans become increasing irrelevant as a driver for reform at the grassroots level?

THE REPORTS JUDGED HARSHLY THE RESULTS OF REFORMS OVER THE PREVIOUS DECADE. NOW THERE IS SIGNIFICANTLY MORE DATA BUT THIS DOES NOT EXTEND TO QUALITATIVE DATA FROM CONSUMERS, THEIR FAMILIES AND CARERS AT A NATIONAL LEVEL NOR DOES IT COLLECT RECOVERY DATA FROM SERVICES DELIVERING MENTAL HEALTH PROGRAMS.

Future directions

When the National Mental Health Strategy began no information was available about the extent and impact of mental illness in Australia. Now there is significantly more data but this does not extend to qualitative data from consumers, their families and carers at a national level, nor does it collect recovery data from services delivering mental health programs. As all plans have recognised the need for a change in the way governments respond to mental illness (2009) this is where the Australia could make vast improvements.

Outcome data from consumers and their families and carers must inform the evaluations of the national mental health plans, the Strategy and the way forward. Without this crucial data, the National Mental Health Strategy's evaluations are incomplete and we will never truly know if access to timely, effective mental health services has improved for Australians currently experiencing a mental health difficulty.

IMMIGRANT + REFUGEE COMMUNITIES & SYSTEM REFORM

by Prof Harry Minas

Chair of the Executive, Mental Health in Multicultural Australia,
and Director, Centre for International Mental Health,
School of Population and Global Health, The University of Melbourne

& Prof Nicholas Procter

Member of the Executive, Mental Health in Multicultural Australia,
and Chair, Mental Health Nursing, Division of Health Sciences,
School of Nursing and Midwifery, University of South Australia

> *'Multicultural Australia is not a vision or an ambition, much less an ideology or creed. It describes us as we are and as we are destined to be'*
>
> **(The People of Australia, The Australian Multicultural Advisory Council)**

All Commonwealth, state and territory mental health policy documents recognise that Culturally and Linguistically Diverse (CALD) populations need special attention to ensure equity. Reforming the national mental health system requires a clear statement of rights and responsibilities, the development of national standards for service delivery, a commitment to evidence-informed policy development, service delivery and reporting of progress against policy intent, and a focus on the results of this service.

Within all this protocol, are we able to judge whether mental health reform has benefited CALD communities particularly non-English speakers, the most recently arrived, and refugees and asylum seekers, who are among the most vulnerable members of the general community?

Although most mental health policies include statements on the importance of population diversity, such statements generally do not come with implementation objectives nor funding to support implementation of CALD community policy. Reporting of progress against CALD-related policy intent is also inadequate. Yet, to ensure that all Australian residents benefit from mental health reform, CALD-relevant mental health policy statements need to be translated into those very implementation objectives and resources allocated to meet them.

It is essential to evaluate and report on progress against CALD-relevant policy objectives – something that does not happen at the moment. Mental Health in Multicultural Australia (MHiMA) has designed and is trialling what is known as the Organisational Cultural Responsiveness Assessment Scale that will enable mental health services to track their own provision of culturally responsive services.

We know that many (but not all) immigrant and refugee communities access specialist mental health services far less than the Australian-born, and rates of service use vary enormously across country-of-birth groups. Yet the National Survey of Mental Health and Wellbeing (2007) found that the prevalence of common mental disorders in the overseas-born is not substantially different to that in the Australian-born, although the national survey sample was not sufficient to allow any specific conclusions about even the largest immigrant communities.

While we do not have population data on the psychoses and other severe mental disorders, the international literature suggests that the risk for schizophrenia among immigrants and refugees is substantially greater than for host-country populations. So the rates at which state and territory mental health services are used, particularly in-patient services, should be substantially higher for immigrants and refugees than for the Australian-born. But they are not, which suggests that specialist mental health services are under-used, with possibly large numbers of immigrants and refugees receiving no effective treatment or care. We do not understand the causes and consequences of this under-use and they need to be fully investigated.

Gaps in data collection

The general commitment to evidence-informed policy and mental health service design and delivery only makes sense when the resources needed to gather, analyse and use the required evidence are provided. But there are major gaps in relation to CALD populations, in particular in our collection of data on national mental health outcomes. Because CALD variables are not included as part of such collected data, it is impossible to know whether treatment and care for immigrants and refugees have the same affect on them as on Australian-born. This makes it extremely difficult to plan effectively for the future. Ensuring that national outcomes data can be used to evaluate clinical and social outcomes for immigrants and refugees, consequently, is an urgent priority.

Routine data collections, generally, do not include sufficient CALD-relevant variables or, if they do, they are not systematically analysed and the findings are not reported. None of the National Mental Health Strategy reports, for instance, have included any CALD-relevant analysis, making it impossible to determine whether service standards are met, where the gaps are and whether our mental health system is moving towards equity.

MHiMA is collaborating with the National Mental Health Commission to develop strategies that will improve the quality of CALD-relevant evidence to inform the continuing mental health reform process and contribute to the Strategy's equity objectives.

Cultural and linguistic diversity presents many challenges but also represents an opportunity to improve our understanding of health and illness determinants, and how we can develop more effective promotion, prevention and treatment programs. In the non-communicable diseases field, for instance, there has been an early study of the cardiovascular benefits of the Mediterranean diet.

The drive to develop more effective suicide prevention programs will illustrate the point in the mental health field where suicide rates vary widely among different country-of-birth groups in Australia, as they also do across countries. Systematic examination of this variation will contribute to a better understanding of both risk and protective factors and development of suicide prevention strategies that are designed and targeted for particular circumstances and population groups to make them more effective. By not already investigating these, we both limit our understanding of them and the development of new knowledge that can benefit all Australians.

Although these days we can respond better to the diverse mental health needs of a culturally and linguistically diverse population, much still needs to be done. Representatives of immigrant and refugee communities must be more effectively included in decision-making about all aspects of mental health policy and services, and within consumer and carer organisations themselves. In particular, the quality of evidence that informs such decisions needs to be improved, so that our mental health system fully reflects the diversity of the Australian population.

Most importantly, clear and consistent policy statements on cultural and linguistic diversity need to be implemented, and then that implementation must be monitored, evaluated and reported on. We must move from the rhetorical commitment of policy documents to go on to allocate resources that will create the necessary institutional arrangements to turn policy intent into action that will match the reality — and demands — of Australian cultural and linguistic diversity.

> **REPRESENTATIVES OF IMMIGRANT AND REFUGEE COMMUNITIES MUST BE MORE EFFECTIVELY INCLUDED IN DECISION-MAKING ABOUT ALL ASPECTS OF MENTAL HEALTH POLICY AND SERVICES, AND IN CONSUMER AND CARER ORGANISATIONS.**

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