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Reflections on 30 Years of Mental Health Reform in Australia and Visions for the Future Perspectives Report ConNetica 2013, 231-9

64. “Must try harder” Alan Rosen

Australia’s half-hearted attempts at transition from hospital-centric to community-based mental health services

There is widespread and increasingly consistent international recognition that institutional hospitalization does not offer maximal therapeutic support or care; a movement towards provision of mental health services in the community; innovation in community care, including housing; work; legislative reform; the need for committed leadership, adequate funding, and stigma reduction; and the imperative nature of increasing the mental health workforce and enhancing its skill-set to encourage recovery-oriented treatment.

Evolution of Australian psychiatry

The history of Australian psychiatry is entwined with the impact of European (British) invasion and settlement, initially in Australia, in 1788, to form penal colonies to alleviate the overcrowding of English jails, which generated a masculine-dominated, individualistic culture. As European settlement in Australia expanded, the colonists tried to come to terms with the remote, vast landscape of Australia. Some were detained in our early asylums with diagnoses like “Bush Madness” and “Sunstroke”. They fought over land and resources with the original Aboriginal inhabitants, who had been there between 40,000 and 60,000 years. Dispossessed and displaced Aboriginal communities became doubly colonised: once by European invasion and then by incarceration and forced treatment if they were deemed to be mentally ill[129]. Loss and grief were often mistakenly diagnosed and treated as depression, and protest and defiance as psychosis. Forced removal of mixed heritage children by government policy resulted in trans- generational mental disorders.

More recently, culturally congenial methods of working with indigenous people are being integrated into mental health services, for example professional training, qualifying, mentoring and employing of Aboriginal mental health workers. With accelerating European and Asian immigration, particularly since the 1950s, Australia has become increasingly multicultural in its approaches to mental illness. More recently however, Australian governments’ policies have again artificially manufactured and exacerbated mental illness through

the stresses of remote detention and uncertainties of fate that they place upon asylum seekers and their children.

Australia: A cautionary tale

Australia serves as an example of a country whose mental health provision structure is evolving from institutional to community-based care. It has struggled with translating plans into service, and reflects how programs can degrade without consistent leadership, funding, and coordination.

By the mid-1950s, occupation of psychiatric institutions reached its peak in Australia. De- institutionalisation occurred in the 1960s and 1970s but without significant community supports in place. In a move to appropriately shift mental health care from institutions to the community with adequate planning and funding. The Richmond Report was tabled in 1983 and implemented in NSW from 1984-7. Subsequently, unjustly blamed for unbridled deinstitutionalisation in the state, David Richmond had only clearly pointed out and sought to correct the pre-existing imbalance: that 90% of individuals with severe mental illnesses had already been deinstitutionalised before his study and were living most of the time in the community with only 10% of the public resources devoted to mental health being available to support them. Meanwhile, only 10% were still based in hospitals with 90% of the expert staff and all these resources.

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So the money was not following the patients and, as NSW Secretary of Health, Richmond attempted to correct this, but this was thwarted politically by a subsequent government, which diverted the promised resources for the further development of community teams and resumed investment in the stand-alone institutions. Many NSW people, who unjustly condemn Richmond for deinstitutionalisation without adequate community support, do not realise that he is the same clear and independently thinking leader, widely celebrated, who saved the Sydney Olympics from chaos, as the head of the Olympic Coordinating Authority.

Nevertheless, the important mental health reforms he began led to the First Australian National Mental Health Policy, which was endorsed in 1992 by all Australian health ministers. It provided transitional funding in the national budget through the accompanying National Mental Health Strategy. There have been four distinct phases of the National Mental Health Strategy [130 & 131].

First National Mental Health Plan (1993–1998)

Services were to be shifted from stand-alone psychiatric hospitals to become largely community-based, ‘mainstreamed’ services, integrated with and accessible via general health services, although remaining distinct as specialised mental health services. This included 24/7 mobile community-based mental health crisis intervention services, assertive community treatment teams, a range of supervised community residential facilities, community vocational rehabilitation services and social recovery services,

integrated with local psychiatric in-patient units based in general hospitals. They were to develop strong links with groups of consumers, families, general practitioners, the non-government service organisations, and other non-health services, such as housing, disability services, social security and employment[132].

Second National Mental Health Plan (1998–2003).

This plan focused on the principles of mental health promotion, prevention, partnerships with other (non- health) providers of services, and quality. A new emphasis on early intervention programs began to emerge based on the internationally pioneering work of McGorry and colleagues in Melbourne (http://www.orygen.org.au)[133 & 134].

Third National Mental Health Plan (2003–2008)

There is now broad agreement that the Third Plan, despite a welcome focus on service responsiveness and partnerships, lacked real accountability mechanisms, and provided few incentives to the states to complete even the first two Plans[135]. Accordingly, the substantial early achievements of the National Strategy began to fray, and gaps in services began appearing as evidence-based community services were short-funded, diluted and/or retracted increasingly to hospital sites[136]. There was also an unanticipated growth in acute presentations of co-morbid drug abuse and mental illness[137], which overwhelmed emergency and inpatient departments.

Media glare on the human consequences of these problems led to serial national inquiries by the Mental Health Council of Australia[138], the Human Rights and Equal Opportunity Commission[139], and the Australian Senate[140]. In response, a substantial injection of federal funding occurred, focusing on paying largely for non-professional support workers to be provided through the non-government sector, subsidising private fee-for-service counselling for higher prevalence milder mental health disorders. The states were unsuccessfully challenged by the Federal Government to match funding to enhance core public services for lower-prevalence severe conditions. Unfortunately, in order to maintain party political control of them, these new federally funded services were deployed in new silos without any articulation or coordination with existing state operated public mental health services.

Fourth National Mental Health Plan (2009–2014)

Accompanied by a new national mental health policy and revised national mental health services standards[141 & 142], it signalled a further retreat from full consultation of stakeholders and the bureaucratic dilution and

downgrading of the national strategy with few specified objectives, goals, targets, or timelines[143].

Advocacy

The Mental Health Services Conference of Australia and New Zealand (http://www.themhs.org) has evolved over the last 23 years into a “strong

independent movement" [144] conducting national forums twice yearly, led by a broad coalition of all mental health professional, mental health leadership and management, consumer, family, trans-cultural and indigenous networks. It organizes bi-national forums for evidence dissemination and debate that push for greater momentum in mental health service reform. In 2010 a pervasive on-line national public lobbying network ("Get-Up") took on mental health and campaigned strongly, particularly for youth mental health.

Politics

As time progressed and deficiencies and outright gaps in mental health services became more obvious as they fragmented, public awareness was expanding. The (temporary) National Health & Hospitals Reform Commission found in 2009 that mental health, among other long-term conditions, badly needed public funding for a more consistent shift to 24-hour continuous community services, equitably deployed across the country. This priority was ignored or postponed by the new Prime Minister, Kevin Rudd, who had established the Commission. Rudd focused almost entirely on acute high-tech hospital care and primary care. Shortly, after announcing his 'health and hospital s reform package, he was dumped by his Labor colleagues.

For the first time in Australia the need for better funded mental health services became a hotly contested issue at the August 2010 Federal Election, with all 3 major parties competing with well-publicised mental health policies, bearing fruit in 2011 with enhanced funding in the national budget. So far, funding has created very few evidence based community services, except for early intervention in young people, with more silos between public, NGO and private fee-for-service funding streams, questionable mechanisms for the low-level expertise coordination of vocational, residential and clinical services[145]. However, several independent statutory mental health commissions have been forming (one national, plus 3 state commissions so far), following new governmental commitments to revive and transparently account for evidence-based, consumer and family congenial, recovery oriented mental health care reform.

Implications

Structural reform of mental health services is easier to achieve than improvements in service quality; support of clinicians, consumers and care-

providers is a critical factor in the success of mental health reforms[146]. Mental health reform in Australia looks good on paper, and has been heading broadly in an appropriate, more community focused and recovery oriented direction. However, these reforms are often fragmentary and keep losing momentum. Core local public community mental health services lack adequate investment, are being eroded by plundering by their custodian Local Health Networks or have never developed sufficient breadth[147 & 148].

After a period of sustained growth in spending on mental health services, and, following a lull, even with the Federal enhancements announced for 2011-16, Australia still lags behind similar Western countries in terms of the proportions of gross domestic product and national health budget spent on mental health services[149 & 150]. For example, New Zealand's per capita expenditure on mental health far exceeds Australia's, now spending 11% of its health budget on mental health services, whereas in Australia, this proportion continues to hover around less than 8%, in spite of the fact that the average burden of disease due to mental ill health is more than 14% (and growing in proportion) of all diseases internationally[151]. Strong independent advocacy from several new reform-oriented Australian mental health commissions may be able to convince governments to remedy this[152].

Current state of play in Australia

Most Australian governments, state and federal, do not provide incentives or pricing signals which will shape more community based integrated health systems[153]. New federal pricing mechanisms favour hospital-related services, and therefore are regressive in terms of where mental health service reform needs to go. Their initiatives often appear to be piecemeal and to primarily serve political expediency. They rarely seek, build or abide by any unifying vision, model or trajectory.

Rather they leave dis-articulated silos of public, NGO and private fee-for-service elements, trying to support and grow both archaic stand-alone institutional mental health services, psychiatric beds in general hospitals and emergency departments, without any evidence of their effectiveness, and community mental health teams all at the same time. Most of our states have uncritically backed all of these approaches simultaneously. Spreading your resources too thinly while trying to be everything to everyone is not much of a clinical strategy, and even a doubtful theological one. Consequently, we have ended up in most states, possibly excepting Victoria, with "ambivalent non-systems of care", rushing off madly in all directions at once, and ultimately petering out. Meanwhile our human and financial resources are soon dissipated, becoming ineffectively but completely spent.

Australian Governments politicise their attempts at health service reform so much that they often turn out to be an unworkable mess or uncoordinated tangle of fragmented services, sometimes duplicating each

other, and failing to plan or work together. This is as if Governments have "a reverse sausage machine" which starts with a well-formed sausage at one end, and produces a limp pile of mince at the other, leaving it to service providers on the ground to pick up the randomly spat-out bits and desperately fashion them into a vaguely useful system of care, which may provide some rough semblance of a service. It sometimes seems like governments are embarking on an absurdist enterprise, finely mincing a good steak in the

attempt to reconstitute and recreate a facsimile of a fairly ordinary soya bean[154].

Conclusion – Australia must be squarely part of the global movement towards Community Based Mental Health Practice

Evidence-based global health initiatives for both developing and developed countries are now encouraging a shift of focus from hospital-centred and institutional care to community-based care[155], with closer linkage to or co-location with primary health care.

Much work has been done internationally on the roles, teamwork, leadership, training, and future scope of the work of community mental health practitioners. The terms 'community psychiatrist' or 'community mental health practitioner' should signify an exhortation to 'go wider' in seeking rigorous training and experience in both the *microsphere* of direct holistic clinical and functional care, and the *macrosphere* of improving the wellbeing of whole communities[156]. Many of these experiences, particularly for those who came to terms with old institutional care and thinking, are now emerging as practice-based evidence and outline a real paradigm shift from an illness-focused psychiatry to a person-centred mental health and wellbeing paradigm[157].

We must acknowledge a new landscape in mental health services with a very different funding environment, inviting partnerships across the traditional divides of public, NGO and fee-for-service funded services. We need to rebuild the presently withering evidence-based modules of mental health services into teams that meet all the fidelity criteria and therefore work well and reliably for service-users and their families. The contemporary models with effective outcomes include crisis teams, one-stop shops for every age group co-located in shopping hubs with primary health care, community based residential respite facilities and assertive community treatment (ACT) teams. These teams should be interdisciplinary, including clinicians, peer support workers, drug & alcohol, vocational, housing and family specialists, dieticians, sports physiologists and visiting community pharmacists, Aboriginal & Transcultural mental health workers as required, and counsellors drawn from all those sectors.

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Finally, are community mental health services caught in a recurrent time-warp? Are we destined to fight the same battles to save community mental health over and over again? A shift of gravity of mental health services to community based care is squarely supported by worldwide evidence, and is long overdue in some countries. However, community teams and facilities do not have a high public profile, unlike salient and brooding hospital complexes, so they are vulnerable to variable and chronic underfunding and recurrent attempts to dismantle them on the spurious basis of economy of scale[158&159]. Some argue that mental health reforms with a marked

ideological component and extremely dependent on charismatic leaders are especially vulnerable, given leadership changes and the political powers on which they depend[160]. However, there is no monopoly on ideology: institutionally centred services have been defended on the basis of ideology and without evidence for several centuries. Similarly, there remains an evidence-free reactionary zone defended by a vocal minority of hospital-based clinicians arguing against a shift towards community care. Furthermore, many pioneers of community services state that they were never characterized as charismatic until they succeeded, and prefer that their reforms be judged not on their theories but on evidence of improved outcomes.

Key lessons from all these initiatives relate to planning for sustainability and the need to undertake pro- active and progressive reform of existing institutional structures such as the old style asylums. We need to not only redistribute limited resources to the community, but prevent the regressive influence that a traditional institutional mentality or clinical elite can exert, even after institutions have been downsized or even closed, causing a loss of momentum and transformative culture. This can often result in a return to stasis once the project is complete and the energy for reform has dissipated. We must get beyond isolated great models of best practice in the community separated by vast wastelands of poor service, but instead to achieve regional arm's length purchasing and extensive roll-outs of evidence based service modules or teams, on an equitable and sustainable basis of reform. These must be protected by permanent mental health commissions and local community mental health consortia (like headspace) or boards. The latter, by continuing to evolve, should be structured to withstand changes of governments and political flavors; monitor the quality of services; advocate and report, and represent the consumer voice, to the highest level of governments, legislatures and the public; and work hard to earn and retain the trust of consumers, families, and the community.

Acknowledgement: Based in part on a chapter by Rosen A O'Halloran P & Mezzina R on International Community Mental Health in The Handbook of Community Psychiatry eds. McQuiston H Sowers W Ranz J Feldman J Springer: New York, 2012

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