

mentalhealth

Let's Make it Work



Mental Health Policy Statement
November 2005

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One in five people in Australia will experience a mental health problem in the next 12 months. That means that 250,000 South Australians¹, plus their families and friends will be affected by mental illness either directly or indirectly. None of us is immune to the impacts of mental illness.

The MHCSA vision is that all South Australians with mental illness and their families will have access to best possible supports that allow them to manage their illness and live well in the community.

The supports must include:

- professional medical care including acute and hospital based care
- non-clinical supports including information/education, mutual support/self help, rehabilitation, housing support, respite care.
- Access to safe and secure accommodation
- Support to gain education and employment

South Australia, once a leader in mental health in the early 90's, has over the last 10 years fallen behind the other states. To regain our leadership position four ingredients are essential:

- Model
- Plan
- Participation by all
- Resources

Model

Increasing rates of mental illness² and systemic failures³ to address the needs of people with a mental illness have led to an understanding that our current model of service delivery is a failure. The current model of mental health service delivery has evolved from a historic model of treating illness.

Our vision of mental health reform requires a shift to a model of care which aims to support people to live and stay well in the community. Clinical services which treat the acute phase of illness will remain important but their effectiveness will be enhanced with greater availability of non-clinical supports to help people to stay well and avoid relapse into acute care.

It is well documented that support services, delivered in the community by an evidence-based model, help people to stay well⁴ and can dramatically reduce use of the clinical and hospital-based services. Whilst the pressures on acute care

One New York study showed a benefit of up to \$34 for each extra \$1 spent on including psychoeducation of family members in the treatment regime for people with mental illness. Savings were in reduced psychotic relapse, symptom status, medication compliance, rehospitalization and increased employment.

Source: McFarlane, W. R., Lukens, E. & Link, B. (1995) Multiple-family groups and psychoeducation in the treatment of schizophrenia. Archives of General Psychiatry. 52, 679-687.

services in SA are currently severe, the recommendations proposed here for the mental health budget represent a cost-effective solution that is sustainable in the long term.

Plan

Major and sustained reform is required to achieve the vision of supporting people to stay well in the community. A well-articulated plan for South Australian mental health reform is needed if we are to work together to achieve this. The plan will need to identify the major barriers and how they will be overcome. It will also need to set targets, measure progress and report on achievements. Specific emphasis will be required to ensure effective supports for indigenous people, people from culturally and linguistically diverse (CALD) backgrounds, young people, aged people and people living in rural and remote areas.

The National Mental Health Policy and the three national mental health plans over the last 12 years aimed to dramatically improve mental health services and treatment throughout Australia. The plans were necessarily ambitious and have led to a great deal of research, many pilot programs and national standards for mental health service delivery⁵. We now have the evidence base to show what types of services work well and how to build a comprehensive system of supports that will help people stay well. This national work provides a wealth of experience for us to draw on.

Independent evaluation of the 'Housing in the North' accommodation support service showed that supporting 14 people to live independently cost \$19333 per person. This saved between \$36000 and \$44700 per person in use of acute hospital beds and freed up 4.2 acute beds for a whole year.

Source: Parliament of South Australia (2003). Inquiry into Supported Accommodation. P.193

Participation by All

Mental health reform will require significant community engagement to be successful. Consumers and carers who are affected by mental illness need to participate in all stages of planning, evaluation and implementation. Involvement of independent stakeholders is needed to maintain focus, momentum, transparency and accountability.

Stigma is a significant barrier and community engagement will help to reduce stigma and raise awareness, particularly within mental health services.

Resources

Driving such a major change will require significant financial investment. Being the state with the lowest per capita spending in Australia is a major barrier to providing an effective mental health service in South Australia. An initial recurrent increase in the mental health budget of \$50m is required to kick-start the changes, building to \$100m per annum over 5 years.

Moving from the present crisis-driven model, where treatment is provided on a revolving-door basis in response to crisis, will require substantially increased recurrent funding to the non-government sector. Why? Because they deliver services in the community to meet the on-going support needs of people with mental illness and reduce pressure on acute services. These supports are the building blocks for people with mental illness to build a good life or 'recover'. The types of services required are education and information, peer support, housing support, carer and family support and flexible rehabilitation and recovery support.

Increased funding to the non-government sector will create a balance between acute care and recovery in the delivery of mental health services in this state. This change is long



¹ ABS, Australian National Survey of Mental Health and Wellbeing, 1999

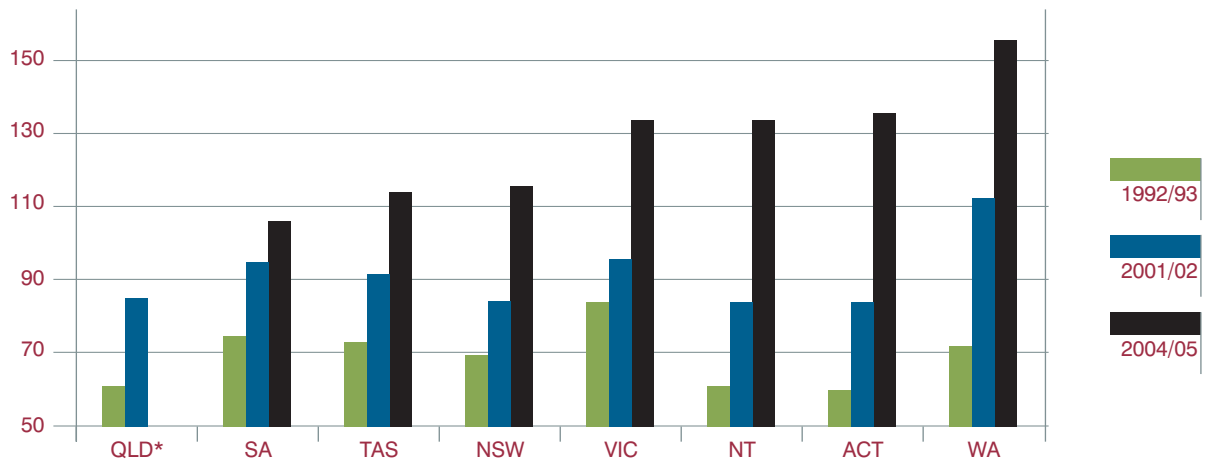
² World Health Organisation (2001). The World Health Report 2001: Mental Health – New Understanding, New Hope. World Health Organisation: Geneva

³ 'Better Choices, Better Health – Final Report of the South Australian Generational Health Review', April 2003. http://www.dh.sa.gov.au/generational-health-review/documents/GHR_Main_Report_WEB.pdf. Brennan Report

⁴ Hickie, I, Groom, G and Davenport T (2004). Investing in Australia's Future – the personal, social and economic benefits of good mental health. www.mhca.org.au.

⁵ National Mental Health Report (2004). Commonwealth Department of Health and Ageing

► Mental Health per Capita Spending by State



*QLD 2004/5 figures not available

Source: 92/93 and 2001/02 data – National Mental Health Report 2004. 2004/05 data - sourced from relevant state government departments' estimates/budget papers and funding announcements

overdue⁶ and makes economic sense. Continuing down the current path of increasing investment in high cost acute services will not reduce demand. Investing in relatively inexpensive community supports will reduce demand on acute services and will make a difference in the lives of people with mental illness and their families.

There are other barriers to achieving true mental health reform which will require much pro-active work to drive the change. True reform will require changes to the legislative environment, effective planning and change management, an appropriate funding framework and workforce development.

Psychiatric disability can often be complex. All services which support people with mental illness or psychiatric disability must use an evidence-based model and engage sufficiently skilled staff to deliver the outcomes required.

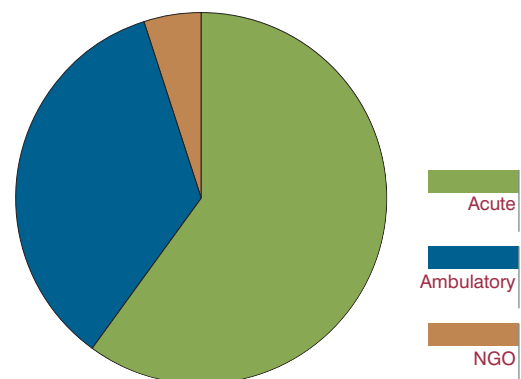
The cost of inaction

The model for mental health reform described here is the only long-term, cost-effective solution to South Australia's growing mental health burden. The historic approach of over-investment in expensive acute services will not ease the growing pressure on acute services. Without reform, the high prevalence of mental illness will grow and further impact on family breakdown, homelessness, education, unemployment, corrections and harmful alcohol and drug use.

Through supporting people to stay well in the community, the mental health services in Trieste, Italy have reduced spending on acute hospital beds to 6% of the mental health budget. In SA we spend over 60% on acute hospital-based services.

Source: Roberto Messina 2005, THEMHS Conference Adelaide and National Mental Health Report (2004)

► SA Spending by Service Type 2001/02



Source: National Mental Health Report 2004.

Keeping well in the Community - Whole of Government response

Mental health reform and the mental health budget is only one part of the picture. We need to reduce fragmentation within our systems of government and develop effective cross portfolio approaches that aim to support people with mental illness to live well and stay well.

A wellness model means having the supports available for people to manage their illness and stay well in the community. To do this effectively requires a focus on more than just health. A balanced life depends on access to housing, education, social networks and employment.

Important areas to address are disability supports, drug and alcohol services and carer/family support services.

Failures in the system result in people with mental illness being overrepresented in prison populations and homelessness.

To achieve comprehensive mental health reform requires a coherent whole of government response to mental health issues.

Rights

All Australian governments have obligations under the international treaty on human rights. The Burdekin Report 1993⁷ detailed the appalling treatment of people with mental illness at the time.

A recent report by HREOC and MHCA⁸ details many examples of failures in the mental health system and documents some of the lived burden of the many individuals, their families and friends affected by mental illness. The report shows that, despite improvements since the Burdekin report, we still have a long way to go in terms of human rights.

We need to respond in a way that shows the courage, the will and the commitment to stamp out human rights abuses and treat our fellow Australians with dignity and respect within our mental health system.

South Australia has started to address this through the Department of Health document 'Your rights and responsibilities - a charter for SA public health system consumers' and the Carer Recognition Bill currently before Parliament. The Health and Community Services Complaints Act 2004 goes further and contains Charter principles which creates a framework of entitlements for health service users in the public, private and non-government sectors⁹.

A review of SA mental health legislation has also been completed which recommends a wide range of reforms in mental health and justice systems. The recommendations include amending the Equal Opportunity Act to covers mental illness/psychiatric disability, increasing advocacy services and establishing a Official Visitor Program to independently report on service quality.

We need to enshrine equity principles in the way we support people with mental illness. If the benchmark for affordable accommodation for mainstream society is 25% of income, we need to ensure that the many people with mental illness who pay up to 85%¹⁰ of their income have access to more affordable options.

Human rights for people with mental illness or psychiatric disability include the right to employment, education, affordable housing, social participation and transport. We need to actively work to support people to access those rights. There is a growing evidence-base which shows that access to these rights of citizenship is essential for people to recover from mental illness and build a fulfilling life.

State Commonwealth interface

A major barrier to moving forward in mental health reform is Commonwealth - State relations.

Commonwealth areas of responsibility such as the Medicare system, health insurance, employment and welfare payments are all significant to a system of wellness and inclusion for people with mental illness.

The Medicare system, for example, places the emphasis on funding particular clinical interventions sometimes at the expense of what could be more appropriate treatment regimes. People who may benefit from time-intensive assistance to change behaviour or thought patterns often have very limited access to affordable supports. This can include aspects of anxiety, mood, obsessive-compulsive, eating or personality disorders and some forms of depression. The result can be over-reliance on funded interventions such as use of pharmaceuticals which may be unnecessary or more effective if other supports to change thoughts or behaviour were more accessible.

Access to employment and purposeful activity is a basic right for people with mental illness. The current system is not well-designed to support people with psychiatric disability to enter and stay in the workforce. Many people with psychiatric disability may need ongoing low-level support and episodic high level supports. More effort is required from the Commonwealth to assist people with psychiatric disability to enter and remain in the workforce.

Family carers of people with mental illness consistently find that they are not eligible to receive payments and/or allowances for their caring role because they do not meet the strict assessment criteria of physical care requirements. They are effectively locked out of the Commonwealth income support system and struggle to meet their caring role along with the need to be in paid employment. They therefore go unrecognised and are at risk of suffering the ill-effects of carer burnout.

People who come to our country as migrants and refugees have the right to receive appropriate treatment for their mental health problems. This needs to recognise the possible impact of previous traumatic experiences prior to coming to this country.

Improved mental health services is a fundamental need for Aboriginal and Torres Strait Islands people . There are many complex issues including the need for cross-border arrangements and service delivery to remote, scattered populations. The Commonwealth has traditionally taken a role in Aboriginal health and this needs to be built on co-operatively.

⁶ National Mental Health Policy 1992; Second National Mental Health Plan 1998, Third National Mental Health Plan 2003, National Mental Health Reports 1993, 1994, 1995, 1996, 1997, 2000, 2002, 2004. All Commonwealth Department of Health and Ageing.

⁷ Human Rights and Equal Opportunity Commission (1993). An inquiry into the rights of people with mental illness. HREOC: Canberra

⁸ Human Rights and Equal Opportunity Commission, Mental Health Council of Australia and Brain Mind Institute (2005). Not for Service. MHCA: Canberra. (Ligare P/L)

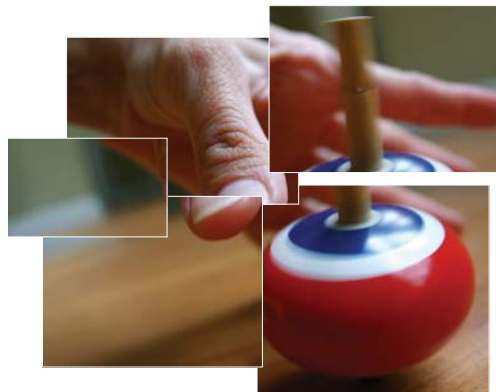
⁹ Health and Community Services Complaints Act (2004). Section 22 a-f.

¹⁰ Parliament of South Australia (2003). Inquiry into Supported Accommodation. P.107

Actions

- 1. A model that supports people to stay well** - We need to change the model from one designed to treat people only when they are acutely ill to a model that supports people to stay well in the community. This approach is the only cost-effective long-term solution to the on-going pressure on acute services such as emergency departments.
- 2. Mental Health Reform Plan** - We need a roadmap to guide services towards mental health reform. The plan must include targets and a measuring and reporting framework. It must also be cross-referenced and connected to other SA Government plans and initiatives.
- 3. Community Action Taskforce** - This group would help drive the major changes required to achieve mental health reform. We currently have a clinical senate to guide clinical practice and reform, but there is no similar body, independent of government with a vital interest in mental health.
- 4. Resourcing** - An increased recurrent investment of \$50m initially building to -\$100m over 5 years is needed into the SA mental health budget. A minimum of 50% of new money in the mental health budget to be spent on non-clinical supports that help people to stay well in the community and reduce the burden on acute services
- 5. Quality in service delivery** - Services which support people with mental illness or psychiatric disability should be evidence-based and delivered in the context of a psychosocial rehabilitation model with a mechanism for evaluation and review.
- 6. Whole of government planning** for mental health - That a whole of government plan be developed to ensure people with psychiatric disability have access to quality services that help them to stay well in the community: including drug and alcohol, disability, rehabilitation, pre-vocational and vocational employment and transport.
- 7. Housing and housing support targets** - That the state government set a target of ensuring that all people with psychiatric disability support needs have access to affordable and appropriate housing and housing support services
- 8. Psychiatric disability support** - That funding for psychiatric disability support through the Department of Families and Communities be provided in proportion to prevalence of psychiatric disability. These services must also be of a quality appropriate to the needs of the client group.
- 9. Education and justice systems** - That cross portfolio plans be developed to support people with psychiatric disability and mental illness maximise their educational opportunities and to support people before, during and after contact with the justice system
- 10. Human rights plan** - That the state Government demonstrate its commitment to human rights for people with psychiatric disability and/or mental illness by:
 - developing a strategic response to the HREOC/MHCA report on human rights for the mentally ill including an implementation schedule
 - funding an independent organisation (such as HREOC) to review progress on human rights for people with mental illness every three years
 - Develop an implementation schedule for the recommendations in the Mental Health Legislative Review Report including:
 - ensuring that psychiatric disability and mental illness are included in the SA Equal Opportunity Act
 - the establishment of a community visitor scheme to independently report on mental health services.
- 11. Commonwealth – State relations** - That the State Government through AHMAC and other Commonwealth relations processes advocate for mental health reform in joint or Commonwealth areas of responsibility including:
 - **Commonwealth commitment to mental health** - Commonwealth allocate \$1.1b per annum to mental health and work with the states to ensure that it is used to refocus the system towards keeping people well rather than treating them when they are acutely ill. Programs should include specific focus on Aboriginal people and people from culturally and linguistically diverse (CALD) backgrounds (including migrants and refugees).
 - **Employment** - That the Commonwealth Government invest in appropriate pre-vocational and vocational support services to assist people with psychiatric disability to enter and stay in the workforce
 - **Welfare payments** - That the Commonwealth Government ensure that welfare payments support people with mental illness to stay well and are not a disincentive to entering the workforce. That carer payments are accessible to help families to cope with the burden of mental illness.





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