

# Turning the Tide

## **Turning the Tide – what is the future of mental health service delivery and what can we learn from the past?**

**“ The theme of the conference is ‘ turning the tide’ This is in recognition of the increasing understanding that clinical treatment alone is not enough, that care in the community and the impact of socio-economic factors must be considered in both intervention and relapse prevention. This conference is designed to promote a turn in the tide – away from a purely clinical approach to a recognition and understanding of the range of factors that are required to assist people towards recovery.**

### **Aims of the conference:**

- **Develop a coordinated approach to programs and services which better meet the diverse needs of individuals and families;**
- **Develop services and programs which enhance a sense of community for all;**
- **Raising the profile of the NGO sector and our ability to attract funding from a range of sources enhancing opportunities for people with mental health problems and disorders.**
- **Recognise the willingness of all sectors to work together and this is evidenced by more than 300 registrations for the conference, only the second conference coordinated by the MHCC.**
- **And lastly to give hope back to a mental health system in crisis. Not only to consumers who need hope to assist them on their journey toward recovery, but to service providers who I think desperately need hope to continue to explore models of innovation and try and get the balance right between biomedical and psychosocial treatment and support.**

**So lets have a look at the history of mental health services in NSW and Australia to see how far we have come and what we have learnt., the first-**

purpose built asylum in NSW was established in Tarban Creek in 1838 ; and over the next fifty years many more were established , however a Royal Commission into asylums took place in 1888 and the Zox Commission as it was known recommended to improve the standard of asylums and to include a system of boarding out of patients who were ready to return to the community.

In the twentieth century, the development of more psychological and social explanations and treatments emerged for mental illness.

In 1949 a Melbourne Psychiatrist invented the first psycho tropic drug, Lithium, in the 1950's more psychotropic drugs were introduced and there was an optimism about people being able to live in the community. The fifties gave rise to a steady transfer of care from hospital to the community.. However it wasn't until 1973, that the new Labour Government provided funds for community based facilities.

In the seventies and eighties the role of institutions were challenged and policy focus shifted toward rehabilitation, rather than custody and control. Employment and housing assistance and out patient treatment centres grew from this era.

Then along came the eighties (besides bad hair, music and clothes) there was a broadening of preventative work and target groups to include people who didn't have an established diagnosis.

With the release of the first National Mental Health Strategy in 1992 service delivery directions returned to those with serious mental illness.

Since that time there has been a refocus on chemical treatments, the biomedical model and attention on establishing more acute in-patient units. However, there has never been adequate resources in rehabilitation, community based services, supported housing to see if these models really work.

This is evident in the lack of resources allocated to the non government sector who predominately deliver psychosocial models of support. There appears to be a growing amount of people who support a shift back to custodial care, but often this is because there just isn't any alternative to the medical model. Demand is outstripping supply, creating waiting lists for supported accommodation and other community based programs.

Biomedical treatments and psychosocial models should sit by side by side and the most effective approach is identifying what works best for the individual. The future of mental health lies in finding the right balance between the different approaches and resourcing both adequately so that they can complement each other.

So in the year 2004, the focus in the delivery of mental health services across NSW is predominantly based on clinical treatment. However, there are other models of intervention and relapse preventions that are being carried out across the State, by the NGO sector (and in the next two days we are going to hear about some of these) they are extremely effective mental health interventions but do not get the respect they deserve or the resources to build on their capacity.

The 2003 NSW Parliamentary Inquiry into our mental health system – the Pezzutti Report – not only highlighted but recommended that we look closely at the “revolving door” population within our mental health system – the high levels of hospital admissions and readmissions which could be reduced under a new direction in service and funding delivery.

It is well documented that environmental factors including affordable long-term accommodation, access to supported paid employment and programs with a focus on social interaction and personal development are crucial if long-term health outcomes are to be met.

The report also highlighted some of the inaccuracies in policy directions, what I term the myths or misconceptions about the reality of mental health service delivery .-

- The misconception that supported housing and rehabilitation are not forms of therapeutic interventions, yet we provide assertive case management to people who we support. These forms of supports are effective in ceasing the need for people to be readmitted to hospital, care can prevent the need for treatment.
- That people who have severe and enduring mental illness can maintain tenancies in either the private or the public housing market, and the misconception that this market actually exists especially in rural and regional areas. (so for health to say housing is not their business is not an entirely enlightened view)

So, we have reached a point today where we can no longer ignore the inherent problems facing the delivery of mental health services, not only within the health system but within the NGO sector, our focus needs to broaden beyond the existing framework of clinical treatment and ask policy

makers to look at our models of care seriously, but first we need to be able to offer them, and provide evidence on how and why they work..

If we're serious about improving the long-term health and quality of life for consumers and carers, then we need to look critically at ourselves and examine the issues surrounding:

- Models of service delivery
- The short- and long-term outcomes we're trying to achieve.
- How we meet those outcomes when resources across the health sector are already stretched to the point where existing community-based programs and organisations are under-funded and under threat.

That's just for starters. If we're to move forward, then there also needs to be recognition by governments at both state and federal levels that the success of any future model for the delivery of mental health services and programs is reliant on their willingness and commitment to striking a balance between the clinical and psychosocial models already on offer.

Putting aside the social benefits to the individual, their families and friends, and the communities in which they live, a balanced approach to mental health service delivery is imperative from an economic point of view if we are to see real "value for our dollar".

On a good Note, There does seem to be a turn of the tide at a recent meeting between MHCC representatives and Minister Iemma, the ability of NGOs to address a range of existing problems within the NSW mental health system was discussed.

From that meeting, we understood the NSW Government was committed to exploring the social and economic values of enhancing access to a range of community-based services and to improve links with existing acute care services.

- Of particular importance and relevance was the ability of NGOs to attract funding through a range of government departments and other funding sources, while having the ability to deliver and expand community programs with the support of well-trained staff and volunteers. In short, NGOs have the capacity to stretch the health dollar by having access to a range of resources.

And we only have to look around us today to see there is a genuine commitment by all sectors to work together, to build partnerships and to

**assist NGOs to expand their role. The solutions to many of the existing problems within the mental health services are right here at this conference.**

**We have the opportunity to move forward and develop a framework which is inclusive of all players. A new direction in mental health service delivery is not about one sector losing out to another, but working together as a team for the benefit of individuals and their communities.**

**Only when the benefits of community-based psychosocial programs are recognised and supported by a new approach to funding and service delivery will we know that we have “turned the tide”.**