MENTAL HEALTH IMPLICATIONS OF
RECENT AUSTRALIAN HEALTH
INITIATIVES*

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Mental health has traditionally been a semi-autonomous component of the wider health field, with special ties and bridging relationships to the welfare and education fields of activity in society. The accelerated change of delivery patterns of all services is now having major effects on the mental health field.

Some of the issues arising from such change were well foreseen in two editorials of the Medical Journal of Australia in 1972 (Editorial 1972a, 1972b). The closing paragraph of the first editorial is an attempt to bring all in the field together in a common enterprise in regard to change, and I quote:

"Traditionalists may look at these developments and possibilities with horror, but they will do better by playing their part in seeing that the changes follow a sane and constructive course. Those keen on change will see not only a challenge, but also the possibility of new achievements for both the mental health and the health fields."

During 1973 and 1974 the pace of new health care delivery programs has quickened as the Australian Government has, through its Hospitals and Health Services Commission and Department of Health, taken more direct roles in regard to health care, particularly concerning planning and program innovation. The programs concern:

- Community Mental Health, Drugs and Alcohol
- Community Health
- Health Services Research and Planning
- Hospital Development
- Family Planning
- University Chairs of Community Practice

There are other national reports on which no implementing action has yet been taken. These concern:

- Medical Rehabilitation
- Continuing Medical Education

Other health matters on which reports are expected in the next six months include:

- Rural health
- Health Careers and Personnel
- Health Transport
- Review of School of Public Health and Tropical Medicine
- Review of Wollongong Medical School Proposal

The measure of the significance of these changes is that over $70 million will be spent on the first group of programs in this financial year. Integral concern with mental health is a feature of all these programs and overt reference and even preference to the mental health and psycho-social facets of care will be found in the published reports and documents.

The reports concerning community health (National Hospitals and Health Services Commission, 1973), medical rehabilitation (National Hospitals and Health Services Commission, 1973), and hospitals (Hospitals and Health Services Commission, 1974), will be used to illustrate this point and as a lead to examining the mental health issues. Details on the other programs can be obtained from the 1973-74 Annual Reports of the Director-General of Health (Director-General of Health, 1973/74) and the Hospitals and Health Services Commission (Hospitals and Health Services Commission, 1973/74).

The Community Health Program has received the greatest publicity and is often inaccurately seen as a health centres program, or, worse, as a salaried general practitioner program. In reality it is a broad and flexible approach to upgrade community care by seeking to integrate the components which make up primary care health services at local and regional levels.

Psycho-social facets of both needs and services are emphasised and mental health is overtly included in

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primary care. The earlier announced community mental health program is co-ordinated with the Community Health Program and will be totally integrated after June, 1975.

Generally the Australian Government involvement lies in funding specific and block grants and in participating in planning and evaluation. Direct Australian Government action to design and build centres is occurring in the Territories and in some overt health services scarcity areas such as Deer Park in Melbourne.

Mental health professionals can already take great credit in Australia for the number of wider community health projects that have developed from their initiative and sponsorship. Community mental health centres in many States are now diversifying into resources health centres, with often the psychiatrist being retitled community physician in charge.

The Medical Rehabilitation Report similarly recommends the integration of all medical rehabilitation services on a regional basis. It is still under Government consideration in the wider context of the Woodhouse Report on Rehabilitation and Compensation.

The need for medical and related rehabilitative services for the mentally ill and the mentally retarded was totally included with facilities envisaged at regional general hospitals, special units, health hostels and in the community, integrated as appropriate with other community health services. A sum of $50 million over three years is recommended.

The Hospitals Program, recently approved by the Government, is concerned with the provision of capital funds for all health residential and related facilities. This includes general hospitals, nursing homes, health hostels, mental hospitals and other special facilities. Again the emphasis is on effective planning on a regional basis. The specific recommendations in regard to mental health facilities are as follows:

1. Decentralised mental health residential facilities should be provided on the basis of a minimal target of 0.5 beds per 1,000 population over the next five years for regions lacking mental health residential facilities.
2. As part of this decentralisation, acute and rehabilitation units should be developed adjacent to or as integral parts of general hospitals.
3. Health hostels in the community with adequate numbers of trained staff should be developed for rehabilitation and long-stay purposes.
4. Residential facilities, particularly health hospitals, for the mentally retarded should be developed as a matter of urgency. Present State plans should be expedited where necessary to meet urgent waiting lists.
5. Necessary improvements within mental hospitals should be carried out.
6. Staff of mental hospitals should participate in planning and developing decentralised facilities, services, and future roles for mental hospitals.

This program implies major changes over the next five years in the distribution of psychiatric facilities and in their relationship to other health facilities, with priority going to high need areas lacking such facilities. It is to be hoped that these steps will also have the effect of bringing the public and private sections of the specialty into closer relationship in general hospital units.

Dimensions of Change:
The above programs and reports can be examined on a number of dimensions within which change is occurring. The major dimensions are:

Centralism/Regionalism
Separation/Integration
Specialism/Generalism
Decrease/Increase in Delegation

At this stage the general movement on each of these is to the right, although the opposite is occurring in particular need situations. The important point is to recognise the relevant dimension and direction of change with a view to both policy analysis and evaluation.

Centralism/Regionalism: The delivery of mental health services is one of the more centralised parts of the health care system. Mental hospitals have been concentrated in particular sectors of capital cities, or, worse, be placed well outside the urban concentrations they serve. Rural services have also been centralised.

No-one would debate the need to distribute mental health services more widely and a regional basis for such distribution is logical. Perhaps more important is the deliberate delegation of authority for conducting services to the regional level so that decisions can be made closer to the point of action and in closer co-ordination with other health services in the region.

This implies not only the provision of regional units at general hospitals but also the local development of hostels of varying size and purpose and further improvements of community services. This dimension extends beyond regionalism to localisation which is the provision of appropriate services at levels of population of the order of 10,000 people. Such localisation can be seen in the inclusion of both mental health functions and staff in a number of comprehensive community health centres.

It is quite possible to analyse all components of the mental health system in terms of the appropriate population size at which the function is performed.
on a full time basis. Such analysis is helpful in devising strategies as to the appropriate population size for which particular centres are devised. There seems to be general agreement of the need for area health centres concentrating on population sizes of 50,000 to 100,000 with a view to their both providing services directly and back up resources to more localised centres.

There are even more specialised community and clinic functions such as forensic services and mental handicap assessment centres which can only be logically provided at the regional level of approximately 250,000 population. Even more specialised functions such as in-patient units for disturbed adolescents or narcotic addicts will require larger populations again and these can only be provided on a multi-region or State-wide basis.

Separation/Integration: Mental health services have been delivered separately from other health services for reasons including tradition and stigma. This separation has also produced some creativity such as effective team work relationships and therapeutic community approaches. It is easy to see the logic of provision of services within a region from locations and buildings conducted in company with other health care services.

Such grouping of services requires further examination of the degree of separation and integration in regard to the administrative control and leadership of services. This permits both more logical planning and implementation of service delivery. The sacrifice of the autonomy of previous separate services is well repaid by the administrative challenge and opportunity in regard to the whole range of services.

Specialism/Generalism: There is a step beyond that of services sharing common facilities and administration. This involves the deliberate promotion of multi-purpose or generalised staff roles. This has been discussed in relation to a number of the professional roles in the system in a previous publication9, and is best seen in the concept of the comprehensive community nurse and the generic social worker.

Equally there are some areas of health activity where a greater use of specialised personnel may be more appropriate such as in dealing with alcoholism and drug dependence where there is clear evidence of the failure of generalist staff to face up to such problems.

Decrease/Increase in Delegation: While professionalism in the various roles of the health field has offered a great deal in regard to the excellence of services provided, it has also tended to lead to a delivery pattern often said to fit better the needs of the professions than of the consumers. There are constant cries about the need for more and more of each of the professional roles already recognised in the health field. When one adds these to the general world demand for trained professionals in all fields of endeavour, the manpower projections make it clear that no solution will ever be possible through this approach.

Exciting possibilities are suggested by approaches from the opposite end of the spectrum such as examining the needs to be met, defining the tasks necessary, developing roles from appropriate combinations of these, and specifically training the personnel necessary. The increased use of professional aids is merely one facet of this alternative. Certainly it is most inappropriate to use highly trained staff to undertake tasks for which minimal training is necessary. The more appropriate use of health personnel offers more hope in solving the manpower problem.

Residual Mental Health Gaps

Because the improvements in mental health service delivery are an integral part of all the programs and reports mentioned previously, it is by no means an easy exercise to outline gaps which cannot be filled through one of the existing programs and reports being implemented. For example, many have appealed for improvements in child psychiatric services. There clearly are gaps in this area and others will become more evident as child care centres increase in number. However the filling of such gaps can be undertaken through the Community Health Program, the Hospitals Program or, if not these, the Medical Rehabilitation Program when it is implemented. In fact, the varying linkages between child psychiatric care, educational services and present community health services are an area which should provide a range of creative and innovative solutions within the Community Health Program as a whole.

Residential assessment and community support services for the mentally handicapped can all be provided under these programs and many of these are already funded under the Community Health Program. Frequent appeals for improved research knowledge in the area can be met by the presentation of well organised requests for research grants from the National Health and Medical Research Council and the Health Services Research and Planning funds of the Hospitals and Health Services Commission.

Improved forensic mental health services are clearly needed in Australia. In fact, the assessment and community components of such services are already being funded under the Community Health Program in one State. However, residential mental health services for those in prisons and corrective institutions do not seem to be met and this clearly will need further consideration. Early discussions with the relevant agencies concerned in these institutions will be undertaken to examine this issue further.

In summary then, it is clear that a wide range of Australian Government programs and reports have outlined ways in which the delivery of mental health care can be improved along varying lines according to both needs and necessary requirements for flexi-
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bility. Those wishing to see other improvements in mental health services would be well advised to examine the new situation that has arisen before pressing their requirements and suggestions in detail.

REFERENCES


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