Lessons learned in developing community mental health care in Australasia and the South Pacific

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This paper summarizes the findings for the Australasia and Pacific Region of the WPA Task Force on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. We present an overview of mental health services in the region; discuss policies, plans and programmes; chart progress towards achieving community-oriented services, and detail the lessons learned.

Key words: Community mental health care, Australasia, South Pacific, mental health services, lessons learned

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This paper is one of a series which describes the development of community mental health care in regions around the world (see 1-3). In implementation of the WPA Action Plan 2008-2011 (4,5), a Task Force was established to produce a WPA Guidance on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. The purpose, methods and main findings of this Task Force have previously been published (6). This article describes these issues in relation to Australasia and the South Pacific.

Australasia includes Australia and New Zealand. While there are areas within both countries that are impoverished, overall they can be classified as high income countries. The population of Australia as at June 2009 was 21,874,000, with the indigenous population of Aborigines and Torres Strait Islanders representing 2.5% of the total. The population of New Zealand was estimated at June 2009 as 4.27 million, with the indigenous population of Maori representing 15% of the population. The Pacific Island states are mainly low income countries, broadly grouped within Micronesia, Melanesia and Polynesia. The population is increasing rapidly. It is currently estimated at 32 million, with Melanesia the largest population group at around 7 million and Polynesia accounting for 1.2 million.

Based on recent epidemiological surveys, lifetime prevalence rates of mental disorders is 45% in Australia (7) and 46.6% in New Zealand (8), with around 20% prevalence rates in both countries over the past year. There is no comparable data available for Pacific nations.

MENTAL HEALTH SERVICES IN THE REGION

Mental health services in Australia and New Zealand have developed along similar lines in terms of models of service delivery. However, some Australian jurisdictions, such as Victoria, have more in common with developments in New Zealand than others. Pacific nations, by comparison, are at a rudimentary stage of development and are just beginning to set in place the processes to properly address the needs of their people with mental illnesses.

Both Australia and New Zealand have a mix of local and regional, public and private mental health services, albeit the private system in New Zealand is insignificant compared with Australia. These services provide mental health care for children and adolescents, adults and the elderly. While significant service gaps remain in some areas and many services are still not adequately integrated (9), taking the countries as a whole, a comprehensive mix of hospital and community based services has been established (Table 1).

It is important to note that in both Australia and New Zealand, and especially in the latter, most of the services included in the table have been further differentiated in terms of specialization, providers and target groups. Specialist community services, supported in some cases by residential programmes, have been established to provide care for people with specific disorders and circumstances, including forensic psychiatry, maternal mental health, peer support, early psychosis, mental health of indigenous populations (especially in New Zealand, with the establishment of Maori and Pacific Island mental health services), homelessness, eating disorders, addictions (ranging from alcohol and drugs, to problem gambling and Internet addictions), post-traumatic disorder (covering sexual abuse and family violence), affective disorders, anxiety disorders.

There is now a range of providers, from primary health care

Table 1 Range of mental health services available in Australasia and the South Pacific

Service	Australia	New Zealand	Pacific nations
Primary health care	+	±	+
Outpatient/ambulatory clinics	+	+	±
Community mental health teams	+	+	—
Acute inpatient care	+	+	±
Long-term residential care in the community	+	+	—
Rehabilitation, work, occupation	+	+	±

+ present, ± variable, — absent

clinicians to non-governmental organizations (NGOs) and peer workers, providing services for people that would otherwise have been the exclusive domain of specialist clinicians.

While many rural areas have similar service and staffing issues to those of low-medium income countries, most medium to large urban areas have a full range of clinical and non-clinical mental health professionals employed in services and are developing new occupational classes of workers to be employed in them. Support for rural areas is often provided by larger urban services and visiting practitioners.

By contrast, as Table 1 indicates, mental health services in Pacific nations are significantly underdeveloped. They are delivered mainly through village or community based, primary health care clinics, linked in some cases to regional clinics or national hospitals. In higher population nations, inpatient units are also available, but often the care they provide is not particularly differentiated in terms of specific disorders. Moreover, some inpatient units remain unused because of concerns about safety and/or insufficient staff to manage patients. As a result, some people with serious mental illnesses are detained in police custody, without access to appropriate treatment (10).

Fully trained mental health clinicians are employed in some nations but are not employed in anywhere near sufficient numbers to address need. Pacific nations rely instead on generally trained health professionals (often nurses), NGOs and other workers such as traditional healers, who are engaged to assist in the care of people with mental illnesses and addictions. There are few permanently based psychiatrists, although this situation is ameliorated to some extent by the employment of visiting psychiatrists from Australia and New Zealand and in some cases America.

POLICIES, PLANS AND PROGRAMMES

The establishment of recovery focused, community oriented services is government policy in both Australia and New Zealand. In contrast, it is not possible to determine overall policy in the Pacific nations. Policy, planning and programme development in these countries is proceeding in a variety of ways.

Australia and New Zealand both have national mental health plans. In Australia, each of the states and territories have their own plans, which incorporate elements of the national plan and areas for service development relevant to their jurisdiction.

Australia developed its first national mental health plan in 1992. This plan promoted the integration of inpatient and community services into a cohesive mental health program. The second and third national mental health plans continued in this direction, but expanded the focus of reform to include additional activities, such as promotion and prevention, to complement development of the specialist mental health service system (11).

Australia has a set of national mental health standards and

national practice standards for the mental health workforce. Other key reports include the national mental health and well-being surveys (7).

New Zealand developed its national mental health strategy "Looking forward" in 1992. Together with its revision in 1996, "Moving Forward", it formed the basis of the first national mental health plan. The second mental health plan (Te Tahuhu) was released in 2005 (12).

The Mental Health Commission (established in 1996 to ensure implementation of the national mental health plan and to act as an independent voice for service users and families) developed a national Blueprint for the funding of mental health services (13). Based on a recovery approach, it provided a practical framework for service development. As of 2009, the Blueprint has been 80% implemented and seen a 154% increase in the funding of mental health and addiction services.

New Zealand had a set of national mental health standards. These have now been incorporated in the national health and disability standards (14). Other key documents influencing the development of mental health and addiction services include those relating to primary mental health care, workforce development, a Maori mental health strategy (15) and a national information systems strategy (16).

A variety of programmes are offered in both countries addressing mental health promotion, anti-discrimination and destigmatization, prevention, psychiatric treatment, primary mental health care, recovery and service integration. Despite this, however, considerable unmet need still exists in both countries.

By contrast, while some Pacific Island nations have mental health policies and/or plans (such as the Solomon Islands, Samoa, Papua New Guinea, Guam and Kiribati), few have been resourced and governed in a way that is ensuring their implementation. This situation is, however, changing with the inception of the Pacific Islands Mental Health Network (PIMHnet), a joint initiative of the World Health Organization (WHO) Regional Office for the Western Pacific and the WHO Headquarters in Geneva. PIMHnet currently has 18 member countries.

Considerable progress has been made by PIMHnet member countries in identifying their mental health needs and resources, and in developing plans to address these needs. The PIMHnet's vision is "the people of Pacific Island countries enjoying the highest standards of mental health and well-being through access to effective, appropriate and quality mental health services and care". Its mission is "to facilitate and support cooperative and coordinated activities within and among member countries that contribute to sustainable national and sub-regional capacity in relation to mental health".

Twelve countries now have mental health human resource plans in place, designed to facilitate the development of human resources in ways that best meet the needs of individual countries. Furthermore, fourteen countries have a final draft of a mental health policy. The development of mental health policies provides a firm basis for gaining government commitment to the protection of the rights of people with mental ill-

ness and, where necessary, also provides a structure for new or updated mental health legislation.

PROGRESS TOWARDS ACHIEVING COMMUNITY-ORIENTED SERVICES

Priority has been given to the seriously mentally ill in the development of community mental health services in both Australia and New Zealand. At the same time, treatments for high prevalence disorders are receiving increasing emphasis through primary mental health care initiatives established over the past 5 years. Many would argue that there is a need for considerably more service based research. However, in both countries up to date reports on progress with the development of community oriented services have been carried out; in Australia by the Federal Government (11), and in New Zealand by the Mental Health Commission (17). There is also a considerable body of research, particularly in Australia, evaluating programs for people with a variety of conditions.

The proportion of state and territory mental health spending for community based services was 29% at the commencement of the Australian strategy, whereas it increased to 51% by 2005. By contrast, in New Zealand, 69% of mental health funding had been invested in community based services by 2007.

Despite the significant progress that has been made, there are still major problems, such as difficulty the public has accessing services (especially in both busy urban and rural areas) and disruptions to the continuity of care received by service users and their families (18,19). This is related to increasing problems with alcohol and drug consumption and its manifestation in comorbidity with mental disorders, the under-resourcing of services, a failure to provide sufficient and adequately coordinated training for the range of mental health workers now in the field, and insufficient attention given to integrating philosophies and models of care across the sector.

In Australia, criticism has been directed by some observers at health authorities, who have given increasing priority to funding hospital based care delivered through emergency departments and intensive acute and rehabilitation inpatient units (20). Similar concerns, relating to access and integration, have been raised about services in New Zealand. However, the intention to proceed in the development of community care has been recently expressed by the government of the latter country, through plans to shift the focus of some secondary mental health services to primary health care.

It is difficult to estimate the proportion of community mental health services in Pacific Island nations and it is questionable how meaningful it would be in any case, given the challenges of their current state of development. Mental illness is still not clearly discerned as such and resources dedicated to it are meagre at best. In addition, mental health initiatives do not readily attract sponsorship from private or corporate donors, particularly in view of the long-term commitment that is required.

In Australia and New Zealand, community based services

are supported by acute inpatient services provided through general and private hospitals (the latter being insignificant in New Zealand). Care for people with longer term disorders is provided mainly in the community by public community mental health teams and NGOs. There are also inpatient rehabilitation and forensic services provided through the public sector in both countries.

An increasing and organized focus on high prevalence disorders has been taking place over the past two decades, with more attention and funding being given to the delivery of services through primary health care. Additional services for the treatment of people with mild-moderate disorders are occurring through the delivery of web-based programmes, mainly funded by government agencies.

The range of specialized programmes such as early psychosis, maternal mental health, peer support and alcohol and drug services are largely provided by community based agencies, including public and private mental health services and NGOs.

In Pacific nations, most mental health care is delivered by generally trained medical and nursing practitioners. However, many Pacific countries do not provide training in mental health/addiction and there is considerable stigma about mental illness (10). There is still a relatively restricted access to medication, both as a result of cost and limited laboratory facilities, as well as poor diagnosis.

PIMHnet has supported the building of infrastructures within individual countries, which may decrease reliance on external measures such as visiting clinicians. This includes the development of local training initiatives for primary health workers (including designing or adapting assessment tools for local use), and the provision of mentoring and support services within and between countries, using technological tools such as tele-health.

A recent review of PIMHnet concluded that “a very successful project has been implemented and the interventions so far have been implemented well, measured at this early stage primarily in outputs delivered. The achievements are significant given the short period of time that the project has been in place and the number of countries that are now benefiting” (21).

LESSONS LEARNED

In the Pacific nations, the challenges involve education about the recognition of mental illnesses and changing attitudes to them in terms of management. Beyond this, there are serious issues relating to the resourcing and prioritization of mental health services that affect the establishment of policy and plans for their development.

Lessons learned thus far relate to the importance of:

- National policies and plans to address the needs of those with serious mental illnesses based on models of community care.

- Educational efforts to increase the understanding of local people's knowledge of mental illness and what can be done to help their family members who have developed mental illnesses.
- Educational opportunities for general health professionals to gain and upskill their knowledge and practice in the recognition and treatment of mental illness.
- Making it possible for visiting specialist mental health professionals to provide consultation-liaison support for generally trained health professionals.
- Acknowledging and engaging the input of traditional healers and family members.
- Encouraging the development of mental health care pathways and referral systems.

Such initiatives need to be built on a collaborative basis from the "bottom-up" and to involve local people wherever possible. Only by doing so will Pacific nations have the opportunity to develop mental health services that are appropriate to their cultures, their needs and their aspirations. This approach is crucial in ensuring that the vision of PIMHnet is achieved.

In Australia and New Zealand, lessons learned relate to the recognition that the development of community oriented services is a long-term challenge and requires:

- A sustained incremental approach over decades to succeed.
- Bi-partisan political support for policy settings and commitment to sufficient funding to cover transition.
- Planning that is accompanied by costed, resourced, scheduled and well managed implementation plans allocating monies and roles to particular agencies and individuals.
- Mandated ongoing process of transparent consultation.
- Champions who can lead, inspire and drive the process.
- Involvement of service users, their families and other carers.
- Expertise and commitment to models of collaborative care.
- Understanding of community and processes necessary to engage community support.
- Broad based coalitions involving consumers, family members, NGOs, clinicians and administrators to guide and support the collaborative processes involved and ensure that the needs of service users and families are paramount.
- Financial expertise and wise stewardship.
- Protection of monies dedicated to mental health development (ring-fencing).
- Innovative solution focused strategies, expertise and adequate quality and quantify of personnel.
- Clearly defined care pathways and stakeholder engagement for them.
- Focusing on the provision of best practice while having the capacity to risk manage incidents and other threats to project implementation.

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