We’ve got to stop doing this – simple tricks to keep us on the slow road to recovery

MARGARET TOBIN AWARD PRESENTATION

John Allan

CONGRESS 2015 BRISBANE
National framework for recovery-oriented mental health services
The framework defines personal recovery as:

‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’
Public policy refers to the principles that underpin courses of action, regulatory measures, laws, and funding priorities concerning a given topic promulgated by a governmental entity i.e. administrative and executive branches or its representatives.

The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives and is characterized by an explicit concern for health and equity.
Splendid Isolation
10B: THE NOT SO IVORY TOWER
The crimes of 10B - A therapeutic community gone wrong

- Excessive doses of medications voted on in meetings
- Punishments – seclusion, isolation from family
- Rigidity of the “new” model
- Staff did not question
• **Clause 20.5** The mentally ill population deserves expert care, compassion and solicitude, not abuse and rude confrontation, and above all they deserve to be spared from the excess of those who would wish to impose upon them eccentric and idiosyncratic treatment philosophies. Even more so, they deserve to be treated with all of the skill and learning which the caring professions can offer them.

THREE TYPES OF INQUIRY IN PSYCHIATRIC SERVICES

1. The potential scandal that cannot be contained
2. Service improvement
3. Loss of confidence in processes by the authorities
• Clause 20.4 The primary lesson to be learned from the findings of the Commission of Inquiry is that what happened in Ward 10B between March 1975 and May 1987 must never be allowed to be repeated in this or any other psychiatric unit in any hospital in the State.

THINGS FORESHADOWED IN THE STUBBINS REPORT

- Moving the acute unit to the ground floor  
  - 1994

- Integration of community and hospital services  
  - 1990

- A special focus on Aboriginal Torres Strait islander people  
  - 1993

- Closure of Mosman Hall  
  - 2000

- Building a rehabilitation unit  
  - 1992

- Getting a library and connecting to JCU  
  - 1990

- Registrar training scheme  
  - 1991

- Building forensic unit  
  - 2001

- Building a child and adolescent unit  
  - 2012
10B – THE LEGACY 1989 - 2009
• What were we left with?

• Traumatised but engaging

• A lot of hope for the future
EARLY: A FULL SYSTEM SHAKE UP AND SETTLE DOWN

- Re-engagement
- Recognition of trauma
- Funded first NGO partnership for service delivery in 1990
- Multiple groups, starting the Mental Health Association
- Academic, community – finding a broader support
FOR THE SYSTEM – the first few years

- Banning Therapeutic Community in the Mental Health Act
- Integration of all Mental Health Services
- The Queensland Minimum Service Standards later to evolve to the National Mental Health Standards
- The chief psychiatrist’s audit
- A decade of mistrust but not for us?
- Actually the entrée to a decade of rebirth
MIDDLE: THE RECOGNITION OF THE POWER OF HEALING

- Upskill staff and demonstrate humanity
- Registrar program
- psychotherapy
- Kirwan Rehabilitation Unit
- Consortium
- Actually had excellent policy makers in QH
- Outreach and ATSI
- Case vignette
LATE: A TRULY STRONGER CONSUMER VOICE

• Mind survivors Townsville

• Funded CAG 1997

• Palm island vision planning – our first decision to close beds and employ community development officers

• The building and recruitment programme

• Talking Heads and the second consortium

• Handling further setbacks
Main tip?

- Getting noticed can be painful but it is worth it
Phillipe Pinel 1745-1826
1. Reducing suicide and deliberate self-harm in mental health services and related health service settings

2. Reducing use of, and where possible eliminating, restraint and seclusion

3. Reduce adverse drug events in mental health services

4. Safe transport of people experiencing mental disorders
National Action on S&R from 2006
THE SIX STRATEGIES

1. Leadership towards Organisational Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of Seclusion and Restraint Prevention Tools
5. Consumer Roles in Inpatient Settings
6. Debriefing Techniques

(From Huckshorn and others 2004 and republished in NMHSRP strategy 2009)
SOME MYTHS ON SECLUSION AND RESTRAINT

- Seclusion is ‘Therapeutic’ and prevents violence
- Seclusion and restraint prevent injury to staff and patients
- After 4-5 years we all know the definitions of what is and is not seclusion or restraint
- We don’t use it for punishment
- Some people just have to be secluded to protect them
- If I give up control I won’t have power anymore
- Reduction in seclusion is not possible in busy settings with high turnover of unknown clients and drugs are involved
- Smoke free wards have higher rates of violence
SECLUSION AND RESTRAINT

- Annual ad hoc data collection
- Developed a “Seclusion and Restraint DSS” and shared KPIs
- Reporting on AIHW website
- Increased reporting of individual hospital/ward data
SECLUSION RATES BY TARGET POPULATION
2008-09 TO 2012-13

Events per 1,000 bed days

- Adult: 11.6, 11.4, 11.5, 13.3, 10.3, 10.8
- Child & adolescent: 10.3, 10.0, 10.0, 10.0, 6.9, 6.8
- Older Persons: 0.7, 0.7, 0.7, 0.7, 0.7, 0.7
- Mixed: 18.1, 18.1, 14.5, 15.1, 11.3, 11.3
- Forensic: 17.1, 17.0, 17.0, 17.0, 17.0, 17.0

Legend:
- 2008-09
- 2009-10
- 2010-11
- 2011-12
- 2012-13
RANGE OF SECLUSION RATES 2012-13

Hospital

Events per 1,000 bed days

mean 9.6
**COERCION AS AN IN INPATIENT**

<table>
<thead>
<tr>
<th>Admission continuing</th>
<th>Verbal intimidation</th>
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<tbody>
<tr>
<td>Seclusion/Restraint</td>
<td>Patronizing communication</td>
</tr>
<tr>
<td>Forced medications /injections</td>
<td>Atmosphere or culture of control</td>
</tr>
<tr>
<td>Restricted movement/visitors</td>
<td>Confiscating property</td>
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</table>
WHAT WE HAVEN’T TACKLED IN A SYSTEMATIC WAY YET?

- Restraint – first collection 2014, definitions?!
- Emergency departments
- Transport – we set principles but have not measured them
- All age ranges
- Kids – Now doing better
- Older people - Have different problems
- All staff & families involved
• Gives equal weight to reduction of seclusion and restraint

• Decreases time to review

• Increases observations to continuous for seclusion

• Limits prone restraint to 2 minutes for safety reasons

• Set a target of 15% reduction
DEVELOP A COERCIVE TREATMENTS INDEX

• A way of looking at autonomy and dignity of risk

• Legal status

• Activities carried out – seclusion. Restraint, enforced medication

• Subjective measure of perceived coercion

• High perceived coercion at admission

• Subjected to measures against your own will during treatment
FOUR KEY MESSAGES

• Accept this is a challenge of clinical practice for us not a patient caused issue and requires a change in practice to early recognition and engagement, rather than late intervention which can escalate

• Leadership at all levels but commitment by senior people is crucial as is overcoming the tradition of skepticism and ambivalence

• National or comparative data that are consumer informed - the suite must have a subjective component

• Careful response to all six strategies but number one is involvement of families and consumers
Main Tip?

- Measure just a few things that are meaningful as key indicators of the health of the system and choose something that has some spread to improve but don’t keep at it once you are done.
- Governments will do better if they release the hard news.
Expected length of life at birth, by sex, Australia, 1901-10 to 2004-06

Sources: ABS Cat No. 3302.0; ABS Cat. No. 3105.0.65.001
WHY SMOKING CESSATION?

- Second major cause of death in the world and fourth most common risk factor for disease worldwide (WHO). Tobacco smoking remains leading single cause of mortality and morbidity and the main or significant cause of many diseases.

- In Australia, there is significant disparity in smoking prevalence between general population (20%) and mental health population (32%). Consequently, burden of tobacco-related disease is much higher for people with mental health problems (ABS, 2006).

- Smoking in psychiatric inpatient units often reported as high 70-90% (Wye 2010) but in reality smoking status is often not recorded.

- Evidence shows that people with mental illness would like to quit and are able to quit successfully with the right supports in place.

- There is ambivalence within mental health surrounding smoking cessation for people with a mental illness.

- Attitudes and beliefs of workers are sometimes inconsistent and the rationale behind discouraging smoking cessation are at times based on myths.
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<tbody>
<tr>
<td>Smoking status</td>
<td>Everybody smoked everywhere</td>
<td>Smoking bans begin</td>
<td>Smoke-free workplace</td>
<td>Smoking Care</td>
</tr>
<tr>
<td>Where</td>
<td>None</td>
<td>Advertising to hospital — exemptions begin</td>
<td>Inpatient units only</td>
<td>Inpatient and community</td>
</tr>
<tr>
<td>Focus</td>
<td>Staff and patients smoked together</td>
<td>Some staff questioned but agreed smoking helped</td>
<td>Control/temporary cessation</td>
<td>Informed choices/Cessation/harm reduction</td>
</tr>
<tr>
<td>Behaviour</td>
<td>All smokers had started with equal risk of dying</td>
<td>The gaps widen between mainstream &amp; smokers</td>
<td>Consumers and staff become furtive</td>
<td>Consumers and staff acknowledge the problem and talk about it</td>
</tr>
<tr>
<td>Benefit/risk</td>
<td>To smoke and die</td>
<td>Friction and resentment begins?</td>
<td>Staff and nonsmokers main beneficiaries.</td>
<td>Potential health benefit for vast majority of consumers</td>
</tr>
<tr>
<td>Rights</td>
<td>None</td>
<td>MH divorces the mainstream</td>
<td>Violence?</td>
<td>To good health</td>
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<tr>
<td>Policy</td>
<td></td>
<td>MH kicked into action by the mainstream</td>
<td>Fight for choice</td>
<td>MH joins mainstream fight for health</td>
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AMBIVALENCE AND MYTHS

• Not interested in giving up

• Is a form of treatment

• Symptoms will get worse if stop smoking and the illness will recur

• Smoking relieves stress

• Only vice left if so much taken away & may decrease friendships or opportunities to recover

• Smoking restrictions are ineffectual

• Smoking is a lifestyle choice – not an addiction
| Tackle institutionalised ambivalence | • Provide advice and support to mental health professionals, carers and consumers  
• Improve education and awareness  
• Engage and support research |
| Exploring harm reduction approach rather than just a quit approach | • Undertake and support research that explores harm reduction  
• Support and work with stakeholders to develop and implement strategies that incorporate a range of techniques that minimise harms |
| Address smoking cessation from a physical healthcare perspective | • Work with stakeholders to broaden focus of smoking cessation to include physical healthcare  
• Incorporate smoking cessation into new and current physical healthcare initiatives |
| Ensure uniformity of effort | • Develop agreed priorities, commitments and strategies to address smoking for people with mental health issues  
• Encourage and support stakeholders to work in partnership and share resources around smoking cessation for people with mental health issues |
WHAT TARGETS COULD WE SET?

• People with serious mental illness and poor health become a special target group for all governments and we set Hard indicators

• Population: Reduce smoking rates for people with mental illness to general population levels

• MH Services: achieve 100% smoke-free - including staff

• Education and awareness: All mental health staff can and do provide smoking cessation advice and treatments as indicated
An example of Close the Gap Targets for Indigenous Health (2008)

• PREVENTION: Reduction in smoking rates to parity with non-Indigenous Australians
  – 2% annual reduction – population
  – 4% annual reduction – pregnant women
Main Tip?

• Targets are not hard
• Spend someone else’s money on what happens to be your main problem
• If we want to target multinationals who exploit our people big tobacco takes the cake
Contributing lives, thriving communities

Report of the National Review of Mental Health Programmes and Services

Volumes 1–4

30 November 2014

Australian Government
National Mental Health Commission
POPULATION-BASED ARCHITECTURE

**High-Very High Needs**
- Personal and flexible packages of comprehensive health and social care (including housing, income and employment support)
- Specialist mental health and physical health treatments
- Coordinated care: One system, one care plan, one e-health record
- Maintain connections with families, friends, culture and community

**Low-Moderate Needs**
- Targeted and integrated clinical and social support
- Housing, income, psychosocial supports
- Self-directed low intensity therapies
- Early intervention
- Maintain connections with families, friends, culture and community

**Principles for a person-centred system**

- Focus on early intervention at any age or stage of life
- Address social and economic determinants of mental health
- Ensure a stepped care service model: support is appropriate to need over time
- Whatever the level of need, ensure continuing connection with family of choice, social network, job or education

**Population affected at any one time**
- 0.45% Severe and persistent illness with complex multiagency needs—65,000 people, require significant clinical care and day-to-day support.
- 1% Severe persistent—210,000 people. Chronic with major limitations on functioning (i.e., very disabling) and without remission over long period.
- 2% Severe episodic—415,000 people. Severe episodic with periods of remission.
- 5.5% Moderate—1 million people
- 11% Mild—2 million people
- 45% of adults will experience a mental disorder sometime in their lifetime—7.3 million people

**Majority**
- Need for wellbeing and resilience promotion—22.08 million people
Recommendation 7: Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.

### Proposed staged redirection of funds

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<tr>
<td>2017–18</td>
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<tr>
<td>2018–19</td>
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<tr>
<td>2021–22</td>
<td>$300</td>
</tr>
<tr>
<td>Total</td>
<td>$1000</td>
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• The range of ideas the public will accept depends mainly on whether it falls within that window than the merits or individual’s ideas of those propositions.
Main Tip?

• It’s hard not be banal but we have to stop doing this