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# Contextual issues in the implementation of mental health legislation

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ABSTRACT

Mental Health services in Victoria, Australia have seen major reform over the past 30 years. Rights based mental health legislation and major structural changes supported a reduction in bed based services and the development of a strong community mental health sector from the mid 1990's. Community Treatment Orders were established in the Mental Health Act (1986) and widely used across the State. Reformed legislation in 2014 brought greater emphasis on supported decision making and recovery orientation. Funding for mental health services did not keep pace with significant population growth, with consequent reduction in bed availability and intensity of community based services.

This paper considers the impact of funding and service availability on the intended policy and practice directions of mental health legislation with particular consideration of the impact on the utilisation of Community Treatment Orders.

## 1. Introduction

Australia is a Federation with responsibility for mental health services shared between the Commonwealth and State governments. There has largely been bi-partisan agreement in regard to mental health policy and plans. Reform of mental health services in Australia, commencing in the early 1990's, was driven by the National Mental Health Strategy which included development of the First National Mental Health Plan, the Statement of Rights and Responsibilities and the National Mental Health Policy in 1992 (Australian Health Ministers, 1992a; Australian Health Ministers, 1992b). The First National Mental Health Plan focussed on the structural move from stand-alone institutions to mainstreamed inpatient and community based mental health services. This was consistent with changes occurring throughout the developed world. Subsequent Plans included greater emphasis on partnership and consumer engagement. Victoria introduced the Charter of Human Rights and Responsibilities in 2006 (Victorian Government, 2006). The Charter included provisions regarding the right to personal integrity and freedom of movement which directly relate to the provision of compulsory care. It also provided for conditions required when rights could be limited, also relevant to treatment under Mental Health legislation. This paper will consider the impact of mental health reform on service delivery in the context of funding constraints and policy and operational issues in other public service areas.

## 2. Mental health reform in Victoria

Within Australia, Victoria, was in the vanguard of reform of mental health services in the 1980's and 1990's. Closure of the large stand-alone psychiatric facilities was accompanied by the establishment of a range of community and mainstreamed bed based services (Gerrand, 2005; Psychiatric Services Division, 1994). Legislative reform through the *Mental Health Act* (1986) (MHA) introduced external review of involuntary detention through the establishment of the Mental Health Review Board, and the introduction of Community Treatment Orders (CTO) to better support care and treatment in the community (Victorian Government, 1986). By 2003 all mental health inpatient beds other than forensic beds had been moved to general hospital sites, and an age based, area based mental health system was well established. Victorian mental health providers embraced the shift to community based services, including the use of CTO (Light et al., 2012). In 2006 the Victorian government appointed a Minister for Mental Health – one of the first States in Australia to do so. While ostensibly the appointment of a separate Minister for Mental Health may have suggested an increased focus on services for mentally ill people, the separation from Health may have lead to less focus by government on clinical mental health services.

Victoria has continued to be a signatory to National initiatives, the most recent of which is the Fifth National Mental Health Plan

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**Table 1**
Comparison between MHA 1986 and MHA 2014.

| | MHA 1986 | MHA 2014 |
|---|---|---|
| Naming | Involuntary patient | Compulsory patient |
| External review | MHRB* – Within 8 weeks and annually.<br>Reviews decision by Authorised Psychiatrist | MHT* - Within 28 days and when order due to expire<br>Makes Order and sets duration |
| Order stages | Recommendation, Treatment order made within 24 h. | Assessment Order – 24 h<br>Temporary Treatment Order – 28 days |
| | Duration 12 months unless discharged by Authorised Psychiatrist or MHRB | Treatment Order – Inpatient Order max 6 months<br>Community Treatment Order max 12 months |
| Criteria | Has mental illness; needs immediate treatment; unable or unwilling to consent; risk of harm to self and others; no less restrictive means. | Appears/has a mental illness; needs immediate treatment to prevent serious risk of harm to self/others; no less restrictive means |
| Capacity | Unable or unwilling to consent to treatment one of 5 criteria | Presumption of Capacity |
| Decision making | Substituted decision making | Supported decision making strongly encouraged |
| Mechanisms to assist patient | Right to a second opinion, but could be from within service | Independent Mental Health Advocacy<br>Second Psychiatric Opinion Scheme<br>Mental Health Complaints Commission<br>Nominated persons<br>Advance care direction |
| Consent to ECT | Authorised psychiatrist consents if patient lacks capacity | MHT must approve if patient lacks capacity and ECT deemed least restrictive |
| Overarching policy | | Explicit reference to Recovery Orientation, tolerance of degree of risk<br>Explicit push to minimise use and duration of Orders |

* MHRB – Mental Health Review Board; MHT – Mental Health Tribunal.

(Commonwealth of Australia, 2017). Further reform in policy and associated service directions is evidenced by the enactment of new mental health legislation in 2014, *Mental Health Act 2014* (Vic) (Victorian Government, 2014) with an explicit recovery orientation focus and full compliance with the Charter of Human Rights and Responsibilities. The MHA 2014 places greater emphasis on supported decision making and external oversight, explicitly seeks to reduce the number and duration of compulsory treatment orders, and emphasises that treatment should be provided in the least restrictive way. The differences between the MHA 1986 and MHA 2014 are outlined in Table 1. The major differences in relation to CTO pertain to who can make the order and for what duration, and the criteria for making a Treatment Order.

We have examined a series of patient outcomes under the MHA 2014 compared with the MHA 1986. We found that the introduction of the MHA 2014 has been associated with a reduction in the number and duration of compulsory orders made (Vine et al., in press). We found a 25% reduction in the number of days on a compulsory order in the two years after being discharged from a CTO under the MHA 2014 compared with the same period under the MHA 1986. The index CTO was also shorter under the MHA (2014) compared with the MHA 1986. There was a substantial reduction in the number of orders made in the 2 years following discharge from a CTO under the MHA 2014 compared with those under the MHA 1986. Compared with 1.5 CTO made over 2 years under the MHA 1986, only 1.1 CTO were made under the MHA 2014.

But alongside these apparently positive signs of reduced reliance on compulsory care are a number of areas causing increasing concern. We found that those discharged from a CTO by the Authorised Psychiatrist (AP) under the MHA 1986 were less likely to require treatment as an involuntary patient in the subsequent two years than those discharged by the Mental Health Review Board (MHRB) or whose orders had expired (Vine et al., 2016). We hypothesised that this related to more considered treatment planning and patient engagement. This was no longer so under the MHA 2014. The AP was more likely to place a person who was on a CTO back under an inpatient order. We found that almost 30% of CTO 'ended' by being varied to an inpatient treatment order by the AP. This was a significant change from the findings under the MHA 1986. There are several possible explanations for this finding, including the possibility that people are being placed on a CTO too early in the course of treatment, or that community services are not available in sufficient intensity or accessibility to adequately support persons to remain in the community, or that the overall expectations of the Charter have influenced practitioners to minimise the use of compulsory orders. The data we obtained provided evidence of change, but we could not attribute this change solely to a change in legislation and policy. This highlights the importance of examining the context in which legislative change occurs in order to understand any effects of new mental health legislation.

## 3. Contextual issues in Victoria

Despite the commitment to improved mental health services, the last decade or more has not seen growth in funding to clinical mental health services in Victoria proportional with population growth. Victoria had the highest per capita expenditure on mental health in 1994/95 and was still ahead of New South Wales in 2008/09 (Australian Institute of Health and Welfare, 2017). By 2015/16 Victoria had the lowest per capita spend on mental health across Australia (AIHW 2017, Table EXP 4). This occurred as a result of significant population growth, without matching growth in funding for mental health.

This relative decline affected both bed based and community services. Victoria made a massive shift from institutional beds to beds located in acute general health services. In 1993/94 only 7.9 beds of a total of 34.2 per 100,000 were located in general hospitals, but by 2008/09, 18.1 of a total 22.9 were mainstreamed acute beds. This shift in bed location was also associated with an actual reduction in the number of beds, especially long stay beds. The acute bed base dropped from 18.1 per 100,000 in 2008/09 to 17.2 in 2015/16 (AIHW 2017, Table FAC 13) compared to the national average of 29.4 These dramatic reforms from a largely stand-alone asylum style institution based service to inpatient services co-located with acute beds were initially associated with the implementation of a range of crisis and continuing care clinic and out-reach community mental health services (Meadows and Singh, 2003). However, the problems in access to services are also evident in community based services. In 2015/16 Victoria had the lowest number of full time equivalent staff with only 121.5 per 100,000 population compared with the national average of 132.9 (AIHW 2017, Table FAC 37). Measurement of community contacts was impacted by industrial action in 2015/16, but even taking this into account there seems to be a reduction in service availability. Service contacts per 1000 population were 332 in Victoria, suggesting less intensive service availability compared with 393 nationally (AIHW 2017, Table CMHC 2).

**Table 2**
Comparative Mental Health services, (AIHW).

| Per capita number/funding/EFT | 1994/95 | 1994/95 | 2008/09 | 2008/09 | 2015/16 | 2015/16 |
|---|---|---|---|---|---|---|
| | Victoria | National average | Victoria | National average | Victoria | National average |
| Recurrent expenditure per capita* | 128.25 | 113.9 | 192.98 | 203.78 | 197.30 | 226.52 |
| Acute Public beds in general hospitals per capita** | 7.9 | 12.9 | 18.1 | 17.7 | 17.2 | 18.0 |
| Total Beds per capita** | 34.2 | 39.6 | 22.9 | 30.5 | 21.9 | 29.4 |
| FTE equivalent staff per capita*** | 114.3 | 102.9 | 117.7 | 128.5 | 118.2 | 133.3 |
| Proportion of community accessing clinical services**** | | | 1.13% | 1.6% | 1.08% | 1.8% |
| Population (million)***** | 3.32 | 18.07 | 5.44 | 21.69 | 6.24 | 24.13 |

* AIHW Mental Health Services in Australia. Table EXP.4.
** AIHW Mental Health Services in Australia. Table FAC 13.
*** AIHW Mental Health Services in Australia. Table FAC 37.
**** AIHW Mental Health Services on Australia Table KPI 8.1; Victoria's mental health services Annual Report 2016/17.
***** Australian Bureau of Statistics.

As shown in Table 2, compared to other States in Australia, Victoria spends less on mental health per capita, has fewer beds and fewer staff across bed based and community services (Australian Institute of Health and Welfare (AIHW), 2017) (Table 2). We aIso have a lower bed day cost. In a recent review of quality and safety assurance in Victoria, the authors singled out mental health services as requiring adequate funding to deliver safe and timely care (Duckett et al., 2016). It should be noted that the Victorian government has substantially increased funding to community mental health services in the 2017/18 and the 2018/19 budgets, but it will take several years of such increases and further investment in bed based services to bring Victoria back to the national average.

These proportional changes in population in the absence of increased capacity in community and bed based services have resulted in increased pressure on state funded health services. The results include increased throughput with a higher threshold for acceptance and shorter length of stay in inpatient units. An example from NorthWestern Mental Health in Melbourne where one of the authors works is that there were 621 admissions to a 25 bed unit in 2011/12, while the same unit had 704 admissions in 2016/17. There were 1092 admissions in 2011/12 to a 50 bed unit, but this increased to 1394 in 2016/17. The increased rate of throughput is reflected in overall increases in acuity, and higher proportion of new, previously unknown patients. While there is not data to indicate whether services have improved, the sense from services is that the increased pressure on throughput has not supported the aims of person-centred care.

These population changes mean that a comparatively lower proportion of the population accesses public mental health care. Victoria's mental health services annual report shows that the proportion of the population accessing state funded mental health services has fallen from 1.13% to 1.08%, (Victorian Government, 2017). This is far lower than conservative estimates of the prevalence of severe mental illness in our community (Harvey et al., 2007). As a consequence of a number of changes in sentencing practices, there has been a substantial increase in the prison population (Sentencing Advisory Council of Victoria, 2016). There are also anecdotal concerns at the rising number of mentally ill persons in prison and homeless crisis services, increased rates of readmission, sexual and physical aggression on inpatient units, and blockages in Emergency Departments (Duckett, 2017; Tomazin, 2017; Dow Aisha, 2018; Sentencing Advisory Council of Victoria, 2016).

It is possible that some of the changes we noted between the MHA 1986 and MHA 2014 are related not to the impact of policy change, but to very different pressures on access and flow. There may have been improvements in treatment such as the introduction of medication with fewer side effects, and improved psychological and family therapies but we also need to acknowledge societal changes such as increased rates of methamphetamine abuse, homelessness and family dysfunction. Pressure on in-patient units in turn puts increased pressure on community services. Shorter length of stay means that patients are likely to be comparatively unwell when discharged.

## 4. Conclusion

Much has changed since the heady days of the National Mental Health Strategy in 1992, with some commentators noting early in its implementation an increasing distance between what was promised and what was delivered through supposed reforms (Singh and Castle, 2007). It is difficult to determine whether, as intended by those who advocated for mental health legislative change in Victoria, success in achieving the aim of reducing rates and duration of compulsory treatment, represents advancement in care. Unfortunately, as this change occurred at a time of comparatively reduced service availability the good intentions of greater emphasis on recovery oriented services and person centred care may have been confounded by reduced access to appropriate services. From a practitioner's perspective, there is a very real risk that we are no longer able to provide the duration, intensity or accessibility of services that those with severe mental illness and their families should rightly expect. There is a concern that the apparent reduction in use and duration of CTO is not because there is better engagement or better outcomes, but rather because there is reduced access to services. The recognition by government that mental health services have fallen behind acute health services and need greater investment is welcomed. Further research is needed to explore the relationship between policy intentions, impact of legislation and service context, and to link this to patient outcomes.

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