



## Mental health in Australia: The ideal versus financial reality and the role of the mental health nurse

Karla Hayman-White, Silvana Sgro and Brenda Happell

*Centre for Psychiatric Nursing Research and Practice, School of Nursing, The University of Melbourne, Victoria, Australia*

### Abstract

The current mental health policy of Australia is based on an assumption that the standard of care available to people experiencing a mental illness should be of comparable standard to those experiencing a physical illness. However, despite this stated aim, a review of government expenditure clearly indicates that the current proportion of health expenditure afforded to mental health is not comparable to the prevalence of mental illness or the related burden of disease. This paper presents an overview of the prevalence and burden of disease imposed by mental illness. These figures are then discussed in light of government spending on mental health. On the basis of the information presented, it is concluded that a substantially higher proportion of health expenditure needs to be devoted to mental health, if the goals of government policy are to be realised. As the largest professional group of the mental health workforce, nurses need to seek out opportunities to influence policy towards a more favourable treatment of mental health issues.

### Keywords

*Australia, burden of disease, government expenditure, mental health, mental illness, nurses, policy*

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### Introduction

Recently there has been substantial media attention to mental health following the announcement of the Commonwealth Government that an additional \$1.8 billion would be injected into mental health services, accompanied by a call for the State Governments to make a similar commitment. The Commonwealth also announced the expansion of Medicare to include the services of mental health nurses who are considered to have been underutilised to date.

The funding announcement comes after the release of the *Not for Service* report (Mental Health Council of Australia, 2005). The report strongly articulated the view that the deinstitutionalising and mainstreaming of mental health services have not been adequately resourced and have subsequently failed to realise the improvement of service delivery as intended.

Historically, the issue of human rights violations of people experiencing a mental illness in Australia has been documented in a number of government inquiries and Royal Commissions.

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**Contact:** Brenda Happell, Associate Professor/Director, Centre for Psychiatric Nursing Research and Practice, School of Nursing, The University of Melbourne, Carlton Victoria, Australia 3010 [bhappell@unimelb.edu.au](mailto:bhappell@unimelb.edu.au)  
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The Report of the National Inquiry into the Human Rights of People with Mental Illness (subsequently known as the Burdekin Report) is undoubtedly the best known (Human Rights and Equal Opportunity Commission, 1993). The Burdekin inquiry highlighted the inadequacies of the mental health system. For example, in reviewing inpatient care and treatment, more than two hundred formal submissions were received from consumers. The majority of these submissions were negative in their evaluation of the care they had received. To summarize the comments made by consumers, the following statement was made by Burdekin:

*While the inquiry received evidence of harassment, intimidation and physical abuse ... the most frequently reiterated concerns related to the way psychiatric patients were devalued, dehumanized and their views ignored (p.237).*

Formal recognition of the need to acknowledge and uphold the human rights of people experiencing mental illness, however, did not start here. The introduction of a new Mental Health Act in the State of Victoria (Victorian Government, 1986), heralded the move towards rights based legislation as reflected by its stated aims:

*... to establish, develop, promote, assist and encourage mental health services which provide standards and conditions of care and treatment for people with a mental disorder which are in all possible respects at least equal to those provided for people suffering from other forms of illness ... (p.11).*

This sentiment was echoed by the first National Mental Health Plan (Commonwealth of Australia, 1992). Not only was it stated that care and treatment for mental illness should be of equal quality to that afforded for physical illness, but it should be delivered in the least restrictive environment, thus supporting Australia's policy direction towards increased community based and mainstreamed mental health care. The importance of human rights for people experiencing mental illness has continued to be central to mental health policy in Australia (Commonwealth of Australia, 1997a, 1997b).

While few are likely to argue with the sentiment behind this policy, the extent to which it has been realised is more contentious, as the following quote suggests:

*One of the most chronically disadvantaged groups in this country continues to be ignored. After two five-year National Mental Health Plans this does not represent a failure of policy, but rather a failure of implementation. This includes poor government administration and accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutions" (Groom, Hickie & Davenport, 2003, p.ii).*

The aim of this paper is to examine the figures relating to the prevalence of mental illness within the context of government spending on mental health. This discussion of the data will provide a level of critique of Commonwealth Government Mental Health Policy, particularly in relation to the extent to which existing mental health services are of at least equal quality to those provided for the physically ill and injured. The potential role that nurses can play in influencing policy will be specifically discussed.

### **Prevalence of mental illness**

The significance of the revised mental health policy became particularly pertinent as society understands that the prevalence of mental illness is higher than it may have been considered to be. The one in five campaign has been active for some time in Australia, and it is now believed to be widely understood by members of the general population that approximately 20% of the population will experience a mental illness (Andrews, Hall, Teeson & Henderson, 1999; Australian Bureau of Statistics, 1997; Wynaden, Orb, McGowan & Downie, 2000). As a consequence of its high prevalence mental illness is recognised as one of five health care priorities by State and Commonwealth Government in the late 1990s (Commonwealth Department of Health and Family Services, 1999).

The National Survey of Health and Wellbeing conducted in 1997 was a large scale study of Australians aged between 18-99 and representative of the Australian adult population (n=10,641). The findings of this study suggested that a little less than one in five Australian adults (17.7%) had an anxiety, affective or substance use disorder (or more than one of these

disorders) in the past 12 months. These prevalence rates meant that overall, approximately 2,383,000 Australian adults had a mental disorder within the previous 12-month period. It is important to note that these rates are likely to represent an underestimate as they do not include low-prevalence disorders such as schizophrenia, nor responses from homeless people and the residents of nursing homes, hospitals and hostels and prisons where rates of mental disorders are usually found to be higher than for the general population (Ames, 1995; Armitage, Fitzgerald & Cheong, 2003; Crane, 1998; Henderson & Jorm, 1998; North, Eyrich, Pollio & Spitznagel, 2004; Peternelj-Taylor & Johnson, 1995; Sadovey, Smith, Conn & Hall, 1995).

Disablement is associated with poorer life satisfaction and a greater likelihood of not being in the labour force. According to findings from the National Survey of Health and Wellbeing, anxiety disorders accounted for some 2.7 million person days out of role per month among adults in Australia. The corresponding figure for affective disorders and substance use disorders were 2.1 million and 1.1 million person days per month respectively (Andrews et al., 1999; Henderson, Andrews & Hall, 2000).

Despite the magnitude and potentially serious consequences of mental illness and disorders, access to services indicates a significant problem. For all persons who had one or more of the common mental disorders, 64.6% had not used any form of health service in the previous 12 months (Henderson et al., 2000).

While these figures suggest there are problems with the quantity of services available, they also suggest that service quality is effected to the extent that the emphasis of current policy on prevention and early intervention (Commonwealth of Australia, 2003; Department of Human Services, 2002) is not being realised in practice. Of the relatively smaller proportion of people who sought treatment, most sought treatment from a general practitioner (29.4%) rather than a specialist mental health professional (6%) such as a psychiatrist, psychologist or mental health professional (Henderson et al., 2000). Current research

literature suggests that general practitioners frequently do not detect mental illness within their patients, and frequently report not feeling confident in providing treatment for this patient population (Bindman, Johnson, Wright et al., 1997; Leavey, King & Lay, 2002; McCall, Clarke & Rowley, 2004a, 2004b; Secker, Pidd, Parham & Peck, 2000). In the absence of specific interventions to address these deficiencies, the quality of available mental health services is adversely affected.

### **Mental illness and disease burden**

Globally, mental illness accounts for almost 11 per cent of the total disease burden (Murray & Lopez, 1996). In Australia, mental disorders account for approximately 13% of the total disease burden and approximately 30% of the non-fatal burden (Australian Bureau of Statistics, 1997). Years of life lost due to disability (YDL) is one operationalisation of the burden of non-fatal health outcomes. Based on YDLs, mental disorders are the leading cause of non-fatal health outcomes, followed by disorders of the nervous system and sense organs (Mathers, Vos & Stevenson, 1999). Mental disorders account for 55 per cent of the total disease burden for young adults (Mathers et al., 1999).

Depression represents the second leading cause of disease burden, second only to ischaemic heart disease for adults aged between 25-64 years, and the leading cause among females (Mathers et al., 1999). Mental illness is responsible for 0.8 per cent of all deaths, 1.4 per cent of Years lost of life, and 27.2 per cent of YDLs, signifying that mental illness is not a direct cause of death but a substantial cause of chronic disability (Mathers et al., 1999). Home-based individuals with a chronic disease are more likely to have a psychiatric disorder than individuals without chronic disease (Wells, Golding & Burnam, 1989a, 1989b; Wells, Rogers, Burnam et al., 1991).

### **Mental illness and government expenditure**

*Australia's Health* is a biennial report produced by the Australian Institute of Health and Welfare (AIHW). According to the Australian Government's AIHW website, *Australia's Health* is regarded as the "nation's authoritative

source of information on patterns of health and illness, determinants of health, the supply and use of health services, and health services expenditure". Information presented in the following section is based on figures outlined in the latest version of this report (Australian Institute of Health and Welfare, 2004).

Currently Australia spends approximately \$2.56 billion dollars of its health budget on mental health representing approximately 7% of the total budget. Not only does this equate to a short fall of 6% when considering the disease burden of 13%, it falls behind all other developed countries that spend between 10 and 14% of total health expenditure on mental health (Andrews et al., 1999). Furthermore, according to the Australian Bureau of Statistics, Australia's estimated resident population at June 2002 was 19.7 million. Therefore, of the \$3,292 of health expenditure per Australian in 2001-2002, only \$188.17 was spent per person on mental health care (this includes hospitals, aged care homes, out-of-hospital medical services, dental and other professional services, total pharmaceuticals, research and public mental health services).

During the period 2001-2002 (representing the most recent figures available), total health expenditure was \$66,582 million or 9.3% of national GDP (Australian Institute of Health and Welfare, 2004: 229). Health expenditure per person was \$3,292 in 2001-02. Recurrent expenditure on health was estimated at \$62,693 million, or 94.2% of total expenditure on health. The largest component of recurrent expenditure in 2001-02 was for hospital services, totalling \$22,236 million. This was made up of public (non-psychiatric) hospitals (\$16,678 million), public (psychiatric) hospitals (\$409 million) and private hospitals (\$5,149 million). Thus, only 1.8% of expenditure on health or 0.65% of recurrent expenditure on health was spent on public psychiatric hospitals.

During this period, 6.0% (\$2,929 million) of the total health expenditure was spent on mental disorders (this figure does not include \$778 million spent on public community mental health services). Of note, only \$109 million is spent on research relevant to mental disorders. This

constitutes 9.2% of the total amount spent on health research in 2001-2002. Only 0.16% of expenditure on health was spent on mental health research.

The increased expenditure in mental health over the last decade (46%) has been almost totally paralleled by increased expenditure in other areas of health care delivery (42%). In addition, approximately two thirds of the increased funding was believed to cover the increased cost of pharmaceuticals, rather than to support the improvement or expansion of existing services, or support for alternative forms of treatment (Groom et al., 2003).

### **Implications for mental health nursing**

Nurses represent the largest group of health professionals in Australia (Commonwealth of Australia, 2002) and constitute the majority of the professional workforce in the mental health field (Australian Institute of Health and Welfare, 2002). Furthermore, nurses arguably have the closest relationship with consumers (Barker, 1999; Dunwell & Hanson, 1998; Horsfall & Stuhlmiller, 2000; Jackson & Stevenson, 2000; O'Brien, 1999). For this reason mental health nurses have the capacity, and arguably the responsibility, to be influential in policy development and change. The potential role of nurses in mental health service delivery has been reinforced by the Commonwealth Governments intention to expand Medicare to include services provided by nurses.

However, despite the fact that there are currently more than 13,000 nurses employed in the mental health field in Australia, evidence of political activity is minimal. Clear evidence of this is provided by the response of mental health nurses to the Health Workforce Study undertaken by the Productivity Commission, and the Senate Select Committee into Mental Health.

The Productivity Commission received 179 submissions, only one was clearly evident as representing mental health nursing. Submissions were received from other, more general nursing bodies, such as industrial and professional organisations and Schools of Nursing from Australian Universities, however, mental health generally received either nil or scant attention.

This reinforces the fact that mental health nursing must become a political force in its own right, rather than relying on representation from other professions or bodies. It is important that they use the strength of their numbers to collectively agitate for a more equitable funding allocation for mental health.

A greater number of nurses need to become actively involved in professional and industrial organisations and other relevant groups. In this context they can contribute at a formal level to the development of submissions to government inquiries and at an informal level to the popular media through letters to the Editor. Industrial organisations can play a significant role by highlighting the problems inherent in mental health services as part of enterprising bargaining and other industrial campaigns. As the voice of nursing becomes more evident in government and political spheres, nurses are more likely to be recognised as key stakeholders with an important voice. Through their weight of numbers they would be very difficult to ignore.

### Conclusions

This paper presents an overview of the data and literature relevant to the treatment of mental health in Australia. Based on the information presented, it is clearly apparent that the intention of Commonwealth and State Government policy and legislation is not being realized in practice (Commonwealth of Australia, 1992, 1997a, 1997b; Victorian Government, 1986).

The prevalence of mental illness is estimated at 20%. Mental illness has been found to constitute a major burden of disease and be responsible for high levels of years lost due to disability. The significance of the problems associated with mental illness is not reflected in government expenditure. Mental health expenditure in Australia does not reflect either prevalence rates or burden of disease figures. Furthermore, expenditure falls considerably short of the percentage of health expenditure devoted to mental health by other developed nations.

The consequences of under-funding include limited access to services; particularly from those experiencing high prevalence disorders such as anxiety and depression, which, despite being highly debilitating, respond well to timely

treatment. In addition, the insignificant amount of funding dedicated to mental health research has led to a paucity of larger-scale, longitudinal studies to evaluate the long-term effectiveness of mental health interventions, which may lead to certain priority areas being under-treated, but may also impact upon the capacity to deliver best-practice clinical services, and therefore improved outcomes, to consumers.

In conclusion the authors argue that the current state of funding of mental health services within Australia demonstrates the relative discrimination towards mental illness in comparison to illness and injury of a physical nature. Contemporary policy and legislation clearly reflect the desire to provide people experiencing a mental illness with a standard of care which is at least equal to that provided to people accessing the general health care system. However, this cannot occur when such a discrepancy in funding is apparent.

The allocation of funding to mental health needs to be revised to reflect prevalence, burden of disease and years lost due to disability. When this has been achieved, government policy makers and legislators will be in a position to confidently state that the provision of treatment and health services to people experiencing a mental illness is at least equal to that currently provided for people experiencing a physical illness or injury. By virtue of the fact that they constitute a large proportion of the mental health workforce, nurses are not only well positioned, but have a responsibility to become more political in order to agitate for a more favourable funding allocation to mental health services in Australia.

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