TOWARDS BETTER MENTAL HEALTH MANAGEMENT

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Abstract

This article addresses mental health management in an international context where many governments now claim to value health and sustainable development as primary goals. This is also reflected in the NSW state plan. However, the latter appears to present mental health services primarily as specialist treatments. This article argues that the current social incentives encouraging specialist health professionals to provide legal drugs to address distress or social disruption may drive unreasonably, from some perspectives. Medical and psychological approaches to attaining mental health should accordingly be received more critically and accompanied by a wide variety of alternative, more holistic management strategies aimed at improved wellbeing. More coordinated, broadly educational and scientific approaches to identification and treatment of mental and related social problems appear necessary in order to identify those services which seem to meet community and individual needs and related interests best. These are ideally also based on the troubled individual's assisted analysis and treatment of his or her own situation in a related environment. Human services planning for Redfern-Waterloo (Redfern-Waterloo Authority 2005), an economically and culturally diverse community in inner Sydney, may be a model approach to mental health which is suitable in other communities. Better community education and more effectively related competition and consumer policies are also necessary to assist community based management aimed at general wellbeing. Tertiary research and education must be conceptualized in this broad community context.

Mental health problems and key international agreements about treatment

Attacking mental health problems and crime often requires related action. Health needs analysis, crime prevention strategies, education provision and employment are ideally linked activities which are managed in community context and on a program basis. National surveys indicate that 18% of the Australian population experienced the symptoms of a mental disorder at some time during the previous twelve months. Approximately 19% of the population report a disability, of which 12% percent are intellectual, mental or psychiatric. Approximately 3% of Australians live in households where someone has a long-term mental disorder, which is not related to developmental delay. It is estimated that about half such people receive treatment from public mental health services, private psychiatrists or general practitioners. Low socio-economic status, unemployment and aboriginality are also linked to higher risk of poor health, disability, and crime (Australian Institute of Health and Welfare (AIHW 2000; Butler 1997). The Department of Corrective Services reported that 12% of prisoners in New South Wales had been diagnosed with some form of psychiatric disorder, including depression, anxiety, schizophrenia or bipolar disorder. Thirty percent of male prisoners and 50% of female prisoners had contact with public mental health services in the twelve months prior to incarceration. The Disability Council of NSW sees it as inappropriate for a person with a disability to be in the

corrective services system, particularly if they have committed a non-violent offence (Select Committee on the Increase in Prisoner Population 2001).

It is argued later that there is a danger that legal drugs will increasingly be the socially approved answers to the mental health problems indicated by the above statistics. The worried well or angry may be treated in a similarly pharmaceutical fashion for behaviour which may mask broader social problems. A wider range of remedies for improving mental wellbeing and crime prevention should be tried, and their comparative outcomes researched. The United Nations (UN) Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care provide general regulatory and funding legitimation for a broad range of treatments for mental problems. They were adopted in 1991 and state that every patient has the right to treatment in the least restrictive environment and in the least restrictive manner, and that every patient shall have the right, so far as is practicable, to live, work and receive treatment in the community (Singh 2001). Australian health ministers endorsed this in the national health policy and plan of 1992 but the principles were not formally adopted into Australian legislation nor scheduled to the Human Rights and Equal Opportunity Commission Act. This apparent lack of government confidence in the traditional legislative and related adversarial court process, at least in regard to claims of discrimination on the basis of mental disability, is noteworthy. The Universal Declaration of Human Rights does not address responsibilities so it is also noteworthy that ministers think rights should be balanced by responsibilities for all. This is the context for relevant community service.

In 1991, the Australian health ministers' conference also adopted a Statement of Rights and Responsibilities to promote social justice, equity, access and a compassionate society with mental health as its primary goal. These rights rely upon state adoption and educational implementation. They are:

- Access to the best available mental health care
- To be treated with humanity and dignity
- To be protected from exploitation, abuse and degrading treatment
- Not to be discriminated against
- To be able to pursue civil, political, economic, social and cultural rights outlined in UN instruments and covenants
- In the event that the person is deemed to lack legal capacity as a consequence of their mental illness, the right to information, representation and protection of their interests.

(Barrand 1998)

In the Australian Trade Practices Act, however, the term 'access' relates to the right for traders to participate freely and equally in markets. The right of consumers to 'access' services like health care is ignored. Such legislative issues are addressed again later and a more consistent approach is recommended for managing diverse community risks.

In 1993 the National Inquiry into Human Rights of People with Mental Illness investigated sufferers in the context of the requirements of the relevant UN principles, and stated that

many experience widespread systematic discrimination and are consistently denied the rights and services to which they are entitled. The first national mental health plan from 1993-1998 reduced beds in psychiatric institutions by 42%. Funds allocated to mental health non-government organizations grew by 200%, increasing their share of total funding from 2% to 5%. The recent report of the Mental Health Council of Australia and the Brain and Mind Research Institute (MHCA 2005) found that the system may still result in a failure to provide basic health care and may also be characterised by inappropriate use of short term seclusion, confinement or over reliance on sedating medications. The report argued the impact of this may be deteriorating mental wellbeing, suicide, higher rates of homelessness, prolonged unemployment, incarceration, increased financial burden and poverty. It called on all Australian governments to adopt a whole of government service response. Trial of the Redfern-Waterloo human services plan as a mental health initiative is later considered in this continuing context of apparently poor service provision.

What is the best available health care?

Mental illness is usually judged by the specialist health practitioner who examines the presenting person and who may make a diagnosis primarily on the basis of perceived behaviour. However, the dominant scientific authority which is conventionally accorded to psychiatrists in deliberations on mental illness should be considered more critically and its outcomes compared with those of a wide range of service alternatives. The doctor and the psychiatrist have gone through scientific training in medical schools and may naturally think of drugs as treatment. At Sydney University, the discipline of psychology even claims to be a science, rather than a social science. As Gallop wrote in the last edition of Public Administration Today, 'conceptual paradigms may take shape and exercise influence far beyond their capacity to deliver on the claims they make'. This seems likely to be true in specialist mental health areas, especially when investigation and diagnosis are based on question and answer methods. To social scientists using broader perspectives, the mental health researcher may often appear naïve about the fallibility of communication and related classification processes. However, the combination of Medicare and the difficulties of system change provide incentives for diagnostic and drug related approaches to treating depression, and many other socially unwanted, apparently uncontrollable behaviours. Some may think the supposed cure is worse than the disease.

The discussion of mental health and illness below supports the view that a broad range of alternative management approaches are necessary rather than increase in students entering the traditional, specialist, mental health disciplines, which may then drive their professional approaches further. The idea of 'mental health' includes the brain and the mind. The brain is an organ, but the mind is the product of learning and response through interaction with the environment. Freud (1930) pointed out that much of the mind is unconscious and that learning occurs unconsciously as well as consciously. From this perspective, the collective mind is the product of the collective culture, which may be most productively reflected in work or recreation and other cultural pursuits. Mead (1934), stated that the mind is the product of the growing relationship between modern society and the independent, responsible individual. Szasz (1996) argued that the conscious mind enables any person to become an object of study to himself or herself and that what we

'mind' is who we are. However, such broadly sociological and related psychological approaches to mental health and illness appear no longer to be fashionable. This may be partly because specialist mental health professions have had their ability to deliver drugs and questionnaires extended so rapidly in recent years, by Medicare and computers.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV), the official manual of the American Psychiatric Association, is widely used in Australia, although some specialists suggest it is now less well regarded than in former times. However, this diagnostic approach may be welcome in part because its classificatory structure appears to fit well with requirements of medico-legal and insurance practice. On the other hand, some researchers have claimed that such diagnostic approaches are pseudo-scientific and do little more than invent classifications for behaviours which may be inconsistently perceived and identified by practitioners (Szasz 1987, 1996; Gosden 2001). Critics have claimed that such classifications may then be applied to emotional and behavioural diversities which arise naturally, as coping responses to perceived difficulties of living. Once classified, patients are treated with drugs. These products are developed by a powerful global industry and research effort which is heavily subsidised by the public purse, partly as a result of the advice provided to government by practitioners to whom the drugs are marketed (Baume 2001). There is little reason to consider the effectiveness of alternative treatments in this global research and treatment paradigm, which later may turn out to be a costly problem for individuals and communities. Alternative views and related treatments for mental illness should also be effectively monitored, in spite and because of being less 'scientifically' tested, than behaviour changing or masking drugs.

In the medical model of illness, pain and behavioural abnormality are due to physiological problems, including in the organ of the brain. Alternatively, many sociologists have identified apparent sicknesses and related behavioural symptoms as the result of attempts to master anxieties, which may be first produced in childhood as a result of difficulties in learning how to meet the socially expected requirements, whatever they are. Parsons (1951) saw sickness and criminality as the only available escapes from the performance demands of others. Goffman (1959) saw speech as a performance put on for others, and sickness as a form of protection seeking. Goffmann (1963) also argued that the effort to pass as normal may put unbearable pressures on those who have been socially stigmatised for apparent physical or mental disability or a related crime, such as otherwise deviating from the looks or behavioural norms of the dominant social groupings. Competency based psychological therapies take a different perspective from medical or related, neurologically based approaches to treating unwanted depression or other challenging behaviours. Using step by step methods, they try to show people how to approach themselves and their environments, applying broader and more evidence based perspectives, in order to develop more positive ways of thinking about and handling themselves and their surroundings (Tanner and Ball 2000). This teaching may be relatively easily delivered within broader education, which people choose or may be required to undertake, with the aim of dealing with inadequacy or trouble better, both from their own perspectives and from that of their immediate and broader communities. Work and recreation may also be seen as forms of practical education for better self expression within a chosen community.

From such educational rather than medical perspectives, an individual's mentor sees increases in mental health as the ideal product of a person's repeated attempts to deal with anxieties generated by environments which are experienced as difficult. The aim of treatment is to help people attain more normally independent and fulfilling lives. This often requires modification of their environment and provision of new learning opportunities, with the aim of providing the possibility for happier and healthier development. The term 'normalisation' originated in Denmark when the Mental Retardation Act of 1959 defined the aim of services as creating an existence for the mentally disabled person as close to normal living conditions as possible. This included making the client's housing, education, working and leisure conditions as close as possible to those of the general population (Emerson 1992). Wolfensberger (1980) described normalisation as promoting social tolerance and support for difference, whilst assisting people with disabilities to articulate and meet their broadly defined goals of normal life. He saw normalisation as seeking socially valued ends through the process of socially valued means and wrote that the highest goals must be the creation, support and defence of values and social roles for people who are at risk of social devaluation. Although he felt most people wish to be perceived as 'normal' by the communities they want to identify with, he also thought society's negative perceptions about social differences should be challenged and changed to meet diverse community needs and interests more productively.

In 1994 the International Labour Organization, the UN Educational, Scientific and Cultural Organization and the WHO defined community based rehabilitation as:

> A strategy within community development for the rehabilitation (CBR), equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services.

(Working Group on Community Based Rehabilitation of the Regional Interagency Committee for Asia and the Pacific 2001, p.1)

Better coordinated management approaches are now required in Australian communities, to support work, education, recreation and other cultural pursuits more practically for everybody. Although hospital related training has long been part of the medical and allied student experience, there appear to be many other untapped community development and individual mentoring opportunities for enhancing the education and wellbeing of all. Potential clients for mentoring and mutual teaching include:

- Children/adults with a learning disorder, addiction or other disability
- Children/adults who are isolated, at risk of being harmed, or at risk of harming
- People placed in prison, alternative care to prison or who are ex-prisoners
- Families of prisoners who are in need of support
- Victims of violence or sexual abuse
- People who require assistance in order to avoid institutionalisation
- People who require support to assist them to find work or remain in work

- People experiencing levels of work or family related stress, to a level which interferes with their effective functioning in the workplace or community

Rights, responsibilities and the attainment of mental health

Health is essentially about life flourishing. However, it is often difficult to agree on which behaviour is mentally healthy and which disordered, because people who see themselves as sane fight wars. From Jung's perspective (1958), the tendency to project everything wrong onto an opposing side in order to destroy it is madness, entered into collectively. Yet this is the way that lawyers have traditionally been expected to operate in the adversarial court practice which Australians have inherited from a British, feudal, past. In the light of the Australian health ministers' adoption of the Statement of Rights and Responsibilities aimed at achieving mental health which was alluded to earlier, one wonders how the concept of 'access to social justice' should now relate to that of 'access to 'justice'. Legally, the latter means the same as access to a court, which reflects the continuing monopoly power of the pre-scientific legal discourse. The court adversarial process has repeatedly been found to be dysfunctional and courts do not collect useful data to assist injury prevention, rehabilitation or cost containment. Ideally dispute resolution should be seen as community service, like health or education service, and treated accordingly. The corrective to unhelpfully adversarial tendencies in current communities appears less likely to be in courts and more likely to be through development of many, broadly inclusive, scientific approaches to treating problems (Braithwaite 2000). The UN definition of restorative justice as any process in which victims, offenders and other stakeholders participate actively in the resolution of matters arising from crime, often with the help of a fair and impartial third party, may usefully be noted in this context.

From holistic, broadly scientific management perspectives, mental health may be seen as the ideal product of how individuals and communities care for each other's needs, including how they teach each other to communicate and analyse, in order to undertake actions to improve the surroundings for all. A mental health related problem may be broadly conceptualised as any problem which needs to be tackled, so that all people involved in an apparently stressful environment can get on with their lives more effectively. Regional development requires coordination of all relevant stakeholder perspectives to meet the individual and community need for health. Ideally, the outcomes of all services may be compared for their effectiveness by all stakeholders. In this transparent development model, service operators may be held accountable through their openness to scrutiny, and by being required to gather health related data which may help identify related concerns for individuals and communities. All dispute resolution and apparent breach of community standards may be conceptualised in this service context. Such a mental health model may also be a form of continuing community education.

The human services planning approach for Redfern-Waterloo, an economically and culturally diverse community in inner Sydney, may provide a model mental health planning approach. The overall objective is to develop an improved service delivery culture supported by a framework for joint activity by government and non-government service providers and other stakeholders. The planners argue this should produce a more

integrated and effective human service system that focuses better on delivering positive outcomes. Representatives of the Redfern Legal Centre, which has served Aboriginal and Torres Strait Islander (ATSI) people and others in the area for many years, state on an open discussion website that the key outcomes to arise from their consultative processes about the goals of the human services plan have widespread community support. The goals are:

- keeping families and children safe
- improving employment opportunities
- improving school retention
- reducing criminal and anti-social behaviour
- providing ATSI appropriate services
- improving medical and mental health services
- improving drug and alcohol rehabilitation
- improving services to meet needs of vulnerable people

The legal centre applauded these aims and looked forward to outcomes against measurable performance indicators. It is important to prevent silo management developing around the above goals. Information sharing is vital and secrecy the same as ignorance. Broader community education for effective management is vital.

The national aged care funding pool is to be regionally managed, to incorporate residential aged care, home and community care, community aged care packages, and relevant State-funded community health activities. Housing and aged care are being unbundled, with separate funding streams for accommodation, living costs and care needs (Kendig and Duckett, 2001). A regionally pooled funding approach appears suitable for coordinated, programmatic application across all government owned or subsidised housing provision, and in other areas related to attaining community health and development. Many services are ideally considered in a health related development context which extends regional management approaches across the life cycle. The human services plan for Redfern-Waterloo may be conceptualised as a mental health plan in this broadly holistic context.

Australian competition, consumer and sustainable development goals

Popper (1953) famously remarked that all administration should be regarded as experimentation. This requires a broadly thoughtful awareness, rather than automatic, narrowly guided action. Variations from policy, guidelines or apparently expert practice should be made and documented thoroughly, to meet the apparent needs of each specific situation, which is ideally considered holistically. Treatment variations which are clearly documented become part of an overall research database which may also be investigated to advise on policy change in future. Australian health promotion and service planning models stress the importance of data driven, consultatively developed, regional policy and related service aims followed by service implementation and comparative evaluation of service outcomes (Eagar, Garrett and Lin 2001). This administrative practice is also consistent with the requirements of program or project management (Wilenski 1986) and action research (Kemmis and McTaggert 1990). Regionally based, broadly scientific and evidence based approaches to treating community problems contrast with traditional

management in silos, by government bureaucracies and professional groups. Management is ideally applied broadly, with the active participation of communities and individuals.

Since the mid 1980s state occupational health and safety acts have required all managers to identify and control risks at work in consultation with workers who are provided with information and training. Health promotion, risk management requirements and perspectives on alternative dispute resolution, all reflect the same general demand for consultative and evidence based management which is flexibly delivered to meet the specific requirements of individual situations. This management process is ideally designed to meet identified needs in any regionally coordinated community and/or industry context. Injury prevention, rehabilitation and related data gathering and funding are also ideally coordinated, to achieve broader community health and sustainable development goals. In this model, dispute resolution is conceptualised as social service, similar to health and education, which are all ideally designed to achieve identified community aims and to meet relevant community standards. Service provider competition is important for achieving health and environment protection goals, because service outcomes need to be identified and compared to find out which appear to work best.

In 1993 the Hilmer report led to the passing of the National Competition Policy Reform Act (1995) and amendment of the Trade Practices Act (TPA). The goal was supposedly to achieve equal competition by public and private sector service providers and national, rather than state based standards for health and sustainable development. The Productivity Commission is now conducting an inquiry into a related, national consumer policy framework. Hilmer's views on competition, which were embraced by Australian governments, were different from the outcome of their adoption in the TPA. Hilmer saw competition as striving for goals which are not necessarily monetary, such as health, social fairness and environment protection. However, the TPA was amended without changing its original, prescriptive, legislative approach, in which key terms have no clear definitions, and in which it is assumed that traders should compete for more money. Consumers were addressed in a later addition to an already illogical competition policy framework. This prescriptive approach appears generally unable to value conceptual clarity, effective treatment or the related collection of data to assist injury prevention, rehabilitation or cost control. It is ironic that a legal monopoly with many feudal assumptions controls the law about competition, while potentially turning science into junk. Hilmer's recommended principles should instead be enacted into new legislation and earlier legislation should be reviewed and repealed. This was the approach when state occupational health and safety acts were introduced. All engaged in work should logically have a duty of care to protect workers, consumers, communities and their environments. A related duty of care and industry based approach to management also provides the clearest, simplest and most comprehensive approach for effective management of all related risk. Broader, more effective, community education is vital in this context.

In 2005, the elite Australian universities known as the Group of Eight argued that the currently preferred model for a research quality framework in Australia should have a purpose. They suggested that the first elements of this should be to provide governments, businesses, researchers and institutions with the additional information they need to assess the value of their investments in research and to plan future research strategies. However, as the Vice Chancellor of Sydney

University pointed out in a related discussion about the Australian Research Council and its normal method of peer review for allocating research funds:

> One of the dangers in a developed economy is that universities conceptualise themselves partly as businesses, which of course you must, but you must never lose sight of the core objectives of the university, and absolutely fundamental to that is academic freedom. (The Australian Financial Review, 14.1.05, p.29).

Snow (1964) recognized that technocratic endeavour on its own is comparatively soulless and uncommunicative and Foucault (1973) warned against the narrowly driving, controlling tendency of the dominant professional and bureaucratic groups. Without academic freedom of speech and related communication, the orthodox professional, bureaucratic or commercial interests may more easily rule, with the divergent or creative individual in their controlling sights. This may be against the broader community interest in governance to support diverse individual situations effectively.

Conclusion

The medico-legal models of addressing mental health problems appear narrow and open to being driven by professional rather than client and community interests. Their assumptions, goals, and service delivery outcomes should be compared with many other, more holistic management approaches to treating individual and community health and welfare problems, in order to evaluate which treatments seem most effective in particular situations. The community based planning and provision of appropriate accommodation, as well as suitably designed employment, recreation and education opportunities, appear to be the necessary foundations for a related, community based approach to promoting mental health and treating illness. This is consistent with many relevant psychiatric, sociological, psychological and economic approaches to good management and with national policy and planning directions related to health and disability. Many people at risk might benefit from the establishment of mentoring or mutual learning relationships in this context. A vital aspect of the community management process is consultation with individuals to determine their personal treatment preferences and to gain their personal evaluation of their progress towards broadly defined normalisation goals. The draft Redfern/Waterloo human services plan may also be tested as a regional mental health plan in this context. Broader approaches to community management education are vital. Tertiary research and education should be considered in this broader community context.

References

Australian Institute of Health and Welfare (2000) *Australia's Health*. Canberra.
Barrand, H. (1998). Mental health reform and human rights, in Gardner, H. (Ed) *Health Policy in Australia*. Melbourne, Oxford University Press.
Baume, P. (2001) *How Do Decisions on the Listing of Pharmaceuticals Influence Health and Health Services in Australia?* Australian Health Policy Institute Commissioned Paper Series 2001/03. Sydney, Australian Health Policy Institute in collaboration with the Medical Foundation at the University of Sydney.
Braithwaite, J. (2000) *Regulation, Crime and Freedom*. Sydney, Ashgate/Dartmouth.

Butler, T. (1997) *Inmate Health Survey*. Sydney, Corrections Health Service.
Eagar, K, Grant, P, and Lin, V. (2001) *Health Planning: Australian Perspectives*. Sydney, Allen and Unwin.
Emerson, E. (1992). What is normalisation? In Brown, H. and Smith, H. (eds) *Normalisation: A Reader for the Nineties*, London: Routledge.
Foucault, M. (1973) *The Birth of the Clinic,* London, Routledge.
Freud, S. (1930) *Civilization and its Discontents*, London, Hogarth Press.
Goffman, E. (1959) *The Presentation of Self in Everyday Life*, New York: Anchor Books.
Goffman, E. (1963) *Stigma*, Englewood Cliffs, Prentice-Hall.
Gosden, R. (2001) *Punishing the Patient*. Carlton, Scribe Publications.
Independent Committee of Inquiry (1993) *National Competition Policy* (*Hilmer Report*). Canberra, AGPS.
Jung, C.G. (1958) *The Undiscovered Self*, Victoria, Mentor Books.
Kemmis, S. and McTaggert, R. (1990) *The Action Research Planner*. Melbourne, Deakin Uni. Press
Kendig, H. and Duckett, S. (2001) *Australian Directions in Aged Care: The Generation of Policies for Generations of Older People*. Commissioned paper series 2001/05, Sydney, Australian Health Policy Institute, University of Sydney.
Mead, G. (1934) *Mind, Self and Society*, Chicago, University of Chicago Press.
Popper, K. (1972) 'The bucket and the searchlight: Two theories of knowledge' in *Objective Knowledge and Evolutionary Approach*, Oxford, Clarendon Press.
Parsons, T. (1951) *The Social System*, London, Routledge and Kegan Paul.
Redfern-Waterloo Authority. (2005) *Draft Redfern-Waterloo Human Services Plan*, Sydney.
Singh, B. (2001) 'The global perspective', in: Meadows, G and Singh, B (eds) *Mental Health in Australia: Collaborative Community Practice*, Oxford: Oxford Uni. Press.
Snow, C.P. (1964) *The Two Cultures and A Second Look*. Cambridge, Cambridge University Press.
Standards Australia/Standards New Zealand (1999) *Risk Management (AS/NZS 4360:1999).* Sydney.
Standards Australia (200X), *Draft Australian Standard on Dispute Management*, (Revision of AS 4608-1999; to be AS 4608-200X), Standards Australia Committee MB-003, Sydney.
Szasz, T.S. (1987) *Insanity: The Idea and its Consequences*, Syracuse: Syracuse University Press.
Szasz, T.S. (1996) *The Meaning of Mind: Language, Morality and Neuroscience*. New York: Praeger.
Tanner, S. and Ball, J. (2000) *Beating the Blues,* Sydney, Doubleday.
Wilenski, P. (1986) *Public Power and Public Administration*. Sydney, Hale and Iremonger in association with the Royal Australian Institute of Public Administration.
Wolfensberger, W. (1980). 'A brief overview of the principle of normalisation', in: Flynn RJ and Nitsch (eds) *Normalisation, Social Integration and Community Services,* Baltimore, University Park Press.
Working Group on Community Based Rehabilitation of the Regional Interagency Committee for Asia and the Pacific (2001). *Understanding Community-Based Rehabilitation.* Social Development Division, ESCAP, United Nations.

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