

CHAPTER 9

MENTAL HEALTH SERVICES IN THE COMMUNITY

Introduction

9.1 One of the repeated messages to the committee through this inquiry was that although the aims of the National Mental Health Strategy (NMHS) were largely commendable, there has been a distinct failure in implementing the strategy.¹ In particular, the committee heard that funding and development of mental health services in the community have been vastly inadequate to meet increased needs associated with the closure of psychiatric institutions.

9.2 Deinstitutionalisation required not only that therapy and treatment be devolved into community settings, but that a whole range of support and assistance, including housing, living skills, social connection, illness management, meaningful activities and employment be provided in the community. When consumers and carers talk about community-based services, they are looking for this broad spectrum of services.

9.3 The prevailing reality of 'community-based care' is limited and clinically focussed when compared with the needs and expectations of the community. Too many services are being collocated with hospitals or provided out of hospitals, rather than in community settings.

9.4 While recent reports have highlighted an increase in funding to the community-based sector, this positive account does not fit with the experiences shared with the committee. Community-based services remain limited and ad hoc. Many people with mental illnesses are ending up homeless or in prison as community services are not there to support them. Families and carers continue to provide the overwhelming majority of support for people with mental illnesses. They are overburdened.

9.5 This chapter reviews the concept of community mental health services pointing to the absence of a co-ordinated, integrated system. The chapter presents the key issues raised throughout the inquiry in relation to community services: the discord between community expectations and the services actually provided; the mainstreaming of community services into hospital environments; lack of funding and service development for continuous care, including step up and step down facilities; lack of integration of services; and inadequate funding to NGOs. Examples of community-based services are also discussed.

1 See for example, Mental Health Council of Australia, *Submission 262*; Australian Medical Association, *Submission 167*.

What are community mental health services?

Community expectations

9.6 Submissions to this inquiry show that consumers and carers are looking for a range of services which assist people with mental illnesses to live stable and fulfilling lives in their homes or in home-like environments within their local community. Themes in submissions indicate that consumers, carers and service providers perceive community care as:

- actively managing medical and non-medical treatment for extended periods as required, with a focus on recovery;
- skilling people with mental illness to live independently in the community;
- providing access to accommodation and fulfilling employment opportunities and other activities;
- establishing and maintaining mental health centres or facilities that offer a range of support services and information;
- providing outreach services and home based assistance;
- providing case management that acknowledges the episodic nature of mental illness;
- providing timely access to graduated levels of assistance and intervention;
- services that respond quickly when someone is entering an episode of acute illness; and
- recognising and offsetting the significant burden on families and carers through respite care.

9.7 In general, submitters stressed that clinical services are just one part of the community services needed to assist people with mental illness. For example, Lifeline Australia commented on:

...the need to view mental health needs through a wider lens that takes in the full scope of what people are experiencing rather than smaller units of need for care that relate to acute crises and treatment.²

9.8 Professor Rosen and others described the elements of community-based treatment as:

Effective community-based treatment entails: ready access to 24 hour crisis intervention and ongoing care, assertive and intensive community case management, professionally supervised residential treatment in the community as an alternative to confining people to psychiatric institutions

2 Lifeline Australia, 2002, *Lifeline in Mental Health, A Perspective on the Mental Health Needs of the Australian Community, Submission 329 Attachment 1*, p. 15.

and real recovery-oriented vocational opportunities for individuals with mental illnesses.³

9.9 Others pointed to the range of community services required, in response to the range of experiences of mental illness:

Those with mental illness are a diverse group, some start quite unable to manage their life, need basic care and help, retraining in hygiene, management of house and clothing, understanding nutrition, financial management, reintroduction to socialisation, time management, location and travel skills etc., where others have lesser needs.⁴

The National Mental Health Strategy Approach

9.10 The NMHS supported the change from an institutional to a community oriented system of mental health care, stating that mental health services should be delivered in the 'least restrictive environment', and that consumers should have the 'opportunity to live, work and participate in the community to the full extent of their capabilities without discrimination'.⁵

9.11 However, the national policy presented no clear, coherent definition of what a community-based mental health system involved or how it would operate. The NMHS vision was for a continuum of care responsive to individual needs, operating within the general health care system and integrated with wider social services:

A comprehensive mental health service system must provide for continuity of care so that consumers can move between services as their needs change, thus ensuring that they receive the most appropriate service at any time.⁶

9.12 While a range of community-based services were identified in the NMHS,⁷ the strategy was not prescriptive as to which community services were essential, the appropriate 'mix' of services, the coordinating structure to oversee the integration of services or the resources to support a continuum of care. Instead, it was understood that implementation of the NMHS policies 'may occur in different ways, depending on State/Territory and regional/area circumstances'.⁸

3 A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today*, September 2003, vol. 4, no. 9 (*Submission 108A Attachment 3*, p. 1).

4 Name withheld, *Submission 76*, p. 1.

5 Australian Health Ministers, 1992, *National Mental Health Policy*, p. [8].

6 Australian Health Ministers, 1992, *National Mental Health Policy*, p. [10].

7 Australian Health Ministers, *National Mental Health Policy*, p. [10]; *National Mental Health Plan 1992*, p. [21]; *The Second National Mental Health Plan*, p. [27]; *National Mental Health Plan 2003-2008*, p. [20].

8 Australian Health Ministers, 1992, *National Mental Health Policy*, p. [9].

9.13 The national policy recognised that community-based services were underdeveloped,⁹ but did not set targets for their development. The first National Mental Health Plan listed 'expand community based mental health services' as one of its agreed strategies.¹⁰ To its detriment it did not define which services this included or indicate what would constitute 'adequate' levels of service.

9.14 The Mental Health Council of Australia commented on the implementation of the NMHS:

...the Strategy took an ad hoc approach to building the extensive network of support services in the community required to manage mental illness at the primary and secondary levels. Clinical services, housing and community support, employment, adequate access to appropriate justice support systems and drug and alcohol support have all been patched into the system on a fairly random basis which has left the services themselves struggling to build their own local and regional networks and to cope with demand. Large areas of Australia are still serviced poorly or not at all.¹¹

9.15 The committee is concerned that the vague concept of community-based services since the inception of the NMHS reflects an underlying lack of commitment to the development of these services. The Strategy had a clear vision for the closure of psychiatric institutions and mainstreaming of acute psychiatric care, but not for the development of community services necessary to meet the needs that resulted from those policies.

A 'community based system of care'?

9.16 The National Mental Health Report 2005 classifies a range of services under the banner of 'a community based system of care'.¹² However this classification appears to be driven by the need to report relevant funding against 'community-based' services, rather than by the existence of a coordinated, integrated system. The funding reported for 'community-based' services includes:

- *Ambulatory care services* – health services dedicated to the assessment, treatment, rehabilitation or care of non inpatients. These include crisis assessment and treatment services, mobile assertive case management services, outpatient services (whether provided at a hospital or community centre), and day programs such as social and living skills programs.
- *Community-based residential services* – staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Specialised psychogeriatric nursing homes are included in this category.

9 Australian Health Ministers, *National Mental Health Policy*, 1992, p. [10].

10 Australian Health Ministers, *National Mental Health Plan 1992*, p. [8].

11 Mental Health Council of Australia, *Submission 262*, p. 13.

12 Australian Government, *National Mental Health Report 2005*, p. 4.

- *NGO programs* – community support services specifically for people affected by mental illness. Programs include supported accommodation services, vocational rehabilitation programs, advocacy programs, consumer self help services, and support services for families and primary carers.¹³

9.17 The committee is concerned that the wide range of services, including hospital services, in the above groups misrepresents the level of investment in community-based care. Three quarters of the reported 'community based' mental health service funding in 2003 went to ambulatory care services which, as noted above, includes hospital outpatient services.¹⁴ While different from the care provided through inpatient services, the committee questions the extent to which hospital-based services fit the concept of community-based care articulated in submissions to this inquiry. It believes, therefore, that the NMHR is probably over-estimating investment in genuine community care.

Mainstreaming community services

9.18 ACOSS commented on the incongruity between the National Mental Health Reports and people's lived experiences:

...there appears to be some inconsistency between the data reported in the National Mental Health Reports and community perceptions. Current care systems are perceived to be chaotic, under-resourced and overly focused on providing brief periods of medicalised care, largely within acute care settings.¹⁵

9.19 The committee received evidence that community-based services are being withdrawn into hospital settings. The Victorian government noted that all its clinical area mental health services, other than forensic services, have been mainstreamed with general hospitals.¹⁶

9.20 While the NMHS set a clear agenda for mainstreaming, this was targeted at acute care and organisational structures:

Mental health services should be part of the mainstream health system. In some cases, such as acute inpatient psychiatric care, this entails delivering services within a general hospital setting. In other cases a specific mental health service will operate from a central location, but be managed within the wider health system. This policy requires that mental health services be an integral part of whatever organisational structure exists for general health services in a State/Territory.¹⁷

13 Australian Government, *National Mental Health Report 2005*, pp 34, 91, 94–95.

14 Australian Government, *National Mental Health Report 2005*, p. 107.

15 ACOSS, *Submission 457*, p. 15.

16 Victorian Government, *Submission 445*, p. 2.

17 Australian Health Ministers, 1992, *National Mental Health Policy*, p. [8].

9.21 The committee received evidence that relocating community services to hospital sites reflects a broader strategy of dismantling community services in response to financial pressures.¹⁸ Professor Rosen observed:

...a strategy has taken over across Australia lately which is to let the community building blocks go and to have a bed oriented policy.¹⁹

9.22 Professor Rosen commented that mental health centres and community health centres have been viewed as 'surplus property' and sold off, and that mobile crisis services are being dismantled or retracted into emergency departments.²⁰ The result is a reduction in home visits and outreach services and a focus on clinical aspects of illness:

... a lot of crisis services are now based in emergency departments at nights and on weekends. They are doing much less outreach and they are losing that culture of visiting people in their homes and helping people with their crises in their homes. When you present at an emergency department, you tend to present with a lot more clinical symptoms. When you present and get an evaluation at home, you tend to present with more life problems between people. We are losing the ability to see the life problems as well as the high salience clinical issues.²¹

9.23 Submissions confirmed the importance of outreach services and home visits. For example, the Northern Beaches Mental Health Consumer Network commented:

Assistance is needed with meeting basic requirements once discharged, such as shopping, cleaning, or caring for young children. Home visits are particularly important for consumers that are isolated in the community. Visits are an important means of providing support and advocacy to consumers, with the goal of promoting self advocacy and sufficiency.²²

9.24 One of the risks associated with moving 'community' services into general hospitals is that people who are not in contact with, or are suspicious of, the health system will not obtain the assistance that they need. Community care services located at hospital sites can carry with them negatives associated with hospital-based care and

18 Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, pp. 66–68.

19 Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, p. 68.

20 Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, p. 67.

21 Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, p. 67–68.

22 Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 5.

institutionalisation.²³ Blue Care, a community health and residential aged care service provider, observed:

It is our experience that people with a mental illness have often "lost touch" with the mental health sector. They are often not empowered to manage their own care and there is little ongoing support from the mental health sector. The emphasis needs to shift to lifespan care and the provision of practical home care, respite, valuable support to maintain their connectedness to the community, and education on self management.²⁴

9.25 The committee is concerned at the apparent culture of dismantling community-based mental health services and mainstreaming these services with general hospitals. It is difficult to reconcile these developments with a policy of delivering mental health care in the least restrictive environment.

Inadequate funding

9.26 Submitters decried the lack of resources devoted to community mental health services. The effect of inadequate community-based services is reflected in other areas – many people with mental illness are homeless, living in transient accommodation or in prison, readmission rates to hospital are high and the burden on carers can be unrelenting. Anglicare Tasmania commented:

The severe shortage and limited range of community support services including supported accommodation, home help, recreation, family support, employment and education options – all services which assist people to recover from episodes of mental illness and to negotiate the complexities of life on a low income in the community – means that people's problems escalate until they become unwell and ricochet back into the acute care system. Insufficiencies in service provision have meant that acute care services and community mental health teams are over-stretched to the point where their work is largely reactive to crises and the demand for services continues to outstrip supply of beds, health workers and services.²⁵

9.27 Numerous submissions called for increased resources for the community-based mental health sector.²⁶ The Mental Health Council of Australia expressed a

23 A. Rosen, and L. Manns, 'Who owns Callan Park? A cautionary tale.' *Australasian Psychology*, vol 11, No.4, p.449; SANE Australia, *Submission 133 – Attachment 1*, p.8.

24 Blue Care, *Submission 353*, p. 3.

25 Anglicare Tasmania, *Submission 464*, p. 15.

26 See for example, Lifeline Australia, *Submission 329 Attachment 6*; Brotherhood of St Laurence, *Submission 97*; Comprehensive Area Service Psychiatrists Special Interest Group, *Submission 108*, p.1; Mental Health Foundation ACT Inc., *Submission 112*, p.4; SANE Australia, *Submission 133 Attachment A*, p.1; insane australia, *Submission 2*, p.5; ARC Group, *Submission 14*, p.1; Australian Healthcare Association, *Submission 169*, p.8; Anglicare Tasmania, *Submission 464*, Ms Sheelah Egan, *Submission 113*; Australian Medical Association, *Submission 167*.

view that the current funding arrangements for mental health services are inadequate to support a community-based service system:

There is a significant mismatch between the community-based mental health service model and the current system of still allocating funding largely on the old service model of 'beds and buildings'. Community-based services, the key component of the National Mental Health Strategy, are unable to effectively perform their role.²⁷

9.28 In the Council's view, more flexible funding is required:

...the success of the Strategy relied on implementing a service delivery model which required more flexible funding so as to build capacity in community based care. However, funding has failed to flow to early intervention, primary and secondary care sectors, and public and non-government organisations so that they could relieve the pressure on the acute care component of the system.²⁸

9.29 The ARC Group described the ongoing need for funds:

There is simply not enough financial support to cope with the amount of people who have been diagnosed, or have the potential to be diagnosed, as mentally ill. Pleas for increases in government funding to support the mentally ill, whether through community health centres or supported accommodation or general health services have been ignored.²⁹

9.30 In addition to underfunding, the lack of a reliable funding stream for community-based services was raised as an issue. When community care services are cut, blame shifting can occur:

... Where is the fault? The Commonwealth for giving encouragement to provide a needed service and then shedding its responsibility? [The] State for not providing funds to take over when Commonwealth funding ceased? A lack of liaison between Commonwealth and State which could have foreseen the inevitable?³⁰

Areas of need - a continuum of care

9.31 Evidence to the inquiry suggests that funding is required for a range of services, focussed on providing a real continuum of care. Some of the major areas of need described in evidence included step up and step down care, rehabilitation, respite care and case management.

27 Mental Health Council of Australia, *Submission 262*, p. 1.

28 *Submission 262*, p. 12.

29 ARC Group, *Submission 14*, p. 1.

30 Mr Peter Hutten, *Submission 185*, p. 3.

Step up and step down facilities

9.32 A number of submissions acknowledged the importance of 'step-up' and 'step-down' services in an effective community care system.³¹ These services deliver an escalated or reduced level of mental health care in accordance with the needs of the consumer, providing an appropriate level of assistance, as and when required.

9.33 Professor Gavin Andrews stated that the lack of step-down facilities is contributing to the burden on the community of caring for people with needs that would be better serviced in more supported environments.³² This view was held by a number of submitters, including community groups:

Clients who manage to gain access to hospital treatment services often are released back to the street with no accommodation, case management, treatment or support in place. This leaves existing community services, that are already under-funded and under-resourced distressed when trying to manage ongoing health and welfare issues for these people.³³

9.34 Step-down facilities deliver much-needed assistance for consumers making the transition back to community living from hospital-based care. Increased resources for these services can alleviate hospital readmissions by providing a graduated level of return to independent living, minimising the incidence of consumers being discharged without adequate support. In addition, as discussed in Chapter 8, many patients in acute psychiatric care could be better provided for in less restrictive environments if the facilities existed. Increased availability of step-down residential services would provide alternatives for these patients, relieving the pressure of acute care places.

9.35 Evidence also supports the need for improved step-up facilities, to provide more intensive care for people with mental illness living in the community. This approach aims to deliver more support and interventions at an earlier stage, rather than requiring people to become acutely unwell before they can gain treatment. The Committee heard that, for many consumers, the slide into an episode of mental illness is gradual, not sudden; therefore the capacity to access effective support services while a consumer enjoys a measure of insight is critical. As with step-down facilities, step-up facilities can relieve the pressure on acute care services.

9.36 One proposal suggested that community-based residential facilities be referred to as "wellness centres",³⁴ with the underlying aim that facilities such as step-up and step-down facilities be distinguished from hospitals, both to provide a less intimidating setting and reduce the stigma attached to seeking more supported assistance.

31 Australian Medical Association, *Submission 167*, p. 18.

32 Professor Gavin Andrews, *Submission 176*, p. 7.

33 Southern Suburbs Taskforce, *Submission 191*, p. 2.

34 Name withheld, *Submission 102*, p. 1.

9.37 The idea of providing graduated levels of care facilities in the community is consistent with National Mental Health Strategy aim of providing care in the 'least restrictive environment'. However, it extends this principle by acknowledging the episodic nature of some mental illnesses and that occasions will arise where additional support is needed to manage mental illness in the community.

9.38 The committee visited a promising model in the provision of step-up / step down facilities at Shepparton in Victoria. The PARC (Prevention and Recovery Care) on Maude facility provides short term care (usually up to 28 days) to help prevent relapse and to assist recovery. It is a partnership between the state government, through Goulburn Valley Area Mental Health Service (GVAMHS), and the Mental Illness Fellowship of Victoria. The Fellowship funds the facility from its patchwork of funding sources, including contracts, memberships and donations.

9.39 The facility appeared to have several valuable features. The relationship between the groups creating the service helped achieve several goals: it involved a consumer and carer organisation in service delivery; it drew on the different strengths of service providers; and it increased the level of cooperation in the sector. PARC integrates health and non-health needs of people experiencing mental illness, with activities designed to assist in:

living, learning, socialising and working and establish goals to address their areas of need. Participants' goals are achieved through the opportunity to take part in workshops and activities that address life skills, mental health education, exercise, relaxation, creativity and well-being.³⁵

9.40 As well as being a better integrated approach, there were also encouraging signs that the PARC facility was achieving two other promising goals. First, PARC appears to be reducing the level of hospital admissions, meaning people with mental illness were able to stay in the community and not go through some of the traumas that can be associated with emergency admissions and acute hospital care. Second, PARC probably produces cost savings in care compared with hospitalisation, freeing up resources to provide care for others, particularly those with less acute symptoms who often receive no care at all.

9.41 The Cairns Integrated Mental Health Service described its endeavours to develop community facilities based on the Shepparton model. Planned facilities include a residential unit offering short-term, intensive transitional support for up to eight people, and a range of residential rehabilitation units dispersed in the community. Mr Mark Millard, Development Coordinator, explained:

35 Mental Illness Fellowship of Victoria, Specialist Residential Rehabilitation Service (SRRP) and Prevention and Recovery Care (PARC on Maude), <http://www.mifellowship.org/ProgramInfo/ResiRehabSRRP.htm> (accessed March 2006).

We are looking at developing a range of intensive support and rehabilitation options to help people make the transition from acute care back into a more integrated life in the community.³⁶

9.42 The committee heard about some of the problems the Service has encountered trying to implement the project:

Essentially our biggest difficulty at the moment has been with the community and the Cairns city council's acceptance of the appropriateness of this kind of transitional residential in a community setting. We have just recently had an application rejected to use a particular residence. We are looking around at other options right now.³⁷

9.43 Mr Millard outlined some of the community resistance to the project:

A lot of people said to us, 'We understand what you want to do. We understand the need for this, but we don't want it anywhere near us.' A lot of the attitudes that came out reflected misunderstanding. They reflected some of the ways that the media report and treat issues surrounding people with mental illness. They reflected fear of the unknown, fear of uncertainty. It has been a difficult exercise, but we have learned about community attitudes. There is still a lot of stigma, a lot of fear and a lot of misunderstanding out there.³⁸

9.44 The committee considers that there is a clear role for local governments in supporting specialised community assistance for people with mental illness. There is a need for strong leadership at the local level, to overcome the stigma and community resistance still evident in relation to mental illness.

Rehabilitation

9.45 Rehabilitation performs a vital function in the management of mental illness, particularly when recovery is the focus. The concept of rehabilitation is to assist consumers to reintegrate into life in the community and live independently, despite the presence of a mental illness. The Mental Health Coordinating Council referenced the importance of promoting recovery, including the "longer-term involvement of consumers and carers in decision-making, planning of health services".³⁹

9.46 Evidence to the inquiry indicates that not enough attention has been directed towards supporting individuals back into community living. This element of rehabilitation is quite distinct from medical treatment and intervention:

36 Mr Mark Millard, Service Development Coordinator, Cairns Integrated Mental Health Service, *Committee Hansard*, 5 August 2005, p. 10.

37 Mr Mark Millard, Service Development Coordinator, Cairns Integrated Mental Health Service, *Committee Hansard*, 5 August 2005, p. 10.

38 Mr Mark Millard, Service Development Coordinator, Cairns Integrated Mental Health Service, *Committee Hansard*, 5 August 2005, p. 10.

39 Mental Health Coordinating Council, *Submission 173, Attachment 4*, p. 17.

Once stability with medication is seen to be achieved, the system is prone to abandon the patient at that stage of rehabilitation for the rest of his life, although spasmodic efforts are made at random to be seen as attempting to carry through a programme of rehabilitation.⁴⁰

9.47 The Australian Medical Association highlighted the shortage of service providers in the area of rehabilitation and the increasing trend to deprofessionalise these services.⁴¹

9.48 Consumers, carers and their families called for expanded rehabilitation services; notably, residential rehabilitation centres in the community:

There is no point employing case managers to refer patients to Salvation Army hostels for the homeless. This type of discussion frequently occurs when devising management strategies with case managers who act as referral agents to non-existent mental health facilities. The money funding case managers in existing non residential community health clinics would be better spent on bricks and mortar for residential facilities.⁴²

9.49 Historically, most rehabilitation services were managed by public mental health services.⁴³ In recent years these services have been increasingly run by NGOs. There are three broad models for the administration of supported rehabilitation services in the NGO sector:

- NGOs employ staff to provide outreach support or 'on-site' support in a property owned or leased by the organisation. Residents are able to move between different levels of support or to independent housing, depending on needs;
- Through an established partnership between the government and NGOs, a property is owned by the State Government and NGOs are contracted to deliver support services. Varying levels of residential support are available, with regular meetings held between the partners to assess patients' living requirements; and
- Consumers reside in public or private (owned or rented) housing and receive outreach support provided by NGO staff.⁴⁴

9.50 As was the case with step-up/step-down facilities, the committee visited a promising rehabilitation service in Shepparton, based on the partnership model. The Specialist Residential Rehabilitation Program (SRRP) was also a partnership between GVAMHS and the Mental Illness Fellowship of Victoria. Based in a cluster of normal

40 Name withheld, *Submission 59*, p. 1.

41 Australian Medical Association, *Submission 152*, p. 1.

42 Name withheld, *Submission 55*, p. 3.

43 Mental Health Coordinating Council, *Submission 173 - Attachment 4*, p. 15.

44 *Submission 173, Attachment 4*, p. 16.

residential dwellings, it provides a service where people with a mental illness can 'learn or relearn living skills in a supportive and safe 'live in' environment. It assists people who require more support than can be provided by visiting workers'.⁴⁵ As was the case with the PARC collaboration between the same groups, all the benefits of partnership were evident.

9.51 The Mental Health Coordinating Council cites Psychosocial Rehabilitation Day Programs in Victoria as a positive example of available rehabilitation services.⁴⁶ The programs are planned on a state wide-basis and operated by the non-government mental health sector.

Respite care

9.52 The sheer volume of evidence recounting families' and carers' personal experiences demonstrates that a significant proportion of mental health care is provided by ordinary people living in the community. The 'informal mental health workforce' includes families, carers and community members who respond on a local level to the needs of people experiencing mental illness.⁴⁷ Their needs – including emotional support and professional assistance, as well as education and information on mental illness treatment and care – must be recognised and met within the context of a community-based system of care.

9.53 A recurring theme in evidence to the committee was the lack of respite care to assist carers and families supporting individuals with mental illness.⁴⁸ The community is calling for more respite care or supervised beds to assist carers and families who are supporting people with mental illness in the community over extended periods.

9.54 The Mental Health Coordinating Council highlighted the positive work undertaken by the NSW Health and Carers NSW to establish 'family and carer friendly' services to assist in the care and rehabilitation of individuals with mental health, as well as respite programs to assist carers.⁴⁹ However, the Council raised concern about the longevity of such programs if not adequately funded.

45 Mental Illness Fellowship of Victoria, Specialist Residential Rehabilitation Service (SRRP) and Prevention and Recovery Care (PARC on Maude), <http://www.mifellowship.org/ProgramInfo/ResiRehabSRRP.htm> (accessed March 2006).

46 Mental Health Coordinating Council, *Submission 173 – Attachment 4*, p. 18.

47 National Rural Health Alliance, *Submission 181*, p. 25.

48 For example: Australian Medical Association, *Submission 167*, p. 18; Australian Rotary Health Research Fund, *Submission 68*, p. 1–2; Mental Health Coordinating Council, *Submission 173 Attachment 4*, p. 12; National Rural Health Alliance Inc, *Submission 181*, p. 25.

49 Mental Health Coordinating Council, *Submission 173*, p. 6.

Case management

9.55 Evidence to the Inquiry shows that there is a need for ongoing, intensive case management and follow up for some people experiencing a mental illness. Some consumers need assistance that extends well beyond the administering of medication:

Some clients need constant case management to not only take daily medication but to maintain basic functions of a normal life, like eating, bathing, washing etc. These people consistently need food, shelter, support, health care etc. Turning all people out into the community, without these systems in place, signifies a gross lack of duty of care to the most vulnerable people in our community and needs to be rectified.⁵⁰

9.56 However there is a distinct shortage of case management services. The Brotherhood of St Laurence stated that a lack of funding is leading to long waiting periods:

It's hard getting the treatment [case management] you need in the country. First we have to meet the very tight criteria and then you get put on a list and have to wait until someone else drops off and you can take the place. They don't look at the waiting list and say 'maybe we need another worker'.⁵¹

9.57 The Australian Psychological Society Ltd commented on the poor level of discharge planning from acute services and high readmission rates. The Society noted the importance of case management to assist consumers in the process of recovery when reintegrated back into the community and submitted that discharge planners should address both medical and non-medical needs. For example, discharge planning should consider 'agreed responses to early warning signs of illness and risk and protective factors for mental health' and 'goals for rehabilitation and longer-term recovery'.⁵² This emphasises that a holistic approach to case management must be combined with a collaborative approach across the community to managing mental health care.

9.58 The Mental Health Coordinating Council advocates thorough mental health care planning for people exiting hospital-based care, as well as those released from gaol:

...inadequate follow up care was having a major impact on consumers' ability to live in the community with, at times, tragic consequences such as suicide.⁵³

50 Southern Suburbs Taskforce, *Submission 191*, p. 2.

51 Brotherhood of St Laurence, *Submission 97*, p. 2.

52 The Australian Psychological Society Ltd, *Submission 50*, p. 4.

53 Mental Health Coordinating Council, *Submission 173 - Attachment 1*, p. 28.

9.59 Micah Projects Inc discussed the difficulties in accessing case management for people in supported accommodation. The organisation noted that whilst few people had access to a case manager, even fewer people were having their case actively monitored.⁵⁴

9.60 The Health Services Union and Health and Community Services Union described the lack of resources for case management and consequent unbearable workload for case managers:

For community clinicians caseloads have become so great that staff are reduced to a revolving door of crisis management. A high proportion of long-term, high need consumers are using the community clinical services and home based outreach and day program services, thus limiting the capacity of these services to take on new clients.

Community caseloads for community-based workers must be sustained at reasonable levels to allow for proactive intervention that can assist 'recovery' rather than merely maintain people in the community...

In NSW [it is] not uncommon for case managers [sic] to be looking after between 50 and 60 clients. In Victoria, in some instances clinicians have reported case loads of up to 90...⁵⁵

9.61 Addressing the community's need for case management services will therefore require both increased resources and development of the workforce.

Assertive community management

9.62 Case management covers a wide range of services, but also a wide range of illnesses of differing degrees of severity. For people with severe, prolonged illness,⁵⁶ assertive community management is a desirable approach for assisting consumers who can have high levels of care needs.

9.63 Assertive community management is the provision of intensive support and assistance to consumers living in the community with severe or prolonged mental illness. Key features include:

- seven day, 24 hour access to an assertive community treatment team (including crisis response services);
- mobility to travel to a consumer's home or community setting; and

54 Micah Projects Inc, *Submission 67*, p. 5.

55 Health Services Union and Health and Community Services Union, *Submission 223*, p. 13.

56 A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today*, September 2003, vol. 4, no. 9; p. 91.

- services specifically tailored to the psychosocial and pharmacological needs of the consumer.⁵⁷

9.64 Studies into this mode of care⁵⁸ indicate that assertive community management provides improved outcomes for consumers, carers, their families and the community, including:

... greater stability in the community... less revolving door administrations, less hospital days, and improved quality of life.⁵⁹

9.65 Compared with standard case management, assertive community management restricts the ratio of case managers to consumers to ensure an adequate level of service is available. Following discharge from hospital-based care, it requires a higher initial injection of funds per consumer.⁶⁰ However, this is off-set by the substantial benefits that result from this mode of care.

9.66 Benefits of assertive community management include: the active maintenance of contact between the consumer and case management team; a decreased need to access hospital-based services; and reduction in the likelihood of the consumer stopping treatment.

9.67 Assertive community management results in an overall enhancement in the quality of life of consumers, including improving the ability to maintain stable housing and employment, as well as more normalised social functioning. There is also a reduced reliance on hospital-based care and crisis treatment, leading to a decrease in expenditure on healthcare over time.

9.68 Consumers and the community benefit from fewer disturbances which are commonplace when the mental health of a consumer degenerates, sometimes with dire and irreversible consequences. Given the extent of tragic evidence to the inquiry recounting stories of loved ones ending their lives or committing criminal acts in a state of psychosis, this benefit cannot be overstated.

57 A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today*, September 2003, vol. 4, no. 9; p. 91.

58 See for example, A. Rosen & M. Teesson, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, 2001; David Mechanic, 'Policy Challenges in Improving Mental health Services: Some Lessons for the Past', *Psychiatric Services*, vol. 54, no. 9, 2003; A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today*, September 2003, vol. 4, no. 9.

59 A. Rosen & M. Teesson, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, 2001, p. 732.

60 A. Rosen & M. Teesson, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, 2001, p. 736.

9.69 The committee believes an effective system of community care acknowledges the variation in severity of mental illness and the corresponding needs of consumers. Research supports the effectiveness of assertive community management in helping people with severe and prolonged mental illness to live in the community, reducing the need for hospital-based care and involuntary treatment and its resulting burden on society. Several state and territory submissions made mention of new initiatives in assertive community management or other services that appear to be of a similar sort.⁶¹ The committee urges all jurisdictions to move toward the adoption of this model.

Coordination of services

9.70 While submitters overwhelmingly pointed to the need for expanded and enhanced community services, they also stressed that community services need to be better organised and integrated. The current lack of a coordinated approach to community-based services means that people are 'falling through the cracks' and not receiving the services they need.

9.71 The lack of coordination of community care has also contributed to an uneven spread of services across communities, including the range of services available:

...there may be Day Programmes, but not Housing in an area, inadequate Support Workers in an area, depending where the particular sufferers are and how informed their Carers, how able is Advocacy for better service, in different State Mental Health boundary areas.⁶²

9.72 The West Australian Child and Adolescent Mental Health Services Advisory Committee noted the frustration created by "poor coordination, fragmentation and little cohesion" between services.⁶³ The Mental Health Council of Australia also recognised this need:

...making community based care actually work required an increased focus on intersectoral linkages. The National Mental Health Report...does not report on this crucial strategy but consumers report a consistent lack of access to these broader community services which impairs their ability to maintain their health and operate effectively in the wider community.⁶⁴

9.73 Consumers, families and carers are desperately seeking the coordinated management of mental health care across the community. The current disparate and chaotic organisation of community-based services is impacting on the ability of consumers to live in the community:

61 NSW Department of Health, *Submission 470*, p. 25; Western Australia Department of Health, *Submission 376*, p. 20; ACT Health, *Submission 165*, p. 4.

62 Name withheld, *Submission 76*, p. 1.

63 West Australian Child and Adolescent Mental Health Services Advisory Committee, *Submission 24*, p. 2.

64 Mental Health Council of Australia, *Submission 262*, p. 9.

... partly the result of a total breakdown of the Dept. of Housing's emergency housing service and its and the Mental Health Centre's (MHC) inability to co-ordinate or communicate. Similarly, I discovered liaison between the MHC and Centrelink was equally inadequate, resulting in my daughter's rent allowance being allowed to lapse... This is an area that needs professional co-ordination and case-workers with enough time to ensure such muddles are resolved quickly.⁶⁵

9.74 ACROD, the National Industry Association for Disability Services observed the need for a change in ideology:

Because of the continuing prevalence of the medical model of mental illness, health and allied services tend to be viewed as primary (if not superior) and all others as secondary (if not, in extremis, optional). The need to promote inter-sectoral partnerships was a central policy recommendation of the first National Mental Health Plan, but this objective has not been realised in practice. The 2003-08 Plan has the same emphasis. It is essential that this time it be given effect.⁶⁶

9.75 The need for coordination across community support services for people with mental illness is also discussed in Chapter 10.

The NGO sector

9.76 Non-government organisations (NGOs) fill a vital role in delivering community-based programs to people with mental illnesses.⁶⁷ There is growing reliance on NGOs to deliver services not currently available through the public health system. For example, NGOs report that consumers living in supported residential services are 'rarely' visited by case managers or clinical care services from the public mental health system, so the responsibility falls to NGOs.⁶⁸

9.77 The National Mental Health Council provided strong support for the roles filled by NGOs:

The NGOs provide a wide range of services and are often the best placed to provide essential links into the community and between services. They are to some extent the engine room of reform because of these links and because of their capacity to run flexible and consumer-centred care.⁶⁹

65 Name withheld, *Submission 55*, p. 3.

66 ACROD, *Submission 335*, p. 4.

67 beyondblue: the national depression initiative, *Submission 363*, p. 8; Lifeline Australia, *Submission 329 Attachment 6*, p. 5

68 Mental Health Coordinating Council, *Submission 173 - Attachment 4*, p. 17.

69 National Mental Health Council of Australia, *Submission 262*, p. 28.

In the Council's view, 'The lack of funding for non-government services is one of the major factors in the under performance of the [National Mental Health] Strategy'.⁷⁰

9.78 Overall, 6.2 per cent of mental health funding went to the NGO sector in 2003, up from 2 per cent in 1993.⁷¹ Victoria spent the highest proportion of its mental health budget on NGOs, followed by the ACT. South Australia and New South Wales spent the least.⁷²

9.79 A key issue in the delivery of community-based mental health services by NGOs is the lack of funding for delivering day-to-day services.⁷³ The current National Mental Health Plan recognises that NGO funding is limited:

Non-government organisations have performed a key role in providing support services for those with mental health problems and mental illness, in advocating for services to be more responsive, and in educating and supporting carers. While the demand on non-government mental health organisations has increased significantly over the past decade, their funding base remains limited.⁷⁴

9.80 The Australian Mental Consumer Network (AMCN) recommended an increase in funding of 'at least 20 per cent of the mental health grant' to NGOs providing services to consumers.⁷⁵ They noted the importance of directing funds to services shown to produce positive results, arguing that funding 'unexamined community clinical services will be just as wasteful as a deluge of money into the funding of more acute beds'.⁷⁶

9.81 Volunteers are an integral component of the NGO workforce, providing valuable support in community-based care.⁷⁷ Nonetheless, there are limits as to what can be achieved in a cash-poor environment. The Richmond Fellowship of NSW stated that it is very difficult to attract donor funding to mental health NGOs, leaving them particularly reliant on government funding.⁷⁸ The Fellowship argued that funding to NGOs needs to reflect the real costs of delivering services, not only direct program costs but also costs associated with capacity building, meeting OH&S

70 *Submission 262*, p. 10.

71 Australian Health Ministers, 2003, *National Mental Health Plan 2003-2008*, p. 5.

72 Australian Health Ministers, 2003, *National Mental Health Plan 2003-2008*, p. 5.

73 See, for example: Southern Suburbs Taskforce, *Submission 191*, p. 2; Mental Health Coordinating Council, *Submission 173 Attachment 4*, p. 14; SANE Australia, *Submission 133 Attachment A*, p. 16.

74 Australian Health Ministers, 2003, *National Mental Health Plan 2003-2008*, p. 19.

75 Australian Mental Consumer Network, *Submission 322*, p. 2.

76 Australian Mental Consumer Network, *Submission 322*, p. 19.

77 Mental Health Coordinating Council, *Submission 173 - Attachment 4*, p. 9.

78 Richmond Fellowship of New South Wales, *Submission 266*, p. 4.

legislation and accreditation requirements, as well as other risk management considerations.⁷⁹ The Fellowship described its stretched resources:

The Richmond Fellowship, which provides supported accommodation and other support to people suffering from schizophrenia, has to train social workers and other less qualified people to deal with psychiatric patients in the community in regional areas because there are not enough mental health nurses or community nurses. The Richmond Fellowship has a 2-year waiting list, and looks to remain that way indefinitely if current trends continue.⁸⁰

9.82 Greater collaboration and capacity building in the NGO sector will strengthen the role of NGOs to provide mental health services. This includes areas such as outreach services, psycho-social rehabilitation and residential support.⁸¹ A clear definition of the role of NGOs in mental health care and an understanding and recognition of the community services provided through the NGO sector may assist in streamlining services and responsibilities across this sector.

9.83 For example, NGOs may be further utilised to provide a structured outreach service to patients no longer needing intensive clinical case management through GPs.⁸² This would have the advantage of ensuring sufficient time to assess the person's general state of mental and physical health in the patient's home and reduce the focus on assessing clinical aspects of health in perhaps a 'less-friendly' setting. It would also reduce the pressure on GPs to provide ongoing community care, given appropriate circumstances. The success of this approach is, however, heavily reliant upon a formalised arrangement between the outreach provider and medical services, ensuring that 'step-up' assistance is available when required.

Maintaining the focus on community care: the Italian experience

9.84 Italian mental health policy underwent radical reform in 1978 following a decade-long deinstitutionalisation movement similar to that in many other countries including Australia. De-institutionalisation in Italy was initiated by psychiatrists but later joined by other mental health workers, patients themselves, unions, political parties and members of the general public concerned with the state of the country's asylums.

9.85 The 1978 reforms were implemented in Public Law No. 180 (the reform law). Key characteristics of the reform law included:

- the prohibition of the establishment and use of psychiatric hospitals
- development of a network of community mental health services

79 *Submission 266*, pp 4–6.

80 ARC Group, *Submission 14*, p. 3.

81 Miss Margaret Burton, *Submission 35*, p. 1.

82 Mental Health Coordinating Council, *Submission 173 - Attachment 4*, p. 15.

- prohibition on hospitalisation other than in 15-bed general hospitals, and
- prohibition on involuntary hospitalisation other than in particular circumstances (such as a psychiatric emergency).

9.86 These reforms were implemented as part of a major reform of the Italian health system under which all citizens were entitled to healthcare through local administrations responsible for defined geographical areas.

9.87 Initially, the lack of sufficient residential facilities to meet the need for medium- to long-term residential care was a significant source of discontent (particularly among organizations representing families of the mentally ill). There was also evidence that the decrease in the number of psychiatric hospital in-patients was accompanied by reductions in the quality of care and staff commitment.

9.88 The reforms were later bolstered by a series of National Mental Health Plans that enshrined common service and funding standards and emphasised the integration of mental health services with other services and consumer organizations.

9.89 While the development of an adequate level of alternative services took some time, the controversial reforms have been a success:

Presently Italy has the most comprehensive and diffuse disseminated network of community psychiatric services than any other country in the world. Persistent differences in the distribution of resources call for improvement but, in the opinion of a vast number of workers and users, do not imply the repeal of the existing legislation. In those many areas where the reform has been applied, empirical evidence proves the effectiveness of community services in meeting all psychiatric needs, including those of the severely mentally ill and their families.⁸³

9.90 While clearly the experiences of different patients will vary, the support expressed by one patient, Giovanni, a former state hospital inmate and a patient of the South Verona Community Mental Health Services, illustrates the types of benefits some patients see in the Italian system:

I was in the hospital for 12 years, and didn't like it. I prefer by far to live in my apartment and wish to express my appreciation to the workers for their respect and support. Let me recommend that action be taken internationally to develop community services instead of psychiatric hospitals.⁸⁴

83 Lorenzo Burti, 'Italy: radical reform of mental health policy and its consequences', in P. Morrall and M. Hazelton (eds.), *Mental health: global policies and human rights*, Whurr Publishers, London, 2004, p. 75.

84 Lorenzo Burti, 'Italy: radical reform of mental health policy and its consequences', in P. Morrall and M. Hazelton (eds.), *Mental health: global policies and human rights*, Whurr Publishers, London, 2004, p. 74.

9.91 It is notable that Giovanni's enthusiastic support was reportedly the source of some amazement to those observing it as apparently he 'ordinarily spoke only of his delusion of being a descendant of Julius Caesar' and 'had never spoken a complete sentence before'.⁸⁵

9.92 Other observers, however, have urged caution in relation to attempts to adopt 'the Italian experience' in other countries. For example, Australian professor of psychology, Graeme Smith, has noted that while a number of Western countries have engaged in Italian-style reforms:

all have been criticised for basing the changes on ideology or opportunism rather than on evidence, for failing to prepare the community for the impact of those changes, and for failing to fund them adequately. Subsequent research has justified the changes to some extent—it is clear for one thing that they have facilitated the rights of patients—but tragic consequences remain to a varying degree.⁸⁶

9.93 Despite these concerns, the Committee was impressed by outcomes in Trieste, visited by the Chair in January 2006.⁸⁷ The community-based care model sees a strong focus on patients' rights, with very low rates of involuntary treatment and few forensic hospitalisations. Ninety-four percent of the mental health budget is spent on community based care, and savings have actually been achieved compared to 1971 levels of mental health spending. The focus of service delivery is multidisciplinary care delivered through specialised community mental health care centres, with far less reliance on acute psychiatric hospitals than in Australia. The Italian model, as seen operating in Trieste, is a reminder that properly resourced community-based care can be positive for consumers' rights and recovery, as well as for budgets.

Concluding remarks

9.94 Community-based mental health services in Australia are clearly inadequate to enable consumers to live independently in the community. This situation reflects a legacy of underinvestment in service development, and in some jurisdictions the rapid pace of deinstitutionalisation. While the National Mental Health Strategy made broad statements about the need to develop community services, it avoided the hard yet essential task of defining what those services should be and setting targets for their development.

9.95 The impacts of inadequate community care are clear. There is a high rate of homelessness among the mentally ill, many people with mental illnesses are ending up in prison, acute care facilities cannot meet demand and there is a high readmission rate

85 L. Burti, 'Italy: radical reform of mental health policy and its consequences', in P. Morrall and M. Hazelton (eds.), *Mental health: global policies and human rights*, Whurr Publishers, London, 2004, p. 74.

86 Graeme Smith, 'The Italian experience', *Meanjin*, vol. 63, no. 4, 2004, pp. 81–2.

87 For details, see the Chair's report on the visit at Appendix 3.

to acute care facilities. Resources spent responding to these crises will have only limited impact. Longer term relief will not occur without significant investment in community services that provide earlier interventions to prevent mental illness escalating into crisis, and provide post discharge support in the transition to community life.

9.96 Community mental health services need to be located *in the community*. Currently, mental health services remain clinically oriented and there is evidence that community-based services are being drawn back into hospital environments. Wider support services remain *ad hoc*, with little coordination between different service providers. Stigma and community resistance remain an issue in the development of some services. Therefore strong leadership, at national, state and local levels, combined with increased resources to develop community services are required to fulfil the original goals of deinstitutionalisation.

