DISCUSSION PAPER

25 AUGUST 2010

Community-Managed Mental Health in Victoria

The Case for Investment

Psychiatric Disability Services
of Victoria (VICSERV)

Contents

Introduction

A properly funded community-managed mental health sector is the missing link in mental health reform. It is vital in order to give people with mental illness the best chance of living well in the community, in their own homes.

Since deinstitutionalisation there has been a failure by successive federal and state governments to adequately invest in community-based mental health care. This may have initially been explained in part by insufficient evidence to warrant this investment. However this is no longer valid – there is now considerable literature demonstrating the positive impact of psychosocial community support for people with a mental illness. It is also not because the sector lacks expertise or skilled staff – 30 years of operations now ensure this expertise exists. It cannot be because there are not successful operational models working now in Australia – there are in fact many highly successful and professionally-run community-managed mental health services operating today across Australia, many of which are located in Victoria.

The aim of this paper is to bring together the abundant evidence supporting a purposive investment in the services provided by the community-managed mental health sector. The merit of this investment remains, regardless of the outcome of current debates about the respective roles to be played by federal and state governments, hospital networks or Medicare Locals.

This paper is a summation of a literature review undertaken by ConNetica Consulting, in the course of VICSERV's Strategic Sector Development Project.

Characteristics of the community-managed mental health sector in Victoria

Sector funding

Victoria has Australia's most highly developed community-managed mental health sector, yet even here it remains a relatively small component of the overall mental health system. Exact and current figures on mental health expenditure by sector are difficult to find. However, the 2005 Senate Inquiry into Mental Health reported that in Victoria 11.5 per cent of the total mental health budget was directed to the non-government sector[1]. This was at the time twice the national average. Victoria has historically dominated the national picture, accounting for 44 per cent of total state and territory NGO funding in 2004 – 05[2].

The Victorian government allocates around $90 million of its health budget to the community-managed mental health (Psychiatric Disability and Rehabilitation Support Services – PDRSS) sector and a further $40 million is provided by the federal government through several programs, including Personal Helpers and Mentors and Activities of Daily Living.

The consequence of a higher level of funding over an extended period (more than 15 years) means that one finds greater capacity, reach and diversity in community-managed mental health services in Victoria than anywhere else in Australia.

The situation in Victoria, whilst considerably better than the rest of the nation, is still not providing sufficient capacity or spectrum of services for prevention, early intervention and recovery for people with serious mental illnesses.

The sector, its services and standards

According to its 2009 Annual Report, VICSERV had 62 member organisations and many more associate and individual members. It is estimated that the business of providing Victoria's community-managed mental health services is conducted through around 100 contracts between providers and funders. The range of services provided by the community-managed mental health sector includes:

- Psychosocial Rehabilitation Day Programs
- Home-based Outreach
- Respite
- Residential Rehabilitation
- Specialist Residential Rehabilitation Programs (SRRP)
- Prevention and Recovery Care (PARC) services

Employment services of both state and commonwealth departments provide employment placement and support to people with a mental illness, including Vocational Rehabilitation Services, Job Network and Disability Employment Services (DES).

The type of services provided by the community-managed mental health sector is quite similar in each jurisdiction in Australia. However, this has not translated into a set of national standards for psychosocial services. Such standards have been separately developed in Western Australia[3] and Victoria[4].

There are also national standards for mental health services that were initially developed in 1996[5] and have been redeveloped over the past three years. As with its predecessor, the new national standards are intended to operate in any mental health service. However, the revised version has been drafted very much with government-run public mental health services in mind. A process of devising an 'interpretive guide' has started, so as to translate the new standards into a range of settings, including the multicultural community, primary care, non-government organisations among others. It is as yet unclear if the final result will be of any real benefit to establishing and monitoring national standards of care across the community-managed mental health sector.

The community mental health sector workforce

The community mental health sector workforce is diverse and suffering most of the pressures felt by the health workforce more generally[6]. A consistent criticism of government workforce policy is that it has not supported the policy goals of shifting to a model of community-based, recovery-focused care.

Under both the COAG *National Action Plan on Mental Health 2006–11* and the National Mental Health Workforce Advisory Committee, the principle concern has been to husband the 'traditional' workforce, such as mental health nurses and psychologists, roles typically engaged in the provision of government-run services.

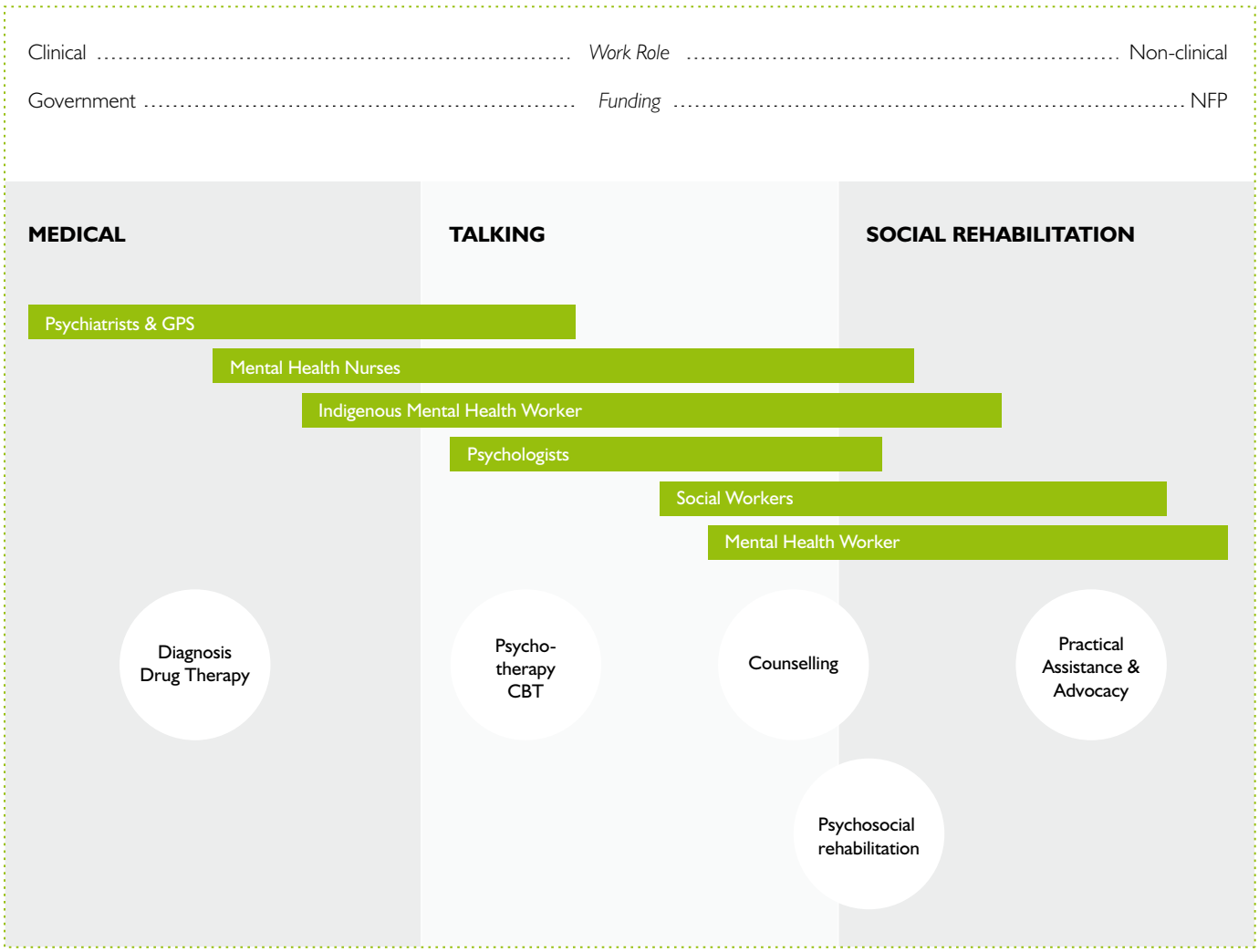
There have not been similar strategies designed to grow the workforce needed to deliver psychosocial and other community-based services. It is understood that the National Health Workforce Taskforce (NHWT), in collaboration with PriceWaterhouse Coopers, has commenced a project that aims to better understand the existing non-government mental health workforce but the results of this work are not yet available. However, there have several training needs analyses undertaken including in NSW[7], South Australia[8], Victoria[9] and Queensland[10]. Another workforce snapshot taken in Queensland[11] reported that half the workers in the community-managed mental health sector had TAFE qualifications and one third Bachelor level degrees.

The mental health sector has traditionally operated within some reasonably strict boundaries, as shown in the diagram below. There is an inherent hierarchy in this depiction broadly from left to right, with the kinds of skills demonstrated by those working in the social rehabilitation sector deemed of less value than those in the medical stream.

This traditional delineation is now seen as being outdated by the Industry Skills Council[12]:

'This [demarcation] is increasingly inaccurate and unhelpful as many NGOs are involved in providing psychosocial treatment and many employ psychologists, mental health nurses and other university qualified workers with experience in clinical care…Establishing a coherent, cross-sector workforce development strategy is crucial if the policy objective of a high quality, integrated community mental health service is to be achieved. Old dualisms of "government" and "non-government", "health" and "community", of "clinical" and "non-clinical" obscure an objective assessment of the sector's skills needs'[13].

Traditional practice and occupational boundaries in the community mental health sector



Source: Industry Skills Council, 2008

There are two critical priorities now with regards to the community mental health sector workforce:

- A need to systematically assess the skills and knowledge required to work effectively in the sector, with a view to developing a unified body of psychosocial practice from which to derive an evidence-based workforce strategy
- A need to consider what training and qualification standards should be set for the sector.

A critical new aspect to the community sector workforce is the peer worker. There is now considerable literature to support the contribution of peer workers in terms of enhanced outcomes and improved recovery for clients where peer workers are part the workforce in a service. This is going beyond a token or representative function. Peer support workers have been reported to enhance outcomes with improved social functioning, reduced psychiatric symptoms and hospitalisation, and improved consumer satisfaction[14].

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The evidence supporting community-managed mental health services

Community services as part of a balanced mental health system

Community mental health services make it easier for people with a mental illness to live well in the community, to enjoy a high quality of life and to fulfil their potential. For many people with a chronic mental illness, over time they may need a mixture of clinical/specialist and psychosocial support services. During acute phases of care, they may need more of the former and less of the latter, with the situation reversed at other times. Community-based services are particularly important to ensure successful transition from hospital-based care to home.

The role of community-managed mental health services

This has been described as a 'balanced' or 'stepped' approach, which is essentially community-based mental health care but with brief hospital stays playing an important back-up role when necessary[15]. In reality, this balance has not been achieved in Australia with the vast majority of mental health spending directed towards hospital-based acute mental health care while community mental health services, particularly social support services have received minimal funding.

Stepped-care model for mental health services

STEPPED CARE – DETAIL

Who provides care?	What is the focus?	What services are provided?
Impatient Units & CAAT	Risk to life, stabilise clinical conditions	Medication, combined treatments, ECI
MH specialists, outpatients & CAAT & community support	Treatment resistant, recurrent, atypical, significant risk	Medication, complex pyschological interventions, combind treatments
Primary care team, consultant specialist, & community support	Moderate or severe mental illness & comordibity	Medication, combined treatment, social support
Primary care team, PMH care worker	Mild depression, anxiety and related	Watchful waiting, guided self-help, e-based CBT, exercise, brief APT
GP, practice nurse	Recognition	Assessment

The current domain of the community-managed mental health sector

However, there is no persuasive evidence to support a hospital-only approach[16]. In fact, the continued emphasis on the hospital as the focus of acute mental health care has come under recent scrutiny. A recent randomised controlled study comparing outcomes of hospital-based acute psychiatric care with short-term acute residential treatment found that the latter approach delivered better outcomes as assessed by both patients and staff[16]. This is consistent with other studies that have indicated the effectiveness of community-based care over hospital-based care[18].

It is also in complete accord with evidence-based global health initiatives, as reported in *The Lancet*, for both developing and developed countries, which are now encouraging a shift away from hospital-based and institutional-based mental health care and towards community-based care, with closer links to primary health care[19].

The evidence is clear that when deinstitutionalisation is carefully managed and underpinned by strong community mental health services, the outcomes will be favourable for almost all clients. For example, the Team for the Assessment of Psychiatric Services (TAPS) study in London[20] completed a five-year follow-up on over 95 per cent of 670 long-stay patients discharged from institutional care, and found:

- At the end of five years, two thirds of the patients were still living in their original residence
- No increase in the death rate or the suicide rate
- Fewer than one in 100 patients became homeless, no patient was lost to follow-up from a staffed home
- Over one third were readmitted during the follow-up period at the time of follow-up ten per cent of the sample were in hospital
- Overall, the patients' quality of life was greatly improved by the move to the community, though disabilities remained due to the nature of severe psychotic illnesses
- There was little difference overall between hospital and community costs: coupled with the outcome findings, the economic evaluation suggests that community-based care is more cost-effective than long-stay hospital care.

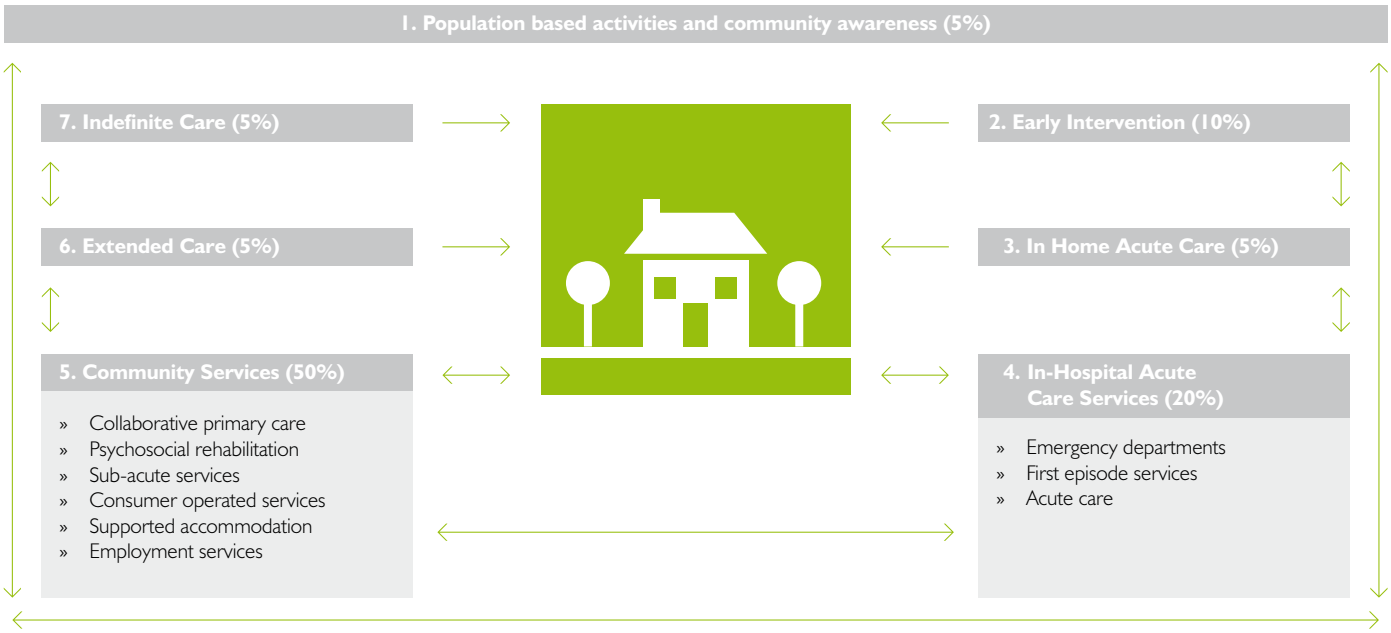
The study concluded that there was now growing evidence that some types of community-based alternative to acute hospital admission may also be cost effective, such as crisis houses and home-based treatment by community mental health teams.

Available evidence is now clear that the most effective mental health care is provided by multi-disciplinary teams of workers, operating in collaboration[21]. This applies as much to community settings as anywhere else. Australia has recently made very significant investments in general practitioner-led primary mental health care. Again, the evidence supports a multi-disciplinary approach – interventions directed solely towards training and supporting GPs have not been shown to be effective[22]. This is evidence which should inform COAG discussions about the establishment of Medicare Locals.

It is worth noting also that the most recent Survey of Mental Health and Wellbeing found that only 35 per cent of people with a mental illness in the last 12 months received any care for that illness[23]. We only know a little about the reasons why so many people with an illness do not seek help. It may be that the inability to access community-based care instead of often-traumatic acute hospital-based care is one reason.

The same collaborative and integrated approach to care has been demonstrated to be pivotal in the success of treatments for people with co-occurring mental and substance-abuse disorders[24]. This is particularly important given that such co-morbidities are commonplace, particularly among young people with a mental illness. Across Australia, mental health and drug and alcohol services continued to be typically arrayed as separate rather than integrated services.

A balanced and integrated mental health system for Australia



Adapted from *Time For Service*, Mental Health Council of Australia, 2005

Note that this diagram includes a recommended allocation of mental health funding to each service element based on evidence on what works. This will require significant re-balancing of the services over time. For example, in-hospital acute, extended and indefinite care receive about 55 per cent of all mental health care funding at present. Under this recommendation, along with in-home acute care (virtually absent in Australia despite strong evidence supporting investment), acute care and extended care would total 35 per cent and there would be significant percentage increases in prevention, early intervention and community support services.

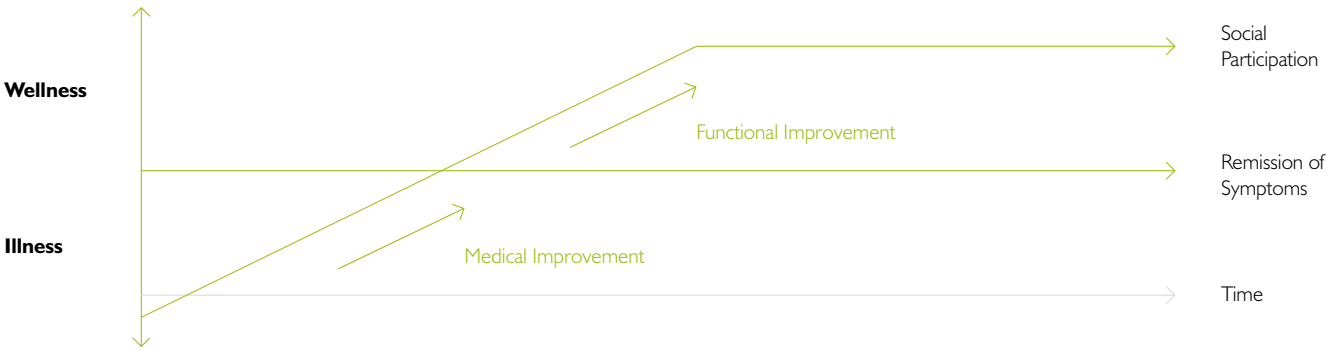
The philosophy of the sector

While the community-managed mental health sector offers a range of services, it does so flexibly, aiming to ensure that it is the consumers and carers who determine the help they need to recover. This is unlike more inflexible models of care typically offered by government and clinical service providers. Due to the lack of service alternatives, there is unrelenting demand on hospital acute mental health care. Overwhelmed staff find it difficult to focus on more than remission of symptoms for individual clients, creating the oft-cited revolving door of dependent clients.

By contrast, community sector approaches strive to operate in concert with best practice with regards to the literature on recovery. While recovery began as a social movement* the research data now supports key tenets of the recovery model – optimism about outcomes from serious mental illness, the value of employment, the importance of empowerment, peer support and others. Over the past thirty years, international longitudinal studies of recovery from major illnesses have demonstrated recovery rates of between 49 and 68 per cent[25]. Yet the concept of recovery has only recently been appreciated by many service providers, administrators and developers.

The community-managed mental health sector aims to move beyond clinical management of symptoms and work with its clients to enable greater participation in society.

Beyond clinical management of symptoms and towards recovery and participation



There is good evidence to support the recovery model beyond support as a social movement. Factors such as optimism, empowerment, interpersonal support and vocational rehabilitation are now empirically demonstrated to support recovery[26].

One element contributing to the success of these factors may be the capacity of the community sector to establish strong therapeutic alliances with its clients, a characteristic demonstrated to yield positive outcomes for people with a mental illness[27].

*A social movement is a form of social action based on shared values, mental models and aspirations and is not necessarily founded on scientific data or evidence.

The evidence base for psychosocial interventions

There is now considerable empirical research which justifies the deployment of a range of psychosocial interventions. Evidence is strong for the use of family intervention[28], social skills training[29], cognitive-behavioural therapy[30], case management[31], psychosocial rehabilitation[32] and supported employment[33].

As a model of care, there is considerable evidence to support the deployment of Assertive Community Treatment (ACT)[34]. Under this model of care more intensive community services are available to be provided 24 hours a day to consumers in their homes by multi-disciplinary treatment teams based in community health centres. There is considerable evidence that this community location and mobility generates better outcomes for clients and reduces hospital admissions but despite this, recent years have seen a systematic dismantling of these teams throughout Australia[35].

There is strong evidence to also support music therapy for people with schizophrenia and similar illnesses as well as psycho-education. Both of these are services typically provided by the community-managed mental health sector and have been demonstrated to reduce negative symptoms, reduce hospital admissions and increase general wellbeing[36].

There is also now quite extensive evidence regarding the positive outcomes associated with supported accommodation for people with a mental illness[37]. The evaluation into the Housing and Supported Accommodation Initiative (HASI) was chosen by the federal government to showcase Australian achievements in mental health as part of the recent Asia-Pacific Community Mental Health Development Project[38]. The HASI program delivered some spectacular outcomes for its clients:

- 85 per cent of program participants remained with the same accommodation provider enjoying housing stability
- 94 per cent of people had established friendships at completion of the evaluation
- 73 per cent of participants were involved in social and community activities
- 43 per cent of participants were either working or studying at the end of the evaluation
- Hospitalisation rates of admission and length of stay were reduced for 84 per cent of participants
- Time spent in hospital and emergency departments decreased by 81 per cent.

By 2008/2009 there were around 1000 HASI Program places across NSW. There is evidence emerging from HASI-type programs in other jurisdictions of similar success[39].

A critical aspect of the evidence is to be found in the voice of the general community which has repeatedly called for greater investment in mental health services available either in, or from the home[40].

This call was a feature of both the seminal *Not for Service* Report[41], produced by the Mental Health Council of Australia and the Human Rights and Equal Opportunity Commission, and in the Report of the Senate Inquiry in Mental Health, entitled *From Crisis to Community*[42]. Add to this the recent recommendations made by the National Health and Hospital Reform Commission:

Recommendation 77: We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

The scale of the resources required

More is known about the shape and nature of Victoria's community-managed mental health sector than ever before – what services are being provided, where, by whom and to what level of quality. A key missing detail however is the extent to which current services are meeting community demand. Simply put, this level of data is not available, beyond the more general figure that only one in three people with a mental illness is receiving any care for that illness.

It is a matter of some urgency that the community-managed mental health sector considers how to fill this data vacuum as part of its ongoing advocacy. Some agencies do keep waiting lists or know how many clients they are forced to turn away and in addition, there are some national data and methods by which the sector could assess if it has the right spread of the right services. This data is based on assessments of population numbers and illness severity and could contribute to at least a broad sense that the community is being adequately serviced.

However, the New Zealand experience is that the community-managed sector can play a much larger role than is currently the case in Victoria with around 30 per cent of total mental health spending being directed to that sector in that country, though recent cuts to New Zealand's mental health budget are noted. Other parts of the world have this level of community-specific spending even higher with the 2006 Senate Inquiry reporting that for example, Trieste in Italy spends 94 per cent of its total budget in this area, with only a tiny fraction spent on acute, hospital-based care. The World Health Organisation has reported that Australian spending on mental health care as a whole has fallen behind comparable OECD nations such as the UK, Canada and New Zealand, all of whom are spending close to double the funding allocated here[43].

Under a 2008 Parliamentary Agreement between ACT Labor and the Greens Party in Canberra's local Assembly, a key aspect of the agreement was to continue to increase the proportion of the health budget spent on mental health, with a goal of reaching 12 per cent of overall health funding and, more specifically, that by 2012, 30 per cent of mental health funding should be allocated to the community sector for the delivery of services.

The case for much greater investment in Victoria's community-managed mental health sector can be easily made and could extend to tripling current spending levels over a similar 4 – 5 year timeframe. It is important to note that increased investment in the sector would not be directed purely at more services, but also at the supporting infrastructure to facilitate the sector's strategic growth, in areas such as workforce development, quality improvement and outcome measurement.

Conclusion

As COAG now considers the development of Health and Hospital Networks and Medicare Locals, the community-managed mental health sector is at a crossroads. With the states controlling the Networks and the federal government the Medicare Locals, the new model of COAG health funding appears to militate against holistic care, with responsibility for client care clearly split between acute hospital care and non-hospital care.

Under this scenario, it is possible to see a split between the Medicare Local as a federally-funded agency responsible for high prevalence mental illnesses while the states retain control of services for the low prevalence psychotic disorders, with their locus of care being the acute hospital. It is entirely possible to see a situation in which funding responsibility depends on what sort of mental illness a person has – this may make things easier for a funder but is unlikely to generate holistic care, particularly for people with chronic and severe conditions, younger people with co-morbidities and others.

The evidence to support increased emphasis on community-based mental health care, both clinical and psycho-social is both clear and generally accepted by Australia's mental health sector. The nature of this care is that it is most effective when provided through collaboration between a team of workers and that this work is grounded in a genuine commitment to recovery. Victoria could rightly be regarded as the wellspring in Australia of this kind of psycho-social innovation and integrated care.

There is a paucity of evidence to justify a continued emphasis on either hospital-centric or GP-focused approaches to mental health care for those with more moderate to severe levels of illness and disability. The wishes of the community align with that of the evidence – to see the emphasis of Australia's mental health system undergo a fundamental shift to community-based mental health care with increased access to range of clinical and psychosocial support services either in, or from the home.

COAG has agreed to discuss mental health again at its 2011 meeting. This coincides with the conclusion of the COAG *National Action Plan on Mental Health 2006–11*. The challenge is to bring about greater awareness and support for the community-managed mental health sector to ensure that as new reforms are put in place, there is room for the sector to flourish.

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