Letter from Australia: mental healthcare in Victoria

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SUMMARY

Mental health services in the state of Victoria, Australia, have undergone enormous change over the past 15 years, with the closure of all stand-alone psychiatric hospitals and a shift of resources and services into the community. Although successful overall, various areas cause concern, including pressure on acute beds, a paucity of alternative residential options, and suboptimal integration of government and non-government agencies concerned with the care of people with mental illnesses. Certain groups, notably those with complex symptom sets such as substance use and mental illness, intellectual disability and forensic problems, remain poorly catered for by the system. Finally, community stigma and lack of work inclusion for mentally ill individuals are ongoing challenges.

DECLARATION OF INTEREST

None.

Since 1994, public mental health services in the Australian state of Victoria have undergone profound reforms (Meadows 2003; Gerrand 2005). Between 1994 and 1999, all 14 state psychiatric institutions were closed and savings reinvested in a restructured model of care. For in-patients, new facilities (co-located with general hospitals) and residential rehabilitation units (including purpose-built 20-bed continuing care units or CCUs) were built. For patients in the community, 24-hour crisis, assessment and treatment teams (CATTs) were established to provide crisis response, while other community-based teams provide ongoing longitudinal care, including, where required, intensive case management. The aim was to establish comprehensive, locally accessible services, with an emphasis on community treatment, delivered by multidisciplinary teams working to a case management model (Australian Health Ministers 1992). As part of this process, a proportion of the mental health budget was earmarked for contractual arrangements with non-government psychiatric disability and rehabilitation support services. The operationalisation of these plans was clearly articulated in state government documentation (Health and Community Services 1994). This Editorial describes the system some

15 years on, and asks what has worked and what has been less successful. I deal here solely with service provision for adults.

What stakeholders think

In June 2006, a conference was organised by St Vincent's Mental Health Service in Melbourne to review the changes by identifying both the strengths and limitations of the current public mental health system (Gerrand 2007). The 80 participants were mental health staff from the 21 state-funded adult specialist mental health services, patient and carer representatives, and staff from psychiatric disability and rehabilitation support (PDRS) organisations.

Inequities in care?

Participants generally felt that the reforms had ensured that priority had been given within public mental health services to people with disabling mental illness such as schizophrenia and severe mood disorders. However, it was thought that other clinical groups were being relatively neglected: for example, people with severe eating disorders or obsessive–compulsive disorder. The private sector has the capacity to assist such individuals, but federal government reimbursement covers only part of the fees, and many people with such disorders do not hold private health insurance. Since 2002, 'primary mental health teams' have been established to assist such individuals and enhance links with general practice, but these teams are small and have limited capacity.

Other patients whose needs are not always adequately met are those with complex 'cross-sector' problems such as mental illness and associated substance misuse or forensic issues. Specialist regional and state-wide services have been developed to support area mental health services (AMHS) in helping such individuals, but there remain problems regarding a coherent and consistent approach to their care and treatment.

Case management

There was agreement that case management had many positives. However, problems have arisen from heavy caseloads and the generic nature of

case management, with corresponding staff de-skilling. In addition, the absence of a specific case manager award meant disparities in grades, pay and award conditions between different disciplines undertaking similar tasks. it was felt that professional expertise and patients' clinical needs could be better matched in allocating a case manager: for example, a psychologist could take on a caseload of people whose main requirement was for psychological treatment. It was agreed that each case manager should have a realistic caseload, with weighting for clinical complexity. Creating a second tier of support staff to assist with practical tasks, such as finding accommodation, would allow mental health professionals to enhance their particular therapeutic contribution. Psychiatric disability and rehabilitation support services could play a role here.

The shift to community care

Participants considered that the move to the community had accelerated desirable changes in area mental health service staff. A multidisciplinary ethos, reduced hierarchy, emphasis on clinical supervision, and sturdier links with university departments had evolved. Recruitment of staff had been enhanced by the possibility of assigning them to positions in response to need. Moreover, many former institutional staff had found work in the community appealing. On the negative side, a number of competent, experienced staff had opted for redundancy. Positions in in-patient units had been difficult to fill, given the competing satisfaction of community work.

It was felt that mental health services had become much more accessible, with many acutely unwell patients cared for in the community. Rehabilitation had also improved, with increased participation in a range of programmes, and links with psychiatric disability and rehabilitation support services. On the other hand, resourcing of area mental health services had been insufficient for the spectrum of community-based clinical programmes, especially psychological treatments, to be fully implemented. Coordination had not always been effective, particularly between area mental health services and psychiatric disability and rehabilitation support services, with both types of service at times proving inflexible, using arbitrary eligibility criteria and ways of operating. This had impeded access for certain patients.

Emergency and in-patient care

The availability of 24-hour service provision ensured that emergencies could be dealt with at a local level and access to care simplified. Conversely,

increased demands on services had, arguably, undermined their quality and comprehensiveness. In-patient units were exceedingly pressured, with ever shorter length of stays and continual demand for beds, notably from the crisis, assessment and treatment teams and emergency departments. This had resulted in a suboptimal environment in many in-patient facilities. The problems were exacerbated by insufficient step-down facilities and lack of longer-term housing options. Services originally designed to be longer term (e.g. community care units) had become time limited. All this had placed an increasing burden on carers, who often felt themselves to be unsupported by the 'system'.

Early intervention services

The development of discrete services for early psychosis intervention, pioneered by the Early Psychosis Prevention and Intervention Centre (EPPIC) in the west of Melbourne, had a mixed reception. Staff within such services generally felt they were able to offer more optimal care to young people in the early phase of illness. However, silo effects (a lack of communication and common goals between services), de-skilling of staff in generic services and the difficulties of transitions from specialised early-episode psychosis (EEP) to generic adult services, were seen as negatives. This led some participants to question the positioning of such services and some to call for their integration into the mainstream services.

Stigma

Another area of ongoing concern was the fact that, despite the stalwart efforts of organisations such as SANE (www.sane.org) and beyondblue (www.beyondblue.org.au), there remained significant community stigma regarding mental illness. This affected patients, families and service providers and compromised community reintegration expressly for people with disorders such as schizophrenia.

Unrealistic expectations?

Thus, in reviewing mental health service provision in Victoria some 15 years after deinstitutionalisation, I find many positives but still some negatives with the new model. Elsewhere, my colleague Bruce Singh and I have asked whether some of the perceived failures of the system could be explained in terms of unrealistic expectations of the new model (Singh 2007). Specifically, we pointed to expectations that:

- the newer antipsychotic medications would be much more beneficial for patients than the older agents, whereas, in reality, many patients still do not respond adequately, notably in terms of

negative and cognitive symptoms, and suffer side-effects such as metabolic problems;

- modern treatments would improve 'insight' and medication adherence: there is no evidence that this is the case;
- intensive case management would have enduring effects, whereas benefits are often lost when the intensity of clinical input is reduced;
- patients would gain more insight into the negative impact of illicit substances on their health, whereas substance misuse has escalated among people with mental illnesses, with detrimental effects for patients and their families, and an increased burden on services;
- community acceptance of the mentally ill would improve: in reality, stigma remains a major problem impeding reintegration of people with mental illnesses such as schizophrenia;
- adequate accommodation options would be available for hitherto 'long-stay' mental hospital patients, whereas, in reality, housing options remain very limited;
- mainstreaming with general health services would improve the medical care of people with mental illnesses: in fact, hospital emergency departments generally do not deal well with the mentally ill and, overall, medical illnesses among this group remain underrecognised and undertreated;
- community care would result in a massive drop in the requirement for acute beds, whereas, in reality, bed pressure is a major ongoing problem within the system as a whole;
- the new model would be cost-effective, whereas it is probably, if anything, more expensive than the old institutional model.

Thus, overall expectations have in many cases not been met. In part this was because (and no one is specifically to blame) the expectations were themselves unrealistic. Nevertheless, the field needs to acknowledge and respond to the burden of resentment among many patients, families and also staff of the mental health system regarding what they see as 'broken promises'.

Conclusions

In the end, I believe that the overall direction of mental health services in Victoria is correct, and affords better care and quality of life for people with a mental illness. However, the system needs to remain adaptive to existing and new challenges. In this, particular attention should be paid to overall coherence of the model and excellent interagency collaboration, ensuring appropriate longitudinal care in an integrated system and encompassing the needs of patients and their families as well as those of the mental health workforce.

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