Why are community psychiatry services in Australia doing it so hard?

Bruce S Singh and David J Castle

A fundamental paradox appears to have arisen in the 15 years since the National Mental Health Policy was implemented in Australia in 1992.[1] This paradox is the dissonance between the perspectives of mental health professionals and patients on the one hand and the general public on the other, on the success or otherwise of the deinstitutionalisation components of the policy. Many mental health professionals find operating in a "least restrictive" manner enables a broader and more humanitarian model of practice, and most patients of the system who experienced the institutionalisation era report an enhanced quality and enjoyment of life living in the community.[2] However, to many within the mental health system and many who interact with it, there are ongoing frustrations and difficulties with the new approach.[3] Indeed, many experts, individuals, bodies and politicians are calling for an abandonment of the policy. Some are even suggesting reinstitutionalisation in the interests of patient and community safety.

How could a policy greeted with such enthusiasm and embraced by so many of the stakeholders be now so soiled and devalued that many would wish to throw it out? And what are the possible alternatives? In this article, we examine the overt and underlying assumptions which have driven community care reforms in psychiatry in the developed world, including Australia over the past half a century. We also examine the limitations of those assumptions that have come to light over this period. We concentrate on adults with enduring mental illness. This does not prejudice against strategies aimed at prevention and early intervention for mental illnesses; it is just that such strategies have not yet brought about a major reduction in the numbers of individuals living with disabling chronic mental illness.

ABSTRACT

- Since the National Mental Health Policy was implemented in 1992, dissonance between mental health professionals and the general public on the success of the deinstitutionalisation components of the strategy has grown.
- Many of the premises on which the deinstitutionalisation components were based are false, and this has led to many problems in the system.
- Community psychiatry is not fundamentally flawed, and what has been learned in the past 15 years can be used to build on the foundations that have been laid.
- Better cooperation between state and federal governments is needed to effect real change.

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Assumptions and limitations of the community psychiatry model

It seems clear that, laudable as the goals of the National Mental Health Policy were, they never "promised" as much as appears to have been expected of them. Even though deinstitutionalisation was only one of 12 areas covered in the policy, it has come to be seen as the cornerstone of the policy despite the fact that most long-stay beds had been closed in the 30 years before 1992. However, there is also little doubt that the deinstitutionalisation programs were "sold" to key stakeholders on the basis of a number of premises which were often simplified and overstated. Here we outline some of these premises, and explore their veracity with the experience of hindsight. We should stress that the premises were often neither explicitly stated nor "evidence-based"; rather, they reflected the then-current zeitgeist in Australia regarding community care for people with serious mental illnesses, mirroring to a greater or lesser extent the experience of deinstitutionalisation in the United States and United Kingdom.

The premises

- Psychotropic drugs will control most or all of the psychotic symptoms associated with mental illness, allowing the vast majority of affected patients to return to normal life in the community.[4]

Reality: While advances in psychopharmacology have been spectacular in the past 50 years, antipsychotics continue to offer only partial control of the full range of psychotic symptoms, and only if they are taken regularly and consistently. In fact, many people with disorders such as schizophrenia, even if "adequately" medicated, do not return to full social functioning, but remain significantly impaired in areas such as relationships, living conditions and vocation.[5]

- As a result of treatment, patients will gain insight into their illness and adhere to treatment guidelines.[6]

Reality: "Insight" is not an all or none phenomenon.[7] While insight into the fact of illness may be better, lack of insight into the need for medication is a particular problem, and non-adherence is a potent cause of relapse, with consequent requirement for acute hospitalisation.[8]

- Intensive case management will only be required for limited periods and patients will be able to incorporate the gains achieved during these periods to reduce relapse.[9]

Reality: For many patients, high-intensity case management needs to be continuing and long-term; the benefits may dissipate when such management is withdrawn.[10]

- As a result of insights gained about the effect of substance misuse on their symptoms, patients will be able to modulate their intake, even in communities in which availability and acceptability of use of both licit and illicit substances is increasing.[11]

Reality: People with illnesses such as schizophrenia are at much higher risk than the general population of ongoing use of substances, particularly illicit substances.[12] This in turn leaves them particularly vulnerable to relapse of illness, and to general psychosocial decline, including itinerancy, homelessness, and of falling out of contact with treatment agencies.[13]

- Over time, the community will show increasing acceptance and tolerance of the presence of significant numbers of mentally ill people in their midst, accepting that their human rights need to be honoured.[14]

Reality: Stigma regarding mental illness remains an omnipresent problem in the general community, with substantial community

backlash if a person with a mental illness, for example, acts in an "abnormal" manner, or perpetrates a crime.[15]

- With increasing numbers of people now living more fulfilling lives in less restrictive environments, the community and the media will be more tolerant when individuals with mental illness transgress community or legal norms.[15]

Reality: People with an untreated or partially treated mental illness are more likely to engage in illegal activity, and the prison system has an over-representation of people with a mental illness.[16]

- Adequate safe accommodation options will be provided for those no longer living in long-stay institutions, but who do not require acute hospitalisation.[17]

Reality: There is a chronic shortage of appropriate housing for people with a major mental illness, and many languish in sub-optimal conditions or are homeless.[5]

- Moving the care of the mentally ill from institutions to the community will reduce the stigma they experience within the general health sector, which will acknowledge and meet their needs.[18]

Reality: The mentally ill are over-represented in general hospital emergency departments, often because they are forced to seek help "in crisis" as a result of lack of early intervention services.[19] Also, the severely mentally ill carry a grave burden of physical health problems, including diabetes and cardiovascular problems; these health problems are often not adequately managed, and they result in premature mortality.[20]

- Effective community service will reduce the need for acute mental health beds, and virtually eliminate the need for long-term adult psychiatric beds.[21]

Reality: There is ongoing intense pressure on acute beds,[19] continuing need for midterm (step-up or step-down beds), and greater-than-expected need for some long-term psychiatric beds.[21]

- Demand for mental health services will remain stable or increase only gradually.[22]

Reality: Increased awareness in the general community, as well as greater community expectation of what will be provided, have led to much greater non-specific demand on mental health services.[23]

- The cost of the community care service model will be constrained by limiting service to the "severely" mentally ill (essentially those with psychosis and the most severe of the high prevalence disorders), with treatment of most other mental health problems being left to private psychiatrists and general practitioners.[24,25]

Reality: Increasing numbers of those whose illnesses are too severe or complex for private system care, or who cannot access the private system because they have limited or non-existent private health insurance, are being left to fall between the cracks in terms of service provision.[26] This has led to increasing dissatisfaction by patients, their families and their doctors.

Are there solutions?

As we have outlined above, there are many problems with the current arrangements for mental health services, but is it a system beyond repair? Have the reforms failed or has the ability to implement them been thwarted by the reality of the underlying assumptions? Would it be better to now refine the assumptions and modify the system to deal with the reality of mental illness as it is today rather than causing the pendulum to swing back to the post, or even sideways?

We argue that the policy of deinstitutionalisation was fundamentally right in that it sought to treat people in an environment which is as "normal" as possible. The acid test is whether people with a mental illness are indeed happier under this new system compared with the old institutions, and the evidence suggests that this is the case.[2] It would seem, then, that we should accept the fundamental thrust of the approach, but refine the system to better deal with the deficits we have outlined.

The system is clearly underfunded for what it is expected to provide. The delivery of mental health services in the community is highly labour-intensive, often depending on one-to-one interactions between professionals and patients. New technologies have not reduced this burden as they have in other parts of the health care system. Unless funding is significantly increased, it might be best to revert to a minimalist system, providing only welfare care for most patients, and diverting scarce community resources in a targeted manner to those who will benefit most (eg, "revolving door" patients).[27]

A continuing major deficit is in providing a gradation of accommodation options for people with a mental illness, with levels of input from clinical and non-clinical staff that are relevant to the particular needs of individuals at their particular stage of illness recovery. Many of these grades of accommodation can be provided at a much reduced cost if they are run and staffed in conjunction with the non-government sector.[21]

Better continuity of care and integration of different components of the mental health system, as well as other service delivery agencies, including general practitioners, the private sector, non-government psychiatric disability and rehabilitation organisations, vocational and other services, can only be achieved by empowering patients and their familles to negotiate this complex set of systems more effectively.[28] As part of this process, the physical health care of people with a mental illness, with appropriate monitoring and interventions, needs more consideration.

There is also a need for specific or enhanced programs for individuals with particularly complex sets of symptoms and disabilities, such as psychosis and substance misuse, or severe personality disorders. It seems that caring for such people would be most appropriately arranged in an integrated manner rather than resorting to boutique stand-alone services, as continuity of care is vital. In particular, there needs to be much better integration between the drug and alcohol and mental health sectors and between the legal system and the mental health system, with appropriate use of diversion schemes facilitating better transition back to the community from institutions or prisons.

Conclusion

While many of the original assumptions underlying community psychiatry were not valid, we believe that the premise underpinning community psychiatry is not fundamentally flawed. We should continue to build on the foundations that have been laid, while designing new components that can take the old and new realities into account. A better working alliance between the state and federal governments is needed to effect real change. The Council of Australian Governments initiatives for mental health[29] are a welcome step forward in this context. In particular, the new arrangements within Medicare, allowing non-medical mental health professionals to be reimbursed for their services, is an important potential step towards meeting the psychosocial needs of people with a mental illness. Such initiatives need to be

balanced by enhancements at state and territory level to ensure more effective and more uniform approaches to the comprehensive treatment of a most vulnerable group within our society.

Competing interests

None identified.

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References

1 National mental health policy. Canberra: Australian Government Publishing Service, 1992.
2 Leff J. The outcome for long-stay non-demented patients. In: Leff J, editor. Care in the community: illusion or reality? Chichester, West Sussex: Wiley, 1997: 69-91.
3 Harvey CA, Fielding JM. The configuration of mental health services to facilitate care for people with schizophrenia. *Med J Aust* 2003; 178 (9 Suppl): S49-S52.
4 Hale T. Will the new antipsychotics improve the treatment of schizophrenia? *BMJ* 1993; 307: 749-750.
5 Jablensky A, McGrath JJ, Herrman H, et al. Psychotic disorders in urban areas: an overview of the Study on Low Prevalence Disorders. *Aust N Z J Psychiatry* 2000; 34: 221-236.
6 Oehl M, Hummer M, Fleishhacker WW. Compliance with antipsychotic treatment. *Acta Psych Scand Suppl* 2000; 407: 83-86.
7 David AS. Insight and psychosis. *Br J Psychiatry* 1990; 156: 798-808.
8 Kemp R, Kirov G, Hayward P, David A. Randomised controlled trial of compliance therapy. *Br J Psychiatry* 1998; 172: 413-419.
9 Bachrach LL. Lessons from the American experience in providing community-based services. In: Leff J, editor. Care in the community: illusion or reality? Chichester, West Sussex: Wiley, 1997: 21-36.
10 Dixon L. Assertive community treatment: twenty five years of gold. *Psychiatr Serv* 2000; 51: 759-765.
11 Ziedonis DM, Trudeau K. Motivation to quit using substances among individuals with schizophrenia: implications for a motivation-based treatment model. *Schizophr Bull* 1997; 23: 229-238.
12 Cantor-Graae E, Nordstrom LG, McNeil TF. Substance abuse in schizophrenia: a review of the literature and study of correlates in Sweden. *Schizophr Res* 2001; 48: 69-82.
13 Dixon L. Dual diagnosis of substance abuse in schizophrenia: prevalence and impact on outcomes. *Schizophr Res* 1999; 35 Suppl: S93-S100.
14 Warner R. Community attitudes towards mental disorders. In: Thornicroft G, Szmuckler G. editors. Textbook of community psychiatry. Oxford: Oxford University Press, 2001.
15 Penn DL, Guynan K, Daily T, et al. Dispelling the stigma of schizophrenia: what sort of information is best? *Schizophr Bull* 1994; 20: 567-577.
16 White P, Whiteford H. Prisons: mental health institutions of the 21st century [editorial]? *Med J Aust* 2006; 185: 302-303.
17 Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care. *Br J Psychiatry* 2004; 185: 283-290.
18 Blashki G, Judd F, Piterman L. Textbook of general practice psychiatry. Sydney: McGraw-Hill, 2006.
19 Knott J, Pleban A, Taylor D, Castle D. Mental health presentations to the emergency department. Melbourne: Victorian Government Department of Human Services, 2005.
20 Lambert TJ, Velakoulis D, Pantelis C. Medical morbidity in schizophrenia. *Med J Aust* 2003; 178 (9 Suppl): S67-S70.
21 Boston Consulting Group. Improving mental health outcomes in Victoria: the next wave of reform. Melbourne: Boston Consulting Group, 2006.
22 Australian Health Ministers. National mental health plan, 2003–2008. Canberra: Australian Government Department of Health and Ageing, 2003.
23 Whiteford HA, Buckingham WJ. Ten years of mental health reform in Australia: are we getting it right? *Med J Aust* 2005; 182: 396-400.
24 Knapp M, Beecham J, Hallam A. The mixed economy of psychiatric reprovision. In: Leff J, editor. Care in the community: illusion or reality? Chichester, West Sussex: Wiley, 1997: 37-47.
25 The world health report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization, 2003.
26 Parliament of Australia. Senate Select Committee on Mental Health. A national approach to mental health — from crisis to community. First report. 30 March 2006. http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/report/index.htm (accessed Aug 2007).
27 Preston NJ, Fazio S. Establishing the efficacy and cost effectiveness of community intensive case management of long-term mentally ill: a matched control group design. *Aust N Z J Psychiatry* 2000; 34: 114-121.
28 Castle D. Improving people's lives: the balance between biology and psychosocial intervention research for the functional psychoses? *J Ment Health* 2004; 13: 229-233.
29 Australian Government Department of Health and Ageing. Council of Australian Governments. COAG mental health. http://www.health.gov.au/internet/wcms/publishing.nsf/content/coag-mental-index.htm (accessed Aug 2007).

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