Failure to Launch – Community Mental Health in Australia

Introduction

Australia can point to repeated evidence ranking its health care system as one of the most effective in the world [1]. However, such assessments typically do not take mental health care into account. More recent analysis of international comparative data suggests the performance of Australia's mental health system is mixed at best [2]. One of the key reasons for Australia's mixed performance has been the limited commitment to community mental health care.

As this article will demonstrate, despite early promising beginnings, Australia's approach to mental health care has become increasingly fragmented and chaotic. While responsibility between governments is clear in relation to primary and tertiary levels of care, secondary care, typically provided in the community, has languished. As a result, for people with mental health problems too complex for primary care, there is often little choice but to go to hospital to seek care and they may not receive community mental health services unless they are either acutely or severely unwell. A recent Victorian Auditor General report confirmed that area public mental health services only see "the most unwell" people, creating significant service problems in other parts of the mental health 'system' [3]. A national approach to hospital avoidance and early intervention in the community has failed to emerge. There are large service gaps.

This article will review how this situation has developed. It will first provide an overview of the complicated arrangements by which Australia's nine

governments share responsibility for different aspects of mental health care. The article will then give an overview of Australian developments in community mental health care, particularly in the early stages of national commitment to mental health policies and plans.

We will then provide an explanation of the current problems affecting community mental health care in Australia, and point to some of the key issues to be resolved if progress is to be resumed. There is little doubt that the development of a robust and well-organised system of community mental health care is central to future national mental health reform efforts.

Responsibility for Mental Health Care in Australia

It is not possible to understand the Australian context without some appreciation of the political system.

There are eight state or territory governments and one federal (national) government. Responsibility for health care, including mental health care is split,

with the federal government responsible for Australia's national system of public health insurance, the Medicare Benefits Scheme (MBS), and for the Pharmaceutical Benefits Scheme (PBS) which subsidises medications. The MBS covers primary and allied health care in the community, particularly those services provided by general practitioners. By contrast the states and territories manage hospital-based health care, including emergency, inpatient and outpatient services. Australia's constitution provides the states and territories with autonomy in relation to health care, including mental health [4]. This has given rise to some variation between jurisdictions. The mental health system of New South Wales looks different to that of Victoria. Part of this is about how jurisdictions respond to their geography and demography. But this variation also reflects policy, funding and service choices made over time.

Despite these regional differences, it is possible to see some important national trends in relation to community mental health in Australia. These will be the focus of this article.

Background

Australian community-based mental health care developed gradually in the twentieth century, especially after World War 2 [5]. This period saw the uncoordinated development of community clinics as well as community psychosocial support services, emerging from the charitable and welfare sectors. Australia was one of the first countries to embark on a national mental health strategy. The first National Mental Health Policy was published in 1992 [6]. This progressive document referred to several key principles, including the rights and civil liberties of consumers and carers. A key goal of this Policy was to enable the

states and territories to close the long-term psychiatric institutions, permitting people with persistent mental illness to instead live in the community. For this to occur, it would be necessary to close the old asylums and replace them "with a mix of general hospital, residential, community treatment and community support services" [6].

In order to implement this Policy, Australia has subsequently agreed to five national mental health plans, the latest of which was signed by all jurisdictions in 2018 [7]. A second national Policy was also produced [8].

Despite this apparent commitment to reform, it is worth noting that in 2017-18 there were still 1613 beds in psychiatric hospitals spread across five Australian states, costing $565m or just under 10% of total state spending on mental health in Australia. Half of the remaining institutional beds are in one state, New South Wales (NSW) [9].

It is also worth noting that the current 5th National Plan does not provide a definition of community mental health care and does not refer at all to the term 'hospital avoidance'. Recent changes to the way health services are funded have compounded the confusion surrounding the ultimate goal of mental health reform in Australia. The application of tools such as Activity Based Funding has been seen by some to incentivize admitted care over other forms of care, including in relation to community mental health [10]. Some have even suggested that a core problem facing Australia is in fact a lack of acute mental health hospital beds [11]. Across Australia, the average length of stay in a mental health unit at a public hospital has been reducing. It was 15.1 days in 2010-11 and only 13.1 days in 2017-18 [9] which arguably provides some support for the latter assertion.

As a final contextual matter, it is important to understand that despite repeated policy concern and attention since 1992, expenditure on mental health was 7.3% of total health spending in Australia in 1992-93 and 7.6% 2017-18 – largely unchanged [12]. Australian data suggests mental illness represents around 12% of the total burden of disease. While this gap between disease burden and expenditure may not explain everything, it surely suggests one key reason why Australia has found it so difficult to sustain mental health reform.

Community Mental Health in Australia

In the absence of a nationally agreed approach to community mental health, different perspectives or models have emerged. From the point of view of most states and territories, community mental health services are typically comprised of health professionals working in teams. These services, which might include psychiatrists, clinical and registered psychologists, mental health nurses, allied health professionals (occupational therapists, social workers for example) and others, operate under a variety of names such as:

- community crisis teams
- home care teams, such as those based on the Assertive Community Treatment model
- early psychosis intervention teams
- youth mental health teams
- residential rehabilitation units

Effective community-based treatment typically entails: ready access to 24-hour crisis intervention and ongoing care, assertive and intensive community case management, professionally supervised residential treatment and rehabilitation in the community as an alternative to confining people to psychiatric institutions and real recovery-oriented vocational opportunities for individuals with mental illnesses [13].

There is evidence to suggest that community-centred health care of this nature is both more cost-efficient and cost-effective than hospital-centred care, particularly where community services are physically placed in the community and linked closely to both primary health care and hospital-based services [14].

In addition to this rather clinical definition, consumers (service users) and carers in Australia have also repeatedly expressed their views about a more holistic vision for the role community mental health care should play [15], including:

- 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, and supporting accommodation and fulfilling employment opportunities and other social and recreational 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.

Table 1 below shows state and territory spending on mental health care since 2007-08, by the percentage each key service component represents of total spending. Some trends are clear. The first is that spending on public acute services is an increasingly important element of spending nationally, now accounting for more than 35% of all spending. There are jurisdictional differences which are further highlighted when considering public psychiatric hospitals as well as mental health services provided in general public hospitals. For example, in 2017-18 NSW spent 54% of total mental health expenditure on admitted care, Victoria only 34%. The states also vary markedly in their approach to community residential spending.

Table 1 – Variations in % Expenditure between Australian States and Territories Across Key Mental Health Service Components

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust Average*
Public psychiatric hospital									
2017-18	14.6	4.0	6.9	10.9	15.0	–	–	–	9.4
2011-12	17.0	4.0	10.9	15.3	18.6	-	-	-	11.9
2007-08	17.5	4.9	12.5	16.9	29.2	-	-	-	13.5
Public acute hospital									
2017-18	39.7	30.5	31.5	35.3	30.6	28.9	37.3	37.1	34.3
2011-12	36.5	27.1	30.0	28.8	21.5	37.7	24.5	32.9	30.7
2007-08	32.9	27.5	35.7	28.3	21.8	37.1	26.7	33.5	30.6
Total admitted patient									
2017-18	54.2	34.5	38.3	46.2	45.6	28.9	37.3	37.1	43.7
2011-12	53.5	31.1	40.9	44.0	40.1	37.7	24.5	32.9	42.5
2007-08	50.3	32.5	48.2	45.2	51.0	37.1	26.7	33.5	44.1
Community residential									
2017-18	0.5	14.1	4.0	3.7	7.3	25.5	10.5	10.0	6.2
2011-12	0.9	16.2	-	3.7	5.4	18.5	13.9	3.1	5.6
2007-08	1.5	16.3	-	2.3	2.3	21.0	12.4	1.3	5.7
Ambulatory									
2017-18	32.4	37.0	44.7	38.7	37.6	30.8	41.4	41.6	37.3
2011-12	35.7	38.9	45.0	41.3	42.2	31.9	44.7	47.9	39.7
2007-08	35.9	37.8	40.1	43.7	35.8	31.7	45.2	47.1	38.3
Non-government organisations									
2017-18	7.0	8.0	7.3	5.8	6.8	11.0	7.9	7.5	7.3
2011-12	5.0	8.3	7.8	5.5	9.8	6.1	13.3	7.3	6.9
2007-08	5.8	8.2	6.3	5.3	8.9	5.1	10.2	11.0	6.8
Indirect									
2017-18	5.8	6.3	5.6	5.5	2.7	3.8	2.9	3.9	5.5
2011-12	4.9	5.5	6.2	5.5	2.5	5.9	3.5	8.8	5.2
2007-08	6.4	5.2	5.3	3.4	2.1	5.2	5.5	7.0	5.2

Ambulatory services also vary between jurisdictions. However, analysis here is complicated by the fact that this label in fact refers to a mix of services, including those provided in a range of hospital outpatient clinics, telephone calls, community visits and other matters. It is not possible to clearly divide those services listed as 'ambulatory' between those actually provided at hospital versus those genuinely available in the community or people's homes.

While the percentage of total expenditure associated with ambulatory services has gone down over the past decade, the number of recorded services has grown appreciably, from 5.66m in 2005-06 to 9.7m services in 2018-19.
However, the proportion of these ambulatory services taking less than 15 minutes per client has risen over this same period from 38.6% in 2005-06 to 44% and overall, the average duration of each recorded community mental health service has declined from 45 minutes to 35 minutes [16].

Interactions of this brevity suggest that an increasing proportion of so-called ambulatory care is in fact short, regular visits by patients to hospital outpatient clinics or telephone calls rather than home visits or genuine community-based care. These data may reflect workforce capacity restrictions and growing demands on overstretched services highlighted elsewhere [3]. They may also be consistent with recent trends in some jurisdictions, such as Victoria, to provide fewer home care and outreach services in the form of Assertive Community Treatment.

Table 1 above also clearly demonstrates the peripheral nature of non-government organisations (NGOs) as part of the mental health service landscape. Unlike other places, for example New Zealand where spending on NGOs has been as high as 30% of total expenditure on mental health [17], in Australia this sector has languished at around 7%. This has deprived Australia of a range of psychosocial rehabilitation and support services, as alternatives to or as a means of minimizing prolonged or avoidable hospitalization. One explanation for this stunted growth is the early split between clinical and psychosocial support services which occurred in Australia, which arguably led to greater fragmentation of community-based services and less visibility for the important complementary role of these support services [18].

One practical manifestation of this split has been Australia's reluctance to invest in a peer workforce in mental health. While these roles have become commonplace in other countries [19], here in 2017-18 consumer workers in paid roles represent just 6.4 out of every 1000 full time equivalent employees in mental health, and carer workers 2.4 out of every 1000 [9]. Australia's response to mental illness continues to depend heavily on trained health professionals.

Again, unlike other countries [20], Australia maintains quite a strict and unhelpful delineation between clinical and non-clinical mental health services, with separate professional training arrangements. This makes holistic, comprehensive, and multidisciplinary care less likely.

In addition to the state and territory resources described above, the Federal government had begun to demonstrate greater interest in community mental health.

Since 2006 the Federal government has made a large investment in public access to psychology services (now costing around $16m a week [21]) and in other programs like the Partners in Recovery Program and Personal Helpers and Mentors which aimed to improve access to, and coordination of, community-based services for Australians with mental health problems [22].

However, investment in community mental health by all Australian governments has now been affected by the implementation of the National Disability Insurance Scheme (NDIS). Akin to Australia's investment in a national public health insurance scheme (Medicare), the country recently chose to address the lifelong costs associated with permanent and severe disability through a similar national insurance arrangement. Mental health was a late addition to the discussion about how to design the National Disability Insurance Scheme (NDIS). Its eventual inclusion has not been straightforward.

Of most relevance to this analysis however was the decision by all nine governments (state and federal) to shift the funding associated with psychosocial mental health support services to the NDIS, as part of setting the new scheme up. As stated earlier, Australia's psychosocial support service sector has always been a marginal element of the service landscape. Even in places like Victoria and the ACT, where the investment was appreciably larger than in other jurisdictions, at their zenith these services only represented around 15% of total spending on mental health care. In NSW, it was more like 7%. However, the vast bulk of this spending has now been transferred to the NDIS and then to individualized care packages.

Community-managed organisations, some of which had been providing psychosocial community support services in Australia for decades, found that without the traditional block funding arrangements, they were not able to offer sustainable employment contracts to their staff. Ironically, while the NDIS has brought more and new funding to disability services, its impact in mental health care at this stage has been to lessen choice and availability of specialist psychosocial services, excluding some with manifest psychosocial disability.

Where to from here?

Mental health remains a critical area of political and community concern in Australia, with widespread appreciation of systemic deficiencies. Mental health is surely one of the most investigated areas of public policy in Australia. There were 32 separate statutory inquiries into mental health between 2006 and 2012 alone [23]. With three current Royal Commissions and one Productivity Commission inquiry underway, this trend continues.

A common finding of these past inquiries has been chronic underfunding of community-based mental health services. The 2006 report by the Australian Senate for example suggested in response to this finding that Australia build around 200 community mental health centres [15].

While it is possible to point to some of these major trends affecting the development of community mental health services across Australia, again it should be stressed that the picture varies between jurisdictions. At some periods, most Australian jurisdictions have established some level of community mental health care.

However, this has been uneven, uncoordinated and unsustained. Hospital-centred services continue to dominate mental health care services in Australia. This has implications for our mental health workforce and whether they have the training, skills and attitudes and motivation required to work in community settings [24].

While the Australian community and successive inquiries have identified the need for much greater investment in community mental health services, blending both clinical and psychosocial elements of care, the prevailing reality of 'community-based care' is limited, increasingly restricted to brief episodes, and overly clinically focussed when compared with the needs and expectations of the community. There is evidence of a retreat from, or even dismantling of, community mental health services [14]. Too many services are being collocated with hospitals or provided out of hospitals, rather than in community settings. Opportunities for early intervention are lost.

Perhaps the first and most important thing Australia can do to arrest this costly and often traumatic situation is to re-assert the vision originally described in 1992, of a shared goal to enable people with mental illness to wherever possible, live with dignity in the community. Re-dedicating our policy and funding effort in mental health towards this shared goal would see home and community-based mental health care prioritised above hospital-based care. It would also see a better balance established between people's clinical and psychosocial needs [25] with the emphasis being on earlier intervention.

To this renewed vision should be added more practical pathway-type data, clearly demonstrating when and how community mental health care fits with primary and tertiary care. This is not available now in Australia, and this lack of role clarity contributes to the vulnerability of community mental health services. The recent reallocation of responsibility for mental health planning to regional networks in Australia offers some new opportunity to develop this pathway [26].

However, reform must be supported by the right financial incentives, enabling community care to be prioritised over hospital-based mental health care and waiting times in Emergency Departments. Indeed, this would recognise that good community care can decrease re-admissions to hospital [27]. Regional reform must also seek to integrate funding from different sources, including the National Disability Insurance Scheme, in order to ensure that all components of community mental health care are available and can flourish.

Lastly, it would be prudent to ensure that this new prioritisation of community mental health was supported by an effective and comprehensive process of accountability and governance [3]. Current systems are weak and do not permit a detailed understanding of the impact of care on the patient's quality of life [28]. For the purpose of impelling systemic quality improvement in mental health, it is vital service providers can determine whether the care provided has resulted in effective outcomes and recovery.

More than 25 years after Australia's first national mental health plan was produced, the establishment of a vibrant community mental health system remains Australia's greatest and most urgent challenge.

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