5. PROVIDING THE RIGHT TYPE OF CARE

5.1 Shift to community

Hospital-based mental health care, including acute and crisis care, is one part of a good mental health system, but it should be accessed only when community-based support is not feasible. This approach is consistent with our human rights obligations and our NSW 2021 goal of keeping people out of hospital and well in the community. It also makes good economic sense in terms of having a sustainable health system. But we have a long way to go to achieve this.

NSW remains overly reliant on hospitals in the delivery of mental health care, spending less per capita on community mental health care than any other state or territory. While funding for community mental health care in NSW has increased, most mental health sector spending occurs in expensive acute hospital settings.

In 2011-2012, almost 54 per cent of the NSW Government’s mental health budget was spent on inpatient services in public psychiatric and acute hospitals. Only 36 per cent was spent on community mental health care and hospital-based ambulatory care settings. Less than 1 per cent was spent on specialised community residential services such as crisis and respite places, community residential units and tenured housing.

Similarly, there has been limited investment in psychosocial rehabilitation and support services often provided by the community-managed sector, with NSW having the lowest rate of expenditure (6 per cent) of any state on non-government organisations.

The failure to fund and develop community-based services has meant consumers and their families and carers have had limited access to services that would enable people with severe mental illness to live well in their community. This creates a revolving door for consumers. Because there is inadequate care in the community, people are readmitted to hospital. For the mental health system, it creates a vicious circle: the lack of care in the community increases pressure for expensive inpatient mental health care, which draws more money from community-based services.

The present situation often leads to people being ‘lost’ to follow-up care in the community after a hospital admission. This can result in tragedy as seen all too commonly in the stories of those who become forensic patients and those who complete suicide after discharge.

Another perversity is that for those who do need hospital care, the pressure on the system is so great that they receive suboptimal care in quality and duration.

The impact of this system is felt well beyond the individual and their family and carers, and beyond the health system. Failure to provide adequate mental health support in the community leads to crisis and difficulties maintaining continuity of services for those in need that directly impacts on other government agencies and the broader community. Police, ambulance, housing and community services can all attest to the cost of dealing with immediate crisis and the high transaction costs of connecting and reconnecting with a person whose life is regularly disrupted because of inadequate mental health support in the community. Furthermore, even with the best will in the world, in the absence of a strong community mental health service there is nothing for these other government agencies to connect to or partner with.
A rational approach to mental health care in NSW requires that we recognise and interrupt these cycles. Many of those receiving care in hospitals would recover better in community settings. We should admit people to hospital only because they need specialist, inpatient care and support. Admission to hospital should never occur because we have failed to make more effective care available in the community.

The hospital is too often the front door for mental health services. We must urgently make hospitals our last resort. Under this Plan, community-based care and support will become the locus of the mental health system. This is not a new or radical idea and it is fully consistent with the goals of NSW 2021, but we have failed to deliver it. To make a successful transition to a community-centred mental health system, we must break from the gravitational pull of the hospital system.

**A better community-based system**

An effective community system wraps services and support around people living with severe mental illness. This includes mobile treatment and crisis resolution teams and whole-of-person support services with a variety of residential alternatives to hospital. An effective community system also requires strong integration and partnership among clinicians in hospitals and in the community, such as general practitioners, private psychiatrists and other care providers. These partnerships support community clinicians, and GPs in particular, by giving them access to specialist advice. This focus on community and partnership allows the Local Health Districts (LHDs) to make the best use of scarce specialist clinical resources and over time will greatly reduce the demand for hospital admissions.

Under the reforms in this Plan, LHD boards will need to make a clear choice about how to revitalise and build their community mental health system. One option will be for the LHD to retain its community mental health services ‘in house’. But this means boards will need to examine why such approaches have not realised their potential to date. Boards may also embark on more sophisticated and extensive partnerships with the community-managed sector. Or they may embark on public-private models, competitively tendering their community mental health services to private sector providers. Or they may do a mixture of both.

Whatever option is taken, Local Health Districts are responsible under the *Health Services Act 1997* for providing care and treatment to sick and injured people and for the promotion, protection and maintenance of the health of the community.

In the context of the shift to community and contracting out of services, it will be important that any existing service provided directly by the LHDs is not switched off until there is a sustainable alternative. This could be particularly difficult where community-based services depend upon non-recurrent Commonwealth funding – such as for the National Perinatal Depression Initiative for early detection of antenatal and postnatal depression. This was initially funded from 2008 until 2013 and subsequently extended, but without any guarantee about its longer term future.

There are exciting community-based initiatives that we can learn from, such as Tupu Ake in Papatoetoe, New Zealand. It is a peer-led acute service for people struggling with mental illness in the community and provides a real alternative to hospital admission.

The NSW Government has already laid the groundwork for more extensive partnerships with the community-managed sector. NSW Health’s Grants Management Improvement Program will reform the
purchasing of existing community-managed activity and, under modernised contracting arrangements, open up avenues for community-managed organisations to tender for a wider range of services. The reforms include a transition from a system based on grants allocation to one that uses contracts to better align the activities of community-managed organisations with NSW Health priorities and allow closer performance monitoring.

The NSW Health reforms explicitly seek opportunities for services delivered in the public sector to be devolved to the community-managed sector, including the full range of clinical and non-clinical community mental health services.

As government moves towards efficient and high quality services through contracting models, it will be important to ensure the capacity for innovation is not lost. This could happen in particular if the community-managed sector, which has been a source of innovation, becomes entirely responsive to contract specifications.

**Commitment, resources and collaboration**

Developing a contemporary, community-focused, integrated mental health care system will require commitment, human and financial resources, and co-operation and collaboration at the community and state level. We need to strive for a mental health care system that directs energy and resources towards services outside the hospital, delivered close to home. It needs to place greater emphasis on providing support that helps people remain in their communities and avoid hospitalisation.

To achieve meaningful psychosocial rehabilitation in the community, the community mental health service must include step-up and step-down care as an alternative to inpatient admission or to provide support after an acute episode of illness. This will allow hospital services to support community-based care with accessible and responsive service for acute-phase needs requiring hospital stabilisation and care. In turn, community-based care will support hospital services to achieve the best use of their limited beds and scarce specialist clinical resources.

These refocused efforts will result in the better provision of mental health care and will help those with serious mental health problems to participate more fully in community life. A reconfigured mental health system will divert patients from expensive inpatient treatment to less expensive community care and catch mental health problems before they reach a crisis stage. This will increase capacity in the hospital system to meet unmet demand in areas such as eating disorders or specialist care for the young and the elderly.
Essential elements of community mental health

With shared Commonwealth and state responsibility for health services, the delivery of a good community mental health system involves some complexity in achieving a balance.

While mental health service provision operates in a policy-rich environment at both NSW and Commonwealth levels, we lack a clear articulation of what a community mental health system should look like. To start to address this gap, the NSW Mental Health Commission has begun work with NSW Health on an essential care components framework that outlines the necessary elements of community-based mental health care. This will aim to define a 24-hour, locally based, co-ordinated and seamless community mental health system comprising primary care and specialised community-based mental health services. Such a system would reduce the need for hospital admissions and readmissions by allowing people to seek support earlier.

Given the challenges inherent in a state the size of NSW, we cannot provide the same level of services everywhere. But we need to know what is required in order to find innovative ways to meet the need. For community-based care to be effective, we must ensure:

- easy access and availability of services
- co-ordination and continuity of care
- early detection and intervention
- evidence-based medical and psychological treatments
- safety and risk management
- acute and emergency interventions
- rehabilitation approaches that support social inclusion
- opportunities for learning, employment, housing and social relationships.
Actions

5.1.1 Rebalance our mental health investment to transform NSW from the lowest spending to the highest spending Australian jurisdiction, per capita, on community mental health by 2017. This will involve:

- The NSW Ministry of Health directing all mental health growth funding to community mental health.
- The NSW Ministry of Health using its service agreements with Local Health Districts to purchase greater community activity volumes to rebalance existing investments.
- Local Health Districts adjusting the mix of local services to achieve the rebalancing required and reporting regularly on activity levels and against service performance measures established with the NSW Ministry of Health
- Local Health Districts forging new partnerships with community-managed organisations and/or the private sector to: coordinate mental health care in the community; leverage and integrate with general practice, and private psychiatry and psychology; and explore opportunities for new models and service arrangements that offer efficiencies and meet the needs of people with mental illness and their families and carers.
- The NSW Ministry of Health providing leadership to the reforms through the articulation of a new framework for a contemporary NSW community mental health system, underpinned by recovery-oriented values.
- Supporting the development of innovative community-based alternatives to hospital admissions. This could include the use of social benefit bonds and other mechanisms.

5.1.2 Local Health Districts will work with the National Disability Insurance Agency to ensure that eligible people with a psychosocial disability obtain packages under the National Disability Insurance Scheme.
5.2 De-institutionalisation

In the 19th and the early 20th centuries, ‘asylums’ were the main place of care for people with severe mental illness. These institutions isolated people with mental illness from the outside world, subjected them to dehumanising, prison-like routines and stripped them of any identity beyond that of psychiatric inpatient.88

Now the detrimental effects of institutionalisation are well recognised. As the World Health Organisation stated more than a decade ago: “Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost effective and respects human rights”.89

In 1983, David Richmond led the NSW Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled. That inquiry recommended that a gradual process of de-institutionalisation begin in NSW. Long-stay psychiatric hospitals were to be gradually reduced in size and replaced by “a system of integrated community-based networks, backed up by specialist hospital or other services as required”.90 However, while some long-stay psychiatric units were subsequently closed, the community-based networks have not been fully developed.

Long-term institutionalisation is a continuing practice. In February 201491, there were 2337 mental health inpatients in the NSW public health system and a quarter of them, or 566 people, had been in hospital for more than a year. About 87 per cent of these long-stay patients were accommodated in older, stand-alone psychiatric institutions known as Schedule 5 hospitals. In its response to the 2012 report by the NSW Ombudsman, Denial of rights: the need to improve accommodation and support for people with psychiatric disability92, the NSW Government has already committed to resolving the systemic issues leading to these circumstances, and to developing appropriate care plans to support these individuals’ transition into the community. But there is still a long way to go and the process of de-institutionalisation must address the community-based support services needed by each individual.

Into the community

With the right community-based support, including that offered under the National Disability Insurance Scheme, the vast majority of long-stay patients in NSW will be able to return to live in the community. Some will require supported, community-based accommodation, such as that offered under the Housing and Accommodation Support Initiative. A minority will require long-stay care in a safe, supported environment, outside an institutional setting.

If this is to be done effectively, government will need to consider transition funding to allow the timely provision of community-based alternatives. This funding would be recouped in the medium term from recurrent funding now going into Schedule 5 hospitals and long-stay beds. If any recurrent savings come from the closures, they must be used to expand community-based mental health services. If this does not occur, we risk repeating the mistakes of the past where much of the money disappeared out of mental health.

Similarly, if it is necessary to develop purpose-built accommodation as part of the move to the community, funding would be required for that. In the longer term this should be recouped as noted below from the realisation of the existing sites.
The mental health workforce also needs to be considered in the closure of these institutions. Staff may be displaced and we can’t afford to lose their expertise. For those who choose to move to community-based services, NSW Health will need to ensure they have access to the training and transitional support required to work in the community-based mental health sector of the future.

**Reinvesting in mental health**

The question of what happens to the sites of the remaining Schedule 5 hospitals, once they are no longer required, is important. These institutions represent a misguided investment in mental health but an investment nonetheless. They were places of great suffering for people with mental illness. Much of this suffering is recent and many in our community remain traumatised by their experiences. There is therefore a strong moral argument for the Government to ensure that any funds raised from their sale or re-use are used solely to address the substantial remaining need for community-based alternatives to hospitalisation, including for those in our community who require continuing care after their experiences of these institutions. This would not preclude some re-use for appropriate commemoration of the history of the sites.

The Schedule 5 hospital sites remaining in NSW include Gladesville, Kenmore (54 beds), Morisset (130 beds), Macquarie (195 beds), Cumberland (261 beds) and Bloomfield at Orange (235 beds). Not all these beds can be lost to the mental health system. For example, the capacity of the forensic units at Morisset and Cumberland would need to be replicated elsewhere if these sites were to be closed. In addition, these sites house services run by other areas of NSW Health (ranging from education to linen facilities) as well as other government and community-managed organisations. The re-location of these would need to be factored into any site closures.

The controversial closure of Rozelle Hospital, known as Callan Park, demonstrated that any decision about realising the economic value of a site needs to involve respectful engagement with people with lived experience of mental illness, families, carers, clinicians and the broader community. Ensuring total transparency about the use of any capital obtained through the sale or re-use of these sites will be required.
Actions

5.2.1 NSW Health, in partnership with the NSW Department of Family and Community Services, should complete the work of finding appropriate community accommodation and support for individuals still in long-stay psychiatric institutions by 2018. This work should consider the availability of community-based supports to be provided under the National Disability Insurance Scheme.

5.2.2 The recurrent funding which supports individuals in long-stay beds should, in the first instance, be used to provide the appropriate level of community-based or other support for those who are discharged. Any remaining funding should be redirected to expand community-based mental health services more generally.

5.2.3 Any planning process for the realisation of the value of the Schedule 5 hospital assets should:
   - engage consumers, carers, clinical professionals and the local community in the decision making
   - ensure, through a transparent mechanism, that the proceeds of any sale are fully directed to the development of mental health services in accordance with the reform priorities.
5.3 Addressing inequalities

We know that access to the NSW mental health system is not equitable. The pattern of service provision and access is uneven, with some areas apparently reasonably well served by services and staff while others miss out.

People living with mental illness can face significant issues when needing to travel to health services – sometimes because of symptoms associated with their illness and the side effects of medication. This is more difficult where public transport is limited or unavailable, such as in remote and rural areas.93

Others, including those with a mix of complex health problems, find major gaps in access to specialist services and that the system does not connect up all their care needs.

Many of these impediments are interrelated, which means people risk being channelled towards the wrong forms of care or receiving no care at all.

Responding to complexity

There are significant service gaps for:

- people in rural and remote NSW
- Aboriginal people
- young people
- people from culturally and linguistically diverse backgrounds
- lesbian, gay, bisexual, transgender and intersex people
- people with multiple issues, for example, when mental illness and intellectual disability affect each other.

There is a cluster of people with more complex problems, such as eating disorders, who cannot access specialist treatment services and the families of these people say lives are put at risk.94

Families that are poor or have children with other disabilities or health concerns have an especially difficult time getting services that would identify, prevent or treat mental health problems. And many people find it difficult to navigate an often complex health system.

Service systems should be able to respond to the needs of people of all ages but some groups are missing out. There is a lack of mental health services for children and adolescents – and a lack of mental health workers with special training to work with children. Children and young people, whose need for mental health care is greatest, have some of the lowest access to care. For example, only 13 per cent of young men with a mental illness get assistance.95 Even among those who do receive care, many don’t get the most suitable treatments at the most opportune time.

We also know that demand for services for older people is increasing rapidly – 2.8 per cent a year96 – and we do not have the resources to meet this need.

In NSW, great effort has been put in over many years to develop models to guide the distribution and development of services in response to population need. Most recently, the NSW Ministry of Health has led work on the National Mental Health Services Planning Framework. While still in draft, this population-based
planning tool tells us that the distribution of beds across NSW is uneven with some Local Health Districts having high numbers of acute inpatient beds for their population, and others too few. We also know there are not enough beds for specific populations, including the young, elderly and those with particularly complex conditions such as eating disorders. The framework identifies that the greatest gap overall is in community-based services.

**Is the system safe?**

It is not appropriate or possible for uniform service provision to exist in every area or across all age groups. Nonetheless, we should strive for equality of access and quality.

One of the fastest ways to achieve equity is to close the gap between what we know and what we do, and to ensure a consistent approach in service delivery in all mental health services. However, there is evidence of considerable variation in clinical practice. Unchecked, it has the potential to reduce safety, quality, effectiveness and efficiency.

For instance, the seclusion rate for mental health in-patients in NSW hospitals is 6.9 episodes per 1000 bed days. This is the lowest rate since recording began in 2008. However, the statistics exhibit high levels of variability among mental health units, which suggests that not all units are using contemporary good practice and there needs to be more focus on these ‘hot spots’.

While policy, clinical standards and audits have a role in reducing clinical variation, engaging clinicians and information systems and data are the foundation for quality improvement.

The NSW Ministry of Health leads benchmarking initiatives for the public mental health system. Benchmarking provides an opportunity for public mental health services to examine data on their models of care, service usage and outcomes. The intent is to improve the experience and outcomes of care by using routinely collected information to understand variation, learn from services that are doing well and focus efforts on areas that require improvement.

The Agency for Clinical Innovation’s specialty clinical networks engage clinicians and community members to design and support the implementation of models of care which spread best practice in the health system and meet the needs of consumers, and their carers and families. At the instigation of the NSW Mental Health Commission, a Mental Health Clinical Network is soon to be set up.

To improve access, we need an agreed range of service options, in the health and community support sectors. This means providing the right funding to the right places, as well as innovation in service delivery to ensure an appropriate mix of services. For the consumer, this means access to the services they need, when they need them. We can’t simply say everyone has a universal entitlement to access to subsidised medical services under Medicare if people cannot realise that entitlement because there are no GPs in their community.

Strengthening our community mental health system and completing the process of de-institutionalisation will ease some of the pressures on inpatient services and allow existing resources to be refocused to better meet the needs of those missing out. This work should be informed by population-based planning frameworks that specify the mix and level of services required, along with resourcing targets to guide planning and service development based on evidence, such as those contained in the draft National Mental Health Plan.
Health Services Planning Framework. We also need mental health services to work together to achieve the most effective and efficient use of services, minimise duplication and streamline access.

**Actions**

5.3.1 Local Health Districts should implement strategies to ensure that scarce clinical skills are employed to best effect by maximising their face-to-face time with consumers. This could include employing more peer workers and utilising community-managed organisations to provide non-clinical services.

5.3.2 NSW Health should use the draft National Mental Health Services Planning Framework to determine the right level and mix of services to cater for needs at the local level and, over time, redistribute funding in accordance with need.

5.3.3 Local Health Districts should examine their pathways to care and ensure there is reliable and accessible information about these to assist people in navigating the mental health system.

5.3.4 Build on initiatives such as the Mental Health Emergency Care – Rural Access Program to ensure communities have access to the full range of services through improved technology and specialist mental health support of general health services. Community-based services should be provided with advice and support, through good consultation, liaison, and integration of care arrangements.

5.3.5 Consider the development of specialist tertiary referral and advice centres for the provision of care to people who experience serious mental illness, including psychosis, and the treatments for mental illness, such as electro-convulsive therapy.

5.3.6 Support initiatives to track and publicly report on clinical variation in NSW.