Managing Madness: Mental Health and Complexity in Public Policy

Sebastian Rosenberg and Ian Hickie
Brain and Mind Research Institute
University of Sydney
Author contact: sebastian.rosenberg@sydney.edu.au

Abstract

This paper explores the concept of collaborative care, particularly in relation to a range of new models of organisation and service that are emerging in response to one of the most problematic areas of public policy – mental health. These emerging models of coordinated mental health care are testing the limits of the evidence supporting coordinated care, and require critical evaluation. Myriad concepts of collaborative or coordinated care in health, including mental health, have created multiple definitions. Once definitional issues have been surmounted, however, the evidence for coordination of health care is reasonably strong. There is considerable research about which treatments and programs are best for people with a mental illness. There are few areas seemingly as complex as mental health, given that responsibility for policy and service lies across all three tiers of Australian government and across multiple jurisdictions. It also engages public, private and non-government sectors. Co-morbidities are commonplace, particularly drug and alcohol problems among younger people. Governments in Australia have traditionally taken responsibility for policy, programs and services, either as direct service providers or through contracting outputs from others. Yet the evidence indicates that for people with a mental illness, the best solutions are often not found in government but in the community and in organisations outside of government. New organisations and new structures are attempting more holistic management approaches, combining clinical care, community support, housing, employment and other services. This paper considers some of these new models in the light of existing evidence. The key challenge facing continued reform in mental health is not uncertainty regarding programs or services, but rather how to drive coordinated care for consumers across departments, governments and providers. This review will highlight the key changes that must be made for the benefit of the millions of Australians with a mental illness. Such changes need to empower users of care systems to choose options that actively support coordinated and efficient care delivery systems.

> There are too many silos between central, line and operational agencies. Often they fail to recognize that no-one has a monopoly on experience or wisdom. There are too many ambiguities of role between jurisdictions in the crucial interstices of Commonwealth-State responsibilities for health, education, aged care, disability support and infrastructure development. We focus on jurisdictional cost-shifting: citizens listen and hear only blame-shifting.
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> Peter Shergold, 2005

The provision of services to Australians with a mental illness has long been acknowledged as a challenge facing government and non-government agencies alike. The concept of joined-up government is not new (Cabinet Office UK 1999), and the silo mentality of Australian government agencies was also identified some years ago (Latham 1998).

Despite general awareness of the phenomena and risks, little has so far changed, certainly in relation to mental health. A recent report by the Commonwealth Ombudsman, titled *Falling Through the Cracks* (2010), was prepared in response to the common experience of many people with a mental illness. Services or programs

fail to provide the holistic support people with a mental illness need to live well in the community. It might be the gap between hospital discharge and the general practitioner. It could be that the housing provider is not linked to psycho-social rehabilitation support, or a lack of communication between Centrelink and employment support providers. In all such situations the outcome is the same: people with a mental illness get lost in the system, leaving themselves and their families vulnerable to significant health and social risks.

The aim of this paper is to describe a set of burgeoning new organisations and services designed to plug these gaps.

There is good evidence to indicate that this situation has remained unchanged over the past thirty years, since the start of deinstitutionalisation (Mendoza et al. 2013). The implications of this policy failure are very significant. For example, unlike the situation in many other chronic illnesses, the lifespan of people with chronic mental illness has not changed over the past three decades. This is akin to the disparities affecting Australia's Indigenous communities. Over the past twenty years, Australia has had two national mental health policies, four national mental health plans, a National Action Plan under the Council of Australian Governments since 2006, and now a Roadmap and Report Card. Add to this a number of suicide prevention plans, Aboriginal and Torres Strait Islander-specific plans and other such documents, then multiply all this by each state and territory jurisdiction in Australia.

Despite all this attention, successive reports by governments (for example, Senate Reports 2006; 2010; NSW Legislative Council Select Committee on Mental Health 2002) and non-government bodies (Mental Health Council of Australia 2005) characterise Australia's mental health system as being in crisis (the title given to the bipartisan report of the 2006 Senate Inquiry was *From Crisis to Community*). It is testimony to the ongoing chaotic nature of mental health care in Australia that there have been around 50 separate statutory inquiries into different aspects of failure in the system, between 2006 and 2012 alone.

One recurring reason posited in these reports is the inability of mental health to surmount policy and service silos. This article briefly describes the impact of this policy failure.

We then review the evidence for the application of holistic approaches to mental health policy and the provision of mental health care in Australia. We describe the components and principles that underpin an alternative and more evidence-based approach to mental health care and policy. Concepts of coordinated care are explored and found to be quite robust. There is good evidence to support collaborative approaches to the management of mental illness for improved outcomes. However, there are limitations to this evidence, and this is also explored. Emerging models of mental health care suggest the need to broaden our definition of coordinated care further to incorporate services beyond 'health care' to other types of care. This broadening requires careful monitoring and evaluation.

These limitations become significant in the light of the final part of this paper, which highlights some of the innovative, contemporary models of mental health care now emerging. While often grounded in some evidence, it is fair to say that these new models also push the boundaries in relation to the application of coordinated care to mental health, particularly by seeking to join up health services with a range of other types of necessary care: housing, employment, education, training, community and other support services. This review examines the trend toward new mental health commissions as a way of driving more joined up structures and policies, as well as highlighting some new collaborative service models.

Given the enduring problems it faces in Australia, mental health is a perfect example of the need for public policy to build on what is proven about the benefits of collaborative care, so as to develop new approaches to drive even greater cooperation between service providers. Older style models of managing through either hierarchy or market forces do not seem capable of generating this collaboration (Considine and Lewis 2003).

While many agencies are engaged in the provision of services to people with a mental illness, public policy approaches are characterised by an ongoing concern for outputs such as occupied bed days and processes such as competitive tendering. This unintelligent approach leaves Australia largely outcome-blind with regard to the health, economic and social impact of mental health care (Crosbie 2009), and also generates a sense of unhealthy competition between service providers, rather than collaboration. A key finding of the Senate Select Committee of Inquiry into Mental Health in 2006 was that policy and service silos were preventing effective care.

Mental health is ideally suited to the development of a more integrated public policy approach because:

- it is complex and multi-factorial in causation;
- the knowledge and resources to deal with the issues are located across many sectors and do not lie exclusively within the public sector;
- there are a growing number of non-government agencies with shared goals in addressing the issue; and
- meeting multi-dimensional client needs will require the involvement of several agencies involved in service delivery, particularly for individuals with the most critical needs.

Governments and others are beginning to invest in a range of new models to deliver this flexible and integrated approach. This paper aims to present some of these models in the hope they are fully evaluated and add to our understanding about effective collaborative mental health care. Ending the enduring sense of crisis enveloping mental health in Australia depends on our capacity to develop new ways of delivering this care.

Search strategy

Several strategies were used to identify papers and studies relevant to this report. A keyword search was undertaken on a number of research databases, particularly in relation to the application of coordinated care to mental health and mental health policy generally. Further examination was undertaken of the bibliographies of research papers and reviews to identify studies not stored on these databases. Given the nature of the topic, it was important to also undertake a review of the publication pages of several professional bodies, government agencies and departments. Finally, we drew on consultations with academic colleagues.

What is mental illness?

About one in five Australians will experience a mental illness, and most of us will experience a mental health problem at some time in our lives. Mental illness is a general term that refers to a group of illnesses, in the same way that heart disease

refers to a group of illnesses and disorders affecting the heart. A mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. Furthermore, these problems appear to be increasing. According to the World Health Organization (2001), depression will be one of the biggest health problems worldwide by the year 2020.

Mental illnesses are of different types and degrees of severity. Some of the major types are depression, anxiety, schizophrenia, bipolar mood disorder, personality disorders, and eating disorders. Of these, depression and anxiety are the most common. While effective treatments are available, failure to treat even more common mental illnesses can have extremely serious impacts on a person's health.

Australia has led the world in policies and plans designed to address mental illness. This paper reflects on some of these policies and, in particular, their implementation.

Impact of policy failure on mental health

> By countering social exclusion, we reduce the costs to the economy caused by lower workforce participation, preventable health problems, long-term welfare dependence and increased rates of crime, distrust and social isolation in the most disadvantaged communities.
>
> Australian Social Inclusion Board 2011

The impact of service gaps in relation to mental health in Australia is stark.

Despite a twenty-year effort, Australia's mental health system has a very limited penetration of services; only 35 percent of people with a mental illness receive care (ABS 2008). Depressingly this rate of access is largely unchanged over the past decade, a finding reported by the Council of Australian Governments as being 'contrary to common expectation' (COAG 2009). Perhaps it is not surprising given that while mental illness accounts for 13 percent of the burden of disease in Australia (Begg et al. 2007), it accounts for only around 5 percent of total health spending ($6.9bn out of $130.3bn in 2010-11) (AIHW 2013).

The data indicate that while mental health spending has increased over recent years by an average of 4.8 percent, it has failed to keep pace with the increase in overall health spending over the past decade (5.3 percent) (AIHW 2012). Surprisingly little is known about the fortunate minority who do receive mental health care, the nature of their illnesses, and whether they get better as a result of their care. Even less is known about the 65 percent of Australians who have a mental illness but do not access national or state systems of care.

The major contribution to recent funding for mental health has been through the Council of Australian Governments (COAG) National Action Plan (NAP) on Mental Health 2006-11 (COAG 2006), which provided $5.5bn – an initial $2.2bn from the Australian Government, and $3.3bn from the states and territories. While COAG's NAP identified four agreed priorities, there were no agreed definitions as to what activities could or should occur under each priority, and jurisdictions had complete autonomy over how money was spent and reported. Consequently, very significant variations have been reported in the spending effort of the respective jurisdictions (Rosenberg et al. 2012). COAG's NAP looks piecemeal rather than contiguous.

Continuing a trend over recent years, the proportion of Disability Support Pension (DSP) recipients with a psychological/psychiatric primary medical condition (29.5 percent) surpassed musculo-skeletal and connective tissue (28.2 percent) for the first time in 2011 (Australian Government 2011). This group has been growing in number by an annual average of 5 percent since 2001, at more than twice the rate of overall

growth in DSP recipients (Council of Australian Governments 2011). Australia is about half as successful as the OECD average in finding work for people with a mental illness (Mental Health Council of Australia 2009). Mental illness affects one in five people but this is one in three for recipients of government income support.

The Australian Institute of Health and Welfare has highlighted mental health as a key area of national reporting weakness in relation to health outcomes data (AIHW 2012) and as stated, Australia's approach to accountability for mental health has been described as outcome-blind (Crosbie 2009). Given that 75 percent of all mental illness manifests before the age of 24 (McGorry et al. 2007), the failure to properly manage mental illness has profound, lifelong consequences for individuals, communities and the economy.

While this situation is alarming, it is paradoxically clearly at odds with the stated priorities of the Australian community. The recent Kings College international survey (2010) showed the utmost importance placed on the issue of mental health by Australians, who went as far as to rank the issue as the third most significant challenge facing this country, well ahead of other nations and second only to the economy and global warming.

A key issue affecting mental health care in Australia is its shared responsibility, involving the Commonwealth, states and territories, and the non-government and private sectors, as shown in Figure 1 (Mental Health Council of Australia 2006).

Figure 1 Responsibilities for mental health care by sector

Quality mental health care is not possible if these relationships are not working and clearly, based on the available data, we have a long way to go.

What does fragmented mental health care look like?
Jack's story (Part 1)

Jack is a twenty-two year old man, living at home again with his parents and awaiting the outcome of a magistrate court hearing on an assault charge. Prior to his arrest, he had been 'couch surfing' in the inner urban areas of one of our larger capital cities. This had followed a period when his family had tried to limit his use of alcohol and other drugs at their home; they had been concerned about his increasingly aggressive outbursts towards his mother and younger siblings. They had been pushing Jack to behave in a more reasonable way and to seek daytime work. They had also suggested that he might need to access mental health care as they were increasingly unable to comprehend his reasons for becoming more isolatory, staying up most of the night and behaving in a more belligerent way towards them. Consequently, three weeks before his arrest he had disappeared from home and only sent occasional text messages to his mother to say that he was living in the city.

Three years previously Jack had taken himself to a local general hospital seeking help for his depressed mood and suicidal thoughts. By that time, he had been out of education and work for over three years. He had left school at age 16 after a long period of poor school attendance and academic failure. He had been assessed at the emergency department and told that as this was his first presentation for care, he was not unwell enough to be admitted to hospital or receive care from the community-based public mental health services.

As he was living with his family, he was advised to seek help from a private psychologist. His parents arranged this initial consultation, but as the psychologist was concerned that the young man may have an emerging psychotic illness, she suggested assessment by a private psychiatrist. Again his parents arranged this assessment, and the psychiatrist advised the young man to commence medication (consisting of both an antidepressant and a low-dose antipsychotic medication). The psychiatrist met with the parents and suggested that the young man had developmental learning difficulties, an anti-social personality and a current depressive illness. The psychiatrist also suggested that it was possible that Jack was developing a psychotic illness.

At this time, no assessment of his physical health was made. His parents were advised to supervise his alcohol and drug use at home and to seek assistance with unemployment benefits from social services. After attending the psychiatrist on two occasions, Jack decided to cease medication (as it caused some degree of impotence), and did not return for further appointments.

Three years later, in an intoxicated and psychotic state, Jack assaulted an elderly man in a public park. He believed that the elderly man was mocking him and was working with his family to have him locked up. The police were called and took Jack into custody. While in the police cells he stripped himself naked and smeared excrement along the walls. Initially the police believed that Jack was simply intoxicated and antisocial.

However, as his mental state deteriorated over the next 24 hours they became increasingly concerned that he had a mental illness. They were able to locate his father and he was eventually released into his father's care. His father attempted to re-

engage the private psychiatrist, who was now unwilling to deal with both the clinical emergency and the potential forensic and legal aspects of the case. Consequently, he took Jack to a public hospital, where he was detained for 48 hours and then released, on antipsychotic medication, to his father's care at home. The community-based acute care team attended the home on one further occasion, but Jack refused to speak to them. The parents continued to supervise the provision of medication for a further four weeks, during which time Jack's behaviour improved considerably.

Jack's story so far illustrates the reason some new structures and service types are emerging, aiming to surmount the barriers and silos that have traditionally had a negative impact on mental health. These new entities have their roots in solid evidence in the benefits of coordinated, integrated care.

Definitions and evidence for care coordination

The way health care providers work together affects the quality of the health care that they provide. Problems in communication and interaction can lead to problems in patient care. The evidence about the power and potential positive impact of collaborative care or care coordination has been understood for some time, both in relation to general health care (Zwarenstein et al. 2009) and mental health more specifically (Archer et al. 2012).

The challenge in relation to a review of care coordination is less about finding evidence of its effectiveness and more about actually pinning down a definition. While assumptions of common understanding are often made, the actual term used to describe care coordination in fact varies considerably and could include case management, collaborative care, interprofessional management, multidisciplinary care, shared care and team coordination, to mention just a few. It is noteworthy that in its seminal investigation into care coordination as a quality improvement strategy, the US Agency for Healthcare Research and Quality (McDonald et al. 2007) identified forty separate definitions of care coordination. Its massive review of the literature incorporated nearly 5000 articles and found 75 systematic reviews of coordinated care, including 28 specifically in relation to mental health. These reviews covered a heterogeneous set of patients, populations, settings and organisations, including chronic illnesses, mental health, cancer and others. These differences highlight that so far, what qualifies as coordinated or collaborative care varies according to setting. Despite this, the Agency was able to propose a considered summary definition based on its review (McDonald et al. 2007):

> Care coordination is the deliberate organisation of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organising care involves the marshalling of personnel and other resources needed to carry out all require patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

This definition is supported by Ehrlich et al. (2009) who state that the concept can be broadly defined as the delivery of systematic, responsive and supportive care to people with complex chronic care needs. It is likely to involve coordination between a range of care providers, including not only professional service providers but also family and friends (Self-Directed Care Scotland). Further components of care coordination are provided in the definition offered by Brown (2009):

> Care coordination is a client-centred, assessment-based interdisciplinary approach to integrating health care and social support in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

In its important review of the literature, the Mental Health Coordinating Council of NSW (2011) outlined a useful set of key guiding principles for service coordination, indicating it should be:

- person directed driven and centered;
- inclusive of family, friends, peers and community;
- culturally safe and appropriate;
- recovery oriented;
- socially inclusive and seeking to address discrimination; and
- tailored and suited to individual needs, consistent with individual preferences.

A common principle often added to this list is that the services must be relevant – the right service at the right time and in the right place.

Despite or perhaps because of the breadth of interest in establishing collaborative models of care, the evidence is quite robust in relation to defining both coordinated care and a set of useful characteristics or principles that underpin this type of care. If establishing this definition was difficult, by contrast there is little problem finding evidence to demonstrate the benefits of care coordination, both for chronic conditions generally and in relation to mental health specifically. It should first be noted that the need for and desirability of care coordination and the significant role it can play in service quality improvement has been widely noted by both clinicians and consumers (McDonald et al. 2007).

There are improvements in quality of life and better health outcomes particularly in clients with severe mental illness (Meehan et al. 2010). These positive impacts have been replicated in a NSW supported housing program that is described in more detail later in this paper (Asia-Pacific Community Mental Health Development Project Summary Report 2008). This study is important as it permits the concept of coordinated care to be tested outside of the traditional remit of healthcare, to include housing, community and other support services. The success of this program in reducing hospitalisations and increasing social connectedness among clients is important evidence indicating the robustness of the care coordination approach.

There is also good evidence to indicate that collaborative care drives quality improvement (Scott et al. 2009; McGorry et al. 2007). Similar findings were reported by the Institute of Medicine (2001), which emphasised the key role collaboration plays in the delivery of quality care and service to people with a mental illness. There is further evidence in relation to improved medication management (McDonald et al. 2007) and reductions in re-hospitalisation for people with a mental illness (Gorey et al. 1998).

Given the level of unmet need in mental health, it is also important to acknowledge that care coordination has been associated with both a reduction in service duplication and some improvement in addressing unmet need – service coordination reduces service duplication (Schifalacqua et al. 2003). This issue of better addressing unmet need was a feature of some of the coordinated care trials undertaken in Australia a decade ago (Perkins et al. 2001).

There is also evidence to indicate that care coordination, despite the requirement for some initial investment, can deliver better care, more cheaply (Singh and Ham

2005), while delivering higher levels of consumer satisfaction (Bodenheimer 2008). Limitations of evidence preclude these findings being generalised to ethnic communities where it is likely that the implementation of coordinated care across cultures may require different strategies (Betancourt et al. 2003).

The breadth of evidence in relation to care coordination is considerable, and reflects widespread interest in and concern for getting this aspect of care right, from primary care, to cancer, to mental health and so on. The evidence supporting coordinated care in mental health is strong, based on the formal evaluations of various collaborative approaches. Nevertheless it is also reasonable to conclude that care coordination interventions represent a wide range of approaches at the service delivery and system level. Without standard definitions, what qualifies as coordinated can vary and make standardisation of approach or comparison difficult, even when everybody seems to be talking about the same thing.

As pointed out by McDonald et al. (2007) and others, the effectiveness of these coordination efforts most likely depends on appropriate matching between the type of intervention and the nature of the care coordination problem. In other words, efforts to coordinate care must be carefully considered; there is no cure-all or single-sized approach. This is despite the extensive research evidence identified by the Agency for Healthcare Quality and Research and discussed above.

Patients and their families are assuming increasingly active roles in health care decision-making, and are navigating an increasingly complex health care system with consumer-driven health plans and other efforts to involve them more, including through the National Disability Insurance Scheme, the Partners in Recovery Program, and others. The patient often experiences first-hand problems of coordination (for example, missing records, having to tell their stories multiple times etc.). Service users are just as likely to be motivated to promote care coordination as service providers.

Despite this mutual realisation and common goal, and despite the very considerable evidence regarding the merits of mental health care coordination, it is not possible to posit one model to follow. Health care providers acknowledge the lack of a model of care coordination. This represents a considerable barrier to evaluating quality of care, risks additional expense to the system and even potentially compromises patient outcomes and satisfaction. It is possible to suggest some common principles (McDonald 2007):

1. Numerous participants (including the patient) are typically involved in care coordination.
2. Coordination is necessary when participants are dependent upon each other to carry out disparate activities in a patient's care.
3. In order to carry out these activities in a coordinated way, each participant needs adequate knowledge about their own and each other's roles and available resources.
4. In order to manage all required patient care activities, participants rely on exchange of information.
5. Integration of care activities has the goal of facilitating appropriate delivery of health care services.

Based on this evidence and applying these principles, governments and others are increasingly looking to new structures to support the application of more coordinated care to clients with complex needs.

Joined up structures

As we now start to contemplate the nature of new joined up models of care in Australia, the evidence indicates such approaches can be significantly strengthened if some key questions are routinely asked (McDonald 2007):

- What are the coordination needs related to care of the client?
- Who are the participants in care and how are they dependent on each other for a given care situation?
- What are the factors already in place that may facilitate care coordination, for example personal resources and information systems? How does coordination draw on these resources?
- What are the factors that influence the motivation of those involved in coordination, such as their attitudes, any incentives or sanctions?
- What impact is coordination going to have on the actual way people work and processes, such as:
  - Getting the necessary information across interfaces, such as different settings of care;
  - Establishing an understanding of the relationship of one individual's work to the overall goals and to those of others involved in client care?
- How are the interactions of these factors and coordination processes expected to affect service processes and outcomes? In other words, what is the hypothesis about why the new collaborative care model will work?

In relation to the literature, Fuller et al. (2011) found four major collaborative structures have been identified:

1. Direct collaborative activities, e.g. link working, co-location, consultation liaison, shared care management (assessment, review, follow up, linking with other services, defined care pathways).
2. Agreed guidelines, e.g. protocols for assessment, treatment and referral, stepped care and transitions.
3. Communication systems, e.g. team/partnership meetings, shared client records, client held records, consistent processes for notifications, standardised letters, referral and reports, templates for meetings, invitations and for recording minutes and outcomes, enhanced referral processes.
4. Service agreements, e.g. formalised contracts or funding mechanisms about how services will work together.

For the purposes of this discussion, however, of particular interest is the application by several Australian and international jurisdictions of a new, statutory authority-type model of organisational mental health governance. Since 2010, mental health commissions have sprung up in Western Australia, New South Wales and most recently in Queensland. A national commission run by the Federal Government started on 1 January 2012. Canada and New Zealand have both had mental health commissions for some time.

Rosenberg and Rosen (2012a) have already noted differences between the jurisdictional approaches. However, across all jurisdictions there is increasing evidence that this new model of governance in mental health is delivering better resources, better services, increased accountability, and heightened levels of stakeholder engagement (Rosenberg and Rosen 2012b). New Zealand is able to point

to real structural changes in the way mental health care is delivered, epitomised by the shift in spending on non-government services, which now account for just under 30 percent of total mental health spending. In Australia, this figure would be closer to 10 percent, making the NGO sector still a largely peripheral element in the domestic mental health service landscape. Overall, Australian evidence regarding the impact of commissions is quite weak, reflecting the very new and limited experience jurisdictions have with commissions. There is a need for ongoing conceptual and evaluation research so as to more fully assess the impact of these new organisational structures.

Surveys also indicate that staff feel a greater sense of ownership and autonomy when working in these mission-focused 'micro-agencies', in comparison to the usual larger bureaucratic structures (APSC 2012).

Mental health commissions represent an important, contemporary example of governments striving to better coordinate efforts in relation to mental health – beyond the health system to encompass employment, education, justice, housing and so on. This breadth of scope and interest was reflected in the recent legislation passed in NSW to create its new Commission and is very much in line with the principles of coordinated care described earlier (Parliament of NSW 2012). Commissions represent a governmental solution to the complexity posed by mental health, an attempt to surmount departmental boundaries and create a champion to advocate for the issue and facilitate action across government (APSC 2004).

In the United States, they are familiar with the concept of the 'medical home', developed originally in primary care to provide accessible and accountable services for individuals with chronic medical conditions. Smith and Sederer (2009) call for the application of this concept to mental health, so as to build a model of central responsibility for issues such as access to and coordination of services, integration of primary and preventive care, adoption of recovery orientation and evidence-based practices, and family and community outreach.

Despite recent moves in some jurisdictions towards more joined up structures such as commissions, structures and services remain very fragmented and piecemeal. Federally funded initiatives such as the new Partners in Recovery program[1] indicate an increased understanding of the need to drive new levels of coordination. However, even here the message is somewhat confusing:

> PIR is not intended to offer a new 'service' in the traditional sense. Rather, it will assist in better coordinating existing services and supports. PIR will provide a 'support facilitation' service focusing on building pathways and networks between the sectors, services and supports needed by the target group.

With access to mental health care still a critical issue in Australia, there first need to be services available to coordinate.

In addition to ongoing access problems, both the quality and nature of the mental health care available to Australians varies wildly depending on where a person lives (Senate 2006). This is quite unlike treatment for cancer – it has much more standardised care and treatment pathways.

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[1] <www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir>

Joined up services

> Most of us are familiar with the policy 'silos' which exist at a local level … institutions working separately from each other, following different policy objectives and working to different time scales. Such divisions are often taken for granted, blamed on historical working relationships ('it has always been like that') and organisational challenges cultures ('they don't work like we do'). However, these divisions come at a cost. The issues and challenges facing local communities are often complex, and require a holistic approach to be resolved … It is rare in OECD countries to find holistic policy interventions at the local level which tackle diverse aspects of a problem simultaneously, are well targeted and have sufficient resources to succeed.
>
> OECD 2008

In recent times greater understanding and discussion of the interconnection between mental health, physical health and social wellbeing has resulted in attempts to break down the barriers between service systems. There has been increased recognition of the need for holistic mental health services to properly reflect a person's need for housing, employment, education and training, and a host of other support services in the delivery of mental health care (Cappo et al. 2011).

Older segmented models of mental health support cannot provide this holistic care. Recent efforts here focus on the Better Access Program, which places the general practitioner as the locus of care, making referrals to a new set of publicly-funded psychologists for six sessions of therapy. However, the effectiveness of this model is unclear. Since November 2006, GPs have written almost 3.8 million Mental Health Treatment Plans under the Better Access Program, but only 1.4 million of these have been reviewed as intended under the Program. Their role in care coordination seems fragile on this basis (Rosenberg and Hickie 2012).

The involvement of an increased range of players has in turn led to a greater emphasis in mental health policy on service coordination and service partnerships. These partnerships should enhance cooperation, better define local problems and challenges, and build trust between organisations that might otherwise operate quite separately. The OECD (2008) identified a lack of clarity regarding the roles and responsibilities of different stakeholders as a key impediment to cooperation. Often at issue is a lack of understanding by organisations of respective roles or coverage of potential partners, as well as the unhelpful competitive tendering arrangements commonly used by governments to allocate service funding. While some tension between organisations may be associated with increased creativity, such arrangements militate against cooperation and can stimulate duplication of effort.

It is in this context that the following examples are offered of a new set of services or programs designed to facilitate a more holistic approach to mental health care. It is important also to note that a critical element of these services is their capacity to provide care to new communities, particularly regional and rural areas. Existing fee-for-service approaches to mental health care leave many such areas poorly serviced, and these new models offer promising alternatives in regional service delivery.

1. headspace: the National Youth Mental Health Foundation

headspace, the National Youth Mental Health Foundation, was launched in 2006 as part of the Australian Government's commitment to the Youth Mental Health Initiative (YMHI). It was established to promote and facilitate improvements in the mental health, social wellbeing and economic participation of young people aged 12–25. *headspace* aims to achieve this by:

- providing holistic services via Communities of Youth Services;
- increasing community capacity to identify young people with mental ill-health and related problems as early as possible;
- encouraging help-seeking by young people and their carers;
- providing evidence-based, quality services delivered by well-trained professionals; and
- impacting on service reform in relation to service coordination and integration within communities and at an Australian and state/territory government level.

The core element of the *headspace* initiative consists of 30 (still increasing) service delivery sites across Australia, called Communities of Youth Services, that provide services for young people. These communities are supported by a number of other *headspace* components: the *headspace* National Office; a research and information dissemination component (the Centre of Excellence); a Service Provider Education and Training Program; and a community awareness program.

The five components aim to work together to enable young people to get assistance from accessible, quality, holistic and coordinated services. The communities of service aim to support early identification of those young people who are at risk of mental health problems and related issues, but so too do the other *headspace* components. Community awareness aims to increase early help seeking; the education program aims to support service providers to identify early-onset mental health problems; and the centre of excellence aims to assist practitioners to identify young people early by devising a psychosocial screening tool.

Once young people access a *headspace* community of service, they have access to quality, holistic and coordinated services. Service coordination is the primary role. The holistic focus of *headspace* is assisted by the fact that each centre is a hub where young people can access several practitioners with expertise in mental and physical health, substance abuse, and social and economic participation, and who can provide services that are integrated and coordinated. The evaluation of *headspace* undertaken by Muir et al. (2009) made a number of findings in relation to service coordination and collaboration, including:

- cross-disciplinary training and involvement of external providers in case review meetings built improved relationships, reduced overlap, improved selection of appropriate care, and improved care coordination;
- increased communication between the *headspace* service and other providers was a key factor in effectiveness and appropriateness of referral pathways;
- a shared respect for the young person and their condition and a common work culture that includes cooperation as a goal impacted on the success of coordinated care;
- co-location on its own does not result in effective service coordination. Co-location needs to be supported by a shared model of care, and commitment to collaboration;
- barriers to effective referral pathways included staff turnover, client confidentiality, and competition between service providers.

In truth, establishing this multidisciplinary service has not been easy, given workforce and funding constraints, with some *headspace* sites more successful than others. A good example is the staffing profile of the Mid North Coast *headspace* site

in NSW, which includes an Operational Manager, three Administration and Welcome staff, a Development Manager, two Visiting Psychiatrists, four General Practitioners, a Credentialed Mental Health Nurse, four Psychologists, and three Youth Workers.

The *headspace* model is a promising new and integrated infrastructure, designed to provide primary mental health, early intervention services to a key group of people currently missing out on care, young people aged 15-25. The model is not consistently applied across all *headspace* sites, and recent government changes to related programs, such as the Mental Health Nurse Incentive Program, further highlight the fragility of the model in place in the Mid North Coast.[2] Overall, *headspace* faces huge workforce challenges if it is to meet its future brief (Freijser and Brooks 2013).

2. Family Centred Employment Program, Goodna Qld.

The Family Centred Employment Program (FCEP) is located in Goodna, Queensland. It is a three-year national demonstration project for the Australian Government that aims to address social exclusion by helping jobless families with children into sustainable employment and ensuring their children have a good start in life. The participation of jobless families in the project is voluntary.

FCEP service providers are partnering with the Australian Government's (formerly named) Department of Education, Employment and Workplace Relations (DEEWR) and existing local organisations to holistically meet the needs of jobless families whose members are likely to have long standing and/or multiple barriers to employment participation.

As at 30 June 2011, 56 client families were deemed eligible for the program. Of these 38 were deemed to be 'engaged' (i.e. had completed Family Care Plans) and 75 percent of these had achieved or were working toward employment outcomes. The employment, education/training and social outcomes achieved to date have all exceeded the targeted number prescribed by DEEWR.

3. The Prevention and Recovery Care (PARC) Model – South Yarra, Melbourne

In Victoria, PARC services are managed by the local adult mental health service in conjunction with a mental health NGO. PARCs offer step-up/step-down care and are typically staffed on a 24-hour basis by NGO mental health workers, with clinical staff visiting and 24-hour back-up care provided at the South Yarra PARC by the Alfred Hospital. The first PARC service was established as a pilot in 2004. There are now around 14 operating around Victoria and one in the ACT. Most are located in suburban streets and accommodate up to ten clients in single bedrooms. The length of stay is approximately one to two weeks, with a maximum of 28 days. Patient records are held by the Alfred Hospital.

Over the past seven years, Victoria has established 68 step-up/step-down PARC beds, with another 70 promised. Evaluation of the PARC model is positive (Dench et al. 2008), noting particularly its capacity to bring together clinical services and psycho-social services, including living skills, rehabilitation, employment, housing and other services.

PARC-type services operate in both metro and non-metro areas and are now opening up across different jurisdictions.

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[2] <www.acmhn.org/news-a-events/in-the-media/acmhn-media-releases.html>

4. The Housing and Supported Accommodation Initiative (HASI) in NSW

HASI has already been extensively evaluated and can demonstrate startling results in reducing hospital admissions for people with low prevalence disorders, such as schizophrenia (University of Melbourne 2008). While there are different models included under the program, HASI effectively mixes housing and mental health care, clinical and psycho-social support.

5. Doorways Housing and Support Program, Mental Illness Fellowship Victoria (MIFV)

With its origins in the evidence-based Housing First Program (Tsemberis et al. 2004), MIFV's Doorways Program is currently providing long term, stable, private rental accommodation and supported psychosocial rehabilitation services to fifty Victorians with a mental illness. Referrals to the Doorways program are made through the mental health units of Austin Health, St Vincent's Melbourne and Latrobe Regional Hospital. To be eligible for the program, a person must be case-managed by one of the three participating clinical mental health services; homeless or at risk of homelessness; and referred by their clinical mental health service to Doorways. Doorways blends clinical and non-clinical approaches and marries longer term housing needs with enduring mental health support.

6. Orygen Youth Health, Parkville

Funded as an acute unit with 16 beds at Royal Melbourne Hospital, Orygen provides leading edge, multi-disciplinary early intervention for psychosis among young people. Part of the collaborative approach to care includes psycho-education and vocational support. There is also 24-hour triage and an assertive community team that operates across their area health service as well as group programs and case management.

Orygen operates as part of the Royal Melbourne Hospital, but it clearly offers a much broader set of community-based mental health services than those traditionally associated with hospital psychiatric wards.

What does integrated mental health care look like? Jack's story (Part 2)

Due to Jack's impending court appearance in relation to the assault charge, his solicitor suggested the need to urgently obtain a relevant psychiatric assessment, formal psychiatric diagnosis, and active management plan. If successful, this approach had the capacity to divert Jack from the criminal justice system to the mental health care arena. As the first private psychiatrist refused to provide an urgent assessment, the father sought help from a new youth focussed mental health service (operated under the *headspace* system, but with additional specialist services support).

A senior psychiatrist saw Jack urgently and documentation was provided to his solicitor. As it was clear that Jack had an active psychotic illness of at least three years' duration, and was willing to receive psychiatric care and social support under the direction of the court and provided by the same youth service, the court transferred his care to that service. The parents were actively engaged in his ongoing care, medication was recommended, and an appropriate multidisciplinary outreach team (centred on a male mental health nurse operating under the new Federal systems) was used to maintain active engagement.

Physical health monitoring commenced – which was particularly important, as Jack had engaged in a large range of risky sexual and drug-related behaviours. Specialised neurocognitive testing, brain imaging and brain electrical measures were conducted. These not only excluded other brain pathology, but confirmed the fact that Jack was of above average intelligence; however he had a number of specific learning and social deficits that had never been addressed.

A program of re-engagement in education was commenced through an externally-funded arts education program, with supervision being organised through a trained vocational professional. Over the coming year a program of gradual return to post-school vocational training was implemented. Part-time work was coordinated through occupational contacts of the family.

Specific family meetings (focusing on psychoeducation, active management of alcohol and drug problems and protection of other siblings) were held to promote ongoing active connection with Jack's family.

Future accommodation options were actively pursued as Jack still wished to reside long-term in the inner urban areas. After forming a relationship with a young woman, Jack moved into shared accommodation in the city. Ongoing dialogue with the family and Jack focused on the instability of these arrangements and the need to move towards a more stable plan. Continuing alcohol and substance misuse remained highly problematic, and Jack's girlfriend was engaged in an active program of moving to a harm reduction focus.

Over the following 18 months an active program of mental health treatment, educational and vocational engagement, family support and physical health care was maintained. The majority of these services were centrally coordinated and did not rely on conventional state mental health services. Active engagement with innovative youth services, family and community-based resources and services from the educational and vocational sector were essential.

Conclusion

Holistic mental health care is complex in that it requires the active engagement of multiple players, different tiers of government, and a mixture of professional and non-professional support. Australia's response to date has been to build a service system characterised by fragmentation and inconsistency. The services a person gets vary depending on where they live and quality varies as much as access. This is a situation unlike most other areas of health care in 21st century Australia. It is is frankly unfair and leaves people with a mental illness and their families very vulnerable to lifelong disadvantage.

There is excellent evidence to suggest that collaborative and coordinated care delivers the best quality mental health services. Australia now has emerging models of governance and service that seek to deliver more holistic care. Some of these models will test the evidence in relation to coordinated care, seeking to join together not just health service providers but also housing, community support, employment and other services. Models such as HASI and Doorways both show that such coalitions are faithful to the evidence about collaborative care and demonstrate their effectiveness for clients.

However, as these new models emerge more broadly, there is an obligation on policy-makers and others to establish an adequate level of conceptual and practical evaluation. We must ensure these models are achieving what they set out to do,

breaking down silos between traditionally separate service providers and delivering good client outcomes. This is a perennial public policy challenge, but critical if reform in mental health is to be pursued.

Mental health commissions have been set up in several jurisdictions and charged with the provision of strategic advice about how to improve the experience of care for people with a mental illness. They have all been given licence to look beyond health and into the broader perspective of the lived experience: employment, social inclusion, housing and so on. The inappropriateness of attempting to segment the experience of mental illness into its departmental components is now recognised. Whether the commissions will have the necessary power and resources to effect real changes across this spectrum of interest remains to be seen, but early indications are promising.

Concepts such as the 'medical home' from the United States, while perhaps using different language, are further evidence of models in place elsewhere awaiting more detailed application in an Australian context.

There is also an emerging range of new service models from both within government and without that are designed specifically to meet the holistic needs of people with a mental illness. This includes new individualised packages of support such as those to be offered through the National Disability Insurance Scheme. These approaches do not pass the buck or shift responsibility to other organisations once their role in care has been completed. They take responsibility for all facets of care, and provide this in an enduring rather than desultory engagement with the person. They link and provide services hitherto separated: mental health care, physical health care, employment, housing, psychosocial support and beyond.

These new organisations and services are consistent with the evidence about the power of coordinated care, and represent Australia's best bet in relation to driving mental health reform.

References

Archer, J, Bower, P, Gilbody, S, Lovell, K, Richards, D, Gask, L, Dickens, C and Coventry P 2012. *Cochrane Review: Collaborative Care for People with Depression and Anxiety*, October 17.

Australian Bureau of Statistics 2008. *National Survey of Mental Health and Wellbeing 2007*, Canberra.

Australian Government 2011. *Characteristics of Disability Support Pension Recipients*, June, viewed June 2012, <www.fahcsia.gov.au/sa/disability/Documents/dsp_characteristics_june2011.pdf>.

Australian Institute of Health and Welfare 2012. *Australia's Health,* Canberra.

Australian Institute of Health and Welfare 2013. *Health Expenditure Australia 2010-11*, Canberra, viewed August 2013, <http://www.aihw.gov.au/health-expenditure/>.

Australian Public Service Commission 2004. *Connecting Government: Whole of Government Responses to Australia's Priority Challenges. Good Practice Guides*, Management Advisory Committee, Canberra.

Australian Public Service Commission 2012. *State of the Service Report, Microagency Survey Results 2012*, viewed July 2012, <www.apsc.gov.au/about-the-apsc/parliamentary-reports/state-of-the-service/microagency-survey-results-2012>.

Australian Social Inclusion Board 2011. *Addressing Barriers for Jobless Families,* Australian Government, Canberra.

Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L and Lopez, A 2007. *The Burden of Disease and Injury in Australia 2003*, Australian Institute of Health and Welfare PHE 82, Canberra.

Betancourt, JR, Green, A, Carrillo, J and Ananeh-Firempong, O 1996. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and healthcare, *Public Health Report*, 118(44): 293–302

Bodenheimer, T 2008. Coordinating care – A perilous journey through the health care system, *New England Journal of Medicine*, 358: 1064–70.

Brown, R 2009. *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses*, National Coalition on Care Coordination (NC3), University of Birmingham.

Cabinet Office, United Kingdom 1999. *Modernising Governance*, CM4310, Her Majesty's Stationery Office, London.

Capp,o D, McGorry, P, Hickie, I, Rosenberg, S, Moran, J and Hamilton, M 2011. *Including, Connecting, Contributing: A Blueprint to transform Mental Health and Social Participation in Australia*, viewed June 2011, <sydney.edu.au/bmri/docs/260311-BLUEPRINT-SUMMARY.pdf>.

Commonwealth Ombudsman 2010. *Falling Through the Cracks*, Report No. 13/2010, Canberra.

Considine, M and Lewis, J 2003. Bureaucracy, network or enterprise? Comparing models of governance in Australia, Britain, the Netherlands, and New Zealand, *Public Administration Review*, 63(2): 131–140

Council of Australian Governments 2006. *National Action Plan on Mental Health 2006-11*, viewed November 2010, <www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health .pdf>.

Council of Australian Governments 2009. *National Action Plan on Mental Health, Second Progress Report*, September, Canberra.

Council of Australian Governments 2011. *National Action Plan on Mental Health, Third Progress Report*, June, Canberra.

Crosbie, D 2009. Mental health policy – Stumbling in the dark? *Medical Journal of Australia*, 190(4): S43-S45

Dench McLean Carlson 2008. *Final Report for Evaluation of the Prevention and Recovery Care (PARC) Services Project*, viewed May 2012, <www.health.vic.gov.au/mentalhealth/ publications/parc-evaluation.pdf>

Ehrlich, CE, Kendall, E, Muenchberger, H and Armstrong, K 2009. Coordinated care: what does it really mean? *Journal of Health & Social Care in the Community*, 17(6): 619.

Freijser, L and Brooks, P 2013. *Addressing Workforce Challenges for Youth Mental Health Reform,* The Australian Health Workforce Institute and Orygen Youth Health Research Centre, viewed August 2013, <http://oyh.org.au/sites/oyh.org.au/files/ymh_reform_workforce_report.pdf>.

Fuller, JD, Perkins, D, Parker, S, Holdsworth, L, Kelly, B, Roberts, R, Martinez, L and Fragar, L 2011. Building effective service linkages in primary mental health care: A narrative review part 1, *BMC Mental Health Research*, 11(72), viewed July 2012, <www.biomedcentral.com/1272-6963/11/72>.

Gorey, KM, Leslie, DR, Morris, T, Carruthers, WV, John, L and Chacko, J 1998. Effectiveness of case management with severely and persistently mentally ill people, *Community Mental Health Journal*, 34(3): 241-50.

Institute of Medicine 2001. *Improving the Quality of Health Care for Mental and Substance Abuse Conditions,* The National Academies Press, Washington DC.

Kings College London 2010. *World and Challenges Survey*, London.

Latham, M 1998, *Civilising Global Capital*, Allen and Unwin, Sydney.

McDonald, KM, Sundaram, V, Bravata, DM, Lewis, R, Lin, N, Kraft, S, McKinnon, M, Paguntalan, H and Owens, DK (eds) 2007. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies,* Technical Review 9.7, Agency for Healthcare Research and Quality, Publication No. 04(07)-0051-7, Rockville, MD.

McGorry, P, Purcell, R, Hickie, I and Jorm, AF 2007. Investing in youth mental health is a best buy, *Medical Journal of Australia*, 187(7): 5-7

Meehan, T, Madson, K, Shepherd, N and Siskind, D 2010. *Final Evaluation Report of the Qld Government's Housing and Support Program (HASP)*, Department of Psychiatry, University of Queensland, Brisbane.

Mendoza, J, Bresnan, A, Rosenberg, S, Elson, A, Gilbert, Y, Long, P, Wilson, K and Hopkins, J 2013. *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future*, ConNetica Consulting, Caloundra, Australia.

Mental Health Coordinating Council of NSW 2011, *Care Coordination Literature Review and Discussion Paper*, July, Sydney.

Mental Health Council of Australia 2005. *Not For Service*, Canberra.

Mental Health Council of Australia 2006. *Time for Service*, Canberra.

Mental Health Council of Australia 2009. *Let's Get to Work: A National Mental Health Employment Strategy for Australia,* Canberra.

Muir, K, McDermott, S, Gendera, S, Flaxman, R, Patulny, R, Sitek, T, Abello, I, Oprea, I and Katz, I 2009. *Independent Evaluation of headspace: The National Youth Mental Health Foundation,* SPRC Report 19/09, Social Policy Research Centre, University of New South Wales, Sydney.

NSW Legislative Council Select Committee on Mental Health 2002. *Final Report*, December, Sydney.

Organisation for Economic Cooperation and Development 2008, *Breaking Out of Silos: Joining Up Policy Locally*, Working Paper, OECD LEED Programme.

Parliament of NSW 2012. *Act to Establish a NSW Mental Health Commission 2012*, viewed May 2012, <www.legislation.nsw.gov.au/sessionalview/sessional/act/2012-13.pdf>.

Perkins, D, Owen, A, Cromwell, D, Adamson, L, Eagar, K, Quinsey, K and Green, J 2001. The Illawarra coordinated care trial: Better outcomes with existing resources? *Australian Health Review*, 24(2): 161–171.

Rosenberg, S, and Hickie, I 2012. Better Outcomes or Better Access – which was better for mental health care? *Medical Journal of Australia*, 197 (11): 619–620.

Rosenberg, S and Rosen, A 2012a. It's Raining Mental Heath Commissions – Prospects and Pitfalls in Driving Mental Health Reform, *Australasian Psychiatry*, 20(2): 85-90

Rosenberg, S and Rosen, A 2012b. Can Mental Health Commissions really drive reform? Towards better resourcing, services, accountability and stakeholder engagement, *Australasian Psychiatry*, 20(3): 193-198.

Rosenberg, S, Russell, L and Mendoza, J 2012, Well Meant or Well Spent? – Accountability for $8bn of Mental Health Reform, *Medical Journal of Australia*, 196(3): 159-161.

Schifalacqua, M, Hook, M, O'Hearn, P and Schmidt, M 2000. Coordinating the care of the chronically ill in a world of managed care*, Nursing Administration Quarterly*, 24(3): 12–20.

Schizophrenia Research Institute 2012. *About Schizophrenia*, viewed July 2012, <www.schizophreniaresearch.org.au/ index.php?r=3&menu=About Schizophrenia>.

Scott, E, Naismith, S, Whitwell, B, Hamilton, B, Chudleigh, C and Hickie, I 2009. Delivering youth-specific mental health services: The advantages of a collaborative, multi-disciplinary system. *Australasian Psychiatry* 17(3): 189-194.

Self-Directed Care Scotland, *Summary – Self Directed Care Scotland,* viewed July 2012, <www.selfdirectedsupportscotland.org.uk>.

Senate Report 2006. Select Committee on Mental Health, *From Crisis to Community*, Canberra.

Senate Report 2010. Senate Community Affairs Committee, *The Hidden Toll*, Canberra.

Shergold, P 2005. Bringing Government Together, speech to the IPAA SA conference *Connecting Government*, 8 April.

Singh, D, and Ham, C 2005. *Transforming Chronic Care: Evidence about Improving Care for People with Long-term Conditions*, Health Services Management Centre, University of Birmingham, Birmingham.

Smith, T and Sederer, L 2009. A New Kind of Homelessness for Individuals With Serious Mental Illness? The Need for a 'Mental Health Home', *Psychiatric Services*, 60(4): 528–33.

Tsemberis, S, Gulcur, L and Nakae, M 2004. Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis, *American Journal of Public Health*, 94(4): 651–656.

University of Melbourne 2008. *Asia-Pacific Community Mental Health Development Project Summary Report*, Melbourne.

World Health Organisation 2001. *Mental Health: A Call for Action by World Health Ministers*, 54th world health assembly, Geneva, viewed October 2013, <www.who.int/mental_health/ advocacy/en/Call_for_Action_MoH_Intro.pdf>.

Zwarenstein, M, Goldman, J and Reeves, S 2009. *Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes*, Cochrane Collaboration, July 8, viewed at <http://summaries.cochrane.org/CD000072/interprofessional-collaboration-effects-of-practice-based-interventions-on-professional-practice-and-healthcare-outcomes>.