Evidence based community alternatives to institutional psychiatric care

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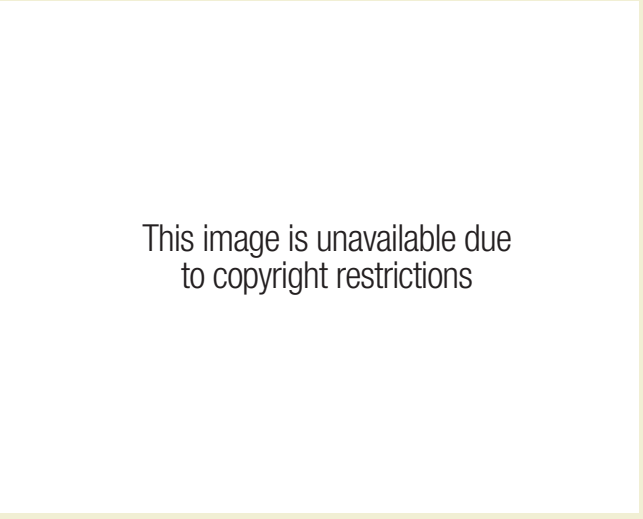
Policies of deinstitutionalisation in Australia and overseas have resulted in the majority of people with a mental illness now living in the community.



STONE

International and Australian research shows consistently that community based treatment is superior to hospital centred care for the vast majority of people with acute and long term mental illness. Therefore, as in the management of many clinical conditions, the emphasis in psychiatric treatment is shifting to community based care, with briefer hospital admissions only if necessary.

In the headlines

Among recently renewed calls to return to psychiatric institutional care was a front page headline in *The Australian* reading 'Community care fails mentally ill'.[1] This newspaper article and its accompanying feature and editorial misrepresented the truth; it was based on hearsay from pro-institutional sources and omitted the evidence from scientific trials. Community care clearly works, but only where it has been implemented in accordance with the evidence. It has been the provision of resources to support community care, not the model of community care itself, that has been inadequate and has sometimes failed people with mental illness and their families.

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What are 'recovery oriented' services?

The past decade has seen the development of an individualised 'recovery' philosophy in mental health services, and the adaptation of this philosophy is increasing throughout many community based services in Australia. US consultant educator Ms Laurie Curtis points out that 'recovery means that a person with a psychiatric disorder lives a satisfying, productive and meaningful life irrespective of the disorder or consequent disability'.[2] It also involves regaining full membership of the community.

Services need to develop a culture to 'stimulate, enhance, and support individual recovery by promoting hope, healing, empowerment, and connection in the lives of each individual served'.[2] Providers of services need to envisage that some form of recovery is possible for each and every mental health service-user, so there should be no more psychiatric 'maintenance' or 'warehousing' programs.[3]

Service-providers should step back from doing things to service-users and increasingly do things with them, as active partners. They should employ therapeutic optimism, which instils hope and assures service-users that whatever has occurred, there is someone who believes in them and their potential. Components of recovery models of management include collaborative symptom management and individual decision making, including encouraging the person to choose his or her own life direction.

The GP's role

The GP's role is pivotal in terms of having knowledge of the person and his or her family, and being in a position to organise all aspects of clinical care. Furthermore, for the individual with mental illness who has been stabilised for a long period, transfer to the GP for co-ordination of care may be the preferred

and most 'normalising' option. This is usually supported by a local, shared mental healthcare co-ordinator who ensures crisis care availability and regular reviews. Our GP shared mental healthcare programs focus on prescribing, counselling and support, as well as physical risks associated with sedentary lifestyles and cigarette smoking, and medications that may cause weight gain and can be diabetogenic.

Crisis intervention

The evidence now clearly indicates that 24-hour home visiting crisis response services should be integrated into local services for people seriously affected by mental illness and their families.[4-6] The superiority of 24-hour mobile crisis intervention and continuity of care in the community for severe mental illness as an alternative to hospitalisation plus aftercare was established by a US randomised control trial.[4] This was replicated in a trial in Sydney,[5] and later elsewhere.

People severely affected by psychiatric illness are much more likely to co-operate when interventions are individually tailored to their needs and when they and their families are given choices and retain a sense of autonomy regarding interventions.[7-10] Co-operation is further enhanced when they and their families receive sufficient information and explanation, when low key and low dose interventions are offered (at home on their own 'turf', if possible, rather than on ours), and when the trauma of involuntary hospitalisation and heavy sedation are avoided. Inpatient psychiatric care is sometimes essential but should be arranged on a voluntary basis, if possible.

Family interventions

Family interventions that provide information, education and support, and that give family members new coping techniques for crises have been shown to prevent relapses, particularly in people with schizophrenia.[11-13] These techniques include improving communication and problem-solving skills to minimise conflict and hostility.[11]

Assertive community treatment

'Assertive community treatment' is an intensive, mobile, community case management system for people with severe and prolonged mental illness (see the box on this page). It has been extensively researched in randomised studies, including two in Australia, showing that it is one of the most efficacious and cost effective interventions in contemporary psychiatry.[14] It works best for individuals who are frequent and heavy users of mental health services or those experiencing severe symptoms or disability, whether continually or intermittently. These services originated to prevent repeated 'revolving door' hospitalisations and to help long term service-users live more stable lives in the community.

Day and evening programs

Just as sedentary mental health services have shifted towards mobile community treatment, the role of day treatment centres has changed drastically. Many Australian services have shifted to programs being run by the service-users, including drop-in centres and the 'club house model' (where the service-users are the members and both manage and participate in the centres' work-related activities).[3] Service-users are increasingly gaining paid employment within mental health services for roles such as:

- advocacy, for example, providing peer support, transport and social program co-ordination
- representing service-user interests on management committees
- promotion and education of mental health issues within the wider community.

Vocational rehabilitation

Community mental health facilities historically provided rehabilitation focusing on living skills and leisure activities. More recently, training and work programs have developed, and in Australia many rehabilitation services create work opportunities

Principles of assertive community treatment*

Structure of services

An average of one staff per 10 service users
Available seven days and nights a week
Supported by 24-hour crisis services
Mobile to the person's home and local environment
Unlimited timeframe (i.e. services ongoing for as long as they are needed)
Individualised/tailored to the service-user

Services provided

Counselling and behavioural interventions
Medication administration
Treatment and monitoring of psychiatric and other medical needs
Interdisciplinary management (from psychiatrists, nurses, social workers, occupational therapists and psychologists, with vocational and substance abuse expertise within the team)
Assistance with functional needs (e.g. self-care, social, vocational, financial and accommodation)
Accompanying the service-user to doctor appointments and maintaining linkage to regular GP
Providing support, education and practical skills training to service-users and their families
Promoting the service-user's integration into the community

*Adapted from Rosen A, Teesson M. Aust N Z J Psychiatry 2001; 35: 731-746.

or encourage access to outside agencies for vocational pathways.[3] The value of work cannot be underestimated in a person's recovery, and many service-users actively seek work and training opportunities.

All types of work can be pathways for other opportunities.

Open employment

For some people with mental illness, open employment on the competitive market is an achievable goal. There are traineeships and apprenticeships that are specially funded for people with disabilities; particularly, but not solely, young people should be encouraged to pursue these opportunities.

Individual placement and support shemes

There is now a strong evidence base for individual placement and support schemes.[3] These schemes entail service-providers assisting service-users in finding a job fitting the user's interests, and then providing support for both the employee and employer.

Supported employment

One of the successes of vocational rehabilitation is supported employment. Fulltime and part-time mainstream jobs at award rates with on the job training and support are provided for people with mental illness by social enterprise businesses set up by mental health services.[15] Examples of businesses in Australia that are in partnership with health are cafes, nurseries, bush regeneration contractors with local councils, and gardening businesses.

Transitional and sheltered employment

Transitional employment is offered by some services, such as clubhouses. This enables members to have short term jobs (e.g. three to six months) in local businesses with support, which provides work experience, confidence and skills. If a worker is off sick, the clubhouse guarantees to provide another worker to take his or her place. Sheltered work opportunities are also available and traditionally include production and piecework at productivity based wage levels.

Service-users as paid service-providers

The services create paid work for service-users from within the mental health service budget. Work opportunities within the mental health arena have included consumer team leaders, individual care assistants, leisure co-ordinators, support people and drivers. Evidence from high quality studies clearly demonstrates that 'real work for real pay' correlates strongly with positive outcomes in people with a mental illness.[3]

Studying the shift to community care

A Sydney study, the Factors Affecting Community Tenure Study (FACTS), followed 47 long stay residents in a psychiatric hospital from six months before discharge into the community, until two years after discharge.[16-18] A brief six-year follow up was performed in 2000-2001.[19]

The residents had been continuously in the institution, which was closing, for between two and 43 years and would not usually have been considered for discharge at that point in time. With one injection of Commonwealth funding, they were resettled to four sets of households where they had 24-hour supervision, by familiar staff wherever possible.

The original study followed the residents for two years after discharge. In that period, seven residents returned to hospital for long term care, and one died of medical causes. All were replaced in the community by other long term hospital residents.

In residents who achieved two years community tenure (n=35), there was a significant improvement in psychotic symptoms without a significant change in the amount of neuroleptic medication used. There were no statistically significant changes in living skills, depressive symptoms or social behaviour problems. Importantly, there was an increase in residents' life satisfaction. Many of these findings were sustained at the six-year follow up,[19] and in an economic evaluation, community care was one-third to one-half of hospital costs – analysed on an occupied bed per day basis.[18]

These findings fairly closely replicate outcomes from the larger TAPS study in the UK, except that the costs of community living in the UK study were a much greater proportion of the costs of hospital living.[20-22] The reasons for this difference need to be studied further.

Deinstitutionalisation and community mental health care are not synonyms

Concerns have emerged from advocates of psychiatric hospitals about the aftermath of deinstitutionalisation in terms of homelessness among the mentally ill and the burden placed on families and the community, including the prison system.

Studies have show that many homeless people with mental illness, rather than having been deinstitutionalised, have actually spent very little time in mental hospitals.[23] These homeless are often independent in nature, out of reach of services, or not inclined to ever go anywhere near a hospital.

The myth that there is a linear relation between deinstitutionalisation and the homeless mentally ill population was dispelled in a five-year follow up of schizophrenia in homeless men.[24] Moreover, studies have shown how strategies such as assertive community treatment consistently stabilise homeless mentally ill individuals, including those who would otherwise be repeatedly arrested and imprisoned.[14,25] As Professor Paul Mullens, Professor of Forensic Psychiatry at the University of Melbourne, states: 'forensic psychiatry provides the best evidence that community services actually work!'[25]

Conclusion

Unless rigorous standards are set for the essential components of community mental health services, 'community care' could become a meaningless cliche, a generic expression labelling a diverse range of facilities and services, from the excellent to the gestural or nonexistent. At worst, it may become a cynical euphemism for communal neglect and intolerance and a withdrawal of resources as patients are transferred to the community.

The Australian National Mental Health Standards and its accreditation process help to ensure that the components of service are in place.[26] The main problem is that core community based psychiatric services have been resource starved, putting even more pressure on the remaining inpatient beds. Australian governments have left mental health services severely underfunded in regard to the large proportion of communal disability mental health accounts for, and compared with New Zealand and Europe. In terms of funding, mental health always loses out to more appealing areas of medicine and surgery, and community care is always eclipsed by the black hole of spiralling hospital costs. Good mental health care involves balancing and integrating community and hospital care, and properly resourcing both. MT

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