The configuration of mental health services to facilitate care for people with schizophrenia

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ABSTRACT

- In Australia, the configuration of public mental health services varies between States and Territories, but, overall, community-based services are increasingly integrated and responsive to people with schizophrenia.
- Community-based services include mobile crisis teams, providing home-based acute treatment, and case-management services for ongoing treatment.
- Service improvements have been uneven across Australia. Some people with schizophrenia in psychiatric crisis have had difficulty accessing either home-based acute psychiatric treatment or acute psychiatric beds.
- Social isolation and lack of meaningful occupation continue to be a problem for people with schizophrenia.
- Psychosocial interventions can enhance reintegration into the community. However, the number of community-based psychosocial rehabilitation programs is still inadequate.

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DEINSTITUTIONALISATION of mental health services has occurred over recent decades in many industrialised nations.[1] In Australia, the national framework for this reform was provided by the National Mental Health Policy[2] and the National Mental Health Plan.[3] This has led to the progressive closure of stand-alone mental hospitals, increased provision of integrated community-based services, and the mainstreaming of health services for people with mental illness, including the collocation of psychiatric units with general hospitals. The result has been a reduction in hospital beds for people with mental illness, a shorter average duration of inpatient treatment and more responsive community-oriented services.

Despite this overall progress, service improvements have been uneven, with variation between States and Territories in the provision and configuration of public mental health services.[4,5] The decline in institutional care has also raised public and professional concern about homeless people with mental illness. However, the increased number of these people is unlikely to be a direct or inevitable result of hospital closures,[6,7] and may have more to do with inadequate implementation of the deinstitutionalisation policy and inadequate provision of alternative community mental health services.[6,8] The difficulty of providing comprehensive community services in rural and remote areas is a further complication. Confronting these challenges has given rise to some innovative solutions, such as the use of telepsychiatry[9] and freecall "1800" telephone numbers for mental health triage.[10]

Acute treatment in public mental health services

Most Australian public mental health services provide a crisis/triage/intake access point 24 hours a day for acute treatment and care of people with mental illness, including schizophrenia (Box 1). Referrals for acute treatment are accepted from people in the community, including general practitioners, patients or their families. Scant data are available on the functioning of these service access points and the origin of referrals. One Melbourne study of an Area Mental Health Service found that, for most new referrals, GPs were not involved.[14]

An increasing number of public mental health services have mobile 24-hour crisis teams. These teams can assess and provide emergency treatment for patients in psychiatric crisis (either in their homes or in GP surgeries), initiate intensive short-term treatment and support in the community, or facilitate admission to a psychiatric inpatient unit. Mobile crisis teams offer community-based treatment as an alternative to hospitalisation, an approach that is more acceptable to patients and relatives and less disruptive and burdensome for families than standard care in hospital.[15,16] Where such crisis teams exist, the referrer discusses the situation of a patient in acute relapse with a member of the crisis staff (usually a non-medical team member), who then assesses where and how acute treatment should occur. Here the GP's knowledge of the patient's community support network (of friends and carers) can be helpful in deciding whether community-based acute management is appropriate.

Sometimes, this crisis or triage role is shared with multidisciplinary workers of a community mental health centre. Where community services are less well developed, the access point for people in acute relapse is more likely to be located within the inpatient or emergency service of a mainstream hospital. An increasing number of hospital emergency departments now have an associated mental health service that can provide emergency treatment and appropriate transfer of clinical care. Emergency depart-

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1: Treatment provided by public mental health services

For acute mental illness:

- Access to acute treatment is usually through either mobile 24-hour crisis teams or hospital inpatient and emergency services.
- Access to emergency departments by people with schizophrenia is especially appropriate when there is medical comorbidity.
- An increasing number of general hospital emergency departments now have an associated mental health service to provide emergency treatment and appropriate transfer of clinical care.
- Home-based acute treatment by mobile crisis teams is more acceptable to patients and families, and less disruptive and burdensome for families, than standard inpatient care.
- During psychiatric crises, education and support should be provided for families and friends, as this helps to maintain the patient's social networks.

For ongoing mental illness:

- People with schizophrenia requiring ongoing treatment are typically managed within a community mental health centre. Patients who may benefit from case management include those with frequent relapses, ongoing symptoms and/or substantial limitations of their activities.[11,12]
- Case management has been shown to reduce symptoms, improve social functioning and minimise drop-out from services.[13]
- The case manager has a central role in coordinating, integrating and allocating the care of individual patients.

ments are especially appropriate when there is medical comorbidity, a common finding in people with schizophrenia.[17,18] The growing emphasis on home-based acute psychiatric treatment, together with increasing demand and static bed numbers in some regions, has led to fewer and briefer inpatient admissions, and often a shortage of inpatient beds.[19] In many communities, this has meant that some people with schizophrenia in psychiatric crisis have been unable to obtain either home-based acute psychiatric treatment or a bed in an acute psychiatric ward.[19,20]

Whatever the setting for acute treatment, psychiatric crises are often disruptive for both patients and the people close to them. Through familiarity with the patient's social network, the GP can play an important role in providing timely education and support to help others deal with the emotional and practical impact of the patient's psychiatric crisis. In this way, people associated with the patient may find it easier to continue their support of the patient after recovery. One important aspect of education is to help people close to the patient to better understand the patient's difficult behaviours, such as hostility and social withdrawal, which may be associated with acute relapse. It is often better to sort out these issues between patient and family when the patient's clinical condition has stabilised. It is also important that the family not regard *all* angry behaviour by a person prone to schizophrenia as a sign of "relapse".

Case management: ongoing treatment in public mental health services

People with schizophrenia who require ongoing or maintenance treatment in public mental health services, such as those with frequent relapses, ongoing symptoms and/or major limitations of their activities, are most likely to be managed within a community mental health centre (Box 1). Community mental health centres are staffed by multidisciplinary teams of "case managers". According to the National Survey of Mental Health and Wellbeing,[21,22] 60% of Australians with psychotic disorders reported attending community mental health centres, and 56% had a case manager.

In Australia and internationally, the elements of "case management" provided by case managers are not clearly defined or agreed upon.[23] Hence, there is variation in the types of interventions practised. However, the majority of case management programs target vulnerable patients with prolonged psychiatric disorders who need interventions that will optimise their adjustment to community living and minimise their functional disabilities.[11] A common set of underlying principles includes continuity of care, facilitating access to services, and matching the patient's level of need with the amount and type of support.[11] Evaluating the impact of case-management services is difficult, but the growing consensus is that most services do achieve outcomes that are important for reintegrating people with schizophrenia into the community (namely, symptom reduction, improved social functioning and reduced drop-out of patients from services).[13] GPs play an important role in identifying patients who may benefit from case management, and the key link is the case manager, whose role is to coordinate, integrate and allocate the care of individual community mental health centre patients.[24]

Involuntary treatment under the Mental Health Act

Although details differ, involuntary treatment is provided for some people with schizophrenia under the relevant Mental Health Act in every jurisdiction in Australia. Essentially, where a person (a) appears to be mentally ill, (b) requires treatment of the mental illness and the treatment can be obtained, (c) needs admission for health or safety reasons, (d) has refused or is unable to consent to necessary treatment, and (e) cannot receive adequate treatment in a less restrictive way, the person can be recommended for involuntary admission to a psychiatric inpatient unit. Impaired insight, medication side effects, disorganised or paranoid mental states, adverse previous experiences of treatment, and poor relationships with service providers may all contribute to a person with schizophrenia refusing or being unable to consent to necessary treatment. Each of these problems requires separate attention as part of engagement and ongoing treatment.

In some States and Territories, patients admitted involuntarily can be discharged into the community for involuntary community treatment (eg, under a community treatment order, community counselling order, etc). These orders require patients to receive community-based treatment or return to hospital if their order is revoked. Previous episodes of unsatisfactory or involuntary treatment may make the patient reluctant to cooperate with treatment. Nevertheless, appropriate treatment in a supportive environment often

2: Evidence-based psychosocial treatments for schizophrenia, with level of evidence*

Individual and group therapies (E3)

Well-specified combinations of support, education and behavioural and cognitive skills training.

Family psychosocial interventions (E1)

Combination of education about the illness, family support, crisis intervention, and training in problem-solving skills (at least nine months in duration).

Vocational rehabilitation (E3)

Range of vocational services available for community-dwelling people with schizophrenia who meet specified criteria; prevocational training; transitional employment; supported employment; vocational counselling and education services.

Service systems (E1)

Systems of care serving people with schizophrenia who are high service users should include "assertive outreach" programs and target individuals at high risk for repeated re-hospitalisations or who have been "difficult to engage".

*Recommendations summarised from Lehmann et al[12] and levels of evidence (E1–E3) cited as nearest equivalent to levels of evidence specified in National Health and Medical Research Council guidelines.[33] (For NHMRC level-of-evidence codes, see Lambert and Castle, *page S*57.[31])

produces a subsidence in symptoms and disabilities, with some return of insight and willingness to engage in continuing care.

GPs may be involved in the process of recommending patients with schizophrenia for involuntary treatment. As the number of choices of treatment setting is increasing, this decision is best made by the GP in consultation with an experienced mental health practitioner, preferably a psychiatrist, who can advise on available alternatives.

The role of psychiatrists in private practice

A GP may refer a person with schizophrenia to a psychiatrist in private practice to confirm the diagnosis, to assess how the patient and illness interact in the patient's social context, and devise a clinical management plan. A system of shared care between the psychiatrist and the GP often evolves.[25]

Most private psychiatric services are outpatient-based, and the length of hospital stay in private inpatient clinics is limited by diminution of private-health-fund rebates over time. In general, psychiatrists in private practice do not have the same access to community multidisciplinary care teams and psychosocial rehabilitation as psychiatrists in the public sector. Therefore, people with recurrent relapses of schizophrenia and/or more complex psychosocial needs may not be readily managed by private psychiatrists, unless there are shared-care arrangements with a public community mental health service. However, patients stabilised after an acute episode and compliant with medication may be appropriately managed by a private psychiatrist in conjunction with the referring GP. A therapeutic relationship with the same doctor over an extended period allows greater opportunity to optimise the patient's functioning in the community. This continuity of care is valued by some patients and their families over the public system.[25] Psychiatrists in private practice often have expertise in particular subspecialties, including schizophrenia. Others have a special interest in long-term supportive therapy for patients and families, cognitive behavioural therapy, and psychopharmacology for schizophrenia. Information about these psychiatrists and their special interests is available from private psychiatrist group practices, Area Mental Health Services and the Royal Australian and New Zealand College of Psychiatrists.

Implications of community-based care

In practice, what does the increasing community orientation of services for people with schizophrenia mean for patients, their carers and GPs? The vast majority of people with schizophrenia now spend less time in hospital. This minimises disruption to their lives by allowing greater opportunity to maintain social connections with family and friends, continue studies or employment, and pursue other aspects of daily life without interruption. On the other hand, briefer admissions and increasing availability of home-treatment options for acute episodes place greater demands on family, friends and the GP (the greatest impact usually being on the family).[26,27] Moreover, the lack of readily available supported accommodation[8] as an alternative to living with a family or being in hospital is a significant factor in slowing recovery and promoting relapse.[20,28]

The delicate trade-off between benefits and possible disadvantages of community-based care is reflected in patients' reported experiences of community re-entry after inpatient care and their expressed preference for hospital or community living.[29] Studies report a clear preference of patients for community care, as it offers "freedom, choice, autonomy, mobility, privacy, safety, and proximity to family, friends and town of origin".[29] However, many of the same people describe their lives as lonely and devoid of meaningful activity. Social isolation and lack of meaningful occupation are also commonly identified in large community surveys of people with psychotic disorders in Australia.[8,22] Thus, the move towards community-based care presents complex challenges in maximising the benefits of community living. Well resourced and coordinated clinical services and community-based psychosocial rehabilitation programs provided by disability support services (including the non-governmental sector) are required. (For further discussion, see Crosse, *page S76.*[30])

Many people requiring periods of treatment in public mental health services experience limitations in their everyday activities. For example, over a third of Australians living with psychosis have no intimate relationships (a "best friend" with whom they can share thoughts and feelings), and 72% are unemployed.[22] Of the 42% claiming to have some occupation (including housework or studying), almost a third have experienced moderate or serious difficulty in performing such activities.[22] Pharmacological treatments may play an important role in alleviating such limitations in people's activities (see Lambert and Castle, *page S57*,[31] Pantelis and Lambert, *page S62*[32]). Furthermore, there is growing evidence for the effectiveness of psychosocial

interventions[12] that can enhance reintegration into the community (Box 2). For example, family interventions can reduce relapse rates of people with schizophrenia and improve their social functioning;[34,35] and the "supported employment" model of vocational rehabilitation has helped people with severe mental illness to obtain and keep paid employment.[36] However, complex and unresolved obstacles to service provision mean that psychosocial interventions are not routinely available, and this poses a significant barrier to reintegrating people with mental illness into the community.[37] While there are problems implementing and maintaining best practice, lack of funding has also prevented many services from grappling with these obstacles.

Within a mental health system that is complex and evolving, GPs can get the best out of local mental health services on behalf of their patients with schizophrenia by

- finding out about their local triage access point and the information it can provide on services, advice and referral for acute or ongoing psychiatric treatment;
- consulting an experienced mental health practitioner (accessed through the local triage system) to help make decisions about involuntary treatment and the available alternatives; and
- liaising with the appropriate case manager about all aspects of ongoing care, including any locally available community-based psychosocial rehabilitation services for people with mental illness.

Competing interests

None identified.

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