MELBOURNE HEALTH

MENTAL HEALTH REFORM IN VICTORIA: THE CONTINUUM OF CARE

Ruth Vine
Executive Director, NorthWestern Mental Health

CONTINUITY/CONTINUUM OF CARE

- Aim for same provider/team over time
- Sharing of information between services
- Easy in and easy out for people with chronic mental illness
- 'Stepped care' – range of low level to high level interventions.
- Electronic/self-help, Primary care, short term specialist, private practitioner, public mental health – episodic/ongoing

- **BUT – is it that easy?**

CONTEXT

- Mental Health generally recognised as being underfunded and hampered by fragmentation and confusion about State and Federal responsibilities.
- Australian government changes to funding streams – now to go through the PHN, with ability to change focus to meet community needs
- Increased awareness of mental health issues, but ? Increased understanding of severe mental illness. Note ABC ‘Changing Minds’.

RECENT AND IMMINENT CHANGES

- Development of the 10 yr mental health plan. Initial focus to include workforce (but ?non-clinical), suicide prevention, avoidable admissions
- Shift of responsibility for clinical mental health within DHHS to acute hospital division
- Positive budget outcome for the clinical sector – best in many years and provides for growth as well as new/expanded initiatives (FaPMI, FCS, peer workforce)

AND JUST OVER THE HORIZON

the NDIS

- NDIS represents a major shift in the provision of support to those with a disability
- Great that it has included disability related to psychiatric illness
- But – in Victoria we had prided ourselves on development of psychosocial rehabilitation in the NGO sector.
- PDSS changed to PDRSS changed to MHCSS
- Clinical sector concerned that rehabilitation is not part of NDIS and that the skill set and availability will be lost of reduced
- Will need strong advocacy and evidence to re-create in the clinical sector or to include in NDIS for those eligible

CURRENT ISSUES FOR THE CLINICAL SECTOR

- Escalating demand related to population growth, substance use – not met by increased capacity
- Particular pressure on IPU – increased acuity, decreased length of stay, increased occupational violence, increased direct prison release
- Episodic community care for recurring or enduring illness – a lot of 'churn', increased risk of relapses and consequent disability
- Staff pressures – struggle to keep staff in IPU, workforce availability not keeping up with need across all disciplines

BUT DOES THIS ACCORD WITH EVIDENCE BASED CARE?

- Evidence suggests that assertive engagement, continuity of care and skilled clinical management promotes best outcomes.
- Repeated relapse associated with poorer outcomes and difficulty in treatment effectiveness
- Most important aspect is good biological treatment with psychosocial rehabilitation
- Worrying increase in relapse and readmission over 6 – 12 months

CURRENT ISSUES FOR THE CLINICAL SECTOR

- Policy settings that encourage choice, autonomy, high threshold for compulsory treatment
- Limited access to assertive treatment and support
- Poor physical health outcomes – lifestyle, socio-economic factors, side effects of treatment, ?less access to primary care and physical health treatments.
- Average age at death of NWMH patients <65 who died was 47yrs. Suicide and cardiovascular disease most common causes.

CURRENT ISSUES FOR THE CLINICAL SECTOR

- So it feels like there is a lack of congruity between policy (choice, personal responsibility, autonomy, supported decision making), and the experience of clinical service providers (insufficient capacity resulting in service pressures that have negative impact on the effectiveness and quality of care).

- In some areas, especially growth corridors and prison mental health, service pressure is such that care is inadequate and service at risk of becoming dysfunctional

CRITICAL ACTIVITY

Assumption that we all want

- the best outcomes possible for people with mental illness and their families – good treatment, supportive care, maximum empowerment and agency
- Strong partnerships with other providers in primary care, PHN, NGO, consumer and carer advocacy organisations
- Open and accessible data to inform activity, investment and ensure equity across the State

? CONTINUUM OF CARE

- Will depend on funding and service flexibility.
- Much to be gained – address the premature mortality of people with severe mental illness and inefficient use of available resources by reducing readmission.
- But will require greater trust and acceptance of State and Federal funding lines and a real commitment to reduce fragmentation by funding core services at an acceptable and sustainable level.

Any Questions??