Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF SIMON PETER STAFRACE

I, Simon Peter Stafrace, Associate Professor of Alfred Health, 55 Commercial Road, Melbourne VIC 3004, in the State of Victoria, say as follows:

1 I am authorised by Alfred Health (**the Alfred**) to make this statement on its behalf.

2 I make this statement based on my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

3 As a record of my contribution to the Royal Commission into Victoria's Mental Health System (**VMHS**), I will draw attention to the documents included as attachments 'SPS-11' and 'SPS-12'. These are titled "Alfred Health Submission to the Royal Commission into VMHS" and "Alfred Health Submission for the Consultation on the Terms of Reference for the Royal Commission into Victoria's Mental Health System". These further reflect my thinking about the question of mental health reform being considered by the Commission.

Background and Qualifications

Please outline your relevant background including qualifications, relevant experience and provide a copy of your current CV.

4 I have the following qualifications:

(a) Bachelor of Medicine & Bachelor of Surgery (**MBBS**) from the University of Melbourne;

(b) Diploma of Clinical Hypnosis from the Australian Society of Hypnosis;

(c) Graduate Diploma of Mental Health Sciences (Clinical Hypnosis) from the University of Melbourne;

(d) Masters of Psychological Medicine from Monash University;

(e) Graduate Diploma of Health Services Management from Monash University; and

(f) Masters of Health Administration from La Trobe University.

5 I am a Fellow of the Royal Australian and New Zealand College of Psychiatry (**RANZCP**).

6 I was employed as an intern and Hospital Medical Officer at Box Hill Hospital from 1989-1992.

7 I was a psychiatry registrar in the North Eastern Metropolitan Psychiatry Training Program from 1992-1996.

8 I was a consultant psychiatrist at Bundoora Extended Care Centre (North-Western Area Mental Health Service) from 1996-1998.

9 I was a consultant psychiatrist in private practice in Box Hill, with admitting rights to Northpark Hospital, the Melbourne Clinic and Delmont Hospital, from 1996-2006.

10 I have held honorary appointments at Monash University as Clinical Adjunct Senior Lecturer from 2002-2011 and Clinical Adjunct Associate Professor since 2011.

11 I have held an appointment as a psychiatrist member, Medical Panels of Victoria since 2012.

12 I hold the following honorary appointments:

(a) Board Secretary of Tandem Inc, the peak body for families and carers of people in Victoria experiencing mental ill health.

(b) Board Director of Mental Health Victoria, the peak body representing mental health service providers in Victoria.

(c) Community Member of Inner South-East Metropolitan Partnership, Department of Jobs, Precincts & Regions.

(d) Chair, Community Collaboration Committee of the RANZCP.

13 I started at Alfred Health in 2000, as the Director of Aged Psychiatry at Caulfield Hospital. Since 2006 I have been the Program Director of Psychiatry at the Alfred. Last year, the program changed its name to Alfred Mental and Addiction Health (**AMAH**), and so my current position title is "Program Director of Alfred Mental and Addiction Health".

14 Attached to this statement and marked 'SPS-1' is a copy of my Curriculum Vitae, which sets out further details of my career to date.

Please describe your role and your responsibilities, specifically your current role as Program Director of Mental & Addiction Health at Alfred Health and your previous role as Director of Aged Psychiatry at Alfred Health.

15 In my current position at the Alfred, as the Program Director of Mental and Addiction Health, I have responsibility for the delivery of services at 12 locations across southern

metropolitan Melbourne. These include infant, child, youth, adult, liaison-emergency and aged mental health services, together with a research centre managed in partnership with Monash University.

16 Our program serves the community through seven clinics, two hospitals, three residential units and a series of partnerships. We also work with community providers including Star Health, Access Health, Launch Housing, Wellways, Taskforce, Odyssey, Headspace National and the SouthEast Melbourne Primary Healthcare Network (**SEMPHN**).

17 In my previous role as the Director of Aged Psychiatry at Caulfield Hospital, I was responsible for the delivery of specialist clinical aged mental health services in the inner south of metropolitan Melbourne, including a hospital inpatient service and consultation-liaison service at Caulfield Hospital, a community team, a specialist residential aged care facility (or psychogeriatric nursing home) and a memory clinic.

Alfred Health

What is Alfred Health and what services does it provide?

18 The Alfred is one of Victoria's major metropolitan health services, caring for people living in southern and bayside Melbourne through three hospital campuses, and numerous clinics and community-based services. The Alfred offers an extensive range of statewide services, with 13 programs delivering expert care to people throughout Victoria.[1]

19 The Alfred has a strong focus on education, including undergraduate and postgraduate training for medical, nursing, allied health, and support staff through partnerships with Monash, La Trobe and Deakin Universities. The Alfred also shares important research and development links with research institutes such as the Baker IDI and the Burnet Institute, who are our partners in the Alfred Medical Research and Education precinct.[2]

20 The Alfred has three hospital campuses, namely:

(a) **The Alfred Hospital** – a major tertiary referral hospital, it is best known as having one of Australia's busiest emergency and trauma centres and the State's largest Intensive Care Unit (**ICU**). The Alfred houses statewide services including the Victorian Adult Burns Service and Victoria's only heart and lung transplant service. The Alfred site also includes the Alfred Centre, a short-stay

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[1] Alfred Health, *Aboriginal Reconciliation Action Plan*, 3-4 <https://www.alfredhealth.org.au/contents/resources/corporate-publications/AH-Innovate-RAP-2017-2019.pdf>.
[2] Ibid.

elective surgery service and medical day-service centre which provides a model of care separating elective short-stay surgery from emergency surgery.[3]

(b) **Caulfield Hospital** – specialises in community services, rehabilitation, geriatric medicine and aged mental health. Many services are delivered through outpatient and community-based programs. The hospital plays a statewide role in rehabilitation services, which includes the Acquired Brain Injury Rehabilitation Centre.[4]

(c) **Sandringham Hospital** – is community focused, providing hospital healthcare needs for the local area through emergency, paediatrics, general medicine and outpatient services.[5]

21 The Alfred provides the following mental health services:

(a) ***Adult Community Mental Health Service*** provides mental health assessment, treatment and support to adult clients aged 25-64 years living in the Inner South of Melbourne.[6] : The service is based at the St Kilda Road Clinic (607 St Kilda Road, Melbourne) and /.includes the:

(1) **Navigations Service (**Navigations**)**: established in 2018, Navigations provides an interface with primary and specialist referrers. Navigations also provides intake services; primary mental health consultations; assessment and short-term treatment (1-3 months) for patients referred by GPs and specialist Mental Health Services (**MHS**); and transition of patients with stable conditions managed by the Continuing Care Teams , back to GPs.

(2) **Continuing Care Teams (CCT):** consultant-led multidisciplinary teams that provide ongoing specialist medical and psychosocial care to patients living in their own homes who have a severe and enduring mental illness, at moderate to high risk of clinical deterioration and hospitalization. These patients require medical, psychosocial care in order to achieve recovery. The duration of continuing care is between 3-24 months on average.

(3) **Adult Community Residential Mental Health services:** based at the Alma Road Community Care Unit (**CCU**) in East St Kilda and the Prevention and Recovery Care (**PARC**) Unit in South Yarra. The Adult

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3 Ibid.
4 Ibid.
5 Ibid.
6 Alfred Health, *Adult Community Mental Health* <https://www.alfredhealth.org.au/services/adult-community-mental-health>

Community Residential Mental Health services provide residential community options, to assist people with a need for sub-acute or non-acute care and rehabilitation.[7]

- Sub-acute care is short-term treatment of 1-6 months' duration, for patients recovering from mental illness or who are experiencing the early signs of a relapse of mental illness and who need an early intervention in order to prevent further clinical deterioration. Sub-acute care can be provided in the PARC unit (< 1 month) or the CCU (1-6 months).
- Non-acute care is usually treatment of 6-36 months' duration. At the Alfred, non-acute care is provided in our residential CCU. It involves a period of assessment, during which the resident's medical, cognitive, behavioural, emotional, social and cultural needs are assessed. This is followed by a period of continuing care or rehabilitation, during which the resident works towards identified recovery goals and eventually transitions into longer-term independent accommodation, which may or may not be supported.

(4) **Homeless Outreach Psychiatry Service (HOPS)**: provides comprehensive mental health assessment, treatment and support to adult clients who are experiencing mental health issues and are homeless or at risk of homelessness and are difficult to engage.[8]

(5) **Mobile Support and Treatment Service (MSTS)**: provides intensive mental health assessment, treatment, rehabilitation and support to adult clients who are experiencing mental health issues.[9]

(6) **Southcity Alcohol and Other Drug (AOD) Clinic:** provides clinic-based services for patients with alcohol and opiate-use disorders.

(7) **Specialist consultation services:** within the adult community mental health service include:

- Consumer and carer peer workers which have been since 2016.
- Addiction Nurse Practitioner which has been available since 2017.

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7 Alfred Health, *Adult Community Residential Mental Health* <https://www.alfredhealth.org.au/services/adult-community-residential-mental-health>.

8 Alfred Health, *Homeless Outreach Psychiatric Service* <https://www.alfredhealth.org.au/services/homeless-outreach-psychiatric-service>.

9 Alfred Health, *The Mobile Support and Treatment Service* <https://www.alfredhealth.org.au/services/mobile-support-treatment-team>.

- Physical health hub, which is expected to be implemented in late 2019. . This initiative will include access to an exercise physiologist, dietitian and nurse practitioner.
- Community pharmacist.
- Forensic Clinical Specialists who provide forensic consultation for patients managed by AMAH and are linked to Forensicare, Victoria's statewide forensic mental health service.
- Family services which have been available since 2015.
- Dialectic-Behaviour Therapy (for patients with borderline personality disorders) which has been available since 2008.
- We are now in the process of establishing a Personality Disorders Consultation Service in partnership with Spectrum, the statewide service for personality disorders. This will provide consultation to clinical services at the Alfred and limited structured ongoing treatment for patients.

(8) **Adult Inpatient Mental Health Service** provides care to patients aged 18-64, who require hospitalisation for the treatment of acute, high-risk presentations of mental illness. Based at the Alfred Hospital, there are 58 beds across two wards, including 14 beds in two High Dependency Units (**HDU**) and 44 beds in two Low Dependency Units (**LDU**).

- Four of the fourteen HDU beds are allocated to the **Statewide Intensive Care Service**. This is a service provided to patients who are deemed unsafe in other acute inpatient mental health services, by virtue of aggression directed towards other patients or clinicians[10].

(9) **Liaison and Emergency Psychiatry and Addiction Service:** based at the Alfred hospital and includes the following services:

- **Triage:** a 24-hour telephone support and triage for service users and referrers seeking acute care. The triage phone number allows service users to access any part of the service, even if the need is less urgent.

[10] Alfred Health, *Adult Inpatient Mental Health* <https://www.alfredhealth.org.au/services/adult-inpatient-mental-health>

- **Crisis Assessment & Treatment Team (CATT)**: provides outreach, including in-home, assessment and treatment from 0700-2200hrs.
- **The Alfred Police, Ambulance and Community Engagement Response (A-PACER)**: provides a joint police-mental health response in the community.
- **Consultation-liaison psychiatry and addiction service:** provides liaison and consultation to patients referred from the medical and surgical wards of the Alfred. There is a limited service to Sandringham Hospital.[11]
- **Emergency Psychiatry and Addiction Service (EPAS):** provides consultation and liaison to patients seen in the Emergency Department (**ED**), including the West Wing, the Mental Health-Addiction Hub in ED into which patients are streamed if at low to moderate behavioural risk.
- **Hospital Outreach Postsuicide Engagement (HOPE):** provides follow-up to patients with moderate risk of self-harm, who present to the ED or are admitted to the hospital (mental health or otherwise) following a suicide attempt or with suicidal ideation. This program employs support workers, psychologists, a family therapist, a psychiatrist and a social worker.
- **Alfred Mental Health and Gambling Harm Program:** is a statewide multidisciplinary service that provides support to front-line problem gambling services in their work with clients that are experiencing mental health as well as gambling difficulties. The Program promotes partnerships between Gambler's Help Services and Victorian Area Mental Health Services.[12]

(b) **Aged Persons Mental Health Service (APMHS):** provides mental health services to people over the age of 65 years living in the inner south of Melbourne.[13] It includes;

(1) An **aged inpatient unit** based at Caulfield Hospital, called Baringa, with 15 beds.[14]

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[11] Alfred Health, *Emergency Psychiatry* <https://www.alfredhealth.org.au/services/emergency-psychiatry>.
[12] https://responsiblegambling.vic.gov.au/for-professionals/health-and-community-professionals/who-we-work/alfred-health-program/
[13] Alfred Health, *Aged Community Mental Health* <https://www.alfredhealth.org.au/services/aged-community-mental-health>

(2) **Mobile Aged Psychiatry Service (MAPS)**, which provides outreach assessment, treatment and support to older people living in their own homes, supported accommodation or in residential aged care.

(3) **Caulfield Hospital Consultation-Liaison Psychiatry Service**, which provides mental health services to the aged care, rehabilitation and acquired brain injury services at Caulfield Hospital.

(4) **Headspace-Child & Youth Mental Health Service (H-CYMHS)**, provides a co-ordinated mental health service for young people and their families.[15] It includes:

- **Assessment and treatment sector mental health teams** for the management of mental health issues in children and youth aged 3-24 years and their families;
- An **infant and pre-school mental health service** for the management of mental health issues in children aged 0-3 years and their families;[16]
- A **neurodevelopmental program** for children and youth with autism-spectrum disorders and their families;[17]
- An **eating disorders** program;
- A **forensic youth** mental health program;
- An **Early Intervention Mobile Outreach Service** that provides intensive outreach mental health case management to clients and their families struggling with, or at high risk of, mental or behavioural disturbance.[18]

(5) **Headspace Elsternwick** is a primary mental health program for young people aged 12-24 years, that provides access to GPs, a psychiatrist, psychologists and other mental health clinicians; family therapy services; school and work assistance; vocational support and postsuicide support to schools and the community.

(6) **Headspace Youth Early Psychosis Program** is based at headspace centres in Elsternwick, Bentleigh, Narre Warren, Dandenong and Frankston. It provides access to triage support, assessment & treatment

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14 Alfred Health, *Aged Inpatient Mental Health* <https://www.alfredhealth.org.au/services/aged-inpatient-mental-health>.
15 Alfred Health, *Child & Youth Mental Health Service* <https://www.alfredhealth.org.au/services/child-youth-mental-health-service>.
16 Alfred Health, *Infant and Preschool Team* <https://www.alfredhealth.org.au/services/infant-program>.
17 Alfred Health, *Neurodevelopmental Stream* <https://www.alfredhealth.org.au/services/neurodevelopmental-stream>.
18 Alfred Health, *Early Intervention Mobile Outreach Service* <https://www.alfredhealth.org.au/services/eimos>.

services through the CCTs, mobile support and treatment through the Mobile Assessment and Treatment Service (**MATS**) and a recovery-based psychoeducational service called the Discovery College.[19]

Where does Alfred Health fit within the mental health system?

22 Alfred Health provides clinical specialist services funded by the State (mental health, AOD and justice) and Commonwealth (headspace Elsternwick, headspace Youth Early Psychosis and headspace BounceBack program) governments.

23 We provide integrated[20] catchment area mental health services in hospital and community settings to infants, children, youth, adults and aged persons living in a defined geographical area in the Inner South-East of Metropolitan Melbourne.

24 We provide a regional AOD service, which delivers pharmacotherapy and other services to the southern metropolitan region.

25 We provide statewide hospital psychiatric intensive care and gambling mental health programs.

26 We provide headspace primary and youth early psychosis mental health services with no catchment restrictions.

27 We provide emergency, consultation and liaison mental health and addiction services to the Alfred and Caulfield Hospitals with a limited service to Sandringham Hospital.

Who receives Alfred Health's services?

28 Practice in all programs at the Alfred is changing in the context of the growth in funding that commenced in FY17 and the subsequent strategic and operational planning we undertook in response. We are now developing and implementing changes to our models of care, in order to deliver a broader range of interventions.

29 In order to answer this question, I would like to provide a snapshot of the numbers of people using each service in the past three financial years and the diagnoses with which they presented. This does not reflect our clients' needs, the risks to themselves or others, or the needs of the families who supported them. I simply intend to provide a superficial overview of the kinds of clinical problems managed by clinicians at the Alfred.

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[19] Attached to this statement and marked SS-2 are tables indicating the activity and diagnoses of patients utilising the Adult Community Mental Health Services of AMAH Health, *headspace* <https://www.alfredhealth.org.au/services/headspace>.

[20] i.e. inpatient, community and rehabilitation mental health services.

30 The number of patients who used the Adult Community Mental Health Service **(CMHS**) in FY19 was 1,307. This was a 10.4% increase since FY17. Schizophrenia-related illnesses were the primary diagnosis in 72% of clients; Mood disorders in 12%; Personality Disorders in 6%; Substance Use Disorders (**SUD**) in 5%; and Anxiety, Stress-related and Somatoform Disorders in 3%. SUD were a secondary diagnosis in 38% of clients.

31 Attached to this statement and marked 'SPS-2 SPS-5**'** are tables indicating the activity and diagnoses of patients utilising the **Adult Community Mental Health Services** (CMHS) of AMAH.

32 The number of patients who used the Aged CMHS in FY19 was 364. This was a 12.9% decrease since FY17. Schizophrenia-related illnesses were the primary diagnosis in 32% of clients; Organic disorders (including dementia & delirium) in 20%; Mood disorders in 29%; Personality Disorders in 2%; and Anxiety, Stress-related and Somatoform Disorders in 5%. SUDs were a secondary diagnosis in 2% of clients.

33 Attached to this statement and marked 'SPS-3' are tables indicating the activity and diagnoses of patients utilising the **Aged Community Mental Health Services (Aged CMHS)** of AMAH.

34 The number of patients who used the Child & Youth Mental Health Service (**CYMHS**) in FY19 was 1,016. This was a 7.5% increase since FY17. "Other" diagnoses were the primary diagnosis in 33% of clients; Anxiety, Stress-related and Somatoform Disorders in 23% of clients; disorders of psychological development 16%; disorders with onset in child or adolescence in 11%; Mood disorders in 9%; Personality Disorders in 7%; SUD in 1%; and in 3%. SUD were a secondary diagnosis in 2%.

35 Attached to this statement and marked 'SPS-4' are tables indicating the activity and diagnoses of patients utilising the **Child & Youth Mental Health Services** (CYMHS) of AMAH. CYMHS is a community mental health service exclusively.

36 The number of patients who used the headspace youth early psychosis program in FY19 was 581. This was a 2.3% increase since FY17. Schizophrenia-related illnesses were the primary diagnosis in 35% of clients; Anxiety, Stress-related and Somatoform Disorders in 28% of clients; Mood disorders in 12%; Personality Disorders in 8%; and SUD in 6%. The diagnostic profile is more varied than some might expect because patients are referred when they experience psychosis-like symptoms including delusions, hallucinations or disorganized thinking and behaviour. They may also be referred should they experience early warning signs of psychosis, known as prodromal symptoms. Many of these patients do not go on to develop a psychotic illness, but receive treatment from the program until they have recovered.

37 Attached to this statement and marked 'SPS-5' are tables indicating the activity and diagnoses of patients utilising the **headspace Youth Early Psychosis Program and headspace (primary mental health) Elsternwick** of AMAH.

38 The number of direct assessments undertaken in the headspace primary centre at Elsternwick in FY19 was 1,617. This was a 54.9% increase since FY17. Mood disorders were the primary diagnosis in 31.2% of clients; Anxiety, Stress-related and Somatoform Disorders in 37.1%; Psychosocial issues in 12.8%; Personality and Behavioural Disorders in 7.7%; SUD in 1.2%; and Other diagnoses in 10%.

39 The number of patients treated in adult inpatient unit at the Alfred in FY19 was 951, and total number of separations was 1,291. This represented a 1% decrease in the number of patients treated and a 2.8% decrease in separations since FY17. During FY18 and FY19, refurbishment works led to the closure of beds and the loss of about 3% of total available bed-days. In FY19, primary diagnoses of admitted patients included schizophrenia-related disorders in 41% of clients, mood disorders in 17%; disorders of personality and behaviour in 10%; SUDs in 16%; and Anxiety and Somatoform Disorders in 6% of clients. Patients in whom SUDs represent a primary or secondary diagnosis occupy at least 47 per cent of bed days on our inpatient unit.

40 The number of patients treated in the aged inpatient unit at Caulfield Hospital in FY19 was 128, and the total number of separations was 153. This represented a 9.4% increase in the total number of patients treated and a 3.4% increase in the number of separations since FY17. In FY19, the primary diagnoses of admitted patients included schizophrenia-related disorders in 37% of clients, mood disorders in 33%; organic disorders including dementia in 16%; disorders of personality & behaviour in 3%; SUDs in 3%; and Anxiety, Stress-related and Somatoform Disorders in 4% of clients.

41 Attached to this statement and marked 'SPS-6' are tables indicating the activity and diagnoses of patients utilising the Adult & Aged Inpatient Units of AMAH.

42 In the ED at the Alfred, from FY14 and FY18, an average 3.4 per cent of all presentations were due to 'alcohol or drug intoxication, poisoning or disorder', and 4.6 per cent were due to 'Psychiatric, behavioural, social' causes. I will provide more information about activity in the emergency department later in this statement.

43 Attached to this statement and marked 'SPS-7' are tables indicating the activity and of patients utilising the **Emergency Department (ED) of The Alfred Hospital**.

44 The number of patients treated by CATT/Early Discharge Management (**EDM**) in FY19 was 758, and total number of closed cases (or separations) was 913. This represented a 2.8% increase in the number of patients treated and a 7.4% increase in separations since FY17. In FY19, the primary diagnoses of treated patients included schizophrenia-

related disorders in 34% of clients, mood disorders in 23%; disorders of personality & behaviour in 14%; SUDs in 8%; Anxiety, Stress and Somatoform Disorders in 10% of clients; and other diagnoses in 11%. Patients with a secondary SUD represented 31% of the client group.

45 Attached to this statement and marked 'SPS-8' are tables indicating the activity and of patients utilising the **CATT & EDM (Early Discharge Management- a CATT function)**.

What are the criteria for people affected by mental illness to access Alfred Health's services?

46 The people who receive Alfred Health's mental health services are those who:

(a) call or are referred via the Alfred Health Mental Health Triage (including PACER) or intake or present to an Alfred Health ED;

(b) suffer from severe mental illness or mental distress; and

(c) have experienced a clinical deterioration, with or without evidence of self-harm or attempted suicide; or, are at imminent risk of clinical deterioration and hospitalization and/or harm to self or others; or are recovering from an episode of mental illness or mental distress characterised by these features and are at short-term risk of relapse.

47 Service from intake or triage requires that the person live within a defined geographic catchment or is seeking service from a regional, statewide or headspace service.

48 All patients attending the ED receive an assessment, emergency treatment and a discharge plan.

49 Triage is a clinical telephone service provided by Alfred Health (in common with every other area mental health service) for people experiencing mental illness or their families or referrers. It is used for patients of all ages after business hours. During business hours, calls on behalf of children, youth and older persons are transferred to the intake workers in those service streams.

(a) Triage clinicians assess risk, determine whether a specialist mental health service response is needed and set the urgency of response required. The latter is undertaken using a structured decision-making instrument, called the Victorian Mental Health Triage (**MHT**) Scale. This classifies the urgency of response according to a scale from A-G.[21]

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[21] <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/triage-scale-mental-health-services>.

(b) Any patient who calls triage will talk to a clinician who: is trained to listen compassionately; asks a series of questions intended to help formulate the client's issues; and talks through this formulation with the client and/or referrer. The clinician and the caller will then work out: what needs to be done; whether a service is required from the specialist MHS; the level of risk to the person and/or others; and the urgency of response required from the mental health or other services.

(c) A patient assessed as mentally ill, at high risk and requiring an urgent specialist response will receive a response defined by MHT categories A-D and then either attended to by police and ambulance (category A), or seen by the crisis CATT within 2-72 hours (categories B-D). Non-urgent referrals are referred to a specialist mental health service such as the community MHS (category E), a primary mental health service including GPs and mental health specialists (category F) or given telephone advice (category G).

50 The adult patients who most predictably receive a face-to-face service from the CATT or PACER tend to have an emerging or established psychotic, mood, personality, behavioural or stress-related disorder, with or without a SUD. They are deemed to be at high and imminent risk to self or others by virtue of their behaviour and a primary mental health condition. They are assessed as requiring an urgent response. Some will meet criteria under the *Mental Health Act 2014* (Vic) for an assessment order and compulsory treatment. The typical average duration of contact with the CATT is about 7-14 days.

51 A similar approach is adopted in the ED and in the child, youth and aged persons MHS. In the ED, the assessment of urgency and the workload in ED shapes the time to assessment. Typically, about 80% of patients not admitted to hospital are seen and sent home within four hours in this setting.

52 Adult patients who do not meet criteria for an urgent response can be referred to the community adult mental health service, where the referral will be processed by an Intake clinician. Alternatively, they may be referred to a GP or specialist in the community, depending on whether or not the presentation is complex and what degree of care coordination is required.

53 At The Alfred, the adult (25-64 years) patients who most reliably gain access to the adult community mental health service are those with a severe mental illness who are discharged from a specialist psychiatric inpatient unit or the general hospital and require specialist follow-up. They are typically assessed as being at risk of further hospitalisation. The community adult MHS also accepts referrals from a GP for a primary mental health consultation.

54 The patients for whom access to the community adult MHS is least predictable are those who do not have an urgent need to access specialist services in order to prevent harm, clinical deterioration or hospitalisation.

55 In a similar way, access to APMHS (persons 65 years and over) is available to older persons with complex moderate to severe mental health problems requiring a multidisciplinary or outreach specialist response. Patients requiring assessment of cognitive impairment are referred to the Cognition, Dementiaand Memory Service (**CDAMS**). Patients with delirium are referred to a hospital outreach service, with or without APMHS support, or ED.

56 Patients admitted to the Alfred Hospital medical and surgical units can be referred to the liaison psychiatry and addiction service for diagnostic or treatment purposes.

(a) This team deals with complex mental and addiction health issues. Interventions include pharmacotherapy, managing drug or alcohol withdrawal, and managing behavioural issues such as violence, aggression, self-harm or suicidal ideation. Support is offered to both clinical staff in the medical/surgical units and to patients.

(b) One way in which behavioural risks are managed in the hospital is through the use of additional nurses or care attendants to provide support and closer observation. When this involves a patient with mental health problems, our service is responsible for the allocation of additional resources and the development and review of behavioural plans.

57 Barriers for entry into the child and youth services are much lower because the service framework includes explicitly primary mental health services, in addition to specialist services. For example:

(a) Headspace primary centres (for persons aged 12-24 years) are set up to ensure a “no wrong door” approach. Any young person who contacts intake at headspace will be offered an appointment with a clinician if that is the young person’s preference and a GP provides a mental health plan.

(b) Access to specialist child and youth services, including the **headspace Youth Early Psychosis Program** (**hYEPP**), is open to people with complex and moderate or severe presentations. Access is facilitated by a Single Session Family Therapy service, which provides eligible clients with a family-based assessment. Patients receive individual or ongoing family therapy and continuing care if problems remain unresolved.

Must Alfred Health's clients come from any geographic location?

58 Alfred Health provides specialist clinical mental health services to adults and aged persons living in a defined catchment area bounded by:

(a) The Statistical Local Areas known as Fisherman's Bend, Port Melbourne, South Wharf (Docklands), Southbank & South Yarra-West, in the Melbourne local government area (**LGA**).

(b) Stonnington and Port Phillip LGAs.

(c) Glen Eira LGA, north of North Road.

59 Alfred CYMHS provide:

(a) Child and youth services (0-24 years) to the same catchment area as the adult and aged services;and

(b) Child and adolescent services (0-17 years) in Kingston and Bayside LGA and the Waverley-West SLA in the Monash LGA.

60 The headspace primary centre in Elsternwick and the hYEPP based in the headspace centres in Elsternwick, Bentleigh, Narre Warren, Dandenong and Frankston do not restrict service to residents of a specific catchment area, with the exception of the hYEPP Mobile Assessment and Treatment Service (**MATS**), which restricts its outreach services to the Southern Metropolitan Region.

61 Regional and statewide services include:

(a) Southcity Clinic, an AOD service that specialises in the provision of opiate replacement therapy and the treatment of alcohol use disorders. It serves the Southern metropolitan region.

(b) The Alfred Psychiatry Intensive Care Statewide Service, and acute inpatient service comprising four beds, located in the high dependency area of the Alfred Inpatient Unit (**IPU**).[22]

(c) The Alfred Mental Health and Gambling Harm program, a community-based service that provides support to front-line problem gambling services in their work with clients who are experiencing mental health as well as gambling difficulties.[23]

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[22] <https://www.alfredhealth.org.au/services/psychiatric-intensive-care-service>.
[23] <https://responsiblegambling.vic.gov.au/for-professionals/health-and-community-professionals/who-we-work/alfred-health-program/>.

62 The consequences for patients of having some services limited by catchment areas that do not encompass all age groups are discussed in more detail later in my statement.

Does Alfred Health assist people affected by mental illness with all degrees of severity and complexity? If not, what kinds of providers would meet the needs of those people outside of Alfred Health's reach? What other parts of the mental health system are your patients likely to use (or want to use)?

63 The answer to this question is multi-faceted.

(a) Our child and aged persons' services see mostly moderate and complex or severe presentations of mental illness.

(b) Our youth services (including headspace) see people affected by mental illness of all levels of severity.

(c) Our adult services mostly focus on people who have severe mental illness, are at high risk of harm, clinical deterioration or hospitalization and require an urgent response from a specialist mental health service. Alternatively, patients may be recovering from such an episode of illness and are at short-term risk of recurrence.

(d) Patients with mental illness of mild to moderate severity, including those with complex needs, do not receive a service if their risks (of clinical deterioration) are low, their needs are not urgent, and the risk of hospitalization is low.

(1) These are patients whose clinical needs will be met through the stepped care primary mental health system, comprising some combination of:

- General Practitioners, for physical health and primary mental health needs.
- A clinical or other psychologist or other mental health practitioner, for psychosocial treatment and care including psychotherapy and counselling.
- A psychiatrist, for medical specialist mental healthcare.
- An AOD service for supervised withdrawal, counselling or rehabilitation.

(2) Their psychosocial needs will be met by:

- An NDIS-funded service to support personal and instrumental activities of daily living, employment, training and education, transport and mobility and therapeutic support to enhance relationships, social connection and social participation.

- An Early Intervention and Psychosocial Rehabilitation Service to provide personal and functional support in clients who do not qualify for NDIS.

(e) Other services clients of Alfred Health frequently reach out to include:

(1) clinical mental health services not available at the Alfred, such as eating disorders services and mother-baby units for perinatal care, which are provided regionally in the Southern Metropolitan region at Monash Health;

(2) private hospital mental health services;

(3) housing providers including Launch Housing and HousingVic for public and community housing;

(4) Centrelink for income support;

(5) schools, universities and employers;

(6) Disability Employment Services;

(7) family and domestic violence services including Child First, Orange Door, safesteps, and Centres Against Sexual Assault (**CASA**);

(8) Victorian Legal Aid;

(9) aged care providers for residential aged care and in-home support services; and

(10) Dementia Support Australia, including Dementia and Behaviour Management Advisory Service (**DBMAS**) and Severe Behaviour Response Teams (**SBRT**).

How do your services deliver community-based care?

64 Please refer to my response in paragraph 21(a).

(a) The community services outlined in section 20 are delivered via telephone, clinic-based appointments and home visits to clients, families and referrers.

(b) Clients will engage clinically with psychiatrists, registrars, nurses and nurse practitioners, and allied health practitioners, as outlined in paragraph 21.

(c) Clients also have access to carer and consumer peer workers in all parts of the service.

(d) It bears noting that all classes of clinicians, support and peer workers are limited in number. It is therefore not the case that every patient attending AMAH community MHS see any clinician they ask for. The service is arranged into consultant-led multidisciplinary teams. Clients of the service will have regular

contact with a single clinician known as their case manager. They will have less frequent contact with a psychiatry registrar or consultant, depending on need. Referrals to clinicians from other disciplines are undertaken according to the patient's needs.

Briefly, how is Alfred Health funded?

65 In 2019-2020, Alfred Health's funding will be derived from the following sources:

(a) State government (84%)

(1) Mental Health stream: (83%);

(2) AOD stream: (0.5%); and

(3) Gambling Health stream: (0.5%).

(b) Commonwealth government (15%)

(1) Headspace Elsternwick: (1.3%); and

(2) Headspace Youth Early Psychosis Program: (14%).

Current demands

In your experience, in relation to the needs of people affected by mental illness for clinical treatment:

Is supply keeping up with demand?

66 In order to answer this question, I will assume supply to mean the provision of:

(a) Acute inpatient care for urgently needed specialist diagnostic services, intensive observation and multidisciplinary treatment and care for patients who are severely ill and at imminent and high risk of harm to self or others.

(b) Community-based mental and addiction health services that are able to provide:

(1) early intervention,

(2) short-term therapies or continuing care options for patients with non-urgent complex needs, and

(3) intensive care options, accessible and acceptable to patients with urgent needs.

67 This is a difficult question to answer because there are many moving parts.

68 Between 2013 and 2018, the population of our catchment increased about 12 per cent.[24] In the same period, the total number of patients presenting to the ED with mental and behavioural disorders grew on average about 3.4 per cent per annum.

69 The allocation of beds in our acute, sub-acute and non-acute (rehabilitation) settings has remained unchanged since 2004, despite a considerable increase in the population of our catchment and the metropolitan area more broadly.

70 In contrast, our spending on mental and addiction health services in the general hospital and ED has increased as a result initially of budget bids that were initially approved by the Alfred Health CEO in response to the growing demand in both parts of the health service.

71 The total number of screening registers completed for FY19 was 8,804, an 8.7% increase in number compared to FY17. This increase was almost entirely attributable to demand via the emergency department. It indicates that the specialist services we have put in place in the ED are assessing, treating or providing consultation for more patients than ever.

72 Attached to this statement and marked 'SPS-9' is a table showing the total number of screening registers generated by our emergency intake system through triage, PACER and the emergency department.

73 The Alfred IPU underwent extensive refurbishment in FY 18 and FY 19, as a result of which about 3% of occupied bed-days were unavailable due to bed closures. Alternative beds were commissioned in a separate unit, but these could not be used for high-risk patients. Changes in practice to accommodate the refurbishment were of relatively short duration for the period of the works.

74 Taking this disruption to normal operations into account, the table indicates that the IPU in FY19 discharged 19% more patients per month than in FY14. This increase in activity has been achieved in part by reducing the length of stay (**LOS**) from 19 to 15 days and by ensuring every bed is occupied, all the time. Occupancy, or the percentage of beds used by a patient at midnight each day, has ranged between 98-101% since FY15, meaning that close to every bed in our adult IPU is occupied every day.

75 Attached to this statement and marked 'SPS-10' is Table 17, which provides indicators about the performance of the Alfred Health Adult Inpatient Unit between FY14 and

[24] From 369,260 to 414,760 (ABS).

FY19. This will shed further light on the question of whether demand and supply are matched.

76 What is driving this increased demand?

(a) The data tells us it is not due to a change in practice, such as a change in the revocation of Community Treatment Orders (**CTO**). The proportion of admissions related to revoked CTO actually dropped from 18% to 12% from FY14-FY19. We are also using fewer community treatment orders at discharge- 24% of patients in FY19 left hospital on a CTO compared to 30% in FY14.

(b) Neither is it due to an increase in the proportion of people presenting to the hospital for the first time; patients who may have missed out on the opportunity to receive early intervention from our community services. That proportion has remained stable between 40-43% from FY14-19.

77 A number of factors stand out in this dataset, and to which I will draw attention:

(a) The total numbers of patients with mental and behavioural disorders presenting to ED in FY19 were 27% higher than in FY14, and the numbers of patients who received a service from the specialist Mental and Addiction Health stream in ED increased by 102% in the same period. At the same time, the proportion of bed-days allocated to patients with out-of-area addresses increased from a low of 15% in FY14 to a peak of 27% in FY18.

(b) The number of discharges per month remained high, despite the refurbishment, compared to FY14. The IPU LOS dropped gradually, which could mean that either our care was more efficient or that we were responding to demand pressures by discharging patients earlier. The question arises whether this is inappropriate insofar as patient well-being is concerned. Patients and families are best placed to comment, but I note that our length of stay is high compared to other services in Victoria and our readmission rate at 28 days, an indicator of rapid relapse which could signal inappropriately early discharge (amongst other problems), did not change during this time and remained below state targets.

(c) At the same time, there was a gradual deterioration in ED performance with 4 and 8-hour waits declining from a peak of 74% and 91% respectively in FY15, to 61% and 80% respectively in FY19, with performance in the last two quarters of the year declining further below the average achieved for the full year. Patients waited longer to access a bed at The Alfred in FY19 compared to FY15.

(d) The percentage of patients being admitted directly from the community fell from a peak of 35% in FY16 to 12%. Meanwhile, the percentage of patients being admitted via the medical wards at the Alfred increased from 4% to 20% between FY14-19; and via the ED at the Alfred from a low of 49% in FY16 to a high of 64% in FY19.

78 My conclusion from this is that the demand for mental health and addiction services from adult patients with high risks and urgent needs is not being met adequately.

(a) The increased demand is from both within and outside the catchment, given the increased utilization of bed-days by out-of-area patients.

(b) Patients are waiting longer in ED and some are being admitted to medical wards on their way to a psychiatric bed. This could be an admission strategy to facilitate exit from ED, or the result of injuries or illnesses, which may or may not be related to the primary mental illness.

(c) The lack of beds means that direct admissions of patients experiencing clinical deterioration from the community is getting harder to arrange.

(d) The lack of capacity in the community, which is presently being addressed, may contribute to these trends in that opportunities for prevention may not be available to clients. Regrettably, our dataset does not allow us to explore this hypothesis further.

Is the pressure managed by discharging people as soon as you reasonably can?

79 Discharging people out of hospital as soon as one can is one way in which demand pressures can be managed. Whether this is positive or negative depends entirely on the needs of the patient and the family and the capacity of community specialist and primary services to manage.

80 Let me try to explain further. It is important to remember that every patient and their family, and every journey into illness and recovery, is different. Nevertheless, there are some patterns that do emerge and that can help with treatment planning and decisions about discharge sometimes.

81 In the initial period of clinical deterioration and following admission, the patient's symptoms and subjective distress can be high, and levels of risk can fluctuate markedly. As the patient responds to treatment, this clinical volatility diminishes. Assuming no impulsive or high-risk behaviours and/or substance misuse complicate recovery, the risk of adverse outcomes starts to diminish, even though the need for support and care may still be quite significant. Once the risk of deliberate or accidental harm is assessed as low to moderate, the treating team may consider whether a patient should be discharged, and in doing so, will consider a range of factors, including symptom

improvement, subjective distress, vulnerability to harm, availability of housing and a living income, family circumstances and engagement with treatment. The point in recovery at which a patient is discharged is therefore subject to many variables that relate to the patient and their family.

82 But there is more. Discharge decisions are themselves subject to factors outside the needs of patient and family. Among these is the limited availability of inpatient beds and the competing demands of other people presenting in the ED with acute mental health issues.

83 From time to time, a plan to continue the hospitalization of a patient whose clinical condition has stabilised has to be adjusted to account for demand. In these circumstances, alternate arrangements are made. These may involve setting up appointments with one or more of the following:

(a) GPs, psychologists or psychiatrists in the stepped care primary mental health system;

(b) Specialist clinicians in our continuing care, navigations or assertive case management teams (MSTT or HOPS);

(c) Early Discharge Management, provided by the CATT, whose clinicians can keep in touch via telephone or with in-home visits;

(d) Clinicians and support workers in the HOPE service;

(e) Peer support through the IPU post-discharge support service;

(f) When the client is of no fixed address, arrangements through family, crisis-housing providers, motels, hotels; and

(g) Support provided through brokerage funds to clients or carers in order to facilitate a return to the community by meeting costs for accommodation, travel, cleaning, whitegoods.

84 The decision about when to discharge a patient can be exceptionally difficult when it is driven by factors other than the patient's recovery and the readiness of the patient and family to return home. There are supports in the community, though their availability, impact and interest to (and in) the patient are variable.

In relation to the non-hospital based services, what do you think the system was intended to provide that it is not providing?

85 The mental health system in Victoria does not provide adequately for the following groups of patients:

(a) Patients at risk of, or recovering from, an episode of clinical deterioration and hospitalization, who require intensive community support, in other words step-down and step-up community treatment options that provide mid-term (up to 12 weeks) of frequent contact and multidisciplinary care.

(b) Patients who have a moderate or severe illness, with complex treatment and support needs that are not urgent (the so-called "Missing Middle").

(1) The sub-acute PARC units meet some of this demand, but it is limited in scope and capacity. The PARC at the Alfred provides only 10 beds. It tends to cater for patients who are moderately ill, and who are either experiencing early signs of clinical deterioration or recovering from an acute episode of illness. The needs of patients admitted to PARC tend to be non-urgent but complex, and their risks are moderate to low.

(2) The Department of Health and Human Services (**DHHS**) increased funding to PARC in FY19 with a view to increasing the capacity of PARC to provide care for patients with more complex and urgent needs and higher risks. It is too early to tell how successful this funding will be in driving the required change.

(c) Patients with significant psychosocial support needs who are not eligible for NDIS. The state government provided funding for the Early Intervention and Psychosocial Rehabilitation initiative in 2018. Again, it is too early to tell whether this will effectively meet the needs of clients who are disabled but not eligible for NDIS.

86 The community-based system, as designed in the 1990s, had two key components that are now inconsistently provided in VMHS:

(a) Crisis Assessment and Treatment (**CAT**) teams provide short-term early intervention with a view to preventing admission and early discharge management with a view to facilitating discharge; and

(b) Assertive Community Treatment (**ACT**) teams which were intended to provide longer-term intensive mobile support and homeless outreach to patients with urgent and complex needs and often a pattern of frequent hospitalization.

87 Many Area Mental Health Services (**AMHS**) in Victoria chose to merge their CAT and ACT teams with their CCTs in order to provide a more generic service. Although improvements in continuity of care were proposed as a beneficial outcome of these decisions, a key driver had been budgetary pressure. This has diluted the system's capacity to provide intensive treatment to patients with complex needs.

88 At Alfred Health, we have held a view that people with severe mental illness need a system of specialist mental healthcare that is integrated into a stepped care model. By this, I mean patients with severe mental illness and addiction require "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs."[25]

89 There is no 'one size fits all', and patients need different types of treatment, at different phases of their illness and to address different problems. A specialist mental health system in the community needs to be capable of providing a foundational form of psychiatric care, to which additional resources can be added, thereby adjusting the level of clinical and psychosocial support.

90 It is for this reason that the Alfred continues to provide CAT and ACT teams, although we would argue that this is not enough to meet the need for intensive care in the community.

91 In 2017, we were fortunate to receive funding from the State Government to implement the HOPE program.

92 Suicide is a major public health challenge – it is an outcome of complex clinical, social and personal factors. The HOPE team provides assertive tailored, holistic support to people following a suicide attempt or a presentation with suicidal ideation, with the aim of supporting the individual and their families to build the protective factors that reduce the risk self-harm. Importantly, the HOPE program provides intensive clinical and psychosocial support outside of the ED and ensures that appointments are not missed, a key risk for suicide after service contact[26].

93 In its first 12 months of operation, the HOPE service received 196 referrals. These were for patients who would normally have been directed to primary mental health services, including GPs and mental health specialists in the community. Patients were supported for a period of no longer than 12 weeks and careful attention was paid to ensure that they were linked for ongoing care with health providers in the community. Of interest was the observation that it can take an average of 6 weeks for patients engaged in this way to attend their first appointment. Routine patient reported outcome

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[25] (page 2), PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance- Stepped Care, Department of Health, Australian Government. At: <https://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF>.

[26] <https://www.blackdoginstitute.org.au/docs/default-source/research/careafterasuicideattempt02-09-15.pdf>

measures (PROMs) showed significant symptom improvement, service acceptability and overall satisfaction[27].

If there is unmet need, what needs are the most critical?

What are the key drivers of unmet need?

94 I have outlined my thinking in some detail in the Alfred Health Submission to the Royal Commission into VMHS, which is attached to this statement and marked 'SPS-11'.

95 I would summarise my perspective as follows:

(a) There are not enough inpatient beds.

(b) Hospitals are not consistently designed to be safe and therapeutic. This has an adverse impact on patients, families and clinicians. When some patients experience care in hospital that is traumatic or not responsive to their needs, this makes it less likely they will seek treatment and care in a timely way.

(c) Models of care are needed to support the treatment of patients with mental illness, addiction and at risk of suicide in ED and general hospitals, and support the management of behaviours of concern across health services.

(1) The Mental Health and Addiction Hubs are a welcome initiative.

(2) Consultation Psychiatry and Addiction Health services in general hospitals should be better resourced and more consistently provided.

(d) Genuine alternatives to hospitalisation are required through the development of 'stepped models' of care in the community, to provide greater responsiveness to patients who vary across a spectrum of need. These must allow for:

(1) The management of patients with moderate and severe mental illness, with complex needs. Different models of care will be required depending on diagnosis, risk, and urgency for care.

(2) A pathway to provide psychosocial care for patients coping with or recovering from serious mental illness who are not eligible for NDIS.

(3) Residential rehabilitation for clients with severe mental disorder in secure and non-secure settings, including patients with forensic issues.

(4) The management of severe perinatal and early childhood mental disorders.

(5) The management of severe eating disorders.

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[27] Stuart Lee. Personal communication and Alfred Health Submission to the Royal Commission into VMHS (2019).

(6) The management of severe anxiety, stress and somatoform disorders, including trauma-related conditions.

(7) The management of physical health conditions common in people with severe mental illness, such as obesity.

(8) The management of severe SUD, including in-home and hospital detoxification, in patients with mental illness & complex physical health issues.

(9) Diagnostic and consulting services and structured psychological therapies that are evidence-based and accessible to patients on low incomes with complex treatment needs.

(10) Family therapy and family services to support carers and families of people with severe mental illness.

(11) Integrated homeless services that provide co-location for mental health, addiction, primary care, social support, and housing services.

96 The key drivers of unmet need relate to severe social disadvantage, funding, workforce issues and healthcare models.

(a) Poverty, social isolation and loneliness, unemployment, poor physical health and housing are among the top barriers to recovery experienced by people with psychosis.

(1) The Anglicare Rental Affordability Survey 2019 concluded that there is virtually no accommodation in the private rental market in Australia that is affordable for single people on supported incomes.

(2) This represents a major barrier to service access and patient outcomes, given that over 90 per cent of patients using our acute inpatient services receive Newstart or the disability support or aged pensions, and about 20 per cent are of no fixed address.

(3) In the absence of family support, we are required to discharge patients into secondary (transitional and crisis housing) and tertiary (boarding houses, motels) homelessness every day in order to make room for new patients presenting acutely.

(b) The Victorian Auditor-General wrote:

"DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services ... Real progress is unlikely ... unless DHHS accelerates and directs effort towards the fundamentals: funding, workforce and capital infrastructure. Until the system has the capacity to

operate in more than just crisis mode, DHHS cannot expect to be able to make meaningful improvements to clinical care models or the mental health of the Victorian population."[28]

I agree with this observation.

(c) A trained and competent workforce is emerging as a growing barrier to delivering services even as funding streams improve. Innovative and evidence-based practice must be delivered by a skilled workforce, trained in basic and specialist mental health competencies, and provided with opportunities for learning, reflection and improvement. Time for supervision and reflective practice is as important to achieving proficiency and expertise as is training itself.

(d) Finally, the separation of primary and specialist healthcare, and of Commonwealth- and State-funded initiatives, creates barriers to integrated care and inefficiencies in practice. The headspace model of care at the Alfred shows how integration of state- and commonwealth-funded services can amplify service impact and drive service improvement across the entire system of care. I will elaborate on this experience later in this statement.

What kinds of impact does unmet need have on people affected by mental illness?

97 The impacts are numerous. Unmet need essentially creates barriers for people and their families to return to a contributing life. The impact of unmet need is systemic and effects everyone who is connected to the person experiencing mental illness. It manifests as emotional distress, secondary mental and physical illness, addiction, relationship breakdown, social disadvantage, loneliness and suicide. It is evident in worse physical and mental health outcomes, feelings of worthlessness, shame, depression, anxiety, and fear. It adds to a narrative of exclusion, mistrust and "otherness".

Are there enough beds to service demand for acute need? If not, why not?

98 I believe that bed-numbers in the child, adolescent and aged mental health service systems should continue to be adjusted to keep up with population growth.

99 I do not believe there are sufficient beds to meet demand for acute need in the youth and adult mental health systems, which in much of VMHS are provided in the same setting.

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[28] <https://www.audit.vic.gov.au/report/access-mental-health-services?section=33104--audit-overview>.

(a) I have outlined the reasons why I reached this conclusion in relation to Alfred Health at paragraphs 66 to 84. I suggested that the increased proportion of out-of-area clients indicates that the pressures we are seeing at the Alfred exist in other parts of the system.

(b) I am persuaded by the arguments set out in a letter published by in the Australian & New Zealand Journal of Psychiatry (2017). Allison, Bastianpillai and Castle wrote (pg 91)[29]:

> "Within Australia, state governments have...adopted widely different polices with the two largest states, Victoria and NSW providing a stark contrast. Victoria spends the least per capita on mental health services (AUD197 versus the Australian average of AUD$219 per capita; AIHW, 2014–2015). Victoria also has far lower numbers of publicly funded hospital-based psychiatric beds for people with SMI (22 beds per 100,000 population) than NSW (36 beds per 100,000 population). The Australian average is 29 public beds per 100,000 population. The World Health Organization (WHO) reports that high-income countries have an average of 42 hospital-based psychiatric beds per 100,000 population, and European countries have an average of 45 beds per 100,000 population".[30]

(c) I believe that the need for acute beds is made greater by the lack of affordable housing and the shortfall in residential non-acute or extended care beds, which place people with severe mental illness at risk of deterioration.

In your experience, are clinical mental health services crisis driven? If so, in what respects and why?

100 Mental health services have undoubtedly been crisis driven. This relates to the issues outlined at paragraphs 66 to 84 and 98 to 100 and in the Alfred Health Submission to the RCVMHS. To summarise:

(a) Funding has been inadequate to provide for what is needed in terms of hospital and community services.

(b) Factors that are external to the needs of the patient and their families too often shape decisions made about admission, discharge and the provision of service.

(c) Infrastructure has been neglected, so that our hospitals and clinics do not allow for contemporary practice that is acceptable to patients, holistic, promotes safety and privacy, and facilitates social engagement and group activity.

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29 <https://journals.sagepub.com/doi/full/10.1177/0004867417721019>.
30 <http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf>.

(d) There are difficulties in finding a suitable workforce with the right competencies, proficiencies and expertise.

Do you have any views about how the system can imbed an attitude of change and constant learning?

101 Every AMHS must have capacity to use data, research and feedback from patients, families and clinicians to develop ideas for improvement, rapidly test and evaluate them in practice and then spread those ideas in order to generate learning about what changes actually work, and in which contexts.

102 Service design methodologies are useful in this respect. These seek to understand problems from the perspectives of service users and can create ideas to prototype, evaluate and improve on. The Institute for Healthcare Improvement[31] in the USA, and Safer Care Victoria[32] can provide education, training and leadership in the methodology of improvement science, but services must have capacity to undertake this work and clinicians must be at the forefront of efforts in this regard.

103 Our experience at the Alfred is of how growth and exposure to a different service culture sparked a wave of innovation. This was precipitated by the expansion of our child and adolescent service and the extension of specialist youth services into primary mental health platforms. In 2009, Alfred Health was successful in tendering for the "Demonstration Project for Child & Youth Mental Health Services". This aimed to increase the age of eligibility for service to 24 years. It was followed in 2013, by approval to deliver the hYEPP in Southern Melbourne. This built in part on our lead agency status in the headspace centre in Elsternwick and on the experience we had gained as a result of the child and youth reform in 2009.

104 I have always believed that our involvement with headspace was a massive opportunity to develop a laboratory for innovation, which could be used to prototype ideas to scale up across the program.

105 The state approach to mental health is embedded in compliance, regulation, standard setting and accountability. It values clinical leadership, training and education of the workforce and research and it prioritizes equity, distributive justice and ensuring that populations have their most urgent needs met.

106 Headspace approached the task of mental health service delivery differently, in that it sought to make its product acceptable and even desirable to the consumer. At the time

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31 <http://www.ihi.org/>.
32 <https://bettersafercare.vic.gov.au/about-us/about-safer-care-victoria>.

headspace started in 2006, the organization emphasised the importance of its brand, something I thought was superfluous to the task of service delivery at hand. Since then, our headspace centres have set up youth advisory groups, engaged with our clients about the design and production of care, and used design thinking to create an approach to service delivery and our clinics that – through the behaviour of staff, and through the use colour, furniture and décor – promote respect, hope and a welcoming disposition. This is a stark contrast to the broken equipment, dark corridors, peeling paint, cramped spaces and concrete courtyards one may come across from time to time in adult mental health services, all of which communicates a very different message to patients and clinicians that they do not matter and they are not valued.

107 And of course, leadership matters greatly. Our leadership team and our clinicians opened themselves up to new ideas and allowed themselves to take risks. Innovations included: the Discovery College[33], an adaptation of the Recovery College model in the UK; Open Dialogue, an approach to care that places the client's network (family and friends) at the forefront of communication and decision-making; the peer family and consumer workforce; and the introduction of Single Session Family Therapy[34] into the headspace platform. All of these measures have been evaluated and adjusted to take account of feedback and learning.

108 The innovations in the child and youth sector, in turn, have inspired our approach to service provision in the adult community mental health service. The development of the physical health hub, a family service, the co-location of a drug and alcohol service, and the emergence of our peer workforce were all inspired by the experience we developed in headspace and the hYEPP. These elements of our community MHS are small or emerging and so there is still a long way to go before we can confidently say that every patient will have access as needed.

109 The success of the headspace initiative at the Alfred was, I believe, the result of three factors. First, the state system contributed values of accountability, statutory rigor and the importance of clinical standards. Second, headspace National came to the table with funding, creativity, a participatory ethic and a drive to create a desirable product for young people. Finally, the Alfred contributed a culture of openness and curiosity, and a willingness to take organizational risks to improve patient experience and care.

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33 <https://www.emeraldinsight.com/doi/abs/10.1108/MHSI-07-2018-0023>.
34 <https://www.taylorfrancis.com/books/e/9781351112437/chapters/10.4324/9781351112437-7>.

How do the CAT/ACIS teams work? What are the resourcing challenges with operating a CAT team? If there are barriers to their effectiveness, what are they?

110 CAT teams are an important structural element of the mental and addiction health service at Alfred Health.

111 CAT teams were initially described as the gatekeeper to the system because all patients were expected to have an initial assessment by the CAT team, in order to explore alternatives to admission. The mismatch between capacity and demand quickly emerged as a barrier and, as a consequence, community MHS at the Alfred were authorised to admit directly into our IPU – and by-pass CAT and ED entirely - if necessary.

112 The CAT team at the Alfred is part of an integrated Liaison and Emergency framework, which includes several components of service, roughly divided between a Liaison team in the hospital and an Emergency team in the ED (EPAS) and the community. The role of the CAT at Alfred Health cannot be understood outside of this context.

113 The Emergency Psychiatry and Addiction component of the service consists of CAT, EDM, PACER, Triage and EPAS. A single multidisciplinary team of nursing and allied health clinicians rotate across the different sub-teams. A Bed Manager undertakes the "gatekeeper" role during business hours, handing this over to Triage after-hours.

114 I have already described the diagnostic case-mix of patients who are treated by the CAT in paragraphs 28 to 45. Compared to the IPU, there are fewer patients with Schizophrenia-related disorders, and more patients with Anxiety, Stress-Related and Somatoform disorder, Mood Disorders, and Personality Disorders. Of note, SUDs were a primary or secondary diagnosis for 39% of clients in FY19.

115 I have also described the functioning of Triage, which is the portal of entry into the service, behind which sit the CAT/PACER and the EPAS, which between them assess most patients who are new to the service, and/or who present with severe mental illness, an urgent need for specialist mental healthcare and high risk.

116 The CAT team operates from 0700-2200 hrs. The team includes a psychiatrist, a team leader, a family therapist, and a group including a registrar, a nurse practitioner, nurses, social workers, and psychologists who work on roster. Average duration of contact with the CAT for patients is about 7-10 days.

117 There are two main barriers that limit the effectiveness of CAT teams:

(a) First, the clinicians who care for patients with acute mental health issues cannot provide continuous care. The model is staffed by clinicians working on shifts, which necessarily limits their engagement with patients.

(b) Second, crisis care is unavailable between 10:00pm and 7:00am. Night time services are absent because cost is high, demand is low and risk to the safety of staff is not acceptable (i.e. people are more likely to be consuming alcohol or using drugs and home visits are not appropriate at that time).

118 That said, I believe that the service is valued by patients, given the compliments we receive about their work, and is central to our system of care at the Alfred and in particular the management of acute demand.

What are the critical things that contribute to the success of a mainstream area mental health service?

119 **The following factors contribute to the success of a MAMHS:**

(a) Respect for the needs of people with mental illness and their families.

(b) Commitment on the part of health service boards and executives to providing excellence in mental healthcare.

(c) All the Chief Executive Officers that I have worked with at the Alfred consider mental health as an integral part of the health service. An organisational commitment to the objectives of the mental health service is crucial to success in this setting.

(d) Developing an effective clinical leadership team, with experienced clinicians who are encouraged to be creative and reflective about their services and to stand out as high performing managers in the health service.

(e) Developing a culture of excellence among clinicians, in whose training the service is prepared to invest.

(f) Developing a willingness within the area mental health service of being open to solve problems the health service is grappling with, and about which we have a specific contribution to make, by virtue of our technical expertise. Such problems may include management of occupational violence, management of addiction-related disorders in the general hospital, and contributing to delivering on performance targets that are important to the health service, such as ED waiting times.

(g) Highlighting the contribution of peer carers and consumers in the delivery of services that are acceptable and desirable to patients, as a means of

destigmatizing mental illness and showcasing the value of peer work in managing chronic illnesses other than mental illness.

What are examples in your funding model where the funding of service delivery doesn't meet the cost of delivering the service?

120 Recent improvements in revenue from the state government have meant that our Inpatient service is not being cross-subsidized by any other revenue stream in FY20. This is the first year in which this has occurred since I assumed my current position in 2006.

121 Corporate costs of 10% are charged to the funding received by AMAH.

122 After corporate costs are deducted, the services for which funding does not meet the cost of delivering the service are:

(a) Consultation-Liaison & Emergency Psychiatry & Addiction Service (which includes CL Psychiatry, CL Addiction, EPAS, Triage, CATT and HOPE) (Expenditure exceeds revenue by 77%).

(b) Child & Youth Mental Health Services (Expenditure exceeds revenue by 9%).

(c) Aged Mental Health Services, in both the community and inpatient service (Expenditure exceeds revenue by 18%).

Why does Alfred Health implement so many initiatives independently of government?

123 Alfred Health has implemented a number of initiatives independent of government including:

(a) Inpatient Adult Service

(1) Psychiatric Response to Behaviours of Concern (**Psy-BOC**), modelled on the Medical Emergency Call, the Psy-BOC helped reduce seclusion rates to the fourth lowest in Victoria in the first two quarters of FY19.

(b) Liaison-Emergency Psychiatry and Addiction

(1) Establishment of an addiction liaison service, including the statewide gambling health service.

(2) Establishment of a HOPE team using a hybrid clinical-psychosocial support model, partly based on the Beyond Blue Way Back Support Service (this required state funding, but the model adopted was innovative).

(3) Mental Health-Addiction stream of care and hub in our ED.

(c) ACMHS

(1) The Navigations Team, intended to provide intake, primary consultations, short-term treatment and care and transitions of stabilized patient back into primary care.

(2) The physical health hub, which will comprise dietetics, pharmacy, exercise physiology and nurse practitioner.

(3) REI8- the social skills program.

(4) The Dialectic-Behaviour Therapy Program.

(5) Addiction Nurse Practitioner and integration with AOD public clinic.

(d) Aged Mental Health

(1) Aged Intensive Support and Treatment Team for patients with long-standing mental illness.

(2) Aged and Rehabilitation Hospital and Nursing Home Liaison Psychiatry.

(e) Headspace Child and Youth MHS

(1) Discovery College.

(2) Single Session Family Therapy Model.

(3) Eating Disorders program with Family-Based Therapy.

(4) Implementation of Patient Reported Outcome Measures (PROMs).

(f) Monash-Alfred Research Centre

(1) Women's Mental Health research stream, including published research into novel treatments and complex trauma.

(2) Neurostimulation, including published research into TMS.

124 In reflecting on why Alfred Health has implemented so many initiatives independently of government, I believe I have touched on some of the key reasons in my answeranswers above, about the critical things that contribute to the success of a mainstream AMHS.

125 When we designed these initiatives, we did not act entirely independently. Inevitably, we sought to respond to operational, clinical or ethical problems that placed us in positions that were inconsistent with our values, our performance targets and with the articulated policies of the governments of the day.

126 For example, the Psy-BOC initiative came about when our seclusion practices changed for a brief period and our seclusion rate climbed to a peak of 35 episodes/1000 bed-

days in September 2016[35]. This meant that we had failed to meet the DHHS's target of 15 episodes/1000 bed-days. Not only was this performance troubling to us, but we believed that we were subjecting patients to preventable harm. The psy-BOC initiative was a response to a local problem, which had brought us into conflict with our performance targets, state health policy and departmental objectives.

127 In a similar way, the Mental Health-Addiction (**MH-Addiction**) Emergency Department initiative came about because of a local redesign process in ED. This had been set up in 2012 as a response to the Commonwealth's policy on National Emergency Access Targets[36]. When leadership in the ED stated it needed a different service response to ED waiting times for mental health and addiction clients, the organization was prepared to provide resources in the form of a budget bid and access to the Redesign team at the Alfred.

128 The motivation to implement these initiatives starts with an organizational culture that demands excellence, and rewards innovation and creativity. It is supported by leadership at the level of the Board and the Health Service Executive, who seek solutions to difficult operational problems, are open to new ideas and are willing to provide resources and take risks. It is implemented by clinicians and more recently peer workers at the service delivery level who are engaged in the design of the initiatives and open to change. And it requires a substantial investment in training, supervision and evaluation to ensure that models are deployed faithfully, feedback is sought and responded to, and processes are improved in response to the evidence.

129 For example, our involvement with headspace primary and hYEPP could not have happened without the commitment of leaders at every level of the organization. When funding for hYEPP was threatened in the run-up to the Federal Election 2016,[37] the organisation's commitment to the program, our clinicians and our clients never wavered, even though we were facing a significant strategic, operational and financial risk. In a similar way, the MH-Addiction Hub was funded for 5 years before DHHS was satisfied with the outcomes and was able to provide financial support. None of this would be possible without support at a senior Executive and Board level.

130 The offset to a health executive and board that is willing to support mental health services in innovating and creating, is developing a resource in the search for solutions to complex organizational problems. When The Alfred and Caulfield Hospitals identified behaviours of concern as a major occupational risk, AMAH and its Clinical Services

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35 <https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0009/2857527/Fiona-Whitecross-exploring-the-impact-and-prevalence-of-behaviours.pdf>.
36 <https://onlinelibrary.wiley.com/doi/full/10.1111/1742-6723.12338>.
37 <https://www.sbs.com.au/news/new-funding-model-puts-youth-mental-health-services-at-risk>.

Director, sought to lead the response. We invested in more liaison nurses, a psychologist, addiction medical and nursing specialists and seven-day a week cover for consultation-liaison. In return, we committed to supporting patients who presented behavioural challenges on the medical and surgical wards. We also committed to managing the deployment of additional nursing resources for this purpose. The model has required substantial refinement over many years, but is presently delivering significant savings in "nursing special" costs throughout the organization, and reduced code grey call-outs in pilot wards.

Are there ways in which you think the demand for services of the kind Alfred Health provide is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

131 Over the past 15 years, there has been an increased demand for child, youth, and adult mental health services. Some of this has been driven by population growth, but there has undoubtedly been an increase in the rates of hospitalization/per 10,000 population in the Alfred Health catchment due to all illicit drugs, including cannabis, methamphetamines, other stimulants and heroin,[38] some of which has led to increased demand on mental health beds. Anecdotal reports from our frontline staff indicate synthetic drugs are also having an impact on community morbidity.

132 That said, there have been enormous changes in the community's understanding of mental illness and social expectations about care, participation, autonomy and engagement have shifted

133 The headspace initiative, I think, illustrates well the changes we can expect with respect to mental health service delivery in future. Briefly, my belief is that the most significant change to come will involve a demand for greater participation and value in care.

Mental health system and reform

In a recent opinion piece, you wrote that

> ***"strictly speaking, the mental health system isn't broken – it was just built this way and is producing the results it was designed for. The current version is organised around managing demand for acute hospital beds and is now, apparently, obsolete. The next version, which I believe we have already started working on, needs to aim for zero harm. It must have a greater capacity to serve people in need and provide better access to evidence based treatments, integrated health and community care, the NDIS and a contributing life. It must***

[38] See AOD Stats at: <https://aodstats.org.au/>

adopt information systems and social platforms and embrace human factors in design engineering so that how and where we provide care better enable for the communication and the safety we seek. It must embrace author Jeremy Heimans' and Henry Timm's construct of "New Power" to balance technical expertise with a more fully participatory ethic".[39]

Can you please elaborate on:

The ways in which, in your experience, the mental health system is producing the results it was designed for and, being organised around managing demands for acute hospital beds, is now obsolete

134 I should first emphasise that this analysis represents an opinion, based on my training, experience, reading and observations during the time I have worked in the public mental health system since 1991.

135 It is a matter of public record that the period in Victoria between 1992-1999 saw the most rapid process of deinstitutionalisation in the country. By 1999, all stand-alone mental health hospitals had been replaced by units in general hospitals, community-based rehabilitation or residential care units and ambulatory or outreach mental healthcare services.[40]

136 This process took place in the context of a reform in health, aged and community services governed by a set of key principles. Services were to put people first, ensure a fairer distribution of limited resources, obtain value for taxpayers' funds and provide a better health status and outcome for all Victorians.[41]

137 The principles underpinning mental health reform were articulated in policy and legislation.

(a) The legislative framework stipulated that the purpose of VMHS was to provide for the care and treatment of persons who were mentally ill AND the protection of members of the public. VMHS was required to operate so that persons with mental illness would receive the best possible care and treatment in the least restrictive environment; and any restriction upon the liberty of people with mental illness and interference with their rights, dignity and self-respect was to be kept to the minimum necessary in the circumstances.

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[39] Simon Stafrace, *The mental health system was never broken – it was built this way* (27 October 2018) The Age <https://www.theage.com.au/national/victoria/the-mental-health-system-was-never-broken-itwas-built-this-way-20181025-p50bup.html>.

[40] <http://journals.sagepub.com/doi/abs/10.1046/j.1440-1665.2003.00508.x>

[41] Victoria's Mental Health Service: The Framework for Service Delivery (1994) (at <https://catalogue.nla.gov.au/Record/1681402>).

(b) The law enshrined principles of prevention and early intervention. Treatment was to be accessible, acceptable and comprehensive. Safeguards were developed for compulsory treatment. Care was to be multidisciplinary and provided in the community wherever possible, to support clients living, working and participating in the community and to promote their self-reliance.[42]

(c) Mental health policy determined that services were to be mainstreamed, co-located with and managed by general health services. They were to integrate community and hospital care and focus on the needs of the "seriously mentally ill". The definition of this last term was to shape the nature of service delivery most profoundly in the years to come.

138 The principles outlined above remain indisputably valid today. The problems that have emerged relate to service leadership, resources, service design and implementation of reform.

139 The focus of reform was structural not functional and once the large institutions were closed, efforts to drive continued improvement were hampered by falling investment in infrastructure, evaluation and research, clinical community care and, re-design, and the workforce.

140 The structure and practices required of comprehensive community mental health services were incompletely understood. Initiatives were slow to emerge and were largely defined by inputs, and not activities, outputs or outcomes.

141 The system struggled to define what good looked like, and to hold itself accountable to achieving that.

142 Demand fell disproportionately on hospitals and emergency services and as a result, managing this became the operational focus of VMHS. Significant population growth, changes in the prevalence of harmful use of substances,[43] and increasing mental health literacy in the wider population contributed to this phenomenon and were inadequately responded to.

143 I do not believe the system is obsolete. I used the word "apparently" to signify that I was repeating an opinion that had emerged in the debate to that point,[44] and with which I disagreed. I do believe, however, that it is not producing the results that are sought by the community and by patients and their carers. This is why it must change.

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42 Mental Health Act (Victoria, 1986) at: <http://bit.ly/2J4u0IS>.
43 In AOD Stats at: <https://aodstats.org.au/VicLGA/>.
44 <https://www.theguardian.com/australia-news/2018/oct/24/daniel-andrews-promises-mental-health-royal-commission-as-system-attacked-as-obsolete>.

144 In saying that the system is producing the results it was designed for, I am referring specifically not to the principles and objectives that underpinned its design, but to how it was resourced, and how priorities were set by stakeholders, in particular professionals, clinical and community organizations, communities, policy makers and governments. Arguably, patients and families were the least influential in this process.

145 The reason why I believe this point is worth making is because it locates responsibility squarely with all of us, as Victorians. The alternative perspective, that the system is broken, assumes that it is someone else's fault, that it worked at some point in the past and external forces took it off course. I reject that notion.

146 I would therefore contend that the system is achieving exactly the results it was set up to achieve, every time a decision was made to take funding out, without keeping track of its impact on patients and their families. It is achieving the results it was set up for, every time decisions were made to fragment the system further by introducing elements that linked poorly with one another and that were not integrated with the broader health system of preventative and primary health. It is also achieving the results it was set up for, every time we subjected patients to the soft bigotry of low expectations, and turned a blind eye to the deteriorating hospitals, the sub-standard accommodation, the homelessness, the poverty and the violence that is all too common an experience for people with severe mental illness.

147 The risk is that unless we adopt a different approach to public mental health leadership, the destigmatization of mental illness and its care, and to public and patient participation and leadership in mental health services, we run the risk of finding ourselves in the same place, 25 years hence. Human systems inevitably need to learn from their outcomes, and reorientate themselves to the problems they are trying to solve, as these change over time. VMHS must prove itself capable of adapting much more quickly than has been the case to date.

148 We all have had a hand in where we are today. The questions remain: In the face of uncertainty, how committed are we to developing a system that is capable of analysis, reflection, continuous learning and improvement? How much ambiguity are we prepared to tolerate while we prototype and improve on what we have? What risks are we prepared to take to improve the experience and outcomes of care? And, of course, how much money are we prepared to spend?

What is meant by "zero harm" and how that objective could be reflected in new system design;

149 I wrote in my article: "The next version (of Victoria's mental health system), which I believe we have already started developing, needs to aim for zero harm."

150 I would also add that it needs to aim to be therapeutic in its impact on the lives of the patients and families who turn to it at their most vulnerable moments.

151 These are aspirational statements and hardly original. They have their roots in two well-known ethical principles in healthcare: the first a call to do no harm, and the second a call to do good.

152 Despite their self-evident appeal, achieving this balance represents a significant operational challenge for VMHS, especially with respect to hospital care.

153 Public adult psychiatric hospitals are challenging places to seek care. Patients are admitted voluntarily and on compulsory orders. They may witness physical and verbal aggression, sexually inappropriate behaviour, fire setting, absconding and the use of illicit drugs. They may be subject to a lack of privacy and restrictions of decision-making and movement. Some may also experience or witness the use of restrictive interventions. Within this setting, patients seek to recover from mental illness, build on their strengths, challenge unhelpful ways of thinking, reconnect to their relationships, and address what may previously have been overwhelming social problems.

154 Balancing the need for safety and for clinical settings & interventions that are therapeutic is challenging. Aiming for zero harm does not necessarily mean prioritizing safety over recovery and therapeutic practice.

155 Luxford (2016) identifies a paradox when she suggests that improving the care of patients needs a paradigm shift from "a 'disease-based intervention' model to a supportive 'health' model. Just as 'health' is not the absence of illness, preventing patient harm is not simply avoiding (potentially harmful) interventions. To 'first do no harm' health services need to actively improve their focus on health and the entire patient experience."[45]

156 I believe that we as Victorians should strive to create a VMHS in which the care provided and the setting in which it is delivered is intentionally designed to enhance well-being, while managing the risk of harm.

157 At the time of its construction in 1998, The Alfred IPU had six seclusion rooms across two HDUs, but only one courtyard. Each HDU had a single lounge area, and a single interview room for five patients, that doubled for making tea and receiving family visitors. There were no alternate break-out spaces, no sensory rooms, no additional interview rooms and no additional rooms for receiving family visitors. Each patient occupied a single bedroom, but there was no furniture in each room other than a bed.

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[45] <https://pxjournal.org/journal/vol3/iss2/2/>.

No attention had been paid to the look and feel of the high dependency environment and none of this was designed to appeal and please. There was no gender segregation.

158 The absence of a therapeutic ethic was evident not only in the design of the ward but also in how its refurbishment was conducted in the mid-2000s. In preparing for this project, we were not given approval to relocate our patients to an alternate site (none was available) or to close the beds affected by the project. We were advised that there was no capacity in the system to absorb the demand that would otherwise be met by our HDUs. On the first day of construction in December 2006, hoarding was erected through the middle of what was already a small area in our two high dependency units. The builders cut concrete for several days and the noise was unbearable. Our patients, our staff and I – my office was directly above the construction area and I was clinically active on the IPU at the time – had to endure this excruciating noise for days. Fortunately, there were no serious adverse incidents, though the quality of the environment was seriously compromised for several weeks.

159 One could reasonably reach the following conclusions from what I have outlined above.

(a) The priorities evident in the design of our wards in 1998, imply that at their inception, there had been greater concern for delivering restrictive interventions than meeting the need of severely ill patients for privacy, gender segregation, social contact and sensory modulation,

(b) The willingness of the system to allow construction to take place inside a clinical area being actively used for the most severely ill patients is an example, at best, of what I have referred to as the soft bigotry of low expectations and, at worst, of neglect for the wellbeing of staff and patients.

160 The physical environment of an inpatient unit designed with the aim of achieving “zero harm” would meet a number of pragmatic and emotional needs and would be desirable as a place in which to seek mental healthcare. There would be more sensory than seclusion rooms, more open space than is presently the case, and room for therapeutic activities. The interiors would balance the need for observation and protection against harm, against the need for privacy, small group socialisation, physical activity and visual interest.

The key characteristics of a system that would provide better access to integrated health and community care;

161 Integration at the time of Victoria's health system reform in the 1990s was a reference to the streams of mental healthcare, including acute, community and rehabilitation

services, being brought together under the management of a single area mental health service delivering care to a defined catchment.

162 I believe that 25 years later, VMHS demands a different approach to integration, one that brings together mental health, addiction health, physical health and psychosocial support under the one umbrella.

163 Huang et al (2014)[46] describe current practice as possessing several characteristics that would be familiar to any user of Victoria's health system. Care is typically discipline-specific. Provider expertise tends to be independent and variable. And psychiatrists, medical specialists, GPs, nurses, psychologists, social workers, occupational therapists and others all provide assessment and treatment independently. In both the primary setting and the health service, care is provided in separate spaces. Workflow protocols are independent and care plans segregated and the experience for patients is typically of poor communication, poorly co-ordinated care, frustration and mishap. When it comes to follow-up, this is highly variable and heavily dependent on patient initiative, if for no other reason that the treatment "team" can be incredibly complicated for patients to navigate.

164 Alfred Health has attempted an approach to an integrated service through its primary headspace centre in Elsternwick with its co-located GPs, mental health professionals, employment and vocational services and drug and alcohol services. Similarly, we have looked at implementing this model in our community adult MHS in St Kilda Road, where we have co-located an addiction clinic, are building a physical health hub and where we have trialled (unsuccessfully) to establish a GP clinic.

165 According to Huang et al, an integrated behavioural health service should provide base service assessment and treatment with cross-disciplinary support, which is a version of stepped care, previously described. Healthcare disciplines are co-located, workflow protocols collaborative, care plans coordinated, and follow-up is discipline-specific with clear lines of accountability. The impact then of an integrated approach to mental healthcare is that a co-located team can provide synchronized communication, consolidated care plans and follow-up that is cross disciplinary and targeted to need. Further, such a system can prioritize complex patients in a way clinicians working in isolation cannot.

Integrated care models can then be utilized as a key component of VMHS, to add value to patient care, and health to the patient experience.

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[46] Huang H, Meller W, Kishi Y & Kathol RG. What is integrated care? *International Review of Psychiatry*, 2014; 26: 620–628

What is meant by adopting information systems and social platforms and embracing human factors and systems design engineering, and the benefits those evolutions would bring;

166 This has been outlined in the Alfred Health Submission to the Royal Commission, included in the attachment 'SPS-11'.

167 To recap, the task of providing mental healthcare is one in which the system has to acknowledge it does not have all the answers and therefore has to be open to learning from experience and research. VMHS then, must be explicitly designed for improvement, with the capacity to monitor performance, learn from adverse outcomes, evaluate services and innovation and undertake research into new knowledge through engagement with patients, their families, clinicians and academics.

168 I believe that the Victorian DHHS must provide epidemiological surveillance of psychiatric morbidity in the community, including suicide and SUD, and better reporting of service performance, with a particular emphasis on the development of metrics for community practice in all age groups. The NSW Health Analytics Framework[47] represents a good model for an approach to data analysis that is system-wide and intended to support Local Area Health Districts in making evidence-based decisions about the services they provide to their local communities. The website[48] provided by the NSW Mental Health Commission on Data and Analysis is to be commended for its utility and clarity and should service as a model for the VMHS.

169 In addition, I also believe that every AHMS must have capacity to use data, including patient, family and clinician feedback, to develop ideas for improvement. These should be rapidly tested and evaluated in practice and the ideas spread, in order to generate learning about what works, in what contexts. The Institute for Healthcare Improvement in the USA, and Safer Care Victoria provide education, training and leadership in the methodology of improvement science, but services must have capacity to undertake this work and clinicians must be at the forefront of efforts in this regard.

170 Human factors/ergonomics and systems design are approaches to the ways in which systems (including health services) are set up. They seek to place the patient experience at the centre of care and understand the interactions among the human stakeholders (including clinicians and patients) and the various elements of the system. They seek to create services that address the problems that matter to service users, and promote an approach to prototyping, testing and evaluation that constantly drives improvement.

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[47] <http://www.ehealth.nsw.gov.au/publications/nsw_health_analytics_framework>.
[48] <https://nswmentalhealthcommission.com.au/resources/data>.

171 It is my experience that whilst VMHS has benefited from the efforts of the most dedicated and talented clinicians and service users, it has given insufficient attention to the design of services. We know that service design and an understanding of human factors in systems can better promote the participation of patients, families and clinicians and the values of care we all know to be important. They provide useful frameworks to enhance the patient and clinician experience, reduce costs, and improve safety and therapeutic outcomes.

What is the construct of "New Power" and a more fully participatory ethic, and how those values could be reflected in new system design;

172 New Power is a concept described by Jeremy Heimans and Henry Timms, in their book[49] of the same name.

173 I shall quote from an article titled: "Understanding New Power"[50] that captures the meaning well.

> "Old power works like a currency. It is held by few. Once gained, it is jealously guarded, and the powerful have a substantial store of it to spend. It is closed, inaccessible, and leader-driven. It downloads, and it captures. New power operates differently, like a current. It is made by many. It is open, participatory, and peer-driven. It uploads, and it distributes. Like water or electricity, it's most forceful when it surges. The goal with new power is not to hoard it but to channel it."

174 As a framework for harnessing the power of crowds, New Power allows us to understand something about the opportunities that have arisen within our community as a result of the technological advances of the past 25 years- since it must be said, the Framework for Service Delivery was published in 1994.

175 In many ways, traditional models of healthcare reflect Old Power. Health services are hierarchical, and healthcare is seen as a commodity to be transacted by the provider for the service user. Mental healthcare is even more invested in Old Power, as a result of the combination of professional and statutory hierarchies, the use of compulsory orders, and a patient cohort that is especially sensitive to shame, prejudice and exclusion.

176 In his description of the "motivation paradox", Mulder (2013)[51] describes a problem specific to mental health, that is an association between higher levels of psychosocial disability, lower quality of life and less motivation (and demand) for treatment. This, of

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[49] New Power: How power works in our hyperconnected world. And how to make it work for you. (Doubleday, 2018).
[50] Heimans J & Timms H. Understanding New Power. Harvard Business Review, December 2014.
[51] Mulder CL, Jochems E, Kortrijk HE. The motivation paradox: higher psychosocial problem levels in severely mentally ill patients are associated with less motivation for treatment. Soc Psychiatry Psychiatr Epidemiol. 2014 Apr;49(4):541-8.

course, could reflect something other than a consequence of illness, such as the way in which care is provided. Be that as it may, VMHS is shaped by the experience of treating patients who are disengaged and refuse care, and this reinforces a culture of paternalism and authority.

177 Healthcare, and not just mental healthcare, is dealing with serious challenges with respect to patient experience, patient safety and rising costs. Questions about the value of healthcare draw attention to the fact that health services must deliver value that is defined by patients first and by service outcomes not inputs (Porter, 2010).[52]

178 Many health reform agendas in developed countries have identified stronger patient and public involvement in the delivery of healthcare as a priority. Placing patients and families at the heart of service delivery must involve greater participation in co-design and co-production and to achieve this, power and decision-making must be distributed differently (Ocloo & Matthews, 2016).[53]

179 Heimans & Timms describe the contrast between the values of New & Old Power. New Power is characterised by radical transparency, short-term affiliation, and greater participation. It favours open collaboration, sharing and a do-it-yourself, maker culture. Old Power tends towards greater discretion and confidentiality, long-term affiliation and less participation. It favours exclusivity, authority and professionalism.

180 My interest then is how ideas about New Power can be integrated into the delivery of VMHS. To adopt the analogies used by Heimans & Timms, mental health services are like castles, with old power values and old power models that concentrate power and authority in the hands of technical experts and policy makers. Our services need to harness the power of crowds, create the conditions for short-term affiliation and participation and open ourselves to sharing ideas and adapting to diversity in thought and culture. I think VMHS must bring evidence-based treatments more consistently to the community. However, I also believe that the system must open itself up to a user community that can contribute substantially to how this is to be achieved and how priorities are to be set.

181 I think that the role of the peer workforce in this process is a step in the right direction, but will not be enough. Peer workers will readily be acculturated into the system and their voices must be augmented by those of service users whose relationship with the system is much more transient.

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52 <https://www.nejm.org/doi/full/10.1056/nejmp1011024?v=>.
53 <https://qualitysafety.bmj.com/content/25/8/626.full>.

182 I'm not quite sure where this journey should lead. I still believe that the Old Power models of clinical excellence are central to the success of the system. But the power imbalance locked into services that are charged with the task of managing compulsory patients and caring for a client group that is socially disadvantaged and subject to prejudice requires an accommodation to greater participation, which must be resourced through community engagement initiatives and supported through social technologies.

Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

183 I think the process has already started. The Royal Commission into VMHS has triggered a process of consultation, collaboration and engagement that is without parallel at this scale, in my experience. What makes this process different to others that have come before are the cross-disciplinary and cross-sectoral conversations and the emerging leadership of patients and their families.

184 The Royal Commission has an unprecedented opportunity to transform the system. The fact that this is a policy-building process is central to this possibility.

185 In this statement, I have written a great deal about what I believe will strengthen the performance of area mental health services managed in mainstream settings. These include effective local clinical leadership; a reciprocal interest between mental health services and the local health services they form part of; and a commitment by health service executives and boards to clinical performance and clinical excellence. New Power must be harnessed in order to ensure communities, patients and families are enabled to participate in service leadership, co-design and co-production. The peer workforce must continue to grow and exert an influence on a changing culture of clinical practice.

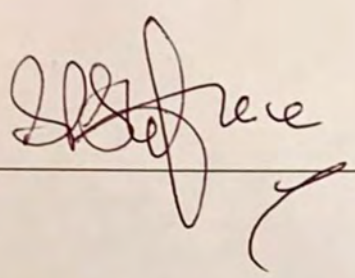
186 I have advocated for the adoption of methodologies such as human factors/ergonomics in patient safety and design thinking in service redesign. I have outlined my belief that in future Victoria's mental health system must develop a capacity for public health surveillance, and service feedback, analysis and improvement through capacity created in local area mental health services.

187 I believe the clinical system must do more to provide sufficient beds for acute care and genuine alternatives to hospitalization, and to develop a workforce trained to deliver the interventions we know work, in ways that promote the engagement of patients and families and their recovery.

188 I believe that Victoria should set an ambitious target of ensuring that its coverage of the population increases from 1% to 3%.

189 A system of adult community mental health centres or hubs should be set up to provide for integrated mental health, addiction, primary health and psychosocial care. These should be provided by clinical services. Co-located community health organizations should provide primary and recovery-oriented services. These centres would build on existing community mental health services and extend upon them, with a specific mandate to provide for patients with moderate to severe mental illness, and complex, but non-urgent need. Community hubs will provide evidence-based interventions including pharmacotherapy, psychotherapy, physical healthcare and functional and social support and a strong peer workforce with a capacity to provide peer-led services. Family support must be integral to the service model.

190 I also believe an Adult and Aged Mental Health Research Institute must be established with campuses at several major mental health services, to drive the research, improvement and redesign agenda. The model should imitate the academic health sciences model and seek to ensure that research breakthroughs are rapidly translated into improvements in patient care. Academic linkages should create opportunities for inter-disciplinary collaboration and partnership in the areas of neuroscience, genetics, clinical trials and service design and evaluation. Such an academic centre could provide a focus for the efforts of Victoria to improve the care provided to the most vulnerable Victorians and create an impact on a global stage.

sign here ▶ 

print name Simon Peter Stafrace

date 7 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SPS-1

This is the attachment marked 'SPS-1' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

CURRICULUM VITA

A/ PROF SIMON STAFRACE

Program Director of Mental & Addiction Health

Alfred Health, Melbourne, Victoria, Australia

CURRENT EMPLOYMENT

(i) ***Alfred Health / Program Director of Mental & Addiction Health (Alfred Psychiatry to 2018)| 2006 - PRESENT***

I lead a public area mental health service in southeast metropolitan Melbourne, with a catchment population of about 400,000. We provide mental health & addiction services in hospitals, community residential units and clinics across 12 sites, as well as an academic/research centre managed in partnership with Monash University. Our budgeted revenue is over $A80 million per annum and we employ over 750 full time equivalent staff.

Since 2006, our team has successfully implemented several initiatives, including:

- A statewide psychiatric intensive care hospital unit (PICU);
- A statewide problem gambling specialist community mental health service;
- An intensive adult community rehabilitation & complex care service, known as New Horizons;
- A restructure of the adult community program stream, including the establishment of a service (known as the Navigations service) combining intake, primary mental health consultation & short-term treatment and transition to primary care.
- An adult sub-acute service in the community, the South Yarra Prevention & Recovery Care or PARC Unit);
- A clinical alcohol & drug service, including a pharmacotherapy clinic (Southcity Clinic) & a hospital addiction liaison service at The Alfred;
- A youth primary mental health clinic known as headspace primary (combining general practice, addiction, employment and mental health services);
- A regional headspace youth early psychosis program (the Southern Melbourne hYEPP), which has integrated Early Psychosis Youth Centre (EPYC) and Open Dialogue models of care;
- A Mental Health & Intellectual Disability service for youth (MHIDI-Y);
- A Forensic Youth community mental health consultation service.

Many initiatives have involved collaboration with providers of community & primary care, disability support, addiction, employment and housing services. Partners have included Wellways, MIND, UnitingCare Victoria, Sacred Heart Mission, Star (Community) Health, Salvation Army's Access Health, Launch Housing, Taskforce, Odyssey, First Step, Victorian Responsible Gambling Foundation and South-East Melbourne Primary Healthcare Network.

(ii) ***Monash University / Adjunct Clinical Associate Professor| 2011 – PRESENT***

I am an active contributor to undergraduate and postgraduate psychiatry teaching at Alfred Health. I am responsible for ensuring the availability of clinical resources for undergraduate teaching and clinical research and am accountable for postgraduate medical training. I lead a service evaluation stream of research. Our initiatives have led to publications in peer-reviewed mental health journals and other mediums. I have delivered oral presentations at national conferences and clinical service forums.

(iii) ***Clinical & Leadership Consultancy in Specialist & primary Mental Health & aged care | 2005- PRESENT***

Clients have included SA Health (including the First Oakden Review[1]), Tasmanian Health Service, Eastern Melbourne PHN, Eastern Health, Ballarat Health, Peninsula Health.

PAST EMPLOYMENT

- **MEDICAL PANELS OF VICTORIA | PSYCHIATRIST MEMBER| 2012 - 2016**
- **ALFRED HEALTH (CAULFIELD HOSPITAL) | DIRECTOR, AGED PSYCHIATRY SERVICE| 2000 - 2006**
- **PSYCHIATRIST IN PRIVATE PRACTICE | INCL. ADMITTING RIGHTS TO DELMONT HOSPITAL, MELBOURNE CLINIC & NORTHPARK HOSPITAL| 1996-2006**
- **MONASH UNIVERSITY | SENIOR LECTURER| 2004-05**
- **ST GEORGE'S HOSPITAL (NOW ST VINCENT'S HEALTH) | PSYCHIATRIST, AGED PSYCHIATRY SERVICE| 1998-2000**

[1] http://bit.ly/2rNdYK2

- **BUNDOORA EXTENDED CARE CENTRE (NOW MELBOURNE HEALTH) | PSYCHIATRIST & ACTING DIRECTOR, AGED PSYCHIATRY SERVICE| 1996-1998**

- **BUNDOORA EXTENDED CARE CENTRE (NOW MELBOURNE HEALTH) | REGISTRAR- ADVANCED TRAINING IN AGED PSYCHIATRY & RESEARCH ASSOCIATE (CENTRE FOR GERONTOLOGY) | 1996-1998**

- **NORTHERN METROPOLITAN PSYCHIATRY TRAINING PROGRAM, VICTORIA| REGISTRAR- BASIC TRAINING| 1991-1995**
    - Adult Psychiatry- Crisis Assessment & Treatment, Plenty Hospital, North-Eastern Melbourne Psychiatric Service (NEMPS)
    - Aged Psychiatry- Assessment Team (APAT), Wildara Community Clinic, NEMPS
    - Adult Psychiatry- Mood & Eating Disorders Unit, Larundel Hospital, NEMPS
    - Aged Psychiatry- IPU & Community- Peter James Hospital (now Eastern Health)
    - Liaison Psychiatry- St Vincent's Hospital (Melbourne)
    - Adult Psychiatry- Inpatient Rehabilitation, Larundel Hospital, NEMPS
    - Child & Adolescent Psychiatry- SE Child & Family Centre (Melbourne) (now Alfred Health)
    - Adult Psychiatry- IPU & Outpatients, Maroondah Hospital (now Eastern Health)

- **BOX HILL HOSPITAL (NOW EASTERN HEALTH) | INTERN & HMO| 1989-1991**

ACADEMIC QUALIFICATIONS & KEY CONTINUING PROFESSIONAL DEVELOPMENT

- **LA TROBE UNIVERSITY | MASTER OF HEALTH ADMINISTRATION (MHA)| 2005**

- **MONASH UNIVERSITY | GRADUATE DIPLOMA, HEALTH SERVICES MANAGEMENT| 2004**

- **ROYAL AUSTRALIAN & NEW ZEALAND COLLEGE OF PSYCHIATRISTS| ACCREDITED MEMBERSHIP OF THE FACULTY OF PSYCHIATRY OF OLD AGE |1999**

- **MONASH UNIVERSITY | MASTER OF PSYCHOLOGICAL MEDICINE (MPM)|1998**

- UNIVERSITY OF MELBOURNE | GRADUATE DIPLOMA, MENTAL HEALTH SCIENCES (CLINICAL HYPNOSIS)| 1998
- ROYAL AUSTRALIAN & NEW ZEALAND COLLEGE OF PSYCHIATRISTS| FELLOWSHIP (FRANZCP)| 1996
- UNIVERSITY OF MELBOURNE | BACHELOR OF MEDICINE, BACHELOR OF SURGERY (MB BS)| 1988

KEY CONTINUING PROFESSIONAL DEVELOPMENT

- LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE| EXECUTIVE PROGRAMME GLOBAL HEALTH LEADERSHIP| 2018
- LEADERSHIP VICTORIA | WILLIAMSON COMMUNITY LEADERSHIP PROGRAM| 2016
- FELLOW, AUSTRALIAN INSTITUTE OF MANAGEMENT| 2002
- PRIMARY CERTIFICATE IN RATIONAL-EMOTIVE BEHAVIOUR THERAPY, AUSTRALIAN INSTITUTE FOR RATIONAL-EMOTIVE THERAPY| 1999.
- AMA 4 GUIDES IMPAIRMENT ASSESSMENT TRAINING PROGRAM, CORE & PSYCHIATRY (STREAM 2)| 2001 & 2011.
- AUSTRALIAN SOCIETY OF HYPNOSIS | DIPLOMA, CLINICAL HYPNOSIS| 1993

HONORS & AWARDS

- WA RANZCP TRAVELLING SCHOLAR| 2019
- HOLT AUSTRALIA DAY AWARD| 2019
- MARGARET TOBIN AWARD, RANZCP| 2016
- TRAVELLING FELLOWSHIP FOR OLD AGE PSYCHIATRY, FACULTY OF PSYCHIATRY OF OLD AGE, RANZCP & LUNDBECK INSTITUTE| 1999

- MADDISON MEDALLION, RANZCP| 1997

CURRENT VOLUNTEER ROLES

- MENTAL HEALTH VICTORIA| BOARD DIRECTOR| 2018- PRESENT
- RANZCP| CHAIR COMMUNITY COLLABORATION COMMITTEE| 2018-PRESENT
- METROPOLITAN PARTNERSHIPS-INNER SOUTH-EAST | COMMUNITY MEMBER| 2017-PRESENT
- TANDEM VICTORIA | BOARD SECRETARY| 2016-PRESENT

PAST KEY VOLUNTEER ROLES

- RANZCP | DEPUTY CHAIR EDUCATION COMMITTEE| 2012-15
- RANZCP| MEMBER, CONTINUING MEDICAL EDUCATION COMMITTEE| 2008-15
- SACRED HEART MISSION, JOURNEY TO SOCIAL INCLUSION PROJECT | MEMBER STEERING GROUP| 2009-12
- RANZCP, FACULTY OF PSYCHIATRY OF OLD AGE| DIRECTOR OF ADVANCED TRAINING (VICTORIA)| 2005-06
- RANZCP, FACULTY OF PSYCHIATRY OF OLD AGE| BRANCH SECRETARY (VICTORIA)| 1999-2006

PUBLICATIONS

1. Lee SJ, Thomas P, Freidin J, Newnham H, Lowthian J, Smith C, Borghmans F, Gocentas R, DeSilva D, **Stafrace S**. Homeless status documentation at a metropolitan hospital emergency department. Emergency Medicine Australasia (2019). In press. Published March 2019 on-line.
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4. Filia SL, Gurvitch CT, Horvat A, Shelton CL, Katona LJ, Baker AL, **Stafrace S**, Keppich-Arnold S, Kulkarni J. Inpatient views and experiences before and after implementing a totally smoke free policy in the acute psychiatry hospital setting. Int J Mental Health Nursing 2015 Aug; 24(4): 35—9.
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7. Kulkarni J, Gavrilidis E, Lee S, Van Rheenen TE, Grigg J, Hayes E, Lee A, Ong R, Seeary A, Andersen S, Worsley R, Keppich-Arnold S, **Stafrace S**. Establishing female-only areas in psychiatry wards to improve safety and quality of care for women. Australasian Psychiatry. 2014 Dec; 22(6): 551-56
8. Lee S, Hollander Y, Scarff L, Dube R, Keppich-Arnold S & **Stafrace S**. Demonstrating the impact and model of care of a Statewide psychiatric intensive care service. Australasian Psych (2013)21; 466-71.
9. Konstantatos AH, Angliss M, Costello V, Cleland H, **Stafrace S.** Predicting the effectiveness of virtual reality relaxation on pain and anxiety when added to PCA morphine in patients having burns dressings changes. Burns (2009), 35(4), 491-499.
10. **Stafrace S** & Lilly A. Turnaround in an aged persons' mental health service in crisis: a case study of organisational renewal. - Australian Health Review (2008), 32(3) 577 – 582.
11. **Stafrace S.** Self-Esteem, Hypnosis & Ego Enhancement. Australian Journal of Clinical & Experimental Hypnosis 2004, 32; 1-35
12. O'Connor D, Horgan L, Cheung A, Fisher D, George K, **Stafrace S**. An audit of physical restraint and seclusion in five psychogeriatric admission wards in Victoria, Australia. Int J Geriatr Psychiatry. 2004 Aug;19(8):797-9.
13. Ames, D., & Stafrace, S. (1999). Psychiatry of Old Age: A Symposium Edited by David Ames and Simon Stafrace: Has the psychiatry of Old Age Come of Age? Australian & New Zealand Journal of Psychiatry, 33(6), 782–784.

14. **Stafrace S.** Hypnosis in the treatment of panic disorder with agoraphobia. Australian Journal of Clinical & Experimental Hypnosis 1994, 22, 73-86.
15. Lydall-Smith S, **Stafrace S**, Ecclestone L. NEMPS Relocation Study. Volume 1: Summary Report. Occasional Paper #3, May 1998. Centre for Applied Gerontology, Bundoora Extended Care Centre, Bundoora.
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ATTACHMENT SPS-2

This is the attachment marked 'SPS-2' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ACTIVITY & DIAGNOSIS ALFRED ADULT MENTAL HEALTH SERVICES

TABLE 1- COMMUNITY ADULT ACTIVITY

TOTAL PATIENTS ALFRED ADULT COMMUNITY MHS	2016/17	2017/18	2018/19
Incl. HOPS, MSTS, CCTs, Navigations			
New	599	674	754
Closed	546	497	674
Total Patients Seen	1184	1211	1307
Num Clients Open at End of Period	660	700	716

TABLE 2- COMMUNITY ADULT DIAGNOSIS

DIAGNOSIS ALFRED ADULT CMHS	2016/17	2017/18	2018/19
PRIMARY			
Schizophrenia, Schizotypal and Delusional	77%	78%	72%
Mood Disorders	11%	10%	12%
Disorders of personality and Behaviour	5%	5%	6%
AOD	4%	3%	5%
Anxiety, Stress Disorders and Somatoform	1%	2%	3%
Other Mental Health	3%	1%	2%
Organic & Symptomatic mental disorders	0%	0%	0%
% 2° AOD diagnosis recorded	34%	41%	38%

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ATTACHMENT SPS-3

This is the attachment marked 'SPS-3' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ACTIVITY & DIAGNOSIS ALFRED COMMUNITY AGED PERSONS MENTAL HEALTH SERVICE

TABLE 3- COMMUNITY AGED ACTIVITY

TOTAL PATIENTS ALFRED AGED CMHS	2016/17	2017/18	2018/19
New	277	253	248
Closed	287	274	251
Total Patients Seen	418	381	364
Num Clients Open at End of Period	143	126	130

TABLE 4- COMMUNITY AGED DIAGNOSIS

1° DIAGNOSIS ALFRED AGED CMHS	2016/17	2017/18	2018/19
Schizophrenia, Schizotypal and Delusional	32%	34%	32%
Organic & Symptomatic mental disorders	25%	20%	20%
Mood Disorders	20%	28%	29%
Other Mental Health	17%	11%	12%
Anxiety, Stress Disorders and Somatoform	5%	5%	5%
Disorders of personality and Behaviour	1%	1%	2%
AOD	1%	0%	0%
% of Aged Community Clients with secondary AOD diagnosis recorded	3%	2%	2%

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ATTACHMENT SPS-4

This is the attachment marked 'SPS-4' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ACTIVITY & DIAGNOSIS ALFRED CYMHS

TABLE 5- COMMUNITY CHILD & YOUTH ACTIVITY

TOTAL PATIENTS SEEN ALFRED CYMHS	2016/17	2017/18	2018/19
New	596	662	610
Closed	545	694	617
Total Patients Seen	945	1084	1016
Num Clients Open at End of Period	469	453	468

TABLE 6- COMMUNITY CHILD & YOUTH DIAGNOSIS

1˚ DIAGNOSIS PATIENTS SEEN ALFRED CYMHS	2016/17	2017/18	2018/19
Anxiety, Stress Disorders and Somatoform	24%	24%	23%
Other Mental Health	23%	32%	33%
Disorders of psychological development	18%	14%	16%
Disorders with onset usually occuring in childhood and adolescence	17%	13%	11%
Mood Disorders	9%	8%	9%
Disorders of personality and Behaviour	7%	7%	7%
Schizophrenia, Schizotypal and Delusional	1%	0%	0%
AOD	1%	1%	1%
% of CYMHS Community Clients with secondary AOD diagnosis recorded	2%	2%	2%

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ATTACHMENT SPS-5

This is the attachment marked 'SPS-5' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ACTIVITY & DIAGNOSIS ALFRED hYEPP & headspace Elsternwick

TABLE 7- COMMUNITY hYEPP ACTIVITY

TOTAL PATIENTS SEEN ALFRED hYEPP	2016/17	2017/18	2018/19
New	359	397	327
Closed	319	373	310
Total Patients Seen	466	568	581
Num Clients Open at End of Period	188	253	327

TABLE 8- COMMUNITY hYEPP DIAGNOSIS

1° DIAGNOSIS ALFRED hYEPP	2016/17	2017/18	2018/19
Schizophrenia, Schizotypal and Delusional	31%	33%	35%
Mood Disorders	14%	13%	12%
Disorders of personality and Behaviour	8%	10%	8%
AOD	3%	6%	6%
Anxiety, Stress Disorders and Somatoform	28%	32%	28%
Other Mental Health	17%	6%	10%
% of Clients with secondary AOD diagnosis recorded	0%	0%	0%

TABLE 9- COMMUNITY PRIMARY HEADSPACE ACTIVITY

Referrals & Patients Seen: Headspace Primary - Elsternwick	2016/17	2017/18	2018/19
Intake Referrals	N/A	1463	1812
Total Patients Seen	1044	1497	1617

TABLE 10– COMMUNITY PRIMARY HEADSPACE DIAGNOSIS

1° Diagnosis: Headspace Primary - Elsternwick	2016/17	2017/18	2018/19
Personality and Behaviour	N/A	8.6%	7.7%
AOD	N/A	0.8%	1.2%
Anxiety and Stress	N/A	41.0%	37.1%
Psychosocial	N/A	10.5%	12.8%
Mood Disorders	N/A	28.9%	31.2%
Other	N/A	9.8%	10.0%
Psychotic symptoms	N/A	0.34%	0.00%

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ATTACHMENT SPS-6

This is the attachment marked ' SPS-6' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ACTIVITY & DIAGNOSIS ALFRED HOSPITAL INPATIENT UNITS

TABLE 11- ADULT & AGED IPU ACTIVITY

Psychiatry Inpatient Unit Discharges			
Data source : CMI			
Alfred	**Financial Year**	**Discharges**	**Patients**
	FY17	1328	961
	FY18	1276	929
	FY19	1291	951
Caulfield	FY17	148	117
	FY18	151	118
	FY19	153	128

TABLE 12- ADULT & AGED IPU DIAGNOSIS

% of Discharges by Diagnostic Group				
Data source : CMI				
	Diagnostic Group - Principal Diagnosis	**2016/17**	**2017/18**	**2018/19**
Alfred	Schizophrenia, Schizotypal and Delusional	49%	45%	41%
	Mood Disorders	20%	19%	17%
	Disorders of personality and Behaviour	12%	14%	10%
	AOD	11%	13%	16%
	Anxiety, Stress Disorders and Somatoform	6%	7%	6%
	Other Mental Health	2%	2%	3%
	Organic & Symptomatic mental disorders	1%	1%	1%
	No Diagnosis	0%	0%	6%
Caulfield	Mood Disorders	38%	40%	33%
	Schizophrenia, Schizotypal and Delusional	31%	26%	37%
	Organic & Symptomatic mental disorders	17%	20%	16%
	Anxiety, Stress Disorders and Somatoform	8%	5%	4%
	AOD	3%	4%	3%
	Other Mental Health	2%	3%	4%
	Disorders of personality and Behaviour	1%	2%	3%

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ATTACHMENT SPS-7

This is the attachment marked 'SPS-7' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ACTIVITY & DIAGNOSIS ALFRED HOSPITAL EMERGENCY DEPARTMENT

TABLE 13A- TOTAL MENTAL & BEHAVIOURAL DISORDERS & % SEEN BY SPECIALIST MENTAL & ADDICTION HEALTH SERVICE IN THE EMERGENCY DEPARTMENT FY13-18

YEAR	#EPS Ax	#TOTAL Presentations Mental & Behavioural Disorders	%Seen/ TOTAL	% Growth PA
2012-13	1980	4090	48%	
2013-14	2193	4269	51%	11%
2014-15	2825	4386	64%	29%
2015-16	3240	4592	71%	15%
2016-17	3598	4746	76%	11%
2017-18	4162	5189	80%	16%

TABLE 13B- DIAGNOSES MENTAL & ADDICTION HEALTH, EMERGENCY DEPARTMENT FY14-18

Diagnostic Group	13/14	14/15	15/16	16/17	17/18
Alcohol or drug intoxication, poisoning or disorder	2055	1910	2085	2275	2465
Psychiatric, behavioural, social	2548	2959	3043	3185	3376
Other	55742	57745	58120	59607	59572
Grand Total	60345	62614	63248	65067	65413

TABLE 13C- PERCENTAGE MENTAL & ADDICTION DIAGNOSES OF TOTAL

Diagnostic Group	13/14	14/15	15/16	16/17	17/18
Alcohol or drug intoxication, poisoning or disorder	3.4%	3.1%	3.3%	3.5%	3.8%
Psychiatric, behavioural, social	4.2%	4.7%	4.8%	4.9%	5.2%

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ATTACHMENT SPS-8

This is the attachment marked 'SPS-8' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

ALFRED CATT & EDM- MENTAL & ADDICTION HEALTH ACTIVITY

TABLE 14- CATT & EDM ACTIVITY

		2016/17	2016/173	2017/18	2017/184	2018/19	2018/19
CATT & EDM		Num Episodes	Num Clients	Num Episodes	Num Clients	Num Episodes	Num Clients
New Episodes	CATT	631	572	582	518	595	526
	EDM	223	207	228	207	314	278
Closed Episodes	CATT	635	578	576	512	596	526
	EDM	215	199	231	212	317	280
Total Clients Seen	CATT & EDM		737		669		758

TABLE 15- CATT & EDM DIAGNOSES

CATT & EDM	2016/17	2017/18	2018/19
Schizophrenia, Schizotypal and Delusional	31%	30%	34%
Mood Disorders	26%	26%	23%
Disorders of personality and Behaviour	21%	18%	14%
Anxiety, Stress Disorders and Somatoform	12%	11%	10%
AOD	6%	7%	8%
Other Mental Health	4%	7%	11%
Organic & Symptomatic mental disorders	0%		1%
% of CATT/EDM Community Clients with secondary AOD diagnosis recorded	25%	23%	31%

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ATTACHMENT SPS-9

This is the attachment marked 'SPS-9' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

TABLE 16- TOTAL TRIAGE ASSESSMENTS UNDERTAKEN

	Triage Category	16/17	17/18	18/19
Alfred APACER	A. Emergency services response	128	94	66
	B. Very urgent mental health response	120	110	142
	C. Urgent mental health response	24	12	28
	D. Semi-urgent mental health response	11	7	10
	E. Non-urgent mental health response	9	12	14
	F. Referral/advice to contact alternative service	6	16	12
	G. Advice or information only / more info needed	59	69	80
Alfred APACER Total		**357**	**320**	**352**
Alfred EPS	A. Emergency services response	91	159	49
	B. Very urgent mental health response	2402	2626	3143
	C. Urgent mental health response	905	873	1055
	D. Semi-urgent mental health response	107	121	101
	E. Non-urgent mental health response	34	32	30
	F. Referral/advice to contact alternative service	35	57	32
	G. Advice or information only / more info needed	203	231	153
Alfred EPS Total		**3777**	**4099**	**4563**
Alfred Triage Service	A. Emergency services response	182	143	136
	B. Very urgent mental health response	128	133	85
	C. Urgent mental health response	354	302	304
	D. Semi-urgent mental health response	424	302	348
	E. Non-urgent mental health response	572	534	672
	F. Referral/advice to contact alternative service	559	558	520
	G. Advice or information only / more info needed	1748	1971	1824
Alfred Triage Service Total		**3967**	**3943**	**3889**
Grand Total		**8101**	**8362**	**8804**

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ATTACHMENT SPS-10

This is the attachment marked 'SPS-10' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

TABLE 17: KEY PERFORMANCE INDICATORS- ACTIVITY EMERGENCY & ADULT INPATIENT SERVICES AT ALFRED HEALTH FY14-19

	FY14	FY15	FY16	FY17	FY18	FY19
Separations per month	91	93	108	110	106	108
Occupancy (without leave)	95%	99%	98%	100%	97%	101%
Length of Stay	19	17	16	15	16	15
Varied CTO triggering admit	18%	15%	13%	14%	12%	12%
1st Episode	40%	41%	41%	45%	42%	43%
Out of Area Admission	15%	20%	20%	25%	27%	20%
Admit via ED	56%	51%	49%	60%	58%	64%
Admit via Medical Unit	4%	9%	9%	11%	10%	20%
Admit via Other AMHS IPU	3%	3%	1%	2%	3%	1%
Admit direct via Alfred Adult CMHS	25%	34%	35%	21%	23%	12%
CTO at discharge	30%	25%	28%	29%	24%	24%
Readmission Rate	14%	11%	13%	11%	12%	11%
ED 4 hour waits	70%	74%	69%	65%	65%	24%
ED 8 hour waits	91%	91%	90%	85%	86%	24%
ED patients seen by EPAS	2193	2825	3279	3598	3845	4434
ED TOTAL patients mental & behavioural disorders	4269	4386	4592	4764	4785	5422

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ATTACHMENT SPS-11

This is the attachment marked 'SPS-11' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

JULY 2019

Alfred Health Submission to Royal Commission into Victoria's Mental Health System

INTRODUCTION

Thank you for the opportunity to contribute to the Royal Commission into Victoria's Mental Health System (VMHS). The Victorian government is to be commended for recognizing the devastating impact of mental illness, addiction and suicide upon individuals and their families; and for responding to the urgent concern among Victorians that the mental health system set up to relieve the associated burden of care, worry and responsibility must do so more consistently, safely and effectively than is presently the case.

People suffering from mental illness and addiction require healthcare in the most holistic sense. The factors that predispose, trigger, prolong or protect against mental illness should be understood as arising from a framework of intersecting biological, psychological, social, familial, and cultural issues. The consequences of mental illness and addiction are similarly multifactorial. Interventions must therefore address systemic factors, in addition to treating the symptoms and complications of mental and physical illness

The provision of multidisciplinary clinical care and support must be a fundamental requirement of mental and addiction health services. This is a well-established principle, but one that is increasingly difficult to deliver in stretched and poorly resourced services. For patients with enduring illness and disability, mental healthcare must be augmented by access to primary health and prevention; secure and affordable housing; a living income irrespective of source; education, vocational training and employment; support in managing family and legal issues; and the formation and maintenance of social networks that create resilience and combat loneliness.

The system needed to deliver on these outputs requires the participation of those with lived experience and their families AND the engagement of technical experts from sectors within and beyond healthcare. In addition to clinicians and peer workers with training in mental illness, addiction and suicide, such a system of care must interface with primary and specialist healthcare, disability and housing support, education and vocational training, and justice and police. It must deliver research that is interdisciplinary and that intersects with the clinical and social sciences, neuroscience and genetics, systems design and safety, and urban planning and housing.

The health sector is in a unique position to provide leadership to the inter-disciplinary collaboration required to respond to these challenges. In making this claim, we draw upon our experience of delivering services to patients and families with urgent and ongoing needs; our work in partnership with the academic and community sectors in research and service delivery; our orientation towards systems thinking and system redesign; and our growing engagement with a participatory ethic in the delivery of our services.

In this submission, we have made eight recommendations to support the continued evolution of the Victorian Mental Health System to better serve and support our community.

We believe that the VMHS must:

1. Provide specialist psychiatric care in hospitals designed to be safe and therapeutic.
2. Deliver specialised models of care to support the treatment of patients with mental illness, addiction and at risk of suicide in the Emergency Department (ED) and the general hospital and support the management of behaviours of concern across health services.
3. Offer genuine alternatives to hospitalisation through the development of stepped models of care in the community, which provide greater responsiveness and intensive care and support for patients referred from ED or the hospital or by GPs and community-based mental health providers.
4. Recruit a trained and competent workforce.
5. Provide resources for families and carers who are supporting the needs of loved ones with severe mental illness.
6. Engage patients, families and communities in choice, education, design and leadership.
7. Develop a culture of improvement and research.
8. Address system issues and structures to better support care delivery.

Alfred Health and our learnings in Mental Health and Addiction

Outpatient and consultation-liaison psychiatry services commenced at The Alfred in 1923. The Inner-South East Mental Health Service was established in 1996, with transfer of responsibility

for adult and aged beds at Royal Park and Heatherton Hospitals, and of the Albert Park and Malvern Community Mental Health Clinics.

Alfred Health today serves a population of about 700,000 people in the inner south-east metropolitan region. The service delivers specialist clinical public mental health and addiction services to children, youth, adults and elderly people; in hospitals, community rehabilitation units and clinics; and at a dozen sites across the southern metropolitan region. We also provide an academic/research centre in partnership with Monash University.

Alfred Health's purpose, presented in its strategic plan, is to improve the lives of our patients and their families, and our communities and humanity. Since 1996, we have worked towards this purpose through a series of important initiatives, including:

- The commissioning of an adult inpatient service at The Alfred and of aged inpatient and residential care services at Caulfield Hospital.
- Improvements in clinical governance and accountability with increasingly detailed public reporting of aspects of clinical performance;
- A reduction in the use of restrictive interventions on inpatient units (IPUs) such that Alfred Health was ranked as having the fourth lowest seclusion rate in the state in the first two quarters of FY19 in the VMIAC "How Safe Is My Hospital" report (April 2019) ;
- Improvements in hospital readmission rates and emergency department (ED) waits and no in-hospital suicides since 2011;
- The development of gender-sensitive practice, regular reporting of sexual safety issues and the establishment of a women's inpatient corridor in one of our acute IPUs, which has been shown to be an effective way to improve the safety and experience of care for female patients;
- The establishment of a statewide psychiatric intensive care service, to provide for improved outcomes among patients deemed unsafe for psychiatric care in high dependency units in other Victorian acute mental health services.
- The establishment of a prevention and recovery care (PARC) unit, to provide for a recovery-oriented alternative in the community. This results in significantly less time spent by clients in acute inpatient care following admission to PARC;
- Improved outreach for suicide prevention through the Homeless Outreach Postsuicide Engagement (HOPE) initiative, utilizing a combined clinical and social support model of care. This showed a significant reduction in ED presentations at 1 and 6 months after the index presentation, and consistently

high ratings of wellbeing and satisfaction on the part of consumers using the service;

- The emergence of a peer workforce and participation of consumers and carers in service design and governance;
- The establishment of a Mental Health-Addiction hub and service stream in the Emergency and Trauma Centre (ETC) at The Alfred. This has delivered improvements in ED waiting times for patients presenting for assessment and treatment, despite an increase in demand and no change in bed availability.
- The emergence of a strong child and youth mental health service system, including the establishment of a primary headspace centre, a regional headspace youth early psychosis program, a Discovery College and a platform for co-design, family engagement and therapeutic innovation;
- Expansion of liaison psychiatry to include addiction and play a crucial role in management of high-risk patients with mental illness and/or addictions and behaviours of concern in the emergency department and general hospital;
- Establishment of an addiction service at our community adult mental health centre in St Kilda Road, to provide referred community clients and registered mental health clients access to treatment of Alcohol and Opiate Use Disorders.
- Redesign of the community adult program to provide for mental health consultations and short-term intensive multidisciplinary treatment of patients referred by GPs; a broadening of specialist family, forensic and physical health consultation and treatment services to existing community clients; and transition of complex case managed clients with stable mental illnesses to primary care.
- Recruitment and retention of an engaged and competent workforce in psychiatry, nursing, and allied health.
- An academic centre with a strong focus on teaching medical students and research in women's mental health, neurostimulation, and service evaluation.

WHAT ARE THE CHALLENGES WE FACE TODAY?

In 2019, Alfred Health is facing a number of challenges in delivering mental and addiction health services.

Our allocation of beds in our acute, sub-acute and non-acute (rehabilitation) settings has remained unchanged since 2004, despite a considerable increase in the population of our catchment and the metropolitan area more broadly. Between 2013 and 2018, the population

of our catchment increased about 12 per cent[1]. In the same period, the total number of patients presenting to the emergency department with mental and behavioural disorders grew on average about 4.3 per cent per annum (pa).

Our clinicians and carers report that our patients are sicker at discharge today than a decade ago, a fact reflected in published statewide data. The observation that trimmed average length of stay in our adult inpatient unit has decreased during this period[2] suggests that we have met growing demand for inpatient care by discharging patients earlier in their recovery. Community clinical mental health services can only provide an intensive level of support for clients and their families post-discharge by exception, and our re-admission rate within 28 days remains high at about 14 per cent.

Our patients continue to present with significant co-morbidity due to substance use disorders and problems with physical health. In the Emergency Department at The Alfred, from FY14 and FY18, 3.4 per cent of all presentations were due to 'alcohol or drug intoxication, poisoning or disorder', and 4.6 per cent were due to 'Psychiatric, behavioural, social' causes. Patients in whom substance use disorders (SUDs) represent a primary or secondary diagnosis occupy at least 47 per cent of bed days on our inpatient unit. There is no dedicated funding stream for addiction specialist clinicians to provide assessment and treatment to patients presenting in the emergency department, in the hospital and in psychiatric services. The model of care for Alcohol and Drug services in the community does not suit clients with comorbid mental illness and SUDs, accompanied by poor motivation and engagement.

Our patients continue to experience severe social disadvantage. Poverty, social isolation and loneliness, unemployment, poor physical health and housing are among the top barriers to recovery experienced by people with psychosis. The Anglicare Rental Affordability Survey 2019 concluded that there is virtually no accommodation in the private rental market in Australia that is affordable for single people on supported incomes.

Given that over 90 per cent of patients using our acute inpatient services receive Newstart or the disability support or aged pensions, and that about 20 per cent are of no fixed address, this represents a major barrier to service access and patient outcomes. In the absence of family support, we are required to discharge patients into secondary (transitional and crisis housing) and tertiary (boarding houses, motels) homelessness every day in order to make room for new patients presenting acutely.

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[1] From 369,260 to 414,760 (ABS)
[2] From 13.2 in 2012-13, to 10.7 in 2017-18

> "Despite the modest increase to Newstart in recent months, it still falls woefully short of what is needed for a motivated unemployed person to survive with dignity while setting about to find a real job."

Access to evidence-based structured psychological therapies for individual patients and their families in the community is limited, for all disorders that cause serious mental illness. Alfred Health provides limited services through our Dialectic Behaviour and Mentalisation-based therapy programs in the Adult and Child and Youth programs respectively, but these treat relatively small numbers of patients and do not meet demand.

Access to services to support families who provide care to people with serious mental illness is lacking, as is access to disability support services through the Mental Health Community Support Services. The NDIS holds promise for improving this situation, but many people with severe mental illness are not eligible for NDIS because they will not engage with the system, find it too complicated or do not meet criteria for support set out in section 24 of the NDIS Act 2013.

The burden of compliance and governance has continued to increase. Mental health services provided by Alfred Health undergo accreditation every three years through the National Safety and Quality Health Service (NSQHS). Our services are accountable to the Mental Health Branch, the Office of the Chief Psychiatrist, the Office of the Public Advocate, the Mental Health Tribunal and Worksafe Victoria. Safer Care Victoria, the Office of the Chief Psychiatrist, and the Victorian Coroner each review some or all adverse events involving patient deaths and injuries. Worksafe Victoria undertakes investigations of staff injuries and occasionally patient deaths.

A trend has emerged in the past year, in which complaints are being made about the same issues through multiple agencies, including the Mental Health Complaints Commissioner, Worksafe Victoria and the Australian Health Practitioners Registration Agency. It must be said that these agencies have had a positive impact on safety, quality, transparency and accountability, but compliance requires resources and training of the workforce, and these have been lacking. Furthermore, the duplication of responsibilities and requirements creates redundancies in process, which are time-consuming, unproductive and should be eliminated.

Funding has not kept up with the growth of patient demand and complexity. The impact of enterprise-based agreements, rising community expectations, and the emergence of new evidence-based treatments are placing cost pressures on services. The requirement for productivity savings year-on-year has had a disproportionate effect on clinical community

mental health services, even as increasing emergency demand has placed pressure upon fixed bed numbers. There has been an undoubted effort to improve funding in the past four years, and this has been most welcome. However, the gap between the investment in Victoria's mental health and health services overall continues to grow, as does the gap between per capita funding of mental health services in Victoria compared to other states. Recent increases in funding will take time to have an impact due to a shortage of qualified practitioners who are in high demand and short supply across both primary and specialist sectors following substantial investments from the state and commonwealth governments.

WHAT ARE OUR PRIORITIES AND ARE THEY RELEVANT TO SYSTEM REFORM?

Between 2015 and 2018, Alfred Health undertook a number of strategic reviews of its mental health services.

This work led to a change in name, from Alfred Psychiatry to Alfred Mental and Addiction Health. Our repositioning is a response to the prevalence of substance abuse and dependence among patients with serious mental illness, in particular those presenting to our emergency, youth and adult services and in our general hospitals. It reflects our belief that Victoria's Mental Health System (VMHS) should provide integrated clinical care for people with Substance Use Disorders (SUDs) that are complex and severe or that complicate severe mental illness. This should combine the disciplines of addiction psychiatry and addiction medicine, to provide services that are multidisciplinary, delivered in hospitals and communities, and oriented towards public health objectives.

Also to emerge from this work was a vision for a model of care that we believe should form the basis for a statewide approach to service delivery in VMHS.

We believe that the care we provide must be safe, effective, personalised and connected.

We believe that our service must be accountable and participatory.

And we believe that our service should be part of a Victorian Mental Health System of care that should seek to achieve several distinct outcomes:

- The promotion of mental health and wellbeing in schools, universities, TAFE, the workplace and aged care services.
- The prevention of mental illness, addiction and suicide, through measures designed to build individual and community resilience, optimize family functioning, and maintain cardio-vascular and neurological health.

- Epidemiological monitoring of mental illness, addiction and suicide in the community and of service performance through metrics and evaluation.
- The protection of patients suffering from severe mental illness from harm. This may be self-inflicted, either intentionally or otherwise, or the result of victimization.
- The protection of the community from harm inflicted by people suffering from mental illness and co-morbid SUDs, either intentionally or otherwise.
- The provision of diagnostic, early intervention, treatment and rehabilitation services for mental and behavioural disorders, through healthcare and social services.
- Assisting people with serious mental illness to access a living income, stable and affordable housing, and opportunities for vocational training, education and employment.
- The support of families of people suffering from serious mental illness.
- Research into mental illness, addiction and suicide, which is inter-disciplinary and directed towards translation and innovation.

How Can Health Services Deliver on the Objectives of Victoria's Mental Health System

We believe that health services can support the objectives of VMHS in the following ways.

1. *Providing Specialist Care in Hospitals That Are Designed to Be Therapeutic and Safe*

Violence is a major risk in the provision of inpatient mental health care. Research indicates that 25-35 per cent of psychiatric inpatients engage in physical or verbal aggression. Patients suffering from serious mental illness and co-morbid SUD or antisocial behaviour are at higher risk of violence than the general population. Absconding from inpatient units and the use of tobacco, alcohol and illicit drugs during periods of hospitalization are additional concerns. Together, these risks shape the way in which inpatient care is experienced by both patients and clinicians, resulting in experiences of trauma and low satisfaction for both service users and service providers.

Alfred Health has sought to describe the functional elements of a future inpatient unit that seeks to minimize the risk of harm to patients and clinicians, without compromising therapeutic goals. This thinking emerged from work done in 2018, to develop a Functional Brief for the redevelopment of The Alfred that will include a flagship mental health unit. Our perspective has been shaped by what our clinicians, consumers and their families told us was important to them, and by our experience using a mental health inpatient unit that is small, has

limited outdoor and indoor space, and runs with an average bed occupancy of about 99 per cent. In this setting, there is a limited ability to separate patients by gender, complexity or vulnerability and as a result, a volatile environment can ensue which exposes patients and staff to the risk of physical and/or sexual assault. The ability of our staff to achieve some of the lowest seclusion rates in the state is testimony to their professionalism and dedication.

We believe that acute inpatient facilities can and must be designed to provide trauma-informed care and therapeutic interventions. They must also minimise exposure of patients and clinicians to violence, and other forms of harm while eliminating seclusion, in-hospital suicide and sexual assault. This balance is difficult and at the root of the complexity of care in the VMHS.

We believe that physical and process design can achieve these outcomes in an acute inpatient unit (whether adult or aged) through:

1. **Streaming** - to support gender AND age-specific care, with clustering of patients according to their safety AND therapeutic requirements. Patients at high risk of violence must be cared for in separate clinical spaces to other patients.
2. **Adequate bed capacity (or genuine alternatives to hospitalization)**
    - Crowding is associated with increased violence on inpatient units and VMHS must aim to have sufficient bed capacity for bed occupancy rates of about 85 per cent.
    - This can be achieved by increasing bed stock or by providing for genuine alternatives to hospitalization through intensive community care options.
3. **Access to space and privacy**
    - Adequate space must be provided to allow for client dignity and privacy, support a trauma-informed approach to care and minimise the contagion of distress and agitation.
    - Space must be designed to facilitate movement and function freely within the unit without fear; and allow for adequate observation, to provide for the client's safety and a continued therapeutic connection.
4. **A customer service approach** that is welcoming of patients and their relationships with families and carers, tolerates their distress and supports their engagement and wellbeing. **This will be reflected in:**
    - **The availability of space** that creates opportunities for patients to meet with family and carers, including children, in safety and comfort are necessary to support and maintain relationships.

- **Technologies that facilitate communication and the sharing of information**. The needs of families and carers will vary and design should consider the need for engagement as a partner in care, as well as their lived experience and individual needs. Alfred Health is exploring a patient portal through its electronic medical record (EMR) platform, which will allow patients access to clinical information and the capacity to contribute to care monitoring and planning. This technology can, with the permission of patients, be extended to families.

5. **An approach to care and design that is led by therapeutic priorities and not risk**
    - **This is not to neglect risk, but simply to suggest that it should not subsume (as it presently does) the therapeutic needs of clients and families.** The constructed environment is crucial in ensuring a therapeutic and safe environment and should be advanced in its technology and construction to support this.
    - **Building maintenance should be responsive and properly funded**. Degradation of the built environment occurs more rapidly in acute inpatient mental health units than in other parts of the hospital.
    - **Design should create formal and informal opportunities for socialisation between individuals through small and large communal zones, and dedicated activity areas.** Sharing experiences and social connections supports recovery. The constructed environment should balance equally priorities of privacy, maintenance of safety, and prevention of loneliness and isolation.
    - **Self-navigation enhances a sense of agency and self-esteem**. A therapeutic environment should support consumers to self-select from a range of stimuli to meet their sensory needs. Design should support independent access to spaces and experiences that do not rely on staff permission or accompaniment. Consumers should feel they are able to move seamlessly from activities and spaces according to their need.

We believe that future acute adult inpatient units should provide 100 beds+. Our Functional Brief proposes a 102-bedded unit for youth and middle adulthood, across three ward areas.

- Male only, specialist high-secure; including mental health intensive care.
- Female-only, medium-high secure; including mental health intensive care.

- Low-medium secure, with dedicated space for youth (< 25 years) and mixed male-female areas. This will allow for programs organized around therapeutic objectives and will provide flexibility for managing emergency demand.

A separate unit for older adults aged over 60 years is proposed separately, located in either an aged subacute or acute mental health setting. It should be a low-medium secure unit with separate spaces for frail elderly patients with cognitive disorders, and patients with functional disorders. Dropping the age of entry criterion removes a group of lower risk patients from the adult system, and allows older age services to engage with a cohort of patients approaching old age for whom preventative interventions, designed to facilitate successful ageing and good physical and mental health, may be effective.

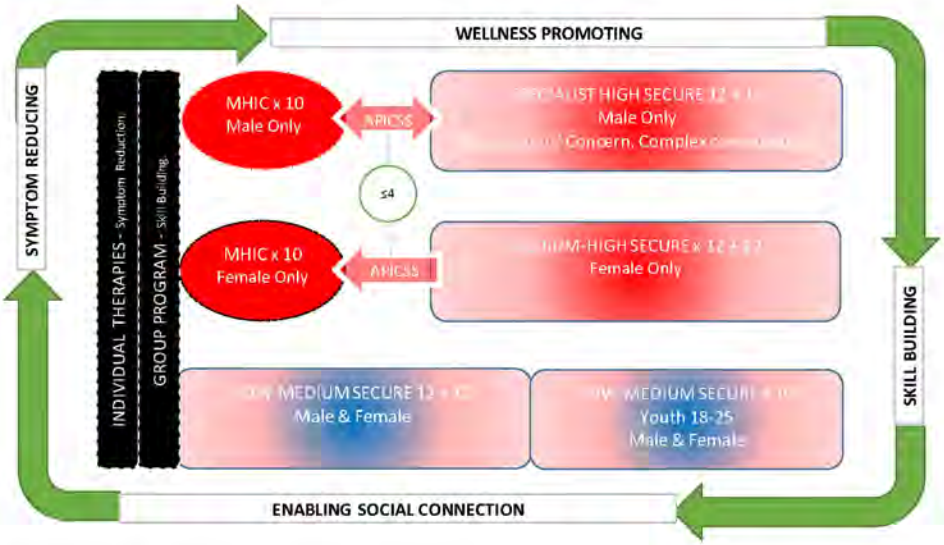

Figure 1: Proposed Youth and Adult Configuration.

2. *Building capacity in Emergency Departments and General Hospitals to provide treatment of mental illness, addiction and suicide through specialist consultation liaison and treatment services.*

General hospitals and emergency department are increasingly important settings in which people with serious mental illness present and require treatment. Specialist mental health and addiction clinicians are required to support these services through consultation-liaison models of psychiatric care.

We have already stated that between FY13 and FY18, the number of patients presenting to ED with mental and behavioural disorders, including alcohol and other drug (AOD)-related disorders grew by 4.3 per cent per annum. At the same time, the total number of patients seen

by mental health specialists in the emergency department (a subset of the total number), grew on average about 18.3 per cent pa. In FY18, 65,413 patients presented to the ED at The Alfred. Of these, 2465 or 3.8 per cent had AOD-related disorders and 3376 or 5.2 per cent mental, behavioural and social presentations.

In 2013, Alfred Health funded a dedicated mental health and addiction service to provide enhanced specialist interventions and a new stream of care in our Emergency and Trauma Centre (E&TC). This formed part of an organizational initiative to meet the National Emergency Access Targets. Known as the Emergency Psychiatry Service (EPS), the team was integrated into a unit structure with liaison psychiatry and the crisis assessment and treatment team (CATT) located in the E&TC as one of several streams of care. The model was developed using design thinking, which drew upon the experience of patients and clinicians in E&TC. In the three-year post-implementation period, the numbers of mental health and/or AOD assessments undertaken in the E&TC increased by 64 per cent. Despite this increase in activity, the time spent by patients presenting with mental health and/or AOD issues in the E&TC was reduced by 20 per cent. In the three years post-implementation, compliance with the National Emergency Access four-hour admission target increased from 58 per cent in FY13 to 72 per cent in FY16. This initiative demonstrated that service redesign and a whole-of-system approach can reduce emergency department waiting times safely, even in the setting of increased demand and no change in the number of hospital beds.

The model has since been revised, improved and extended. It operates seven days a week and includes a Mental Health and Addiction Hub. In 2018, the Government of Victoria announced an extension of this model to six EDs across metropolitan Melbourne. Hubs will be larger, purpose-designed and located in the hospital EDs. An assertive outreach team will support patients for a time- limited period (4 weeks) after exit. We commend the Victorian government for adopting this model and extending it to include a step-down service and we submit that similar resources should be rolled out to all major emergency departments across the state.

The Alfred has also seen an increase in demand for Consultation-Liaison Psychiatry and Addiction (CLPA) services. The team now includes psychiatrists and addiction medicine specialists, nursing and allied health. Service is available seven days a week. Misuse of alcohol and other drugs is common in this patient cohort, as is depression and suicidal ideation. Research shows that people with severe mental illness have shortened life expectancy by 12-20 years. CLPA services have an important role in supporting patients with mental illness to access tertiary healthcare, ensure appropriate care is provided, support communication and mitigate

any behavioural problems. At any given point in time, our CLPA service is engaged in the care of 25-40 patients a day within the hospital, some of whom have intensive psychiatric treatment needs and would be admitted to specialist inpatient psychiatric units (IPUs) were it not for the complications of injury or medical illness. When beds are unavailable on adult IPUs, patients may be admitted to general medical units or transfer from medical/surgical wards may be delayed. Under these circumstances, there is a need to provide capacity in general hospitals for diagnostic assessment, risk management, and active treatment of mental illnesses.

In addition to providing clinical care, the consultation-liaison service at The Alfred has also played a key role in the management of behavioural risk across the organization. A seven-day a week nursing roster provides coordination and authorisation of the use of psychiatric nurses for one-on nursing. Between FY16-FY19, expenditure on psychiatric nurse specials has decreased by over $1.5 million pa.

Consultation-liaison psychiatry therefore plays an important role in the management of mental illness, addiction and suicide risk in patients admitted to medical and surgical wards in general hospitals, and in the management of occupational risks due to behaviours of concern. The VMHS must embrace this model of care, undertake a formal audit of existing services, develop guidelines for appropriate outputs and outcomes and ensure services are adequately resourced.

3. *Offering Genuine Alternatives to Hospitalization, Through the Development of "Stepped Care" Models of Care in Community Adult Services*

'Stepped care' attempts to maximize efficiency by intentionally allocating interventions starting from the least-intrusive and resource-intensive treatment indicated by the patient's current level of medical or psychiatric necessity. It is a hierarchical model of care and when applied to mental healthcare in the primary setting, builds on treatment provided by GPs and e-health resources. Inputs are added to GP care using a range of specialists in psychiatry, psychology, and mental health allied health providers. All Primary Health Networks (PHNs) in Australia, including the South East Melbourne PHN (SEMPHN) in our region, have adopted this approach to the organisation and delivery of Commonwealth-funded primary mental health services.

Alfred Health has long used a similar approach to the management of severe mental illness.

Triage, Navigations and the Community Treatment Teams (CTTs) provide low intensity general psychiatric care.

- Navigations is an initiative introduced in 2018. It provides a soft entry into the service, with intake, assessment and short-term treatment for patients referred by the hospital inpatient unit or GPs in the community.
- The service is augmented by access to a number of specialist clinicians in family intervention, structured psychological therapies, physical health and addiction support.
- Navigations also supports the transition of established community clients, with stable mental health conditions and sustainable social arrangements back into the primary stepped care mental health system.

The Hospital Outreach Post-suicide Engagement (HOPE) service was established in 2017, with funding from DHHS. Clinicians and support workers provide a time-limited support for moderate risk clients following a presentation to hospital for management of attempted suicide or suicidal ideation. The model of care favours psychological and psychosocial interventions.

- Consumers had significantly fewer presentations to The Alfred's Emergency and Trauma Centre (E&TC) in the six months after (mean [SD] = 0.7 [1.3]) than before (mean [SD] = 1.3 [0.9]) commencing with the Hope Team.
- Only 13 per cent of Hope Team consumers attended the Alfred E&TC in 28 days after commencing whereas a 2015 study found that 26 per cent of consumers attending The Alfred E&TC after a suicide attempt re-presented within 28 days. This showed that access to the Hope Team improved aftercare following a suicide attempt or a period with severe suicidal ideation.
- 44 consumers who completed an episode of Hope Team care and consented for their information to be used for evaluation reported significantly increased self-rated wellbeing (d_z = 1.0), hope (d_z = 1.1) and coping belief (d_z = 1.1) and significantly reduced distress (d_z = 1.0) and suicidal ideation (d_z = 1.5) at end of contact.
- Hope Team consumers consistently rated their care experience as very helpful (mean = 9.2 / 10 on a scale 0 = not at all – 10 = extremely helpful). The following quotes illustrate how this was helpful:

> *"I'm alive and happy. I've got a future and will live to see it..."*
> *"I feel like the Hope Team is the only team that has treated me with respect in regards to my mental health"*

"I had someone to turn to finally and listen to (me) and guide me through it and help alleviate my pain"

The Mobile Support and Treatment Team (MSTT or Assertive Outreach Teams (AOTs)), Homeless Outreach Psychiatry Service (HOPS) and Crisis Assessment and Treatment Teams (CATT) provide higher intensity care to complex clients at risk of hospitalisation and clinical deterioration. Elements of the Framework of Victoria's Mental Health Services in 1996, these assertive treatment teams have been abolished or modified since in many area mental health services, typically in response to budget pressures.

At Alfred Health, these teams manage different groups of clients and use different models of care.

- Over 80 per cent of CATT clients do not require case management and transition to primary care after resolution of the episode of acute care. Presentations due to anxiety, depression, suicidal ideation and 'psychological crisis' predominate and interventions include pharmacotherapy, problem solving therapy and single session family therapy.
- In contrast, all clients of the MSTT have accessed other parts of the specialist clinical system, most commonly acute inpatient units or community care teams (CCTs). Most have had multiple admissions to the IPU and almost all suffer from Schizophrenia-Spectrum Disorders (SSDs), with a small percentage suffering from the emotional dysregulation of borderline personality disorder. Interventions involve pharmacotherapy, cognitive remediation therapy, support with SUDs, family issues, housing, income and social connection.
- The Homeless team provides a combination of crisis and continuing care support to patients who suffer from severe mental illness, are hard to engage and are experiencing homelessness. Clinicians in the HOPS have an extensive knowledge of the homeless system and patients can take many months to engage.

We believe that the intensive treatment provided by CATT, MSTT and HOPS should be considered a fundamental component of contemporary psychiatric care in the community.

We further believe that this model should be extended to provide time-limited support to patients with depression, anxiety and psychosis who are moderate risk. They may be transitioning from the emergency department and inpatient unit. Alternatively, they may be

referred from the stepped care primary mental health system by GPs seeking escalation of patients with more complex needs, who may not be at immediate risk of hospitalization but require the input of a multidisciplinary team.

These are the patients who form what has come to be referred to as 'The Missing Middle'. Professor Pat McGorry wrote; "What is needed is a national network of specialised community mental health hubs that can provide rapid and expert backup for GPs or headspace centres and meet the urgent and ongoing needs of more complex patients close to home and which have the capacity for extended hours outreach." These hubs would offer multidisciplinary care and have a capacity for extended hours and outreach.

We agree with Prof McGorry that this population of unmet need does deserve a service response. **We submit, however, that further fragmentation of the VMHS will not serve Victorians well.** The workforce required to deliver these services is being trained in our health services and the patients who need to be treated are presenting to our emergency departments.

We believe that the existing Hospital Outreach Post-suicide Engagement (HOPE) service and the Assertive Outreach Teams proposed as part of the Victorian Mental Health-AOD Emergency Hubs represent a contribution to such a specialised community MH Hub. **Any initiative in this space should be established as a collaboration between the State and Commonwealth, to ensure better integration with existing public mental health and emergency services.**

4. Recruiting a trained and competent workforce.

Recruiting a trained and competent workforce is becoming increasingly challenging for two reasons. First, universities are not producing clinicians who are fit-for-purpose to manage patients in the public mental health system. And second, increasing opportunities for employment in the growing Commonwealth-funded primary sector (in private settings and with NGO-providers) are creating competition for experienced clinicians.

The mental health system is increasingly seeing new graduates and candidates for junior positions presenting with limited skills and experience relevant to working the sector. This is due to the structure of the curriculum in relevant undergraduate degrees and the lack of mandatory placements that provide meaningful clinical experience. Placements in the public mental health sector are typically elective, so there is no requirement to get even a basic grounding in the area. There is little to no training in psychological therapies or in psychodynamic principles, which can provide a bed-rock to a more humanistic approach to mental healthcare.

Innovative and evidence-based practice must be delivered by a skilled workforce, trained in basic and specialist mental health competencies, and provided with opportunities for learning, reflection and improvement. Time for supervision and reflective practice is as important to achieving proficiency and expertise as is training itself. The graduate programs offered in clinical services are increasingly vital in ensuring staff learn basic mental health competencies.

At Alfred Health, the basic therapeutic skills of greatest value are the Safe Wards interventions on our inpatient units; motivational interviewing, CBT and interpersonal therapy for depression, SUDs and anxiety; skills and relaxation training, and anger management. Training in psychodynamic principles can help inform intra-psychic and systemic formulations of mental distress and their management. Specialist training in structured therapies including DBT and MBT for Borderline Personality Disorder, and CBT and Cognitive Remediation Therapy for Schizophrenia is also required but is more appropriately provided through post-graduate training to a smaller group of motivated specialist clinicians.

The Victorian Government should develop workforce plans that predict the need for clinicians in future. It should work with the Commonwealth Government and universities and other training bodies to ensure sufficient university and training places are funded. It should also ensure that undergraduate and Masters-level students have access to teaching and clinical placements, which will allow them to develop4 the foundational and advanced competencies required in the sector.

5. *Provide resources for families and carers who are supporting the needs of loved ones with severe mental illness*

VMHS should provide better resources and support to families and carers to help them support the needs of loved ones with severe mental illness.

The development of guidelines in the implementation of family-sensitive practice by the DHHS represents an important step in the setting of standards and expectations. **We believe that changes in the attitudes, behaviours and practices of clinicians occurs through initiatives that allow clinicians to learn new skills and that provide opportunities for supervision and reflective practice to enable the development of proficiency and expertise.**

Alfred Health provides Single Session Family Therapy (SST), based on the model developed by the Bouverie Centre, to a limited number of clients who access the community adult and aged programs and who utilise our CATT and HOPE services. Alfred Health also provides SST as a first-line intervention to young people and their families presenting for the first time with a mental

health problem in our tertiary child and youth program, our primary headspace centre and our specialist youth early psychosis program. The process and outcome of an SST intervention in a primary mental health setting has been published.

Both young people and their family members rate single session therapy sessions highly. In addition, both parties report improvements in the young person's mental health and wellbeing after single session therapy intervention, with mothers rating the young person's improvement most highly. **SST is an effective intervention in relieving family distress in young people and should be provided as a more widely available intervention in adult and aged services in VMHS.**

Alfred Health has also implemented the Open Dialogue methodology pioneered in Europe, in the Youth Early Psychosis Program (YEPP). The initiative provides a set of values and techniques that seek multiple perspectives and client strengths. Our approach illustrates how design thinking and improvement methodologies can drive learning, and quality of care. Staff across the program received extensive training in the dialogic approach. After the technique was implemented, further training and supervision were provided. Feedback was sought from clinicians, clients and families. Issues were identified with the approach, which required adjustment. The technique has now evolved, in response to differences experienced in the risks of patients, the interface with hospital care, the use of peer workers and the engagement of families. The approach to care continues to emphasise a collaborative adaptive network approach, which is shaped by family engagement and support.

In integrating recovery-oriented values and family-centred practice into our work, we have learnt that the process requires time, resources, training, supervision and a willingness to adapt and learn from experience. These lessons should be taken into account when considering ways in which to reorientate VMHS towards these values.

6. *Engaging Patients, Families and Communities in Choice, Education, Design and Leadership*

We believe measures that engage patients and families in choice, education, design and leadership, will improve the Victorian community's understanding of mental illness, reduce stigma and discrimination and improve the satisfaction of Victorians and their engagement with the VMHS more broadly.

Public mental health services have long enjoyed the contribution of consumer and carer consultants. As the contribution of people with lived experience has become more specialised, there is a need for more consumer and carer educators, consultants and peer workers, with a

technical education that emphasises peer values and intentional peer support. Their participation in the life of public mental health services has improved the experience of care for consumers and impacted positively on the attitudes and behaviours of staff to restrictive interventions, human rights, supported decision-making and stigma.

VMHS should also develop a capacity for community engagement, over and above its efforts to develop a peer workforce. There is a need for services to continually tap into the perspectives and ideas of service users whose relationship with services is new and emerging. Alfred Health has a positive experience of the effectiveness of community development through its engagement with headspace National. The development of Youth Advisory Groups consisting of young people with and without lived experience of mental illness; and the use of social media platforms to reach out to the community have been two effective interventions pioneered by headspace in its engagement with the community.

The greater challenge for public mental health services is to embed a culture of recovery. Alfred Health believes that Open Dialogue is an example of an approach to recovery-oriented practice that locates decision-making in the family network and values multiple perspectives. Another initiative that further illustrates an orientation to values of recovery is the headspace Discovery College established by Alfred Health through the headspace Youth Early Psychosis Program in Southern Melbourne.

> "Recovery Colleges will provide a mechanism for a cultural shift in existing mental health and AOD services, breaking down barriers between consumers and clinicians, providing clinicians the opportunity to take their experiences back to their clinical services and implement change."

Alfred Health partners with headspace to deliver the headspace Discovery College, a youth-focused mental health educational initiative modelled on the UK Recovery College. An education platform, its intention is to bring together people with lived experience of mental illness, family members, interested members of the community and clinicians to develop skills, share knowledge and experience in relation to health and wellbeing and support individual recovery.

Launched in May 2016, the Discovery College is now based at four campuses (Bentleigh, Frankston, Narre Warren and Dandenong), with courses also offered in community-based venues across south-east Melbourne. Over 150 students have participated in more than 30

separate courses. Participants have included young people (aged 12–25), their friends and family members, and professionals working in numerous fields.

The Discovery College as implemented by Alfred Health should be regarded a pilot that is operating with limited resources. The concept has been developed in the UK where there are over 80 Recovery Colleges in almost every Mental Health Trust. **Alfred Health supports the development of adult Recovery Colleges in the Victorian setting and believes that such an initiative would facilitate the engagement of patients, families and carers while accelerating the development of a culture of recovery-oriented practice.**

7. *Developing a culture of improvement and research in Victoria's Mental Health System, which combines clinical, academic and peer leadership, and seeks interdisciplinary collaboration*

Fulford et al (2014) argue for models of collaborative research that adopt a pluralistic or interdisciplinary approach combining sciences of the mind (including the social sciences) and of the brain; and closer collaboration between researchers/clinicians (experts-by-training) and consumers/carers (experts-by-experience). "This is important if we are to meet the specific challenges to translation presented by the complexity of the concept of mental disorder, particularly as reflected in the diversity of desired treatment outcomes[3]".

Much is still unknown about the causes and treatments of mental illness, addiction and suicide and the experience of care is highly variable. **VMHS must be explicitly designed for learning and improvement, with the capacity to monitor performance, evaluate services and innovation and undertake research into new knowledge through engagement with academics, patients and clinicians.**

We believe that the Victorian Department of Health and Human Services must provide epidemiological surveillance of psychiatric morbidity in the community, including suicide and SUDs, and better reporting of service performance, with a particular emphasis on the development of metrics for community practice in all age groups. We submit that the NSW Health Analytics Framework represents a good model for an approach to data analysis that is system-wide and intended to support Local Area Health Districts in making evidence-based decisions about the services they provide to their local communities. The website provided by

[3] Fulford KWM, Bortolotti L, Broome M. Taking the long view: an emerging framework for translational psychiatric science. World Psychiatry 13:2 (June 2014) pg 110

the NSW Mental Health Commission on Data and Analysis is to be commended for its utility and clarity and should service as a model for VMHS.

In addition, we also believe that every Area Mental Health Service (AHMS) must have capacity to use data, patient, family and clinician feedback to develop ideas for improvement, rapidly test and evaluate them in practice and then spread those ideas in order to generate learning about what changes, in which contexts actually work. The Institute for Healthcare Improvement in the USA, and Safer Care Victoria can provide education, training and leadership in the methodology of improvement science, but services must have capacity to undertake this work and clinicians must be at the forefront of efforts in this regard.

Finally, a Mental Health Research Institute must be established to drive the research, improvement and redesign agenda. Alfred Health is in a unique position to provide leadership in this area. Our Mental Health Program has operated a successful research centre under the leadership of Professor Jayashri Kulkarni in partnership with Monash University for over 15 years. The centre specialises in neuroscience research, including neurostimulation, women's mental health, and psychopharmacology and has a long track record in service evaluation. Alfred Health is also host to a significant academic department of Neurology under the leadership of Professor Terry O'Brien, with an expanding research footprint that includes neurodegenerative disorders and neuropsychiatric complications of epilepsy. Academic linkages with Swinburne, La Trobe and Deakin Universities create broader opportunities for inter-disciplinary collaboration and partnership in the areas of service design and evaluation.

An academic Mental Health and Neurosciences Research Centre with a focus on adult mental and neurological illness, service design and evaluation could provide a focus for the efforts of Victoria to improve the care provided to the most vulnerable Victorians and create an impact on a global stage.

8. *Address system issues and structures to better support care delivery*

- **We believe that a well-resourced perinatal and early childhood mental health system of care should form part of the new framework for VMHS.**

Alfred health provides a limited service to infants and young children (from childbirth until pre-school) and their families. This comes in the form of direct clinical support to individuals, families and groups; a consultation service to professionals from agencies that provide services to families and children in this age group, including maternal child and health services and kindergarten programs; and professional

education, training and research. The service does not meet the obvious demand for mental health services in this sector of the community, in particular the needs of families coping with serious mental illness in parents with young children.

The provision of comprehensive perinatal and early childhood specialist mental health services across the state is inconsistent. If a woman or her partner has mental health problems during pregnancy or in the first year after birth, that meet criteria for adult psychiatry services, these are dealt with through mainstream services. Patients presenting with such difficulties and the families that support them require access to specialised perinatal mental health input (social, psychological and pharmacological expertise) that is necessary for meaningful change and recovery. Should inpatient care be required, this should ideally be provided in settings that allow for continued engagement with partners and children.

In the absence of a comprehensive public mental health system of care, treatment for families with young children struggling with mental health issues often falls to the ngo or private sector in many parts of victoria, but it is unclear to what extent this meets the challenges of **effectiveness, efficiency and equity**. This gap in perinatal mental health care is all the more difficult to justify when one considers how universal the provision of maternal child health services is in the state. If vmhs is to commit genuinely to the prevention of mental illness and early intervention, then the praiseworthy efforts to improve the mental healthcare of youth must be augmented by a renewed commitment to young children and their families with a system of specialist support that connects primary health (including maternal child health) and specialist mental health services.

- **We believe that mental health services for homeless Victorians should be provided through platforms that integrate primary care, mental and addiction health and housing.**

We believe that housing is a human right. In our collective experience, homeless people with serious and persistent mental illness require integrated systems of health and social care. We further observe that housing homeless people saves lives and the cost of preventable healthcare. VMHS is inadequately supported to ensure that that no person is discharged from care into homelessness, in particular as a result of poverty and barriers to affordable accommodation for people on supported incomes, specifically social and public housing. Clinical mental health services cannot fulfil their broader responsibilities to the community if they are used as a substitute for housing.

Psychiatric services for homeless people are provided across three mental health services in the inner metropolitan region - St Vincent's Health, Melbourne Health and Alfred Health. Services for primary care and social care, including housing, are provided separately. We believe that this model is problematic for two reasons. First, homeless people in the inner metropolitan region are typically mobile and move between catchments. In the current system, this is a cause of discontinued care. Second, the provision of psychiatric services in isolation is not ideal.

We believe that steps should be taken towards developing integrated homeless health services, which combine mental and addiction health, primary health, and housing in a common platform. This would be defined by single intake, co-location and an activity-based funding model, which encourages continuity of care.

There is an opportunity to consider utilising emergency department contact as a platform for entry into a service pathway that leads to an integrated homeless health response. A study undertaken at The Alfred approached 1208 consecutive patients presenting in a single week to the ED, and prospectively screened 504 who chose to participate. Of these, 7.9 per cent were homeless, compared to 0.8 per cent of ED presentations coded as homeless in the Victorian Emergency Minimum Dataset and 2.3 per cent of the 704 non-screened patients identified as homeless using Victorian Emergency Minimum Dataset Usual Accommodation. Within the screened sample, homeless patients were more likely to be male, arrive by emergency ambulance/with police, have a psychosocial diagnosis, and be frequent presenters.

Re-presentation within 28 days occurred for 43 per cent of homeless and 15 per cent of not-homeless patients. Better identification of homeless status in the emergency department could allow for entry into care pathways that integrate mental, addiction and physical healthcare and social and housing support and act to reduce future emergency presentations through prevention and early intervention. In high needs areas, these could be co-located at sites managed by community health services that provide primary care.

- **We agree with the findings of Victorian Auditor-General who wrote:**

"DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services....Real progress is unlikely ... unless DHHS accelerates and directs effort towards the fundamentals: funding, workforce and capital infrastructure. Until the system has the capacity to operate in

more than just crisis mode, DHHS cannot expect to be able to make meaningful improvements to clinical care models or the mental health of the Victorian population."

Alfred Health has pursued opportunities since 2010 for innovation. This is in no small part due to our success, prior to 2017, in tender processes that have led to funding opportunities from sources outside the normal allocations of state government for mental health activity. These have included initiatives through the Commonwealth and local PHN (headspace Elsternwick 2007; headspace Youth Early Psychosis Program in Southern Melbourne 2013; SEMPHN BounceBack program 2018); the Victorian Responsible Gambling Foundation (Alfred Mental Health & Gambling Harm Program 2007); and the DHHS Southern Regional Office (Southcity Clinic (for SUDs) 2016). This growth has insulated the program from the worst impact of cuts to core services, by allowing the development of an infrastructure that has facilitated further innovation, workforce development, and safety and improvement.

- **We support organising public mental healthcare to service defined catchments, but we believe that the arrangement is not working well and could be improved substantially by adopting the following principles:**

The geographic boundaries of catchments should be reviewed on a regular basis in order to adjust to changes in population and regional changes in burden of disease. Resource allocation should reflect such changes if catchments are to remain meaningful and useful over a longer period of time.

Ideally, the catchment boundaries of VMHS should be aligned with LGA and PHN boundaries in order to allow for maximum collaboration with local government and commonwealth-funded primary health initiatives. Local area mental health services (AMHS) should be organized into regional partnerships, covering areas approximating PHN boundaries. Within these regional partnerships, each AMHS should provide a range of core services for all age groups, including perinatal and mother-baby services. Sub-specialist services, such as eating disorders and neuropsychiatry could be provided on a hub- and-spoke basis with specialist bed-based services in a regional centre and outpatient services located in each catchment.

Activity-based funding mechanisms could create greater choice in the system, for patients requiring ambulatory or clinic-based care. Catchments nevertheless remain a superior arrangement for complex clients with multiple needs, whose care requires the use of outreach services and engagement.

- **We encourage State and Commonwealth governments to consider collaborative service developments and to seek integration between primary and specialist services.**

Alfred Health has a unique perspective on the value of a Commonwealth-State collaboration through its involvement with headspace National and the SEMPHN. Alfred Health is the Lead Agency for headspace Elsternwick and the Youth Early Psychosis Program (YEPP) based at a hub at headspace Bentleigh and provided across four spokes in headspace centres in Elsternwick, Narre Warren, Dandenong and Frankston. The other major provider of public mental health services in this position is Orygen, which provides state-funded Youth Mental Health Services in the North-West Metropolitan region, runs several headspace centres in the catchment, and provides leadership to the national YEPP initiative.

Our participation as Lead Agency enables integration of headspace centres and the local child and youth mental health service. Collaboration extends to shared intake, rapid transfers of care, clinical support through supervision, SST services, on-site patient consultations into the headspace centre, and recruitment of specialist staff. This allows for flexible practice, innovation and the management of higher risk patients in our centres without having to disrupt care by referring patients to other services.

A model of care which allows for collaboration of private practitioners and community services delivering drug and alcohol, employment and vocational, specialist mental health and primary care medical services has much to teach VMHS about the value of breaking down silos of practice to bring together clinical and psychosocial services. Future developments of community adult and aged mental health should consider this approach to service delivery.

CONCLUSION

Alfred Health welcomes this Royal Commission. We believe it will provide a unique opportunity for the community to reflect on the broad nature of mental health problems and reach a consensus about what 'good mental healthcare' looks like. We also believe that it will generate a valuable conversation about how mental and addiction health services can be best set up to counter stigma, deliver good clinical outcomes, avoid harm, improve satisfaction and reverse the poor social outcomes experienced by so many clients and their families.

Thank you for providing us with the opportunity to contribute to this inquiry into Victoria's Mental Health System.

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Royal Commission into
Victoria's Mental Health System

ATTACHMENT SPS-12

This is the attachment marked 'SPS-12' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

JAN 19

Alfred Health Submission for the Consultation on the Terms of Reference for the Royal Commission into Victoria's Mental Health System

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Thank you for inviting Alfred Health to make submissions regarding the Terms of Reference for the Victorian Royal Commission into Mental Health (VRCMH). We consider the VRCMH to be timely – and increasingly urgent.

Located in the inner south of metropolitan Melbourne, Alfred Health serves a catchment population of about 400,000. We provide specialist clinical public mental health & addiction services in hospitals, community rehabilitation units & clinics across 12 sites, and an academic/research centre in partnership with Monash University.

We understand that mental health is strongly influenced by social determinants and our patients are some of the most vulnerable people in Victoria. It is for this reason that many of our services are offered in collaboration with providers of primary healthcare, disability support, addiction, employment and housing services. Active service partners include Wellways, Star Health, UnitingCare, Sacred Heart Mission, The Salvation Army, Launch Housing, Taskforce, First Step and the South-East Melbourne Primary Healthcare Network.

Alfred Heath welcomes the opportunity afforded by the VRCMH. Nevertheless, it should be acknowledged that the clinical sector has achieved the results it was designed to achieve; that many dedicated clinicians have acted in good faith to serve the public with limited resources; and that incremental changes to the framework of service delivery have been successfully implemented.

In particular, we highlight that since 1992, Alfred Health can point to:

- Improvements in clinical governance, accountability and transparency, and increasingly detailed public reporting of some aspects of clinical activity.
- A significant reduction in restrictive interventions on inpatient units, hospital readmission rates, inpatient suicide and emergency department waits.

- The development of a women's inpatient corridor on one of three acute inpatient units.
- The establishment of a prevention and recovery care unit, which provides a more recovery-oriented alternative for clients with mental illness;
- Improved outreach for suicide prevention through the HOPE initiative;
- The emergence of a peer workforce and greater participation of consumers and carers in service design and governance.
- The emergence of a strong child and youth mental health service system, and with it, a platform for co-design, family engagement and therapeutic innovation.
- A research centre with a strong focus on women's mental health, service evaluation & neurostimulation.
- An emergency-liaison psychiatry/addiction service that plays a crucial role in the management of clinical demand in the emergency department and in the management of occupational violence and behaviours of concerns throughout the general hospital.

Nevertheless, Alfred Health has also faced a number of challenges over the past decade:

- The total number of patients presenting to the emergency department with mental and behavioural disorders including substance use disorders has grown on average about 5% per annum between 2012-13 & 2017-18.
- The total number of patients being assessed by mental health specialists in the emergency department (a subset of the total number) has grown on average about 16% per annum between 2012-13 & 2017-18.
- The % of patients being admitted to an inpatient psychiatric bed within 8 hours during this period has remained relatively unchanged (83% in 2012-13; 86% in 2017-18).
- Our allocation of beds has remained unchanged for the past 15 years, since 2004.
- Our clinicians and carers report that our patients are sicker at discharge today than a decade ago.
    - The observation that trimmed average length of stay in our adult inpatient unit has decreased during this period1 suggests that we have met growing demand for inpatient care by discharging patients earlier in their recovery.

- Whether community clinical mental health services have been able to cope with providing the required level of support for clients and their families post-discharge is an issue that is contested by service users and clinicians alike.

- Our patients continue to present with significant co-morbidity due to substance use disorders and problems with physical health.
    - There is no dedicated funding stream for addiction specialist clinicians to provide assessment and treatment to patients presenting in the emergency department, in the hospital and in psychiatric services.
    - The model of care for Alcohol & Drug services in the community does not suit clients with serious mental illness and challenges of motivation and engagement, particularly well.
- Our patients continue to experience severe social disadvantage with poverty, social isolation, limited access to appropriate housing, high unemployment, exposure to violence and poor physical health outcomes.
    - At any given point in time, about 20% of our inpatients are of no fixed address. In the absence of family support, we are required to discharge patients into secondary (transitional and crisis housing) and tertiary (boarding houses, motels) homelessness every day in order to make room for new patients presenting acutely.
- Access to evidence-based structured psychological therapies for individual patients and their families in the community has been limited, for all disorders that cause serious mental illness.
- Access to services to support families who provide care to people with serious mental illness is lacking.
- Access to disability support services through the Mental Health Community Support Services has been limited. The NDIS holds promise for improved access, but many people with severe mental illness are not eligible for NDIS because they will not engage with the system, find it too complicated or do not meet criteria for support set out in section 24 of the NDIS Act 2013.
- The burden of compliance and governance has continued to increase.
    - Mental health services provided by Alfred Health are accountable to the Mental Health Branch, the Office of the Chief Psychiatrist, the Mental

Health Complaints Commissioner, the Office of the Public Advocate and the Mental Health Tribunal.

- Adverse events, including patient deaths, are reviewed by Safer Care Victoria, the Office of the Chief Psychiatrist and the Victorian Coroner.
- The service undertakes accreditation through the Australian Council on Healthcare Standards every four years.
- These agencies have had a positive impact on transparency and accountability
- Compliance requires resources and training of an appropriate workforce.
- Overlap and duplication of responsibilities must be eliminated.

- Funding has not kept up with the growth of patient demand and complexity; the impact of enterprise-based agreements; rising community expectations; and the emergence of new evidence-based treatments.
- The requirement for productivity savings year-on-year has had a disproportionate effect on clinical community mental health services, even as increasing emergency demand has placed pressure upon fixed bed numbers.
- There has been an undoubted effort to improve funding in the past four years, and this has been most welcome. However, its impact will be delayed as services scramble to recruit a workforce that is in high demand and short supply across both primary and specialist sectors following substantial investments from the state and commonwealth governments.
- Victoria's public mental health system is organized to provide services to catchment areas. This arrangement clearly allocates responsibility for the continuity of care and the treatment of complex, hard to engage patients. That said, and in common with other metropolitan services, catchment boundaries for Alfred Health do not align child, youth, adult and aged populations2 and do not match boundaries for LGAs, PHNs, or catchments for education, housing, and other state government activities. This creates fragmentation for consumers and their families, and difficulties with cross-government collaboration.

We note that the VRCMH can be expected to cover topics including prevention and early intervention, accessibility and navigation of the system, integration with alcohol

and other drug services, and community, acute and forensic mental health. We support these themes as representing key areas of concern.

We submit that the terms of reference should specifically consider:

1. **THE SCOPE OF THE SYSTEM & HOW ITS ELEMENTS SHOULD INTERSECT.** What is the purpose of the system? What interventions should it deliver with consistency? How should services be designed to deliver those interventions?

- We submit that the VRCMH should focus predominantly on the role of the clinical sector in managing mental illness, given its central role in treatment, its high cost, public dissatisfaction with its outcomes and the fact that its architecture has not been reviewed in 25 years.
- Nevertheless, we also submit that system outcomes are shaped by the experiences of clients with police and emergency services, prisons and the justice system, addiction services, housing and employment, aged care & the NDIS and family violence services. Furthermore, the needs of families for support of their carer role also strongly influence outcome. These points of intersection should also be considered by the commission.

2. **THE NEEDS OF PEOPLE WITH SEVERE, COMPLEX & CHRONIC MENTAL & BEHAVIOURAL DISORDERS.**

- How should publicly funded services best meet the needs of people with:
  - severe mental illness i.e. diagnosable mental illness which is acute or chronic and which results in severe limitations of social and/or occupational function;
  - moderately severe mental illness who lack health insurance or the means to pay gap fees in the private sector;
  - severe substance use disorders;
  - & their families?
- Victoria's public mental health services predominantly serve patients with schizophrenia, bipolar disorder, melancholic depression,

personality disorders and the behavioural & psychological syndromes of dementia.

- Patients with severe eating disorders; severe anxiety disorders, including OCD, PTSD, agoraphobia & panic disorders; severe non-melancholic depression; and severe somatic symptom disorders also require appropriate pathways of care in public AMHSs and a guarantee of service and access to evidence-based treatment.
- Patients in every one of these diagnostic groups may suffer from comorbid substance use disorders, which complicate progress and limit recovery.
- From a clinical and service delivery perspective, there seems little justification to separate the mental healthcare and addiction sectors3.

3. **WORKFORCE TRAINING & DEVELOPMENT**:

- Presently there are challenges in finding the numbers of clinicians required to staff the system AND to ensure that they have the therapeutic competencies necessary to deliver evidence-based treatments.
- Victoria's public mental health services must accelerate efforts to develop a trained clinician, peer and allied support workforce to deliver the evidence-based therapies and models of care known to produce the greatest benefit to the range of disorders that cause severe mental illness.

4. **SUICIDE PREVENTION & TREATMENT & PSYCHIATRIC CARE FOLLOWING PRESENTATION TO EDs**: Is Victoria's public mental health system effectively set up to deliver on a cornerstone of its purpose and function, that is to prevent suicide and manage patients who present with suicidal ideation or after suicide attempts.

- The development of hospital outreach post-suicide engagement services since 2017 is a welcome initiative.
- There should be further consideration of whether there is adequate provision of coordinated service support and evidence-based therapies for all patients who are not admitted to hospital following a presentation to ED.

- There should be consideration of whether behavioural management hubs for low to moderate risk clients who do not require complex medical interventions, have a role to play in providing patients with an alternative to emergency departments.

5. **SAFE & THERAPEUTIC HOSPITALS**: Whether Victoria's MHS are effectively designed & resourced to provide hospital care that is safe for women; therapeutic for all patients; can ensure the elimination of seclusion and restraint, and allow for the delivery of treatments required to manage the range of disorders that cause severe mental illness.

- Hospital inpatient units for adult and aged patients at Alfred & Caulfield Hospitals were built about 25 years ago, and their design mostly reflects a concern for high risk of violence and suicide.
- The inpatient units at our hospitals provide limited outdoor space, inadequate protection for women, inadequate capacity to stream patients who do not present a risk to others, and limited space for family connection, therapy, and even clinical interviewing.
- We believe that an inpatient unit that is safe for women and other vulnerable patients will be safe for all.
- There is an opportunity for the commission to consider what appropriate spaces for acute inpatient and subacute and non-acute bed-based care might look like if they were designed to ensure no seclusion or suicide while allowing for recovery, social connection and social inclusion.

6. **THE IMPACT OF VIOLENCE ON PATIENT, FAMILY & CLINICIAN EXPERIENCE**: Violence is a common risk in mental health treatment settings. This is both a patient AND an occupational health risk.

- In the past decade, we have had to manage the impact of patient self-harm and suicide in hospital settings; assaults of patients and staff; and the consequences of sexual trauma and inappropriate sexual behaviour.
- Trauma, a recognized risk factor for mental illness, is an all too unwelcome consequence of care for patients, families and clinicians. It

has a profound impact on the attitudes and expectations of people with lived experience AND service providers alike. Trauma further shapes the way in which services are delivered AND experienced.

- We submit that the terms of reference include a consideration of trauma as a consequence of the experience and provision of care, and its prevention through process and hospital redesign, training & education, and clinical & peer leadership.

7. **DATA PROVISION**: How are services informed about the performance of their hospital and community services and their impact on population mental health?

- The provision of data is crucial to the effective functioning of a contemporary MHS.
- Statewide data systems have improved, especially in relation to hospital-based care, but they do not shed light on the performance and impact of community mental health services.
- There is little timely availability of data about patient outcome and patient experience. Current systems for collecting such data are cumbersome and are not fed back to service providers in a timely manner and a format that easily drives improvement.

8. **SYSTEM OVERSIGHT**:

- How government can effectively and efficiently provide meaningful oversight without creating duplication & complexity. The roles of the Office of the Chief Psychiatrist, the Mental Health Complaints Commissioner and Safer Care Victoria in particular should be examined, with a view to better coordination and integration of activities and improved patient outcomes.

9. **CATCHMENTS**: Whether allocating catchment areas to area mental health services remain the most effective way of organizing Victoria's public mental health services and if so, whether

- These should be aligned with catchments for other relevant government services such as housing and education, and with LGAs and PHN catchments.

- Mechanisms should be in place to regularly review catchment boundaries in order to ensure that resources, services and population needs are aligned.

10. **CREATING A CAPACITY FOR CHANGE**: How Victoria's public mental health sector should be set up in order to ensure a greater capacity for dynamic change than has been the case to date.

- Like health systems everywhere, the mental health system is characterised by a static architecture that has failed to adjust to population growth, adapt catchment boundaries to changes in population, allocate resources according to changing community demand, drive improvement through data, audit and incident management, and translate research into treatments and models of care.
- There are multiple ways of knowing that need to be harnessed to create a system that is constantly learning, improving and changing to meet the needs of service users and communities. The system must draw on publicly-funded researchers, quality improvement specialists, clinicians and people with lived experience to be a part of this process.

11. **SPECIALIST STREAMS OF CARE IN MENTAL HEALTH**: How can Victoria's mental health system effectively meet the needs of patients with Acquired Brain Injuries, Autism Spectrum Disorders, personality disorders, Eating Disorders and severe anxiety disorders? Existing models of care in general psychiatric inpatient and community services are not suitable for patients with these diagnostic profiles and there is limited access to more appropriate services in the public sector.

12. **FORENSIC MENTAL HEALTH**: The current system of care provides a centralized specialist system of forensic mental healthcare with limited capacity and an orientation to serving the justice and corrections systems. And yet, many patients with a history of offending and ongoing risk are managed by local AMHS. Enhanced specialist forensic support located in AMHS could further build capacity and facilitate pathways out of forensic mental health for this client group.

13. **THE ROLE OF LIVED EXPERIENCE IN SERVICE GOVERNANCE** and engaging the broader patient community to provide feedback and drive service improvement.

- Consumers and carers should advise whether what they experience in the system makes a difference to their lives, and what else matters.
- Their feedback and participation should drive the system to eliminate unintended and privilege desired consequences.

Royal Commission into
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ATTACHMENT SPS-13

This is the attachment marked 'SPS-13' referred to in the witness statement of Simon Peter Stafrace dated 7 July 2019.

INFOGRAPHIC ADULT MENTAL & ADDICTION HEALTH- ADULT SERVICES