AlfredHealth

Royal Commission into Victoria's Mental Health System

Alfred Health's submission

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AlfredHealth

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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 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 Victoria's Mental Health System (VMS) to better serve and support our community.

We believe that VMHS must:

1. Provide specialist psychiatric care in hospitals that are 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 Emergency Department's (ED) and general hospitals 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 our 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 inpatient units 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 Hospital Outreach Post-suicidal Engagement (HOPE) initiative, utilizing a combined clinical and social support model of care. This showed a significant reduction in ED presentations at one and six months after the index presentation, and consistently showed 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 (E&TC) 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 for 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 by 4.3 per cent every year.

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 and trauma Centre 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 in Psychiatry's 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.

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 Standards (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. Provide 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 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 their engagement as a partner in care, as well as their lived experiences 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.

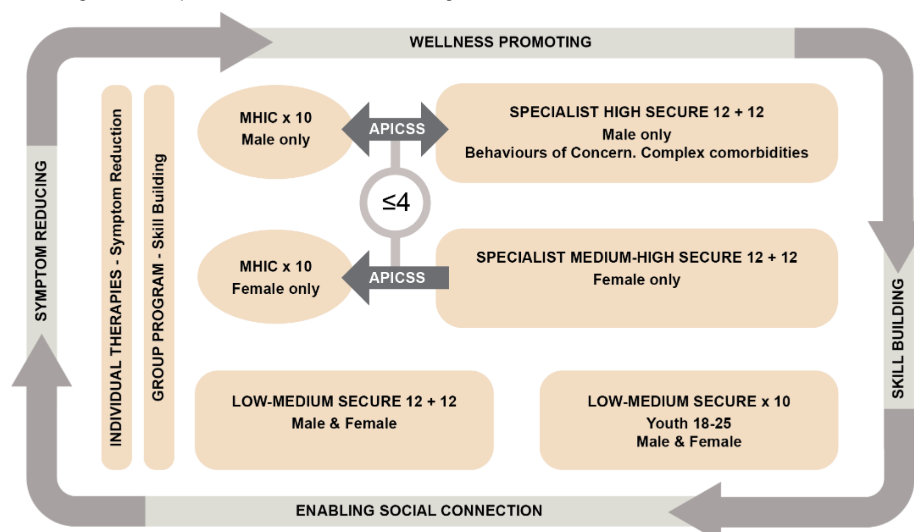
- **Design should create formal and informal opportunities for socialisation between individuals through small and large communal zones, and dedicated activity areas.** Sharing experiences and social connections supports recovery. The constructed environment should balance equally priorities of privacy, 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, 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 other 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. Build 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 The Alfred's E&TC with mental and behavioural disorders, including alcohol and other drug (AOD)-related disorders grew by 4.3 each year.
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 Alfred's E&TC. 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 ED 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 with 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 Victorian State Government announced an extension of this model to six EDs across metropolitan Melbourne. Hubs will be larger, purpose-designed and located in hospital EDs. An assertive outreach team will support patients for a time- limited period (four 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 one nursing. Between FY16-FY19, expenditure on psychiatric nurse specials has decreased by over $1.5 million each year.

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. 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. Offer genuine alternatives to hospitalization, through the development of 'stepped' 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 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.

The Triage, Navigations and 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-suicidal 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 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's 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 care in the HOPE Team 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 illustrates this help.

"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 as 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 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-suicidal 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. Recruit 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 State 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 develop 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. This in turn enables 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.**

We have 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. Engage 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 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. We believe 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 we established 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."

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https://www.mhc.wa.gov.au/recoverycolleges

We partner 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. **We support 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. Develop 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*[1]".

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 the NSW Mental Health Commission on data and analysis is to be commended for its utility and clarity and should serve 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.

1. 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

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Finally, a Mental Health and Neuroscience 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.

We is also host 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 the 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 their 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. However 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 to 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 EDs 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 mpact 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.
We are 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 a 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 that 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.

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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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