WITNESS STATEMENT OF DAVID JOHN PLUNKETT

I, David John Plunkett, Chief Executive Officer at Eastern Health, of 5 Arnold Street, Box Hill, Victoria, say as follows:

1 I am authorised to make this statement on Eastern Health's behalf.

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

Background

Please detail your background and experience, including your qualifications.

3 I have the following qualifications:

(a) Graduate Australian Institute of Company Directors, AICD (January 2017);

(b) Master of Business Administration, Mt Eliza Business School (2003);

(c) Grad. Dip. Business Management, Monash University (1997);

(d) Certificate in Perioperative Nursing, Austin Health (1989); and

(e) Registered Nurse, Latrobe Regional Hospital (1988).

4 I also hold the following additional roles:

(a) Appointed to the Eastern Metropolitan Partnership by Minister for Suburban Development;

(b) Chair, Metropolitan / Regional Public Health Service CEOs;

(c) Chair, Agency Advisory Committee, Victorian Agency for Health Information; and

(d) Board Director, Australian College of Nursing and Mayfield Education Centre.

5 I am currently the Chief Executive Officer (**CEO**) of Eastern Health. I commenced in this role in July 2016, having held leadership roles since commencing at Eastern Health in 2002. Prior to Eastern Health I held various leadership and operational roles in public and private hospitals in Victoria.

6 Attached to this statement and marked 'DJP-1 is a copy of my current Curriculum Vitae.

7 I refer to the questions received by my office on 17 July 2019 and respond as follows.

Please describe your current role and your responsibilities, specifically your role as Chief Executive Officer[1] (CEO) at Eastern Health.

8 In my role as CEO, I am subject to the direction of the Board in controlling and managing Eastern Health (section 65XA of the *Health Services Act 1988* (Vic) (**HSA**)) and have the functions set out in section 65XB of the HSA.

9 Since commencing in the role as CEO, I have been responsible for delivering safe, high quality and timely access to care, and improved financial sustainability, including operating performance and cash management, delivering the Strategic Plan as approved by the Eastern Health Board and Minister for Health, and leading Eastern Health to deliver organisational performance in accordance with the annual Statement of Priorities.

Governance of Eastern Health

Please confirm our understanding of the following establishment and governance arrangements for Eastern Health:

a. Eastern Health is a 'public health service' incorporated under section 65P of the Health Services Act 1988 (Vic) (HSA) and is a body corporate.

b. The strategy and operations of Eastern Health are overseen by a board of between 6 and 9 directors (currently 9) appointed by the Governor in Council on the recommendation of the Minister for Health[2].

c. The board of directors of Eastern Health appoints the CEO but must first obtain the approval of the Secretary of the Department of Health and Human Services (Secretary)[3], and, in your role as CEO, you report to the Board.

d. Eastern Health is responsible for all public healthcare service delivery within its primary catchment area, being the local government areas of Boroondara, Knox, Manningham, Maroondah, Whitehorse and Yarra Ranges – a population of almost 774,000 individuals.

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[1] The functions of the CEO are set out in section 65XB of the HSA.
[2] HSA sections 65S and 65T.
[3] HSA section 65S(2)(e).

e. ***This includes the operation of Angliss Hospital, Box Hill Hospital, Healesville Hospital and Yarra Valley Health, Maroondah Hospital, Peter James Centre, Wantirna Health, Yarra Ranges Health, as well as many smaller sites delivering residential, ambulatory and community-based services including Turning Point Alcohol & Drug Clinic (Turning Point) and Spectrum. All of these services are situated within Eastern Health's geographic region, except for Turning Point and Spectrum which are statewide services.***

f. ***Eastern Health organises its 43 clinical services into nine programs. They are divided into two main areas of clinical operations – one that is largely focussed around planned activity, including surgery, maternity and specialist (outpatient) clinics (SWMMS),[4] and the other which is largely focussed around unplanned activity, including emergency and inpatient care (ASPPA [sic]).[5] The two areas each have an assigned Executive Director of Clinical Operations to oversee the programs.[6]***

g. **The Eastern Health Mental Health Program provides mental health assessment and interventions for people experiencing severe mental illness, and provides a range of services including hospital-based, community and specialist services for children, youth, adults and aged people across the Eastern region.[7] Eastern Health's Mental Health Program is overseen by the Executive Director of Clinical Operations (of SWMMS).**

10 I confirm the above, subject to the following clarifications:

(a) Eastern Health is a 'public health service' incorporated under section 65P of the HSA and is a body corporate.

(b) The strategy and operations of Eastern Health are overseen by a Board of between 6 and 9 Directors (currently 9) appointed by the Governor in Council on the recommendation of the Minister for Health.

(c) The Board of Directors of Eastern Health appoints the CEO, but must first obtain the approval of the Secretary of the Department of Health and Human Services (**DHHS**) (**Secretary**). In my role as CEO, I report to the Board.

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[4] SWMMS stands for Surgery, Women and Children and Acute Specialist Clinics, Mental Health, Medical Imaging and Statewide Services.
[5] ASPPA [sic] stands for Acute and Aged Medicine, Specialty Medicine and Ambulatory Care, Pathology, Pharmacy, Patient Access and Allied Health.
[6] Eastern Health 2017-2018 Annual Report.
[7] Eastern Health website and *Strategic Plan 2017-2022*.

(d) Eastern Health is responsible for all public healthcare service delivery within its primary catchment area, being the local government areas of Boroondara, Knox, Manningham, Maroondah, Whitehorse and Yarra Ranges – a population now in excess of 774,000 individuals. The catchment area for mental health services differs in some small respects from the catchment for physical health services.

(e) This includes the operation of Angliss Hospital, Box Hill Hospital, Healesville Hospital and Yarra Valley Health, Maroondah Hospital, the Peter James Centre, Wantirna Health, Yarra Ranges Health, two state-wide services – Turning Point Alcohol & Drug Clinic (**Turning Point**) and Spectrum (the statewide Personality Disorder service) (**Spectrum**), and many smaller sites delivering ambulatory and community-based services. All of these services are situated within Eastern Health's geographic region except for Turning Point and Spectrum. Mental health services are provided both at the inpatient level and through community care services.

(f) Eastern Health has a staff of approximately 10,500 people and delivers care through 43 clinical services, which are organised into nine programs. They are divided into two main areas of clinical operations – one that is largely focussed around planned activity, including surgery, maternity and specialist (outpatient) clinics (**SWMMS**), which includes the Mental Health Program, Turning Point and Spectrum. The other area of clinical operations is largely focussed around unplanned activity, including emergency and inpatient care (**ASPPPA**). The two areas each have an assigned Executive Director of Clinical Operations to oversee the programs.

(g) The Eastern Health Mental Health Program provides mental health assessment and interventions for people experiencing severe mental illness, and provides a range of services including hospital-based, community and specialist services for children, youth, adults and aged people across the Eastern region. Eastern Health's Mental Health Program is overseen by the Executive Director of Clinical Operations of SWMMS and managed by the Executive Clinical Director Mental Health and Program Director for Mental Health.

Statement of Priorities

Please explain the relevance of Eastern Health's annual Statement of Priorities (SoP) to the services, objectives and priorities of Eastern Health under sections 65ZFA and 65ZFB of the HSA.

11 The Statement of Priorities (**SoP**) is agreed each year in accordance with the requirements of section 65ZFA of the HSA. Eastern Health identifies and aligns its objectives and priorities for the year ahead with the relevant legislation and the priorities of the DHHS and the Minister for Health in each of the 3 major parts of the SoP.

Under section 65ZFA, the SoP is prepared by the Board in consultation with the Secretary and then approved by the Minister for Health. Briefly, how does this process work in practice?

12 In practice, the three parts of the SoP are developed separately and are brought together for final approval and signing.

(a) The development of Part A – Strategic Overview – is led by the Eastern Health Director responsible for Strategy and Planning, in consultation with the Board (through the CEO), Executive and senior leadership team; and

(b) Part B – Performance Priorities (aside from the targets set by DHHS) and Part C – Activity and Funding, are developed directly with the Chief Executive and Chief Finance Officer in collaboration with DHHS representatives to ensure that the SoP meets the needs of DHHS and the Minister.

Once all parts are developed, they are endorsed by the Executive Committee and submitted to the Board for approval. The Chair of the Board then signs the SoP with the Minister for Health.

Can Eastern Health have mental health-related 'strategic priorities' added to its SoP? Has it done so, to your knowledge?

13 The requirements of Parts B and C of the SoP are generally determined by DHHS with input from the health service in relation to a limited number of aspects of performance, for example, the actual number of patients on the elective surgery waiting list and elective admissions from the waiting list. Part B of the SoP includes some mental health key performance indicators.

14 The Strategic Priorities in Part A of the SoP are drafted by the health service and agreed with DHHS. While these deliverables must be aligned with one of the three strategic priorities of 'Health 2040: Advancing health, access and care', or one of the

specific priorities determined by DHHS for the relevant year, Eastern Health is able to include mental health-specific deliverables in this part, and often does. This is most commonly related to a specific priority that is directly focused on supporting the mental health system. For example, the primary mental health deliverable in the 2018 – 2019 SoP was to implement actions identified for year 3 of Eastern Health's action plan to progress the aims and initiatives identified in Victoria's 10 year mental health plan.

Can the Department of Health and Human Services require Eastern Health to prioritise mental health by including mental health-related goals, strategies and deliverables in Eastern Health's SoP? Has it done so, to your knowledge?

15 DHHS can require health services to include a mental health-specific deliverable in Part A of the SoP through a specific priority for the relevant year. It did that in 2018-19 and has done so again in 2019-20. Prior to this, mental health was included as one of a number of 'actions' that health services could prioritise to address through a deliverable, under the domain of 'Supporting healthy populations'.

Is this inclusion of specific goals, strategies and deliverables in the SoP an effective way of achieving improvement in mental health services? Why or why not?

16 By requiring health services to agree and, through their annual reports, publicly report the achievement of specific deliverables in the SoP, improvements in performance have been achieved. However, it should be recognised that this is only one mechanism by which mental health services have been improved. Improvements can also be achieved in other ways, such as through projects that are specifically funded or by example in the annual DHHS Policy and Funding Guidelines.

Prioritisation by the Board

What standing agenda items and regular reporting are used by the Board to monitor the performance of Eastern Health's area mental health service?

17 The Board normally meets monthly and consideration of a comprehensive Report of Operations is a standing item on the agenda. The Report of Operations includes a scorecard that reports a number of key performance indicators, including all indicators in Part B of the SoP. Some of these relate specifically to quality of care, with Eastern Health's area mental health services. The Board considers comprehensive quarterly reports on the patient experience of care, including all serious complaints received by Eastern Health, some of which may involve clients of the area mental health service. The Board is also assisted by the Quality and Safety Committee which monitors patient

safety as part of its role. This Committee reports to the Board and may make recommendations.

How does the Board engage in service improvement planning in relation to mental health services?

18 The Board holds an annual planning day during which a range of improvement priorities are discussed and strategies are considered. This includes the opportunity to consider improvement planning for mental health services.

19 The Board approves the annual Eastern Health plan, which includes items from Part A of the SoP and items of importance to Eastern Health. These may include specific items for mental health services.

20 In addition, Eastern Health's service plans, including for the mental health program, Turning Point and Spectrum, must be approved by the Board. This includes the Strategic Clinical Service Plan that encompasses all streams of care offered by Eastern Health, including its mental health services.

If the Board of a health service wants to improve the prioritisation of mental health services within the health service, what steps could it take to achieve this outcome?

21 The steps available to the Board include:

(a) actions in the annual SoPs agreed with the Minister;

(b) actions in the annual Improvement and Innovation Plan;

(c) communication of its priorities and expectations to the CEO and Executive Team;

(d) targeted monitoring and increased reporting, including discussions with senior staff from the mental health program; and

(e) approval of major expenditure on capital works and other initiatives recommended by management.

What factors influence the level of attention given by the Board to mental health services? For example, does it depend upon mental health having a 'champion' amongst the directors, or is this systemised?

22 The focus of the Board is directed to aspects of health care where assessment of performance has indicated that improvement is required. There are systems in place to report performance and decisions are based on quantitative and qualitative data. It is a

responsibility of the Board to ensure that the services Eastern Health provides meet the needs of the communities it serves; that accountable systems are in place to monitor and improve the quality, safety and effectiveness of those services; and that any issues identified with the quality, safety or effectiveness of the health services provided are addressed in a timely manner.

23 The factors that influence the level of attention given by the Board to mental health services include:

(a) performance against the targets set by DHHS and the Minister through the SoPs and the Policy and Funding Guidelines;

(b) performance against internal targets;

(c) benchmarked performance;

(d) the impact on performance of the implementation of improvement strategies;

(e) feedback from consumers and their carers, for example, complaints made to Eastern Health and to the Mental Health Complaints Commissioner;

(f) feedback from management;

(g) feedback from staff; and

(h) comparative need, as all services provided must be considered.

Oversight by the executive leadership team

What kinds of regular performance and activity information about the Eastern Health Mental Health Program do you receive in your role as CEO? What level of performance oversight does this give you?

24 In my role as CEO, I receive regular activity reports and information across three domains – financial performance, quality and safety, and access to care. Access to care covers compliance with the National Emergency Access Target (**NEAT**).

25 There are a number of other avenues by which I receive regular performance and activity information with general oversight by the Mental Health Program. The Clinical Executive Committee meets on a monthly basis at which point any concerns may be raised. In addition, the Executive Director, SWMMS, who is responsible for the Mental Health Program, Turning Point and Spectrum (and the other members of the Eastern Health Executive) meets with me formally at least monthly to report on her areas of responsibility. Additionally, informal consultation and reporting occurs whenever required by the Executives. If the Executive Director responsible for a particular area

has a concern around an issue of performance outside the reporting timetable or at the time the reports are provided to me, they will escalate the issue to me. Naturally, given the extensive scope of the health services delivered by Eastern Health, the responsible Executive Director monitors the day to day service delivery with the management team. My focus is on situations where there is a variance in performance and consequently, whether anything can be improved to address that variance.

Does Eastern Health track its own KPIs in mental health, above and beyond those set out in the SoP and other standard reporting required by government? What measures do you track?

26 Eastern Health's Mental Health Program has a detailed report which is reviewed on a regular basis. The Mental Health Program also has its own financial reporting. In line with the above, these reports are overseen by the responsible Executive Director and her management team, together with the responsible management accountant reporting through to the Chief Finance Officer. The detailed reports do not come to me. Additionally, some performance reporting goes directly to the DHHS.

27 The responsible Executive Director will escalate performance concerns to me if they see the need to do so. These concerns usually arise from a variance from performance targets or established criteria.

28 Eastern Health has a Daily Operating System (**DOS**) in place each weekday where issues can also be escalated if resolution cannot be achieved at the lowest level in the organisation.

29 The Mental Health Program report covers the same three domains I described in paragraph 24 above. The reporting is ongoing and frequent.

Funding and prioritisation

What is the scope for a public health service CEO to advocate with DHHS for higher funding for mental health in a financial year?

30 As CEO of a public health service, I have strong channels of communication with DHHS. This includes regular meetings with DHHS and Eastern Health's CFO to discuss financial issues. Health services' advocacy is limited by the overall funding pool available to DHHS, and the factors impacting DHHS' decisions with respect to prioritisation of resources across the public health sector are not necessarily known to individual health services in many cases.

31 Eastern Health has successfully advocated for funding for a number of projects to support mental health and alcohol and other drug services, obtaining funding, for example, for:

(a) the development of new inpatient areas;

(b) in years past, the development of new adult inpatient wards and adolescent wards; and

(c) refurbishment and minor capital works to minimise occupational violence and aggression and increase staff safety.

32 These submissions required strong business cases and advocacy by the Eastern Health team with DHHS.

How has the funding that Eastern Health receives for the delivery of physical health services grown over the past ten years compared with the growth of funding it has received for mental health services over the same period?

33 Overall funding increases at Eastern Health can be broken down into two categories – mental health and "non-mental health". Based on the data available in the DHHS Policy and Funding Guidelines, overall funding from DHHS for Eastern Health increased by 50.87% between the 2009-10 financial year and the 2017-18 financial year. The increase in funding during that period for "non-mental health" services was 52.08%. The increase in funding for mental health services was 43.38%.

34 The funding increases described above do not reflect the increase in the cost of health care at Eastern Health.

Implementation and reform

It is understood from Eastern Health's 2017-2018 Annual Report[8] and Eastern Health's Strategic Plan 2017-2022,[9] that Eastern Health is meeting, and in most cases exceeding, the majority of its KPIs for mental health. Are these KPIs adequate to measure:

a. The ability for service to meet demand; and

b. The extent to which a full range of services are delivered in the community setting?

[8] Page 28.
[9] Page 30.

35 There are three key performance indicators specific to mental health services in the DHHS Performance Framework. These are:

(a) The percentage of adult mental health inpatients who are readmitted within 28 days of discharge;

(b) The rate of seclusion events relating to acute mental health admission; and

(c) The percentage of mental health inpatients with post-discharge follow-up within seven days.

36 These indicators, which are centred on inpatient care are important in mental health.

37 However, these key performance indicators are not designed to comprehensively address service demand, but to report on the specific matters identified. They are supplemented by a measure of ambulatory contact hours.

38 Eastern Health Community Mental Health Services have recorded a 24% increase in ambulatory contact service hours over the past 3 years.

Broadly, how has Eastern Health tried to improve access to its mental health services in the last five years? Have these initiatives been directed by government or implemented independently by Eastern Health?

39 Consistently with its values of excellence and agility, and as part of its commitment to being a high performing organisation, Eastern Health's various programs strive to improve their services and the patients' experiences on an ongoing basis. In terms of access to its mental health services over the last five years, the mental health program has provided me with a number of examples of efforts to improve access as follows. I have identified below where the initiatives have been directed by government.

(a) A number of changes aimed at providing a single point of entry to the mental health services including restructuring triage/access by providing more fluidity in senior clinician roles, and a greater staff base to work across telephone triage, Emergency Department (**ED**) response and the Crisis Assessment and Treatment Team (**CATT**).

(b) The Psychiatric Assessment and Planning Unit (**PAPU**) opened at Maroondah to enable patients requiring mental health care to transfer from the Emergency Department to a more appropriate setting without requiring an admission to an inpatient unit or medical bed.

(c) Increased staffing levels early in the patient's episode / journey, including medical staff in the Emergency Departments.

(d) Telehealth was introduced at Angliss ED, which has reduced the amount of time for a consumer to be assessed by a mental health clinician and also reduced the amount of time for that person to either be discharged or admitted to a bed.

(e) MHaPS (**Mental Health and Police Service**) was established, so that clinicians are available to attend mental health assessments at police stations to see people faster.

(f) The Child and Youth Mental Health Service (**CYMHS**) Model of Care was reviewed, eliminating the waitlist, measuring capacity, and streamlining community access.

(g) Priority access to children in out of home care was established. This was directed by government.

(h) A system of priority access to Aboriginal and Torres Strait Islander (**ATSI**) children, those with eating disorders, and those presenting with first episode psychosis was developed.

(i) The CYMHS - Short term assessment and treatment model was developed so that when the service's capacity for case management is low, the patient is provided with 2 or 3 sessions of care before linking them to other services.

(j) The staff numbers in the community mental health teams have increased capacity as directed by government.

(k) There has been an increase in the Consultation & Liaison service to inpatients (admitted for physical health issues) at Box Hill Hospital and Maroondah Hospital on weekends.

40 Eastern Health Adult Mental Health Program was the 2018 recipient of The Victorian Public Healthcare Award for Improving Indigenous Healthcare. The team, led by the Aboriginal Clinical Engagement Clinician, was acknowledged for improving access to recovery oriented Adult Mental Health Services for the Aboriginal community in the east.

How has Eastern Health tried to improve the responsiveness of its mental health services to the needs of the community in the last five years? Have these initiatives been directed by government or implemented independently by Eastern Health?

42 I refer to my previous answer for context and note that the mental health program has provided me with a number of examples of efforts to improve responsiveness to the

needs of the community as follows. I have identified below where these improvement initiatives have been directed by government. Eastern Health:

(a) Introduced a consumer and carer workforce as directed by government;

(b) Developed a Recovery Framework, which was a government initiative implemented by Eastern Health;

(c) Implemented the government initiative, SAFEWARDS, which has been implemented across the state and uses a number of interventions to improve safety;

(d) A number of initiatives to improve mental health services to aged persons and reduce the need for admissions for those over 65 years, namely –

(1) Offering more secondary consultations in aged residential care;

(2) providing GP telephone consultations (including medication advice); and

(3) a Primary Healthcare Network (**PHN**) project for GP liaison with Eastern Health clinicians for specialist advice to enable the GPs to better identify mental health issues in older people, and support GPs to manage them in the community, and in so doing, prevent admissions to hospital, and facilitate timely discharge back to the care of GPs;

(e) Provided education to GPs, practice nurses, and residential care staff to build capacity outside the hospital environment;

(f) As directed by government, established the Perinatal Emotional Health Service at Box Hill Hospital to better serve women in the perinatal period who are at a mild or moderate risk of mental illness;

(g) Established the Infancy access project to allow for the colocation of clinicians in the maternal and child health nurses (**MCHN**) services;

(h) Implemented the PHN – Youth Engagement and Training Initiative (**YETI**) for 12-25 year olds to address the gap, the "missing middle" between Headspace and Tertiary services. This initiative provides clinical case management, flexible outreach, no waitlist, and capacity building with Headspace;

(i) Introduced CYMHS Suicide post-vention – identifying young people who may be at risk of suicide attempt following the suicide of a peer or friend (preventing the contagion effect);

(j) Targeted aboriginal consumers of the Prevention and Recovery Care facility in Maroondah to significantly increase the number of aboriginal consumers accessing services;

(k) Employed Family Violence Advisors to respond to victims of family violence, as well as build the capacity of Eastern Health staff to identify, treat and assist these individuals through consultation and training provision;

(l) Embedded forensic clinical specialists within community clinics;

(m) Embedded dual diagnosis clinicians (dual diagnosis being a diagnosis of both mental illness and alcohol and other drugs issues) within community clinics;

(n) Established Early Intervention Psychosocial Support;

(o) Established HOPE, the Hospital Outreach suicide Prevention and Engagement service;

(p) Improved responsiveness to the ATSI community by establishing an Aboriginal Health Team;

(q) Created a Clozapine clinical team to expand the GP shared care initiative;

(r) Relaxed the Community Care Unit (**CCU**) client entry criteria to include forensic patients; and

(s) Introduced the NDIS program lead position and identified champions and portfolio holders as directed by government.

Are there reforms or service improvements that Eastern Health would like to make to its mental health services, but hasn't been able to?

43 Eastern Health provided detailed submissions in response to the Royal Commission (**Eastern Health Submission**). Spectrum and Turning Point made separate submissions (respectively, the **Spectrum Submission** and the **Turning Point Submission**).

44 Attached to this statement and marked 'DJP-2 is a copy of the Eastern Health Submission. Also attached to this statement and marked DJP-3' and 'DJP-4' is a copy of each of the submissions made to the Royal Commission by Spectrum and Turning Point. These three documents are referred to collectively as the **Eastern Health Submissions**.

45 The recommendations in the Eastern Health Submissions recognise and highlight the fact that that collaboration between consumers, carers and key stakeholders is key to success in the delivery of effective and responsive mental health services. The

recommendations across the Eastern Health Submissions are reflective of reforms and service improvements that Eastern Health would like to make to mental health services.

46 The Eastern Health Submission identified three key priority areas for change:

(a) Urgent investment in mental health services capacity to meet the demands of children, adults and aged persons (including increasing inpatient beds and community services in parallel with workforce to support expanded services);

(b) Expansion of purpose-built infrastructure for current and increasing demand which is safe and provides a therapeutic environment that achieves optimal care and outcomes for consumers, families and carers; and

(c) Review of legislation and protocols to eliminate barriers for information sharing between health services, other service providers and the justice system.

47 The Eastern Health Submission then set out a comprehensive list of recommended reform action items across:

(a) Building a sustainable system;

(b) Building understanding of mental health and reducing stigma and discrimination;

(c) Improved prevention, early treatment and support;

(d) Developing and expanding suicide prevention strategies, programs, research and services;

(e) Accessing, navigating and experiencing mental health services; and

(f) Supporting families and carers.

The action items are at pages 2, 3 and 4 of Annexure "DJP-2".

48 The Spectrum Submission sets out detailed recommendations in relation to the provision of services to people with Personality Disorder treated within the Victorian Public Mental Health Service. The recommendations covered the following areas:

(a) Addressing stigma and promoting help-seeking;

(b) Developing suicide prevention strategies for at-risk populations; and

(c) Building integrated service responses for co-occurring Personality Disorders and other mental disorders.

49 In my role as CEO I do not have to hand the data and the detailed analysis which was used in developing the recommendations. The recommendations in the three Eastern Health Submissions (the general Eastern Health submission, and the separate submissions of Turning Point and Spectrum) were prepared by mental health clinicians across Eastern Health led by the Executive Director, SWMMS (which includes these services).

What constraints or pressures may hamper the implementation of mental health reforms or service improvements?

50 The Eastern Health Submissions identify a number of constraints and pressures which may hamper the implementation of mental health reforms and service improvements. These include workforce challenges and limitations, inadequate (or outdated) infrastructure, the absence of a co-ordinated strategic plan for all mental health services, governance issues, and a lack of information sharing across health services.

Prioritisation of capital expenditure

How does Eastern Health undertake service planning to inform capital investment projects and how does mental health feature in these efforts?

51 Eastern Health undertakes services planning in a planned and structured way. Service planning is undertaken in collaboration with DHHS as a key stakeholder, and utilises the DHHS framework for Service and Capital Planning for such work. Service planning is completed both at a precinct (that is, location) basis and a service basis (meaning that it is aligned to particular patient cohort(s)).

52 Recent precinct based plans have been developed for the Maroondah Hospital Precinct which included some mental health planning (Adult and CYMHS) relevant to the inpatient and ambulatory services provided from across the precinct. Similar planning for Aged Person's mental health was included in the Peter James Centre, Wantirna Health and Residential Aged Care Services Plan.

53 At a specific service level, mental health was included in Eastern Health 2022: Strategic Clinical Service Plan 2012-2022 and the Eastern Health Board recently approved the development of a Mental Health Services service plan. This plan is under development.

54 Master planning for Eastern Health's facilities and sites includes consideration of the future needs of mental health services as they are described in the relevant service plans.

55 Eastern Health has also participated in the development of an integrated regional mental health, suicide prevention and alcohol and other drug plan through the Eastern Metropolitan Primary Health Network for the catchment area they cover.

How does Eastern Health prioritise applications for capital investment projects made to the Victorian Health and Human Services Building Authority?

56 When I consider capital investment, I define it into three categories: first, "Big C" capital; secondly, "Middle C" capital; and, thirdly, "Small C" capital. These are the terms I use – they are not universally used. For that reason, it is entirely subjective which investments fit within each category. "Big C" capital investment includes the construction of entirely new facilities, for example, the new Footscray Hospital. "Middle C" capital investment includes, for example, a new ward in a hospital. "Small C" capital investment includes projects such as refurbishing existing wards/clinics. Previous examples of "Middle C" capital investments for Eastern Health are the building of a new adult mental health unit at Maroondah Hospital and the replacement of the adolescent mental health unit at Box Hill.

57 Overall, Eastern Health's prioritisation of capital investment projects is based on an assessment of the community's needs and their alignment with Eastern Health's strategic priorities. Eastern Health's capital planning and works framework aims to deliver quality, effective, efficient and economic service delivery within buildings and facilities that enhance the ability of Eastern Health to provide the highest possible standard of health services. Eastern Health operates in accordance guidelines published by DHHS, the Minister, and the Victorian Health and Human Services Building Authority (**VHHSBA**). Capital planning is part of the capital investment cycle. It is concerned with the establishment of business need and all pre-planning involved in developing a capital project.

58 With reference to the specific question about prioritisation of applications to the VHHSBA, I note that Eastern Health receives capital funds from a range of sources for the development of major and minor infrastructure projects. The VHHSBA has published guidelines, which are used by Eastern Health.

59 "Small C" capital projects are identified based on risk – both patient and staff risk. The most recent work which was done within this category was work to reduce the occupational health and safety risks of mental health staff (both in the community setting and for inpatient services). We have also refurbished a ward to extend alcohol and drug detoxification services by providing accommodation for higher acuity patients. This refurbishment is a temporary measure. In addition, we are in the process of

refurbishing a physical health ward to accommodate acute adult mental health patients to try to meet demand. The funding for these projects has come from either DHHS or the VHHSBA.

To what extent has Eastern Health been successful in obtaining funding for capital improvement projects to support its mental health services? What led to these successful applications?

60 Capital investment applications are based on submission of a business case. Sometimes we are invited to apply for funding, for example, DHHS released funds recently for work in reducing staff risk and Eastern Health made an application for funding in response to this, which was granted.

61 We have recently been provided with funds:

(a) To repurpose space in the emergency departments at Maroondah and Angliss Hospitals to accommodate a behavioural assessment room (**EBAR**) at each. An EBAR is a low stimuli environment designed to better support some of the most acutely unwell patients presenting to emergency departments with mental health issues. When not in use for patients exhibiting or at risk of aggression or violence that poses a threat of harm to themselves or others, they can be used for other purposes such as, as a low stimulus room for patients to prevent escalation and aggression; and

(b) To develop the Psychiatric Assessment and Planning Unit of Eastern Health (**PAPU**) which is located next to the emergency department at Maroondah Hospital. It is an adult acute psychiatric unit designed to provide fast access to short-term specialist assessment and treatment for people experiencing acute mental health.

62 Sometimes we are successful when we apply for funds and other times we are not. Sometimes we are provided with a portion of the funds we have requested in our business case submission. Generally speaking, I do not have any formal insight into the decision making process. I also do not have any insight into funding applications made by other health services or the success of those applications. In general terms, the demand for funding often exceeds the available money.

Have mental health facilities been given an appropriate level of prioritisation in capital improvement projects within Eastern Health compared to facilities and parts of facilities targeting physical health? Why or why not?

63 Eastern Health prioritises mental health facilities in the same way as non-mental health. It is largely based on the identification of risk.

Catchments

Do you have a view as to the relevance of geographic catchments in mental health service delivery? Is it helpful or unhelpful to require Victorians to seek services in their own catchment?

64 Geographical catchments are useful and necessary, but it is unhelpful that the catchment areas in Victoria for physical health and mental health are not always aligned. Geographical catchments enable the tailoring of services to particular communities. They need to be reviewed from time to time to accommodate changing demographics, but they should not be changed too frequently because that leads to consequential changes in service programs and staffing of those programs – each time a geographical boundary is changed, the health service which governs patients changes, which imports an element of additional risk. What is more important is to review the services of each catchment on a regular basis to make sure that they are appropriate for the particular community's needs as they change over time.

65 The 'catchment area' covered by services provided by Eastern Health is wide and not all of the population across that catchment have the same needs. This will continue to be the case. In the United Kingdom communities are broken down into small 'pockets' and health and social services are designed around the specific needs of each smaller community. The same needs-focussed design would enhance our mental health system. Understanding the small community needs would also help the system become more agile and therefore more responsive.

66 Providing mental health services at this regional level would allow for integrated clinical governance or clinical oversight. This would support the provision of 'wrap around' services, allowing both more comprehensive support, as well as better supervision of the patient's journey across the system to pick up on rising risk.

67 Finally, there are significant opportunities to connect the system if the information in the system could also be connected. At present, this is a real impediment because mental health patient information is not shared on a common platform amongst all service providers. Careful consideration is required of mechanisms to achieve this information

flow while protecting patients' privacy, and in so doing, giving them confidence to seek help from the system.

sign here ▶ _____

print name David John Plunkett

date 24 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT DJP-1

This is the attachment marked 'DJP-1' referred to in the witness statement of David John Plunkett dated 24 July 2019.

DAVID PLUNKETT

PROFILE

I have extensive executive and senior management experience in both the public and private sectors to deliver the organisation strategic directions.

As the leader of a committed Executive team, through living and espousing our values, my focus on people, patients, performance and process have led to improved leadership, including clinical leadership, patient outcomes and experience along with improvements in staff engagement rating the organisation as one that is a safe and patient focused.

With a clinical background as a Registered Nurse, and combined with my leadership experience, I have an extensive understanding of the health system. This includes tactics that assist in strategy development, deployment and delivery. Through utilising the knowledge and experience of this clinical background, I am able to leverage off closer relationships with clinical staff / teams to improve patient and safe experience and outcomes along with developing new knowledge through research and continuous and deliberate improvement activities.

My leadership and focus on the patient and outcomes has been further enhanced through applying learning's obtained as a surveyor with the Australian Council on Healthcare Standards (ACHS).

QUALIFICATIONS

Graduate Australian Institute of Company Directors	AICD January 2017
LINK Program	Department of Health 2011
Master of Business Administration	Mt Eliza Business School - 2003
Grad. Dip. Business Management	Monash University - 1997
Certificate in Perioperative Nursing	Austin Health 1989
Registered Nurse	Latrobe Regional Hospital – 1988

ADDITIONAL ROLES

Appointed to the Eastern Metropolitan Partnership by Minister for Suburban Development, Chair of Metropolitan / Regional Public Health Service CEOs, Chair Agency Advisory Committee, Victorian Agency for Health Information, Board Director Australian College of Nursing and Mayfield Education Centre.

MAJOR PROFESSIONAL HIGHLIGHTS

EASTERN HEALTH

Eastern Health comprises 7 major campuses across metropolitan Melbourne and in 2018/19 provided over 1.33m episodes of care. It has a staffing and volunteer profile of over 10,300 servicing aging population in excess of 773,000 with an annual operating budget in excess of $1.1b.

Chief Executive, Eastern Health, July 2016 – present

- Delivered improved financial sustainability, including operating performance and cash management.
- Lead Eastern Health in the period of transition including preparation to set the Statement of Priorities (both improvement and financial aspects), developing whole of health service strategies to improve operational performance (particularly related to patient flow and emergency access)
- Improved operational performance in areas such as unplanned patient access, the highest number of surgeries in health service records, reduced work cover premiums along with reduced cost per care episode.
- Maximise on preservation of successful strategies and tactics previously utilised whilst 'making it my own'
- Engaging with teams at multiple levels to continue to deliver against Eastern Health strategies and operational goals
- Supported Board Directors in the preparation of the 2017-2022 Strategic Plan including Executive and staff engagement and annual planning to deliver particular new strategic priorities of education and research.
- Delivered improved organizational culture through the systemic implementation of values and behaviours
- Lead the Executive team to embrace and extend 'lean' process improvements that will result in greater reliability in operational performance and patient experience.

Executive Director Acute Health / Chief Nursing and Midwifery Officer, Eastern Health, May 2013 – June 2016

- Acted as Chief Executive Officer during on multiple occasions totally approximately 4 months.
- Lead the operationally commissioning of numerous new capital developments particularly the successful commissioned of clinical service in the new building A of Box Hill Hospital with no increase in patient harm.
- Contributed to the $135m saved as part of the financial sustainability program within Eastern Health. For the directorate this has been through the effective cost and revenue management resulting in at least a 25% contribution margin.
- Negotiated with external providers to lease space resulting in improved financial performance and enhanced relationship.
- Reconstructed the nursing workforce resulting in significant reductions in use of agency staff leading to patient, workforce and financial gains.
- Lead the improvement to the service provided to our community and especially those requiring elective surgery as demonstrated by a reduction in the elective surgery waiting list of over 50% across three financial years.
- Lead the improvement in access performance for patients presenting to the three emergency departments with a 12% improvement against the 4 hour emergency access performance indicator in the environment of greater than 20% increase in demand

- Contributed to the expansion in breadth and depth of nursing and midwifery research and learning strategies resulting in improved reputation of Eastern Health / Deakin University research reputation.
- Lead teams to implement advanced information technology systems to support patient safety and operational performance
- Successfully lead the Eastern Health program during the enterprise bargaining period of the nursing and midwifery EBA leading to positive workplace relationships

Executive Director Nursing, Access and Patient Support Services (Chief Nursing & Midwifery Officer), Eastern Health, Feb 2010 – May 2013

- Acted as Chief Executive Officer during on multiple occasions
- Achieved improvement in numerous patient access KPIs
- Provide leadership for the following functions:
- Medical Imaging, Pathology, Pharmacy, Hotel Services, Infection Control, Biomedical Engineering including Security Services
- Reduced expenditure and reliance on agency staff by 30% in first year

General Manager, Clinical & Corporate Support Services, Eastern Health, Feb 2008 – Jan 2010 (member of Eastern Health Executive team)

- Lead the successful implementation to a new service provider for Medical Imaging (Radiologist) services
- Lead the development of a 5 year plan for Pathology Services in line with statewide agenda
- Lead the implementation of phase 1 of the HealthSMART Clinical project to improve medication safety

Program Director, Surgical Services Box Hill Hospital / Eastern Health Clinical Program Leader Surgical Services, 2007 – 2008

Director of Ambulatory Care, Box Hill Hospital, 2004 –2007 Operations

Manager, Box Hill Hospital, 2002 – 2004

LATROBE REGIONAL HOSPITAL

Latrobe Regional Hospital is a 257 bed regional referral hospital for the Gippsland Region of Victoria. It was the first privately owned and operated public hospital in Victoria, and proved itself to be an operational success, however reverted to public governance due to contractual reasons. Latrobe Regional Hospital has a close relationship with the local and broader Gippsland community providing key services as the regional provider.

Project Development Manager, 2001 – 2002

- Identified financial savings in excess of $1.5M through consultation with all staff
- Coordinated the successful development of a new strategic plan

Director of Nursing & Operational Support / Director Care Program 2, 1999 – 2001

- Lead the multi-disciplinary team through the difficult transition back to public governance without adverse industrial effects.

Manager Bed Utilisation, 1999

- Introduced customer service training and initiatives in order to meet patient and community needs

Nurse Unit Manager, 1998 – 1999

EPWORTH HEALTHCARE - RICHMOND

Epworth Healthcare Richmond is the largest hospital within the health service. During my tenure with Epworth, the campus comprised over 12 operating theatres, an emergency department as well as busy intensive care and cardiac units.

Associate Operations Director, Epworth Hospital 1996 – 1998
Increased surgical revenue through the recruitment of additional surgeons in line with strategic intent of organisation
Increased operating efficiency through reduction in staff hour cost per procedure via enhanced rostering practices

Various public and private hospital positions

REFERENCES

Available upon request

Royal Commission into Victoria's Mental Health System

ATTACHMENT DJP-2

This is the attachment marked 'DJP-2' referred to in the witness statement of David John Plunkett dated 24 July 2019.

easternhealth

Submission:
Royal Commission into Victoria's Mental Health System

Eastern Health
July 2019

easternhealth

5 July, 2019

It is with great pleasure that I formally present, on behalf of the Eastern Health community, a submission to the ***Royal Commission into Victoria's Mental Health System***.

The Royal Commission into Victoria's Mental Health System provides us with a once in a generation opportunity to accelerate improvements in access to mental health services, service navigation and models of care.

At Eastern Health we are uniquely positioned as a major provider of mental health, alcohol and other drug services to contribute to the future of these services for decades to come.

We understand the importance of addressing each consumer's individual needs throughout their recovery journey and actively work with consumers, carers and families to achieve this.

Fundamental to the success of mental health services is the collaborative nature of working collectively to ensure a recovery-oriented service model.

We are proud that across our Mental Health Program, Turning Point, Spectrum and more broadly our entire health service, our people are absolutely committed to placing our consumers, who are often in a vulnerable state with very complex needs, at the centre of everything we do.

Eastern Health appreciates the opportunity to contribute to the Royal Commission into Victoria's Mental Health System and we encourage the Commission to advocate for fundamental change that will benefit Victorians for decades to come.

Adjunct Professor David Plunkett
Chief Executive, Eastern Health

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

About Eastern Health Mental Health Services

Eastern Health provides comprehensive clinical mental health services across a range of emergency departments, inpatient units (acute and sub-acute), community and residential settings. These services cater to individuals of all ages, their families, significant others and other service providers across the local government areas of Whitehorse, Manningham, Maroondah, Monash (part), Knox and Yarra Ranges in the Eastern Metropolitan region of Melbourne. The services also engage with the community sector to improve the response to consumers with mental illness.

Fundamental to the success of these services is the collaborative nature of working collectively with consumers, carers and key stakeholders to ensure a recovery-oriented service model.

The service profile of the Mental Health Program includes:

1. Child and Youth Mental Health Services (CYMHS): Clients are aged 0-24 years with severe emotional and/or behavioural disturbance and mental illness, inpatient and community services.
2. Psychiatric Consultation and Liaison Service: incorporating a newly established Perinatal Emotional Health Service. These services provide support for managing people with mental illness in hospitals.
3. Adult Mental Health Services: clients aged 25-64 with severe and enduring mental illness, inpatient and community services.
4. Eastern Health has 16 short-term (3 to 6 months) placement beds at Monash Secure Extended Care Unit (SECU).
5. Access Stream: incorporating Telephone Triage, Emergency Department Response and Crisis Assessment and Treatment (CATT) services, Mental Health and Police (MHaP) Response and the Psychiatric Assessment and Planning Unit (PAPU).
6. Aged Persons Mental Health Services: clients aged 65+ with severe and enduring mental illness, inpatient, community and residential aged persons mental health services.

   Services are located at:

   - Community clinics which are based in Ringwood East, Box Hill, Lilydale and Upper Ferntree Gully.
   - Inpatient units which are located at Box Hill Hospital, Maroondah Hospital and the Peter James Centre.
   - Residential facilities (both sub-acute and medium term) are located in Ringwood East, Box Hill, Burwood, Mooroolbark and East Camberwell.

Eastern Health recommendations for consideration by the Royal Commission

Priority areas for change

- Urgent investment in mental health service capacity to meet the demands of children and young people, adults and aged persons. This includes increasing inpatient beds and community services along with the workforce required to support this expansion across settings.
- Expand purpose-built infrastructure for current and increasing demand which is safe and provides a therapeutic environment that achieves optimal care and outcomes for consumers, families and carers.
- Review existing legislation and protocols to eliminate barriers for information sharing between health services and other emergency service providers and the justice system.

Building a sustainable system

- Statewide mental health service planning is required, inclusive of capital and infrastructure planning.
- Statewide mental health workforce planning is required.
- Office of the Chief Psychiatrist to lead consistency of practice across mental health services regarding inpatient safety, response to aggression and a system response to consumers with forensic histories.

Improving understanding of mental health and reducing stigma and discrimination

- Implement Youth Mental Health First Aid training in all schools and other youth agencies.
- Resource Mental Health First Aid for older persons to be delivered to staff working in Community and Residential Aged Care Services, General Practitioners, older persons, carers and families.
- Improve capacity building through primary, secondary and tertiary consultation with agencies in the education, health and welfare sectors.
- Expand the Lived Experience Workforce in health and community settings.
- Provide education and training opportunities for all healthcare providers in mental health; and
- Expand public health campaigns.

Improving prevention, early treatment and support

- Increase service capacity to meet the demands of children and young people, adults and aged persons.
- Increase the capacity of CYMHS to manage first episode psychosis, up to 25 years.
- Increase service capacity to provide inpatient and community care for young people and adults with eating disorders.
- Expand Prevention and Recover Care (PARC) services including Youth, Aged and gender-specific PARCs.
- Expand the Infant Access Program (4 years and under).
- Expand the Perinatal Emotional Health Service to meet demand.
- Establish a mother and baby unit in the eastern metropolitan region.

Developing and expanding suicide prevention strategies, programs, research and services

- Expand services to support early intervention and proactive contact post suicidal ideation or self-harm to reduce the likelihood of subsequent attempts.
- Develop a five-day-a-week step-up, step-down Day Program for young people aged 16 to 25 years to facilitate greater engagement and provide targeted therapeutic treatment with skilled staff that have specialised skills in working with and engaging young people and their families.
- Continue to develop the evidence and research into suicide prevention and share findings across the health sector.

Accessing, navigating and experiencing mental health services

- Establish area-based governance systems to address fragmentation of care and encourage integration and collaboration in mental health care.
- Establish an Emergency Department Access Hub in the east.
- Increase resources for mental health/ alcohol and other drug presentations in emergency departments, as well as telephone triage services.
- A state-wide conversation about access to mental health services when consumers present as "out of area".
- Establish an active post-discharge follow-up service for everyone who attends an Emergency Department with mental health, alcohol or other drug issues to ensure appropriate management and support.
- An initial increase of 25 acute adult inpatient beds in the Central East.
- Develop a sub-acute inpatient service to support transition from acute inpatient units to the community by providing time, clinician intervention and good discharge planning.
- Establish an adult inpatient unit that accommodates high risk and forensic consumers (either within the existing forensic setting or within specific Designated Mental Health Services) to support the safety of all consumers, staff and visitors.
- Expand Consultation and Liaison services in hospitals (24/7) to support management of consumers with co-morbid mental health issues and medical/surgical issues.
- Additional resources and expertise for managing consumers with high complexity issues including forensic histories, co-morbid drug and alcohol issues, family violence, personality disorders and suicide prevention (inpatient and community services).
- Create gender-specific acute inpatient units and gender diverse units.
- Establish central multi-agency healthcare hubs that allow populations of all ages to receive coordinated mental health and support services which are integrated.
- Centralise referral systems that include community providers.
- Significantly expand the Personality Disorder Service at Eastern Health, supported by Spectrum.
- Integration of dual diagnosis and alcohol and other drug services with mental health services.
- Investment in Dual Diagnosis Acute Inpatient Units to address specific treatment needs and reduce exposure of existing units to substance use and behaviours of concern.
- Establish a Rapid Response Service for the 65+ population.
- Relocate South Ward (aged persons acute inpatient unit) to an acute hospital site and substantially expand its capacity for future growth.
- Review the model of care for Aged Persons Mental Health which has a focus on managing mental health along with co-morbid geriatric and physical issues, and supporting people in their homes, including residential aged care, with a multidisciplinary team.
- Provide Consultation and Liaison services in sub-acute services (i.e. rehabilitation and Geriatric, Evaluation and Management).
- Establish a clinical sub-acute service for aged persons with mental illness.

Supporting families and carers

- Establish dedicated funding to support carers.
- Establish bed-based respite services for people with enduring mental illness.
- Ensure that families and carers are adequately and truly represented when reviewing, planning and designing future mental health services.

Developing the mental health workforce

- Progress statewide workforce planning to ensure a sufficient supply of staff and an appropriately skilled workforce relevant to the unique needs of mental health service provision, and ensure that supply meets demand in all healthcare disciplines.
- Collaborate with Universities and other educational institutions to tailor education and training for the mental health workforce.
- Provide tailored University training for case management in mental health to appropriately manage the complexities of consumers with mental illness.
- Continued development of the Lived Experience Workforce, including young people.
- Expand programs which focus on the management of occupational violence and aggression to support staff safety and wellbeing.

Improving social and economic participation for people with mental health illness

- Ensure that the National Disability Insurance Scheme (NDIS) caters for the developmental needs of children and young people, including the provision of psychosocial support.
- Ensure psychosocial supports are available for consumers who need support but are assessed as ineligible or not requiring NDIS, and those who choose not to apply for NDIS.
- Ensure psychosocial supports are available for people aged 65+ where social isolation is a compounding factor to their mental illness.
- Invest in Homeless Models of Clinical and Psychosocial Support across the community.
- Invest in housing models including public housing and supported accommodation.
- Invest in specialist accommodation for consumers with high and complex needs (e.g. mental health and intellectual disability with complex behaviours).
- Incentivise education and training entities to take students with mental ill-health and companies to employ people with mental ill-health.
- Maintain the current focus on family violence prevention and management.

Responses to the Royal Commission's questions

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

With greater understanding comes a reduction in the stigma associated with mental illness.

The community would benefit from:

Consultation and education to primary and secondary agency staff to build their capacity and understanding of mental illness

Research shows that early intervention for mental health difficulties in children and young people reduces the severity and duration of mental illness. As a tertiary service, CYMHS provides significant informal leadership and support to partner agencies across the Eastern Metropolitan Region. This includes provision of once-off primary, secondary and tertiary consultations as well as regular, contracted, secondary consultations to key agencies. In addition CYMHS staff host monthly community education seminars. Consultation to other service providers working with children, young people and their families promotes early intervention and effective delivery of primary and secondary level responses for children and young people experiencing mild to moderate mental health issues. Provision of regular, contracted secondary consultation aims to build the skills, knowledge, confidence and capacity for staff working in education, health and welfare sectors to respond to and support children and young people experiencing mental health issues. Efficient coordination, up-to-date documentation and regular evaluation of consultations is essential to ensure work meets agreed goals.

Currently CYMHS offers contracted secondary consultations to nine different agencies including Worawa Aboriginal College, Youth Support and Advocacy Service in Box Hill, City of Maroondah Youth Services and Inspiro Youth and Family Counselling Service. Tertiary services should be required to provide leadership, support and capacity-building through primary, secondary and tertiary consultation with other agencies including education, health and welfare sectors. This should be done in collaboration with the regional Primary Health Networks (PHNs).

Lived experience workforce

Involvement of the lived experience[1] workforce in health and community sectors will assist in understanding of mental illness and reducing stigma and discrimination.

Mental health first aid

Mental Health First Aid training is the help provided to a person who is developing a mental health problem, experiencing a worsening of a mental health problem or in a mental health crisis. The first aid is given until the appropriate professional help is received or the crisis resolves. This education should be broadly available to staff working in schools, youth agencies, community health agencies, general practice and Community and Residential Aged Care Services; consumers, carers and families. Eastern Health staff are trained to undertake this training and build capacity in the community. As a part of the Community Suicide Prevention Strategy, Eastern Health offers community training for frontline services to recognise mental health issues and suicide risk in people over 65, and to respond accordingly.

Public health campaigns

Many agencies have contributed positively to the awareness of mental illness including Beyond Blue and the RUOK campaign. These need to be continued and expanded to increase understanding of mental illness and reduce stigma.

[1] A lived experience worker is a 'person who is employed in a role that requires them to identify as being, or having been a mental health consumer or carer. https://www.mhcsa.org.au/about

Workforce

Undergraduate training for all healthcare professionals should include education, placements and work experience in mental health, as mental illness is frequently co-occurring with physical illness and needs to be managed holistically.

In summary, tertiary services are well-positioned to provide consultation and education to primary and secondary agency staff to build their capacity to effectively respond to children and young people, adults and older people with mild to moderate mental health difficulties.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Early identification and therefore early treatment and support for people experiencing mental health issues for the first time is important for long-term outcomes. Whilst the identification, treatment and support is ideally provided during the earlier years of life, it is equally important to ensure that measures and services are in place that allow mental health services to adequately support people of all ages and stages of life in the early stages of mental ill-health.

There are services currently available that target early intervention, however these services constantly struggle to meet demand. Stringent triaging of referrals occurs ensuring that only the most serious cases are managed. Many people with severe presentations requiring tier 3 multidisciplinary treatment teams rely on community services designed for milder presentations. Tier 3 services are designed for children and young people who have complex and severe mental health complications and/or are at high risk of harm.

Increasing the capacity of the multidisciplinary tier 3 teams in tertiary services would greatly improve the 0capacity to help those with severe mental health disorders currently underserviced, as well as free up community agencies to more adequately meet the needs of those with mild and moderate presentations.

Adolescent Inpatient Unit

The Adolescent Inpatient Psychiatric Unit (AIPU) serves young people aged 13 to 17 living in the Eastern region and rural areas including Goulburn Valley, North Eastern CAMHS Region, Shepparton, Seymour, Wangaratta, Albury-Wodonga and surrounding shires. Between 2016 and 2018 the number of separations has increased from 448/year to 626/year, while the average length of stay has dropped from 5.7 days to 4.1 days, reflecting an increase in demand. While there are outliers in a young person's length of stay, over the three-year period, only 1.2% of separations were longer than 35 days. Recent patient experience of care data has indicated that 23% of young people admitted to the AIPU identified as LGBITQ+.

A dedicated youth in-patient unit would provide greater access to inpatient care for 18-25 years, minimising delays in acute in-patient care and treatment given the current bed demand within the adult mental health program. It would also provide age-appropriate environments, treatment, education and activities to support positive outcomes for young people. As noted in the 2019 VAGO report, in CYMHS there are no youth specific services such as youth in-patient units, youth PARCs or day programs within the Eastern region.

Children aged 12 years and under

In recognition of the under-representation of children aged 0-12 within mental health services, priority access has been implemented to facilitate greater engagement. Whilst this has been somewhat successful, demand again exceeds resources and many children meeting tertiary criteria are not able to be admitted for assessment and treatment. Those children, who are accepted, typically have highly complex presentations including experiences of significant trauma, family violence, severe attachment difficulties, and parental mental illness. The complexity of such presentations requires flexible, outreach models which are difficult to sustain within current resources and is further compounded by the large Eastern catchment area. Without collaborative engagement with families and the system of care, including Child Protection, Child First,

Maternal Child Health Nurses, schools, to name a few, outcomes are poor leading to family breakdown, school disengagement and poor future prognosis.

Children and young people identifying as Aboriginal

Aboriginal children and their families have prioritised entry to assessment and treatment services. This is supported by routine 'asking the question' and where positive, engagement with the specialist Aboriginal Senior Clinical Social and Emotional Wellbeing clinician to ensure a culturally safe and responsive service is provided. Additionally, CYMHS provides secondary consultation to the national entry girls' only Aboriginal boarding house in Healesville, *Worowa House*.

CYMHS Access

Eastern Health CYMHS provides specialist mental health assessment and interventions for infants, children and young people (0-24 years) and their families residing in the Central and Outer Eastern Region of Melbourne. CYMHS is the lead agency in treating severe and complex mental illness and focuses on early intervention using a developmentally informed framework that is holistic, family based and recovery oriented. The service also supports partner agencies within the region that work to prevent, treat or facilitate recovery from the broader spectrum of mental disorders and promote mental health in children and young people, thus working to improve the lives of young people, strengthen diverse communities and reduce morbidity into the future.

In Australia, mental health presentations occupy the top three causes of the burden of disease for 15 to 24-year-olds. Specifically, suicide and self-harm, anxiety, and depressive disorders are the leading concerns for 15 to 24-year-olds, while anxiety and depressive disorders are the second and third causes of disease burden for 5 to 14-year-olds[2]. CYMHS has insufficient resources to meet current demand. Using data collected over a 12-month period from 1 June 2017 to 30 May 2018, over 10,000 calls were received at Access, the dedicated weekday CYMHS referral and information team. Of the 10,000 calls, 3000 of these were abandoned by the caller in part because of waiting times. The 6700 calls answered reflected concerns about 3235 unique young people. Following a detailed screening assessment, 1207 young people were subsequently accepted into community case management, treatment and support. Given the epidemiology and population of the area (the 0-24 population was approximately 250,000 in the 2016 Australian Bureau of Statistics (ABS) census), it is estimated that approximately 6000 young people need assessment and treatment per calendar year.

Outcome measures show that for those attending CYMHS, symptoms become significantly less severe, and functioning significantly better,[3] evidence of the service's effectiveness. Because of limited resources there is a gap between demand and the service's capacity (the percentage of referrals received that have been able to be accepted over the past five years has varied between 30% and 36%), hence there are opportunities for improvement. Additional resources would improve the ability to meet demand and could make a significant difference to young people at a critical point in their lives.

The 2019 Victorian Auditor-General's Office (VAGO) report into CYMHS noted that there is a gap in the ability to provide services to this vulnerable cohort of consumers and their families. Left untreated, these mental health issues will continue to pose a burden, not only to health services, but to other public services, such as police and ambulance. In addition the impact of mental illness will continue to spiral, impacting future engagement within society, education, employment and, left unaddressed, will eventually impact the nation, for years to come.[4]

Given its limited ability to meet demand, CYMHS accepts only the most severe, complex presentations and those who require treatment beyond the capability of tier 1 and tier 2 services. In 2015, CYMHS implemented a new model of care across Access and the Community teams named Initial Consultations and Treatment in Recovery (ICTiR). CYMHS' implementation of the ICTiR model of care eliminated the waiting list, maximised efficiency whilst providing a framework that maintains collaborative, evidence-based, and therapeutic and recovery-oriented practice. In brief, ICTiR calculates sustainable parameters for new

[2] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW

[3] Brann, P., & Coleman, G. (2010). On the meaning of change in a clinician's routine measure of outcome: HoNOSCA. Australian and New Zealand Journal of Psychiatry, 44(12), 1097-1104.

[4] Child and Youth Mental Health Report, Victoria Auditor General, tabled June, 2019.

appointments that allow young people to be accepted for service either immediately (in case of crisis presentations) or within five working days. This is achieved through tracking three measures: staff resources (equivalent full time [EFT]), outcomes and the required average days of assessment and treatment. Changes in EFT automatically lead to changes in the Service's capacity to accept referrals.

ICTiR has assisted the service to focus its limited resources on efficient quality of care for the most complex and severe presentations whilst minimising a reactive, crisis driven approach. Since introducing ICTiR, engagement with young people in the crucial early stages of therapy has increased from 85% to 92%. Failure-to-attend accounts for only 2.9% of case contact time, an exceptional result in a public CYMHS service.

CYMHS assists those consumers it cannot see with sourcing alternative solutions. In 2019, CYMHS implemented a short-term assessment and treatment clinic to assist in bridging this gap. The ICTiR model has proven largely effective with referrals provided with appointments generally within seven days of acceptance. In addition, the absence of a wait list is well received within the community. However, there remains a significant gap in CYMHS resources to meet the needs of significantly unwell consumers aged 0-24, especially considering the limited services available to provide the level of intensive management required. In addition, these issues have a negative impact on staff morale and well-being, particularly the CYMHS Access Team which invests considerable time locating alternative providers for consumers that it cannot service.

CYMHS Community Clinics

CYMHS provides significant community assessment and treatment for young people up to 25 years of age, across a range of sites, within the Eastern Region. Teams utilise a case management model and provide multi-disciplinary, multi-modal treatments including individual therapies, family therapy, parent therapy and group work. There is a significant focus on working collaboratively with partner agencies including schools, health and welfare services.

The Specialist Intensive Mobile Treatment Team provide intensive outreach for young people at significant risk and complexity and are typically within the Child Protection or Youth Justice systems.

The Specialist Child Team works particularly with infants and children under 12 years of age who are highly vulnerable and at risk of requiring Child Protection. The Child Team works closely with Maternal and Child Health Services working with parents and infants with concerns regarding the infants' mental health due to issues such as parental mental health issues, attachment difficulties, or family violence.

The service also provides a three-day a week adolescent day program called Groupworx. This program runs each school term, and is available to 13 to 17-year-olds at risk of school refusal, school isolation, behaviour difficulties, anxiety and depression, or disengaged from, school or work. The program is run in conjunction with Avenues Education. This program accepted 32 young people in 2018 with an average age of 14-15. Most of these young people had either not attended or had disengaged from education, with 10 having not attended school in over six months. Outcomes on education indicated that all but one had re-engaged in school at the conclusion of the program.

CYMHS has a long-standing partnership with Deakin University School of Psychology which provides training for psychology students and includes up to six sessions of brief intervention, typically for children and families with more mild presentations. This work includes group work within local primary schools, one school per term and directed at early intervention for young children presenting with oppositional or conduct issues.

Across all of the community-based teams, there is a strong tendency for adolescents to predominate. Using five-year age blocks, 2.3% of young people were aged between 0 and 4 years at case start, with 7.6% (5-9 years), 27% (10-14 years), 50.7% (15-19 years) and 12% (20-24 years). Comparing the actual case data with an equitable representation of ages indicates that across all elements of the Eastern Health Mental Health Program, young adults are almost equitably represented, adolescents are quite over represented, while primary school aged child are slightly under represented. Infants and pre-schoolers are very much under represented. All age groups are underrepresented in terms of the extent of the community need for treatment of those with severe and complex mental health problems.

The most prevalent diagnoses over the last three years (acknowledging that comorbidities allow for more than one diagnosis per case), were anxiety disorders (25%), mood disorders (20%), personality disorders (8%), eating disorders (7%), adjustment disorders (including PTSD, 7%), psychotic disorders (6%) and pervasive developmental disorders (5%).

As befits the developmental stages of the CYMHS population, and the evidence base on treatment, CYMHS provides treatment through many parties. Just half of all contact time is exclusively with young people. The remaining time is provided with family, referrers or other supporters when the young person is present and when the young person is not present. Of all the additional work provided by CYMHS a significant proportion is directed into clinical reviews, report writing for others and joint clinical work. Focusing on the community teams engaged in the ICTiR model, the average case receives 53 hours of contact time, including all activities attributable to that (e.g. reviews).

CYMHS deliberately targets its limited resources at those experiencing the most severe and complex mental health difficulties. Australian mental health services have a common Outcome Measurement protocol in place. Comparing symptom severity scores with National data on over 58,000 young people entering community treatment within a state-based child and youth mental health service, young people at Eastern Health CYMHS are more severe than those typically seen in ambulatory mental health services at admission. The average intake to community score is a weighted score that reflects the degree of complexity at a point in the continuum of mental health care. The average intake to community score at Eastern Health CYMHS is more severe than 73% of all comparable cases at other CYMHS. Through its recovery treatment approach, Eastern Health CYMHS achieves a reduction of almost one standard deviation in symptom severity. In other words, approximately 71% of cases show significant improvement by case closure.

Eastern Health community service locations enable service delivery close to home, and facilitate close connections with other key stakeholders. However, in its current configuration, infrastructure is insufficient, unsafe and out-dated and there is a lack of medical treatment rooms across the region. It is not unusual to experience late cancellation of appointments, or appointments being held outside of buildings, such as at the local park because mental health workers share spaces with other community services.

Eating Disorders

CYMHS provides priority access to treatment and care for young people with an eating disorder; a decision made because of the increasing incidence of young people presenting to emergency departments with an eating disorder requiring specialist medical stabilisation. The service, developed without additional funding, comprises an integrated paediatric and mental health assessment clinic, Eating Disorders Assessment Clinic (**EDAC**), and provision of evidence-based community mental care. All clinical staff are trained with evidence-based treatments, including family-based treatment for Anorexia Nervosa.

The service has worked in partnership with the Centre for Excellence in Eating Disorders (CEED) to implement multi-family therapy for anorexia nervosa, complementing the suite of clinical interventions. Early recognition and access, either due to lack of recognition by primary health and/or ineffective treatment within Tier 1 and 2 Services [‘tier’ and ‘Tier’ are used in the submission], are ongoing concerns.

Of the 33 young people assessed by EDAC, 13 required immediate hospitalisation for acute medical instability, illustrative of issues with early identification and evidence based early intervention. The Eastern Health paediatric unit expanded its capacity for consumers with eating disorders in 2013 and has high occupancy rates without the benefit of dedicated funding. Funding along the lines of that available to the Royal Children’s Hospital would be desirable. As a consequence, Eastern Health is unable to provide group programs or consistent mental health support across the admission. Young people with a severe eating disorder between the ages of 18 to 25 years are admitted for acute medical stabilisation to a general medical ward. Due to lack of resources, mental health services have been stretched to cover this ward effectively.

Whilst there are funded specialist eating disorders services within Victoria, for the most part they are not accessible to consumers from the eastern region. For example, the BETRS day program located in Kew is inaccessible for clients who are physically or medically impaired, and those who are unable to drive greater

than 40 kilometres for care. The specialist services additionally do not provide case management, nor have any capacity for outreach. As a major mental health condition, eating disorders should be treated and managed within the tertiary mental health service system, a system which provides care within the local community and is in a better position to provide support, coordination and linkages with the broader health system including primary health care.

First Episode Psychosis

There are two Eastern Health Early Psychosis Teams to manage young people presenting with first episode psychosis and mania between the ages of 0-24. The treatment model follows the evidence-based treatment guidelines developed by Orygen Youth Health. The model also incorporates psychosocial support to enable young people continuing with education or employment. The teams provide outreach work to enhance engagement with the young person and family and also deliver consultation and support to the care system to ensure the holistic needs of young people are met. Current resourcing enables a two-year recovery model of care, extended for young people under the age of 18 years and attending secondary school. Thereafter, where acuity remains high, young people are transitioned to the adult mental health service, which is not ideal from a developmental perspective. Where acute inpatient care is required this is provided within the adult mental health inpatient units for young people over the age of 18 years.

Infancy Access Project

The development of this project followed recognition of the under-representation of infants and pre-schoolers under 4 years old within the service. To address these concerns the service embarked on a pilot in 2017 where a senior clinician is co-located with the Maroondah Maternal and Child Health Service to provide conjoint assessment with the Enhanced Maternal and Child Nurse (EMCHN) and mental health clinician in the family home. In particular, referrals are targeted for Aboriginal and Torres Strait Islander families, culturally and linguistically diverse families, refugee families, families with generational trauma/abuse, families with significant mental illness and/or substance abuse, families experiencing violence, or chronic physical impairments, families at risk of/or currently involved with the child protection system. In addition, the service has been contracted to deliver professional development to Maternal and Child Health Nurses regarding mental health.

Pending positive evaluation and resourcing it is hoped to extend the program to the remaining local government areas of Monash, Knox and Manningham.

Older persons GP capacity building project

Nine per cent of people accessing 'Psychological Strategies' mental health supports are aged over 65 in the EMPHN catchment. In 2016, the highest age-specific suicide rate was observed in the male 85+ age group (34.0 per 100,000) with 61 deaths (ABS, 2016). This rate was considerably higher than the age-specific suicide rate observed in all other age groups. Older people are at greater risk due to isolation, loss of identity, emerging physical health issues including mobility issues. There can also be a cognitive decline impacting on an individual's ability to function effectively and independently.

The EMPHN and Aged Persons Mental Health Services GP Capacity building project aims to improve access and understanding of issues and themes related to the delivery of primary care mental health services for older people in the EMPHN catchment. It involves clinical nurse specialists undertaking mental health assessments with GPs in their clinics and the GP having immediate and direct access to a psychiatrist for consultations on medication management. The care and treatment is delivered in the GP practice with engagement of carers and family members. This model of care has mitigated the stigma associated with mental illness as care and treatment is delivered in a GP setting. GPs report a very positive experience and consumers have appreciated the normalising of their mental health treatment with their GP.

Perinatal Emotional Health Service

The Perinatal Emotional Health Service (PEHS) was established in 2018 with specific funding from the Department of Health and Human Services. Eastern Health delivers approximately 5000 babies per annum. It is estimated that one-in-five perinatal women experience depression during pregnancy and across the 12-

month period following the birth of a child,[5] and the Inquiry into Perinatal Services introduced to the Victoria Parliament in 2018 notes that there is a need for greater focus on and integration of perinatal mental health services. This funding will need to be continued and expanded, due to clinical demand from public antenatal services, postnatal services and maternal and child health and primary healthcare. Given service demand and resources, the model of care prioritises women experiencing significant mental illness within the perinatal period. Significantly there are no mother/baby inpatient beds within the Eastern region. This means women requiring inpatient care must travel far from home when they are at their most vulnerable, or be admitted into mental health beds and be separated from their infants/family. This also impacts on discharge planning and connections back to community based local supports.

Youth Engagement and Treatment Team Initiative (YETTI)

In recognition of the importance of effective early intervention the service has developed the YETTI. This service, funded by the Eastern Metropolitan Primary Health Network (EMPHN) is an example of effective partnership between State tertiary and Commonwealth services. The program has established networks and partnerships with primary care in an effort to improve access to early intervention, the YETTI program focuses on young people aged 12-25 years presenting with subclinical forms of serious mental illness, or experiencing symptoms which place them at ultra-high risk of developing such an illness. It operates across the Eastern Metropolitan Region, and through partnership with Austin Health, the areas of Nillumbik and Banyule.

The Program includes consultation, capacity building and support for community providers as well as case management. It has accepted 358 referrals since commencing operations in late 2017. It appears to be meeting an important need in the primary care sector, supporting young people who do not meet the threshold for tertiary mental health services, but who require more intensive follow up than can be afforded by existing providers. This program is illustrative of what can be achieved through the proposed initiative of developing regional mental health governance committees, resulting in a coordinated and shared approach to mental health.

3. What is already working well and what can be done better to prevent suicide?

Suicide Prevention Strategy

The Victorian Suicide Prevention Framework 2016-2025 has set a target to reduce the suicide rate by half over 10 years. Subsequently, Eastern Health was funded to trial a Hospital Outreach Post suicide attempt Engagement (HOPE) Team which commenced in November 2017.

Eastern Health is developing the *Promoting Hope in Life: Zero Suicide Strategy* through research and data-driven decision making, co-designed with people with lived experience of suicide attempts or bereavement by suicide, consultation with local stakeholders in our community, revision of initiatives from other health services nationally and internationally, and implementation of both State (Victorian Suicide Prevention Framework 2016-25) and national (Fifth National Mental Health and Suicide Prevention Plan) frameworks for suicide prevention. Early recommendations for suicide prevention, informed by those with lived experience of suicidal thoughts, suicide attempts, cared for someone who has experienced a suicidal crisis, or were bereaved by suicide include:

- The allocation of resources to enable suicide prevention leadership that includes meaningful participation of people with Lived Experience, their families, and significant persons in the lives of those who have an experience of suicide.
- Understanding, valuing and entrenching the role of the family in the way we provide services and their understanding of legislation including information sharing, supported decision making, duty of care, and confidentiality.
- Ensuring governments understand the scope and extent of suicide and related issues when allocating resource, including the specific needs of target populations e.g. people who identify as LGBTIQ+, Aboriginal Torres Strait Islander, and Culturally and Linguistically Diverse (CALD)

[5] Australian Institute of Health and Welfare. (2012). Perinatal depression: data from the 2010 Australian National Infant Feeding Survey. AIHW: Canberra. https://www.aihw.gov.au/reports/primary-health-care/perinatal-depression-data-from-the-2010-australia/contents/summary (accessed 5/6/2019)

- Facilitation of the release of funding to provide education and training on suicide prevention to families, schools and the broader community.
- Attendance to gaps in resources and navigating the mental health system and other community-based services to enable seamless transition for people at risk of suicide.
- The integration within all frontline services of peer workers who are well trained and educated and integrated with clinicians in the suicide prevention space.
- Modern IT infrastructure that enhances collaboration and information sharing between mental health services and community-based services to facilitate seamless referrals and continuity of care. Examples include Extended Aged Care at Home Packages (EACH), mental health service Neami National and specialist family violence service EDVOS.
- Improved connection and navigation for people with lived experience of suicide attempts and those bereaved by suicide through their care journey 'One person throughout the journey of care'.
- Resourcing of services so that they can provide timely and accessible supports to ensure suicidality is responded to as a mental health emergency at the time when it is needed. 'Instant response' with the right care at the right time.
- Creation of infrastructure to provide dedicated and effective responses to mental health emergencies outside of the current Emergency Departments by designing environments where people and families feel safe and supported, with permanent staffing by peer and clinical mental health staff. This could involve significant expansion of the Psychiatric Assessment and Planning Unit (PAPU) model of care.
- Safe Haven Cafes for addressing suicide prevention and mental health needs outside of a hospital environment. The learnings from medically supervised injecting room (MSIR) services can inform effective suicide prevention. Drop-in centers provide invaluable and accessible community-based support that should be funded and supported by legislation.
- Outpatient group and co-facilitated support programs (e.g. the Alcoholics Anonymous model) for people at risk of suicide.
- Local helplines that provide expertise individualized access to services to support integration into local resources.
- Increased capacity for people to experience more meaningful connection with service providers, having more power and control. Increased staff resourcing to enable a focus on talking, connecting, building a working alliance as a key predictor of mental health outcomes.
- Improved access to psychological therapies provided by psychologists, occupational therapists, and social workers through the GP Mental Health Care Plan for up to 52 sessions per year.
- Generous funding for Suicide Prevention Research Units for all area mental health services
- Identification and focus on the social determinants of health in order to build resilience within our communities and to address risk factors for suicide e.g. homelessness, employment, meaningful activity and social inclusion.
- Establishment of a register for real time monitoring and reporting on rates of suicide deaths to contribute to data driven decision making which engages the public in suicide prevention and health promotion (similar to what is seen in TAC response to address the road toll).

Inpatient services for young people

Young people 18 to 25 years presenting with the need for acute inpatient care are admitted within one of the three adult inpatient units at Eastern Health. This can lead to vulnerable young people being exposed to people with chronic illness and aggression, resulting in the experience of a lack of safety including sexual safety and gender safety, and potentially engendering a sense of hopelessness for their future recovery.

The development of a five-day-a-week step-up, step-down day program for young people with highly complex dual disability presentations occurring between the ages 16 to 25 years would facilitate greater engagement, targeting therapeutic treatment with skilled staff that have specialised skills in working with and engaging young people and their families. These skilled staff also have knowledge related to the developmental tasks that must be achieved in this particular age group. A multi-disciplinary approach incorporating vocational and educational support, potentially through expansion of the existing partnership with Avenues Education, would further facilitate re-engagement to their local communities.

Youth suicide postvention and prevention protocol

The Youth Suicide Postvention and Prevention Project Community Response Plan was developed by a broad range of services across the Eastern Metropolitan Region to ensure that the community is supported following the suicide, or suspected suicide, of a young person within the region. It provides clear and concise information to key community members and agencies to ensure a coordinated and effective response and to minimise the risk of contagion following a suicide incident involving a young person.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

One of the greatest challenges and frequent causes for complaints for mental health service users, carers and other health service providers is the difficulty experienced accessing and navigating the mental health service system, particularly when there are comorbidities requiring other service providers. Whilst services work hard to provide clear referral and care pathways, it is not always achievable due to the often complicated service needs of the person, particularly when alcohol and other drugs are involved.

High level clinical governance

The complexity of the mental health system means that it is difficult for consumers and mental health workers to understand the services available and how to access them. Fragmented and duplicated services and a lack of clinical governance within regions also contribute to the complexity and costs of service provision.

There needs to be a regional mechanism to address fragmentation of care and lack of governance within regions; and to encourage integration and collaboration in mental health care. Tertiary services are well-positioned to lead regional integration. The governance committees would need delegated lines of authorities, terms of reference, performance indicators and reporting requirements. Such robust systems and reporting are supported in both the Adult and Children VAGO recommendations.[6] One example of a regional mental health service alliance is Eastern Mental Health Service Coordination Alliance (EMHSCA). Composed of 30 partner organisations, EMHSCA looks at service gaps and potential improvements. The limitation is that it relies on the voluntary participation and goodwill of the partner organisations.

Adult Community Mental Health Services

Eastern Health provides a comprehensive multi-disciplinary and multi-modality collaborative community care program. Not unlike other sectors of mental health across the State and within the region, community services are under significant pressure with an inability to meet demand due to population growth, increase in mental health burden and limited resources from a workforce, infrastructure and funding perspective.

In January 2017, Adult Community Mental Health Services provided clinical mental health services for 997 consumers in the community as compared to the current 1215 consumers in June 2019. This increase has primarily been in the Case Management teams (both Brief Intervention and Continuing Care) with caseloads having expanded to provide care for more than 200 additional consumers. There is a trend towards a higher acuity and inherent risk in the community cohort of consumers driven by the unrelenting demand on acute adult mental health services. As the length of stay in adult acute inpatient units has decreased, a higher level acuity of mental health consumers was received for treatment in community settings which were not originally designed, nor staffed, for this intent.

The current case management model is no longer sufficient to meet the complex needs of consumers within community settings. This challenge, combined with ongoing population growth and its accompanying mental health disease burden requires a review of the community mental health model of care, with strategic review and planning to cover all resources (funding, infrastructure, staffing skill mix) within the community setting. Adult community mental health services are fragmented and uncoordinated within the region/state. Infrastructure supporting these services is not purpose-built and is out-of-date. There is also

[6] VAGO Access to Mental Health Services report, March 2019 and VAGO Child and Youth Mental Health Report, tabled June, 2019

inadequate funding and insufficient workforce resourcing. These factors result in a service which is scattered and difficult to access and navigate for all stakeholders.

What is needed is coordinated mental healthcare, ease of access, decrease in blockages, increased compliance and improved outcomes (i.e. transportation, travel, time constraints, to name a few.) Including walk-in centres within the model for access to books, informational pamphlets and computers, and early intervention support services, with extended hours; or the ability to reach out in tele-health style, to a mental health worker or crisis support worker, could further address the need for early access and decrease emergency department presentations and waiting times.

These spaces would be designed as gentle spaces to provide for sensory modulation.[7] The type of centre envisioned is not dissimilar to *ConnectedCare Centres* being developed in the United Kingdom. Such an approach supports mental health community services integration into the web of community support, thus increasing awareness and decreasing stigma while empowering the mental health consumer to have an active role in the community as well as their healthcare and thus improving staff, carer and consumer satisfaction and supporting positive outcomes.[8] This cohort requires increased clinical and psychosocial support to successfully transition from inpatient services and optimize recovery.

Adult Mental Health Access Services

Adult Access Services incorporate the Crisis Assessment and Treatment Team (CATT) services, emergency department response, telephone triage, Mental Health and Police (MHaP) response and Psychiatric Assessment and Planning Unit (PAPU). Following the changes implemented on 3 June 2019, the comprehensive suite of Access service functions are now integrated and apportioned to the Outer East and Central East catchments. These changes were part of the broader strategy to build a sustainable workforce creating career pathways for staff, enhance the development of skills for access clinicians and build greater agility to response to service demands at the front end of Eastern Health Mental Health services.

The introduction of telehealth in the emergency department has enabled an improved response time to assessments and the reviewing of consumers on Assessment Orders under the Mental Health Act. In addition, there has been an expansion of the MHaP response to the Central East area and the creation of PAPU, which is a designated Psychiatric Assessment Planning Unit located adjacent to the Maroondah Hospital Emergency Department focused on a short-stay type admission for review and/or management of short term concerns.

Challenges continue with meeting the demand in emergency department referrals for mental health assessments. Over the last 12 months there were 4660 mental health assessments undertaken across the three Eastern Health emergency departments with the most referrals received from Maroondah Emergency Department. In the same period, only 29% of mental health consumers were admitted to an inpatient unit within four hours, impacting the overall ability for Eastern Health to meet its Statement of Priorities target of 81% within four hours. Telephone triage services receive just over 2000 calls each month and the abandoned call rates are approximately 40%. The high rate of abandoned calls in telephone triage is attributed to the delays in answering calls. The current staffing profile for telephone triage does not enable the service to respond to calls within a reasonable timeframe and the demand and resources are mismatched even with the call back functionality of telephone triage. The situation is further exacerbated by difficulties in recruitment to the mental health workforce more generally. There is a requirement to expand the telephone triage staffing resources to match demand with resources by building workforce capacity in the Victorian mental health sector.

There are opportunities for improvement in the delivery of high quality adult access mental health services, and they are set out below for consideration by the Commission:

[7] Williams, B. 2019. *Collaborative and coordinated care: An investigation of the enablers and barriers for adults who experience mental ill-health in eastern Melbourne. pp 36, 43 Deakin University (thesis, publication pending)*

[8] Flatau, P, Conroy, E, Thielking, M, Anne, C, Hall, S, Bauskis, A & Farrugia, M 2013, How integrated are homelessness, mental health and drug and alcohol services in Australia?, AHURI Final Report No. 206, Melbourne, Australia, viewed 7 May 2019, http://search.ebscohost.com/login.aspx?direct=true&db=edsacd&AN=edsacd.293804&authtype=sso&custid=deakin&site=eds-live&scope=site

- ***Emergency Department Access Hubs***

In May 2018 the DHHS provided funding to selected emergency departments (not including Eastern Health) to establish emergency department hubs. These hubs enable people needing urgent mental health treatment to get the specialist care they need, allowing busy emergency departments to treat other patients. It is recommended that emergency department hubs be established at Maroondah and Box Hill Hospitals to support people with mental health, drug and alcohol problems who seek help in emergency departments, when their condition has reached crisis point.

- **Out of area patient presentations**

Consumers may be disadvantaged when presenting to Emergency Departments as 'out of area' patients. Transferring consumers to their usual treating mental health service is challenging, in part due to Health Services prioritising achievement of four-hour access performance targets in their own emergency departments.

- ***Opportunity to create safer mental health services in the emergency department***

Each week between four to five consumers leave the emergency departments prior to being seen by a mental health clinician. This is because wait times for assessment can be long given the limited mental health resources in the emergency department, particularly at peak times between 6:00pm and 11:30pm. In addition, many who present to emergency departments and are discharged do not receive supported mental health services to prevent re-presentation to the emergency department. One option is to establish a post-discharge follow-up service for everyone who attends any of the three emergency departments, similar to the Hospital Admission Risk Program (**HARP**). Mental Health HARP aims to improve people's mental health outcomes and manage the rate in growth and demand for public hospital services by reducing the use of emergency departments and inpatient services where avoidable. Alternative models of care for small cohort of consumers with high visibility and service usage (e.g. substance disorder, personality disorder) should also be established to support highly complex, frequent presenters to the Emergency Department.

- ***Adult Inpatient Service***

The Adult Mental Health Service at Eastern Health provides comprehensive inpatient mental health services for people aged 18-64 (inclusive) who are experiencing serious acute mental health illness. Like many public funded health services, the adult mental health inpatient program is facing challenges related to serviceability, access, care delivery and early discharge, due to increasing pressures in demand, and lack of resources. Eastern Health has 75 adult inpatient beds. In the 12-month period prior to June 2019 approximately 2000 adult consumers with mental illness were admitted to the adult inpatient units.

Aged Persons Mental Health Services

The Aged Persons Mental Health Service is made up of a 30-bed acute inpatient unit (South Ward) and a community mental health team of approximately 23 clinical EFT that services both Central East and Outer East populations. During the period 2017-18 the Aged Persons' Mental Health Service cared for 1035 consumers, with 447 of those being admitted to South Ward.

High quality aged persons mental health services should be holistic with multi-disciplinary teams focusing on the whole person and managing both mental health and other complex geriatric co-morbidities with the aim of supporting people in their homes, including residential aged care.

There are many opportunities for improvement in the delivery of high quality aged persons mental health services, and they are set out below for consideration.

- ***Rapid Response Services tailored for people aged 65+***

There is no specific crisis assessment and treatment services for people aged 65 and over. A crisis response service should be available to support and manage people in their homes, to prevent presentations to Emergency Departments.

- ***Access to acute services for the aged mental health population***

South Ward is currently located on a sub-acute site (Peter James Centre) with limited access to diagnostic support services resulting in frequent transfer of consumers to other Emergency Departments for medical support and for diagnostic services, incurring significant transport costs. Electroconvulsive Treatment (**ECT**) is also currently undertaken in an ECT suite co-located with South Ward. Consumers with medical complications are required to be transported to Box Hill Hospital for ECT. It is recommended that the Aged Persons Mental health inpatient unit be co-located at an acute site with acute services and have access to the full range of diagnostic support services and acute medical specialty intervention and support services. ECT should also be provided at an acute hospital site, with additional staff and resources to deliver this service in line with current best practice. The new facilities would need to be purpose-built to mitigate the major risk areas of falls and aggression.

- ***Access to acute aged-mental health beds***

There are 30 acute aged mental health inpatient beds at the Peter James Centre. Five of the 30 acute beds are in the Intensive Care Area (ICA) that is currently undergoing refurbishment. The ageing population in the Eastern Region will require additional acute aged person's mental health beds. It is anticipated that it will require:

- 25 acute beds for consumers with 'functional' disorders such as depression, anxiety, bi-polar affective disorder, schizophrenia, etc.
- 25 dementia beds in an adjacent but separate unit to maximise the sharing of staffing resources.
- The dementia unit will have five beds to accommodate consumers with delirium and severe behavioural disturbance where a dedicated 'delirium team' offers psychiatric consultation and liaison service across Eastern Health inpatient services to consumers presenting with delirium.

- ***Integrate the workforce through enhancement of an agile workforce that supports learning, career progression for effective and efficient care delivery***

The inpatient unit and community mental health services have separate staffing profiles and work as discrete separate services. The co-location of services provides for good continuity of care with the same medical staff working in South Ward and in the community team. A peer workforce is emerging within South Ward. A geriatric registrar is available on the ward and carries a caseload.

To support high quality aged persons mental health considering the whole person and other geriatric co-morbidities and physical health issues, the workforce needs a combined skill set and multidisciplinary team, with expertise in both mental health and aged care. The teams should work across the care continuum with a focus of supporting people in their homes, including residential aged care. Staffing profiles need to include psychiatry, geriatrics, specialist nursing and allied health (psychology, physiotherapy, occupational therapy, social work, dietetics, speech pathology and diversional therapists).

- ***Connect Consumers with Mental Health issues with community support services as a part of integrated and stepped care, in order to bridge the gap between acute hospital admission and discharge into the community by creating mental health community liaison roles***

One of the major aims of the aged persons mental health service should be to support people in their homes including residential aged care. Currently, consumers who are discharged from South Ward and not requiring ongoing care and treatment by the aged community mental health team are not adequately supported in the community. As the tertiary service in the Eastern region, Eastern Health should provide primary, secondary and tertiary consultation to the community providers, including residential aged care. This may include community development workers roles to link consumers with community supports, following up appointments and general practitioners.

- ***Develop an Innovative model of care for aged persons' mental health***

The aged persons community mental health service currently operates on a traditional model of referrals where the patient has to attend multiple health providers and reports and outcomes are communicated via faxes. The service should ideally work in an integrated model with general

practitioners who can attend appointments with the consumer for joint care planning with direct access to a consultant psychiatrist. Services should be re-configured so that General Practice is the centre of the service. The aged person's community mental health service should see consumers with their general practitioners, or in their residential care service with their general practitioners.

Building partnerships, training and capacity, in particular with general practitioners would more effectively manage the patient's mental health in the community to prevent admissions and Emergency Department presentations which are very traumatic for older consumers and their families.

Homelessness is an increasing issue amongst the aged population. There needs to be a greater focus on support services and advocacy for the homeless and aged population in the catchment.

- ***Enhance the care and treatment of consumers experiencing delirium in sub-acute admissions***

The Aged Persons Mental Health Service (**APMHS**) currently provides a consultation service to the sub-acute services at Peter James Centre and Wantirna Health, but there is no liaison service to support the nursing team to engage effectively with consumers who have delirium or behavioural issues. Consumers with milder symptoms of delirium (a very large cohort) who have been admitted to medical wards could be managed by a consultation and liaison type service that is dedicated to management of consumers with delirium.

- ***Establish a rehabilitation service for Aged Persons Mental Health***

There is no specific rehabilitation service for aged person's mental health in Victoria. A multidisciplinary inpatient rehabilitation service tailored for people with co-morbid physical and mental health issues is required to support recovery with time and clinical intervention with a focus on discharge and community planning. There should be a mix of clinical, psychosocial and other supports that enable gains from the period in the inpatient setting to be strengthened, supplement crisis intervention and enhance access to inpatient services through the prevention of unnecessary inpatient admissions and the provision of an intensively-supported early discharge alternative.

Bed Availability

The percentage of Victorians with mental health issues who have timely and effective access to mental health services is almost half that of other States and Territories within Australia. [9] With 75 acute adult-mental health inpatient beds across Eastern Health providing inpatient treatment to the most acutely unwell consumers, it is difficult to meet demand while supporting an acceptable level of outcome for its consumers. At 1.41 beds per 10,000 people in the 18-64 year-old age group, Eastern Health has the lowest number of acute inpatient beds per capita than any metropolitan health service in Greater Melbourne. The adult acute beds per capita ratio at Eastern Health is well below the metropolitan average and 44% below the health service with the highest ratio of adult acute beds per 10,000 capita. Eastern Health requires a significant increase in acute mental health inpatient beds in order to meet current demand, let alone projected growth over the coming five years.

Box Hill Hospital's adult inpatient unit has run consistently at approximately 98% occupancy over the last 12 months. The unit at Box Hill has seen a significant reduction in length of stay, from an average 11.4 day stay in May, 2018 to an average 9.4 day length of stay in May, 2019. This is well below the State target of 12 days. When length of hospital stay is too short, there is a risk that there is not enough time to establish rapport with a consumer or their family, that the quality of care is not as ideal as clinical staff would like or that it can compromise the ability to undertake comprehensive discharge planning, including basics such as food and accommodation.

When there is insufficient bed capacity in the unit, consumers can be discharged based on an assessment of who is least likely to experience a significant negative outcome (to self or others) in being either discharged, or transitioned into a community service. Re-admissions often occur when the patient deemed to be least at risk needs further care, which they may have had prior to discharge if there had been sufficient bed capacity.

[9] VAGO Report: Access to Mental Health Services, March 2019 https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf (accessed 6/6/2019)

This vicious cycle also plays a role in mental health worker stress levels, desire to work in or remain in mental health and overall general health and wellness of those workers. Some healthcare workers report that it is a constant thought in the back of their minds whether any given discharge, or rejected referral, is the one that may lead to a poor outcome. Consumers are routinely discharged earlier than clinically ideal and are instead treated in the community. Community facilities have limited capability to manage this level of acuity and do not have the appropriate security or safety features.

There is also a need to educate healthcare workers in the community so that they have skills to manage these consumers. Healthcare workers have reported that, at times, the inpatient service is not able to admit people in genuine need of inpatient admission due to capacity or patient safety. As an alternative, consumers are risk assessed and community-based services are organised to support them and their families where required.

Eastern Health is currently in the process of refurbishing an existing ward at Box Hill Hospital for an additional nine adult inpatient beds, co-located with an eight-bed acute drug detoxification unit. There is an urgent need for a purpose-built, 25-bed inpatient unit to support patient safety.

Closing the Gap

Eastern Health Adult Mental Health Program was the 2018 recipient of The Victorian Public Healthcare Award for Improving Indigenous Healthcare. The team, led by the Aboriginal Clinical Engagement Clinician, was acknowledged for improving access to recovery oriented Adult Mental Health Services for the Aboriginal community in the east. Key work was undertaken at Maroondah Prevention and Recovery Care and the Maroondah Adult Inpatient Psychiatric Units where the team worked hard to enhance services and provide a culturally safe environment to improve access and meet the needs of the local Aboriginal community. As a result of the success of the two-year Clinical Engagement Initiative, Eastern Health permanently extended the initiative through ongoing recruitment to the Clinical Engagement role – demonstrating an ongoing commitment to partnering with our Aboriginal Community to maintain improved access to essential mental healthcare.

Collaborative Recovery Model (CRM)

The Collaborative Recovery Model translates a person-centred, recovery vision of mental health to specific principles and practices, which can in turn be used to define related practitioner competencies that are shared across the professional disciplines in mental health. Eastern Health has provided comprehensive training to staff and is currently working to embed the approach into clinical practice. Having a person-centred recovery approach to Mental Health is essential for good long term outcomes. Recovery is a mature approach to consumer management and is a challenging cultural change to the risk management approach embedded in our systems.

Dual Diagnosis

The Department of Health and Human Services estimates that 25% of mental health consumers will have a dual diagnosis; 75% of individuals who experience alcohol issues will have a mental health concern; over 60% of mental health inpatients will have a substance abuse issue, and 90% of people with schizophrenia will experience substance abuse issues.[10] Integrating treatment for both mental health concerns and substance abuse issues will lead to better outcomes than simply treating symptoms. In 2007 the Department of Health (now part of the Department of Health and Human Services Victoria) funded a state-wide initiative "Victorian Dual Diagnosis Initiative" with the goal to positively improve outcomes of dual diagnosis patients.

The Eastern Health Dual Diagnosis service provides the following services to organisations:

- Consultation: Primary, secondary, and tertiary consultations for staff in Community Mental Health Services, Mental Health Community Support Services and Alcohol & Drug Services (adult, youth, and aged).

[10] Department of Health, Substances Abuse and Mental Health Issues. https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/substance-abuse-and-mental-illness-dual-diagnosis?viewAsPdf=true (accessed 17/6/2019)

- Education and training to improve the capabilities of staff in providing integrated assessment, treatment, and recovery.
- Service Development: Building dual diagnosis capacity based on collaboration, development and integrated treatment approaches via the Dual Diagnosis Consumer and Carer Advisory Council and the Linkage network monthly meetings. (The Linkage network includes organisations that represent people with mental health and dual diagnoses, homelessness and families of these people).

In realising that the siloed approach to mental health and alcohol and drug provision was not delivering effective services for consumers with significant mental illness the Eastern Health Dual Diagnosis service was expanded in 2018 to deliver targeted integrated treatment strategies to consumers of clinical mental health services. A brief summary of the early results of this initiative show a positive impact in the following areas:

- Significantly improved engagement by mental health consumers in alcohol and drug interventions.
- Improved engagement by mental health clinicians and medical staff in identification and responding to alcohol and drug issues.
- Improved utilisation of screening tools and improved outcomes for consumers engaging in alcohol and drug interventions and strategies.

Studies are showing a positive impact on integration of the treatment of dual diagnosis with a dual focus on mental health and addiction. However, a multi-disciplinary approach is required with training to ensure that the healthcare provider understands both (a) mental health issues and their treatments and (b) management of addiction and recovery, including acute de-toxification.

Forensic Mental Health

Victoria currently has one forensic mental health facility, Thomas Embling Hospital, which is at capacity and is unable to meet the needs of all incarcerated people with serious mental illness who require urgent mental health treatment. As a result, this group of people are sometimes acutely unwell when leaving custody. At any given time, public health services such as Eastern Health are called upon to care for forensic mental health consumers who may be untreated high risk violent offenders in both inpatient and/or community settings. At any one time, up to 10 forensic consumers are utilising adult inpatient beds (both inpatient and community) at Eastern Health. This equates to approximately 9% of all available mental health beds.

In 2015-16, Eastern Health started noticing increased pressures surrounding management of forensic consumers and began keeping more formal records to track demand. Since that time, this service has received upwards of 100 referrals in relation to prisoners and 83 corrections enquiries, the majority originating in the Ringwood and Lilydale areas of the Eastern Region catchment, and arising from the Ringwood Magistrates Court. Eastern Health has been made aware of an additional 51 Prison mental health consumers whom it may be called upon to provide care for, with insufficient information to appropriately plan for care in a timely and effective fashion.

Typical admitting diagnoses of this cohort includes: comorbid triad of a chronic psychotic illness (schizophrenia or equivalent), personality disorder (antisocial, borderline or mixed) drug dependence (amphetamines, cannabis, opiates, alcohol) in male consumers with co-occurring Acquired Brain Injury, Autism Spectrum Disorder or Intellectual Disability.

Eastern Health has 16 short term (3 to 6 months) placement beds at Monash Secure Extended Care Unit (**SECU**). Currently, the model of care at Monash SECU does not support the provision of care for consumers of this cohort and these referrals are therefore usually not accepted. Eastern Health facilities are not designed to manage this cohort of patient.

Forensic and Correction consumers are extremely resource intensive, both from a clinical and an administrative perspective. There is a great deal of report writing, communications with Courts to vary treatment, etc. In addition, these consumer cohorts are managed, within the corrections system, in a paternalistic, restrictive manner, and thus do not fit with the Collaborative Recovery Model of care. Eastern Health Forensic Clinical Specialists are being called upon to work beyond the scope of practice designed by the Department of Health and Human Services. In addition, considering the breadth and scope of the services required by Eastern Health to provide for this population effectively to date, it would require more

staff resources going forward. Additional resourcing for appropriately trained Forensic Psychiatrist resources will also be required.

Workforce development is also urgently required to ensure that the skill base required to assess, treat and safely manage this consumer group are entrenched into clinical practice.

The National Standards for Quality and Safety in Healthcare (**NSQHS**) Standard 6 requires a health service to ensure that safe and effective handover occurs at every point of service transfer, to ensure information is communicated to allow risk review, needs of patients, carers and families. [1] It is difficult to meet this obligation in dealing with Prison/Corrections organisations. Timely and complete communication is a key concern, with advanced planning a critical consideration to facilitate risk assessment and ensure availability of resources to properly provide for safe and effective care of the forensic consumer, as well as other consumers, staff and visitors. Forensic/Justice and related information from interstate is a challenge that appears nigh on impossible to address. Mental health staff need to be able to access consumers and their information while in prison, prior to presentation to the service, which rarely occurs.

Multidisciplinary care

Consumers admitted to adult inpatient services have severe, enduring mental health issues complicated by poly-pharmacy, physical health issues, intellectual disability and socio-economic issues including homelessness, unemployment, social isolation, drug and alcohol abuse, family violence, stigma and low self-esteem. Managing the complexity of this cohort requires a multidisciplinary approach. Current levels of inpatient funding do not allow for the required staffing profiles and so it needs review. The staffing profile includes, but is not limited to: allied health workers, dietician/nutritionists, dentists and pharmacists. The multidisciplinary approach needs to continue into the community and work collaboratively with other jurisdictions and agencies including justice, domestic violence, employment and housing.

Prevention and Recovery Care (PARC)

Eastern Health has two sub-acute mental health PARC services operating in community settings. PARC services are delivered through a clinical and community partnership model, with both clinical mental health services and Mental Health Community Support Services collaborating to provide an accessible, supportive and therapeutic model of sub-acute care. Changes across the clinical mental health service delivery system at Eastern Health over the past few years have prompted the need for a thorough review of the PARC model of care.

Contributing factors include:

- A sustained increase in the number of ‘step down’ admissions to PARC from Acute Inpatient Services.
- Consumers requiring more complex medication regimes impacting on medication storage and administration practice.
- Increased number of referrals to Maroondah PARC resulting in clinical governance risk issues and the closing of the waitlist to non-Eastern Health consumers in May 2017.
- DHHS has formally acknowledged the significant change in the client group accessing PARC services since its last review in February 2016. In response, additional funding for 6 PARC services in Victoria has commenced for a four-year ‘Clinical In-reach’ Project. Eastern Health was advised in August 2018 of the new ‘Clinical In-reach’ ongoing funding from 2018-19 to enhance the clinical in-reach into PARC.
- Residential Bed Occupancy – Data obtained from Department of Health and Human Services (Extended Treatment Setting Mental Health Quarterly KPI Report) for 2015-16 Quarter 4, 2016-17 Quarter 1 and 2016-17 Quarter 2 indicate that Eastern Health PARC services are averaging at or above the statewide average for bed occupancy for PARC services for each quarter.
- Residential Length of Stay – Analysis of the data also indicates that the average length of stay at Eastern Health PARCs is well below the PARC services State averages for each quarter.
- Health of the Nations Outcomes Scale (HoNOS) – In comparison to other PARCs in the State, clients at Eastern Health PARCs are reported to experience significantly higher symptoms associated with

their mental illness than the State average; indicating that the Eastern Health PARC model is currently treating and supporting a more sub-acute group of consumers.

Whilst DHHS has recently invested in six PARC services across the State to enhance the clinical in-reach and capacity in response to a change in demand, further reforms in the sub-acute adult mental health area are required. It is recommended that short stay sub-acute clinical services be established to address the gap in the current system for consumers exiting an acute inpatient unit. An interdisciplinary clinical service, 24 hours a day, for post-acute care and enhanced discharge to community planning is required to maximise the gains made during the acute care phase and better prepare consumers for community living.

Sub-acute facilities are a large gap in the mental health service. There is a need for sub-acute beds which provide a transition for consumers from acute inpatient settings to the community by providing a safe and supportive clinical environment which allows for more time for recovery, more intensive clinical intervention including stabilisation of medications, psychology and activities of daily living and comprehensive discharge planning. The facilities should not be stand-alone community facilities such as the PARCs, but co-located with other acute facilities with access to medical and emergency response.

Personality disorders

Another challenge being faced in the community setting is the increasing prevalence of Personality Disorder diagnosis within the consumer cohort. At Eastern Health, 28% of adult acute inpatient admissions are for people with a diagnosis of personality disorder, resulting in an increasing profile of consumers with personality disorders referred for case management in the community and residential settings.

From July 2017 through June 2018, there were 549 inpatient admissions at Eastern Health with a primary diagnosis of Borderline Personality Disorder (**BPD**). Eastern Health admits more consumers with a diagnosis of BPD (17%) compared with other mental health services (5% or less for six comparable services). While these inpatient admissions tend to be brief (on average 4.2 days at Eastern Health versus 3.1-10.6 days at other services, and as compared to average 8.9 days for all mental health diagnoses at Eastern Health), frequent readmission suggests that patients' needs are not being adequately addressed in the current community service system.

The substantial expansion of a service to consumers with Borderline Personality Disorder is needed to target consumers with severe personality disorders who experience multiple symptoms and pathologies. Typically, consumers will have a chronically high risk for suicide and high lethality self-harm, with clinical co-morbidities (substances, psychosis, etc.) and their treatment needs are high and complex. They often struggle to engage with treatment.

Direct service needs to be flexible and include both individual and group options, with secondary consultation, education and training (supported by Spectrum). In the current mental health climate, skills are geared more toward generic clinical mental healthcare issues, due to lack of resources and skill deficits.

Seclusion and Restraint

Eastern Health has a strong focus and an ongoing program of improvement work underway to minimise seclusion and restraint, however, high levels of seclusion and restraint continue. During the 12-month period between May 2018 and May 2019, restraints were required in 191 instances involving 75 consumers at Eastern Health. This is 3.1 % of 2445 admissions, with the highest occurring at Box Hill (76) followed by Maroondah IPU2 (65). A multitude of factors contribute to the use of restraint and seclusion, including:

- High volatility of the units given the patient acuity. In the past, the patient mix was a more manageable mixture of acuity, with consumers who were moving along the wellness spectrum; some acute and just entering care with associated high need, a number in the mid-acuity range who experienced periods of wellness with periods of higher need, and those who were pre-discharge and only required supportive-educative care. This complexity results in use of restraints and high costs and quality issues associated with bringing in additional temporary staff to provide closer observation of consumers.
- Lack of experience of inpatient unit workforce with increased graduate nurse requirements to grow the future workforce, medical staff including the most junior trainees and Consultants and significant community growth drawing experienced staff from the inpatient units.

- Facilities which are not purpose built to manage the high acuity of consumers admitted to the units.
- Workforce challenges which mean there is a junior workforce on the adult inpatient units, limited senior support and high casual and agency use.
- Increasing levels of aggression.
- Lack of resources, including staffing, diversional activities and security presence.

Sexual Safety

Eastern Health's inpatient services have had a strong and proactive approach to improving sexual safety on inpatient units. Work has included training, infrastructure (within a limited scope), processes, orientation practices, resource availability and leadership. As a result, Eastern Health has seen a reduction in sexual assault incidents in the adult inpatient units in particular.

Ongoing challenges associated with the patient acuity in the adult inpatient units has led to the exploration of gender specific units at Eastern Health. It is proposed to convert one 25-bed unit into a female (and those identifying as female) unit and another into a male (and those identifying as male) unit, with the remaining unit to retain its mixed gender capacity. This will allow consumer choice. Currently within the Victorian acute mental health system, there is limited resource availability for people who identify as transgender or require specialised response due to a range of diversity needs. It would be beneficial for this population to be able to access specialised inpatient care and support when this is required, in addition to local specialist support within the communities.

Eastern Health would encourage the Commission to consider gender specific acute units, gender diverse units, and higher acuity forensic units (either within the existing forensic settings, or within specific designated Mental Health Services) at it will greatly support the safety of consumers, staff and visitors.

5. What are the needs of family members and carers and what can be done better to support them?

The complex need for support for families and carers of people experiencing mental illness, whilst acknowledged as significant, can often be underestimated and undervalued. Needs of family should be included in all aspects of their loved one's recovery. Families need support, information, respite, to be heard and responded to in times of crisis and to be provided with options of care.

Foot in Both Camps Program

This program is an example of proven supportive mechanisms occurring at Eastern Health. Eastern Health received funding from DHHS to trial the Foot in Both Camps Program. The program is a support group for staff who are carers for a loved one experiencing mental illness. The employment of a peer workforce for carers has proven to be beneficial, particularly when it comes to designing local service improvement that is more tailored to the needs of consumers and the people who care for them. It is critical that these roles continue to grow along with the rest of the workforce, and be engaged at all levels of planning and design, so that a service can be delivered that is truly person-centred.

Post Discharge Peer Support Program

Ten Eastern Health Consumer and Carer Peer Workers have been trained in the internationally recognised Intentional Peer Support Model. This model incorporates the lived experience of mental health illness as a therapeutic tool to engage current consumers and their carers to identify those areas of their life that promote and support recovery following an admission to a psychiatric inpatient unit. The referral process includes participation at multidisciplinary handovers where Consumer and Carer Peer Workers and Clinical Staff collaborate to identify consumers and carers ready for post discharge follow up. Co-design has been a key feature of this new service, where all ten consumer and carer peer workers together with clinical leadership staff, have been engaged in the development of guidelines and processes for referral, documentation and supervision. This program operates across Aged, Adult and Child and Youth mental health services and includes an Aboriginal Peer Worker.

6. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Clinical vacancies continue to be a chronic issue in mental health services statewide. Significant work is underway to improve recruitment processes and ensure that Eastern Health is an attractive employer to support recruitment and retention of staff. It is well-recognised that public and private health services are competing with one another to attract a diminishing number of appropriately qualified and skilled professionals.

Mental health-specific training is under-developed in areas of the current tertiary education system. The cohort of consumers using mental health services come with a whole range of complexities, with more presentations relating to drug and alcohol use, forensic patients, and multiple medical comorbidities.

Clinical staff have undertaken specialist undergraduate and postgraduate education but the rising complexity of mental health presentations and the changing landscape of healthcare (e.g. legislative and governance processes) have created challenges for the mental health workforce. The rate of growth in knowledge requirements challenges the health service to maintain the currency of the knowledge and skills of the workforce.

Adult Community Case Management Model

The current Case Management Model utilised in community clinical services is under pressure as a result of increasing complexities and acuity of mental health consumers. The current workforce is inadequate, from a knowledge, skill mix, resource and funding perspective, to work effectively with this higher risk cohort. Case managers are recruited with a clinical background (nursing or allied health) however there is no specific training for case management for the highly complex consumers managed in the community. Case managers are expected to have a high level of skill in expert areas including personality disorders, drug and alcohol use, forensic backgrounds, family violence and suicide-prevention with a Collaborative Recovery approach. An educational certificate in case management, enforced supervision, career progression opportunities for research and academic linkages with universities, higher remuneration and continuous training structures similar to the medical model for continuing medical education would ensure staff retention, service development and better outcomes for patients.

Occupational Violence and Aggression

Over recent years, the adult inpatient mental health units have been admitting more acutely unwell consumers with a corresponding increase in occupational violence and aggression. This is partly due to the limited bed capacity, as only the most unstable and acutely unwell consumers can access a hospital bed; with others being managed in the Community, also resulting in increased risk to those consumers and staff working in the Community. Other contributing factors to the increasing acuity include:

- Increased alcohol and drug use in the community and admissions related to methamphetamine and other illegal substance use.
- Increasing numbers of consumers with forensic backgrounds with associated risks are being placed on treatment orders from the Courts and/or Prisons and being transferred for admission to the adult inpatient units.
- With limited powers to search an individual's possessions, a variety of weapons are making it into the Units. Hunting knives, blades, fake firearms and pieces of metal are just a few examples.
- Socioeconomic factors including family violence. One-in-six Australian women and one-in-sixteen men will have been impacted by family violence beginning from age 15 onwards.[11] It is the major cause of homelessness amongst women. The Australian Institute of Family Studies lists (amongst others) substance abuse, homelessness, socially disadvantaged, having an indigenous background, mental health issues, including depression in the family, as risk factors for child violence.[12]

[11] Family Domestic and Sexual Violence In Australia, 2018. https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary (accessed 12/6/2019)
[12] Australian Institute of Family Health Studies, March 2015. *Conceptualising the Prevention of Child Sexual Abuse – Final Report* https://aifs.gov.au/publications/conceptualising-prevention-child-sexual-abuse/a4-mapping-risk-factors (accessed 12/6/2019)

The risk of aggression is compounded by the fact that Eastern Health mental health facilities are not purpose-built to manage the complex consumers being admitted. The Department of Health and Human Services lists environmental design as one of the key considerations to address safety and violence in health services. [13] The minimum design standards for acute inpatient units needs urgent review in light of the changing context.

As a result of occupational violence and aggression, staff are experiencing high levels of stress within the workplace. In the most recent Eastern Health *People Matter* survey, 33% of the Mental Health inpatient workforce indicated that they are experiencing extreme levels of stress at work. Staff are frequently injured during the admission process or when caring for a consumer during their stay. At any one time, there are multiple members of the Eastern Health mental health team who are on long-term personal leave directly related to safety and harm in the workplace.

Partnerships with universities

CYMHS enjoys a longstanding partnership with Deakin University School of Psychology which provides a training clinic for psychology students and includes up to six sessions of brief intervention, typically for children and families with mild presentations and early intervention for children with emerging oppositional or conduct disorders.

In addition to education and leadership support, CYMHS provides psychiatric resources to the two local Headspace centres – Knox and Hawthorn, made possible through specific Commonwealth funding.

Educational institutions and tertiary services need to work together to develop an appropriately trained workforce.

State-wide workforce planning

Planning must include mental health specific training in educational institutions and the healthcare setting, to ensure an adequately skilled workforce relevant to the unique needs of mental health services, and ensure that supply meets the growing demand in all healthcare disciplines.

Availability of a quality, purpose-trained workforce is scarce. Many universities who offer post-graduate nursing courses note mental health nursing as a low priority amongst those nurses returning to training. An ageing workforce also means that many nurses who were previously trained in hospital settings which included appropriate exposure to mental health nursing as a part of their training, and remained in the specialty following graduation, are now leaving the workforce. Over time, challenges on any given day in mental health inpatient units increased along with dissatisfaction by the workforce who view mental health as high risk, unrewarding, and an undesirable risk-filled area in which to work. The Victorian Government recently announced an increase in Clinical Nurse Consultant positions available. The number of positions is grossly inadequate to service every inpatient unit and is leaving many highly volatile units without sufficient senior nursing leadership in the clinical setting. Workforce initiatives have been targeted in community mental health settings with minimal growth in senior inpatient nursing positions in the past 10 years.

The increase in the complexities associated with co-morbid presentations, across mental health, is another workforce challenge. All staff, irrespective of discipline, are now required to have complex understanding of physical health, with cardiac and metabolic issues prevalent in this population as a result of the complex medications required to treat this cohort. Life expectancy for consumers with severe and enduring mental illness is shortened, with no correlating increase in dual-funded training models to resource staff effectively to manage the increasing complexity of presentations. The metabolic issues add further risk for this vulnerable population. Strong relationships exist within the health service to support medical in-reach, however, these resources are insufficient to support the volume of consumers presenting with complex co-morbidities. Complex withdrawal from multiple substances is inadequately understood and limited resources exist in the service to provide guidance in a timely manner to support safety for consumers in withdrawal.

[13] Occupational violence and aggression - health facility design. https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/facility-design (accessed 12/6/2019)

The current Nursing Enterprise Agreement stipulates nursing staff levels in acute units, and health services are reluctant to employ above these minimum prescribed levels due to lack of funding provision. There are no provisions for minimum allied health positions within acute units, and when funding is restricted service wide, these have historically been the positions which are relinquished. The availability of allied health resources, particularly out-of-hours, also impacts on timely access to assessments, supports, resources and family interventions.

Working Collaboratively

Whilst there has been significant investment by the Department of Health and Human Services in the development of the Consumer and Carer Lived Experience Workforce in Adult Mental Health, there has not been a comparable investment in the CYMHS services. A recent benchmarking project examining child, youth and family carer participation across CYMHS was undertaken, revealing a considerable variability in resources to support a youth peer and family carer lived experience workforce. As a result of this work, Eastern Health has recently established a voluntary, bi-monthly CYMHS Family Carer Lived Experience Workforce Advisory Team to advise practice. Attendees include representatives from the Royal Children's Hospital, Orygen, Monash Health, Alfred Health and Ballarat Health.

7. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

One of the main objectives of recovery from a mental health perspective is to support individuals to participate in their regular activities of daily living, such as school or work attendance, as well as improving their social interactions.

Whilst reducing stigma through education and awareness is highly beneficial, additional support (i.e. psychosocial support) is often required, but can be difficult to obtain.

Employment

Incentives are needed for education and training entities to take and support students with mental ill-health and for companies to employ people with mental ill-health. Access to employment opportunities will assist in minimising the impact of mental ill-health and support recovery.

Family Violence

Within the community there is an increased focus on family violence prevention. Reducing the impact of family violence will support people to improved socio-economic participation. One in six women will experience violence in some form from the age of 15, and one in 16 men. More than half of those women will experience ongoing family violence. In 2014-15, it is estimated that approximately eight women (and two men) were hospitalised every day as a result of domestic violence.[14] Many of those experiencing mental health issues, socioeconomic issues and/or other pressure are at risk of being victims of violence. There is an opportunity to improve awareness around family violence across communities.

Eastern Health has commenced a program of work to improve identification and management of family violence, funded by the Department of Health and Human Services. The program is overseen by Specialist Family Violence Advisors with the goal of improving early recognition, increasing awareness and education of team members in how to manage suspected and actual family violence as part of everyday clinical care. This includes skills in assessment and management of family violence to meet the needs of victims and perpetrators who are consumers, carers or significant others in our services.

Homelessness/lack of suitable accommodation

Many of Eastern Health's consumers are homeless or lack suitable accommodation options. Eastern Health bridges the gap through brokerage funding, with mental health consumers being discharged to hotels,

[14] 28 February 2018, AIHW, *Family, Domestic and Sexual Violence in Australia.* https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary *(accessed 15/6/2019)*

motels, or other forms of lodging. Eligible clients have the use of designated funding to purchase goods and services in order to achieve positive housing outcomes. Consumers can qualify for up to $5,000 per annum for emergency housing. There are concerns beyond the dollars expended related to lack of accommodation. Lack of lodging and homelessness are issues which impact on compliance, ability to provide consistent services and less than optimal outcomes. However, in spite of these contributing factors, Eastern Health is proud that it is able to follow up with over 90% of its mental health consumers after they have been discharged from hospital.

Over the past few years there have been a number of boarding houses in the Eastern Region that have closed and the options for safe housing in the area have diminished. At the same time more and more consumers are experiencing housing crises and homelessness due to family breakdown, the severe lack of public housing and a reduction in Community Mental Health Supported Housing. Adults are often inappropriately housed in Supported Residential Services as a last resort impacting them and the often elderly co-residents. The Community Model of Care is not flexible enough to meet the needs of itinerant and homeless consumers and often they return to crisis and emergency services, including acute inpatient care; not having their basic human need for safe housing met directly undermines their mental health.

NDIS and children/young people

A number of CYMHS consumers with severe emotional and/or behavioural disturbance have been found eligible for NDIS. Many of these clients have co-morbid disabilities in the areas of physical dysfunction, autism and/or intellect. There is a lack of expertise amongst NDIS service providers to be able to meet the complex psychosocial needs of these children and young people thus, despite having funding packages, they are unable to access appropriate services and their needs remain unmet.

In addition, many children and young people have significant need for psychosocial support to achieve their goals but are found ineligible for NDIS and thus need to rely on alternate funding such as the National Psychosocial Support (NPS) funding. The alternative funding provided to Eastern Health excludes those under 16 years old. NPS funding for the Eastern Metropolitan Region is technically for the entire age range, however there is a lack of staff trained to work with children and adolescents to address their psychosocial needs.

Funding models for psychosocial support, including NDIS, need to acknowledge the unique needs of children and young people experiencing severe emotional and behavioural disturbance. Providers need to have a skilled workforce to work with this vulnerable population to ensure equitable access to psychosocial support and capacity building.

Psychosocial support

Other key drivers are the systematic reduction of specialist community mental health services in the Eastern Region due to funding reforms over the past five years, including the introduction of the NDIS. This has resulted in fewer specialist mental health supports in the community, fewer skilled mental health workers with experience in the community sector and an increasing demand pressure on community clinical mental health services to provide additional support to cover the gap in care.

8. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Increasing capacity

To achieve service improvement, health services need a greater capacity to be able to better serve their populations. This includes increasing inpatient beds and community services along with the workforce required to support consumers' needs.

Policy reform

A review of policies and legislation to improve collaboration of mental health services with other agencies, in particular the justice system, housing and employment.

Purpose built infrastructure

'Future-proofed', purpose-built infrastructure for increasing demand, which is safe and provides a therapeutic environment that achieves optimal care and outcomes for consumers, families and carers.

9. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Adequate planning at the national, State and local level of facilities/infrastructure, systems, legislation, clinical governance, workforce and models of care that can be sustained not only financially, but also physically by the people who are caring for these individuals.

Capital and infrastructure planning

Required to develop purpose-built, safe infrastructure that allows co-location of agencies and expansion of services to meet demand.

Office of the Chief Psychiatrist

The Office must lead consistency of practice across mental health services regarding inpatient safety, response to aggression and a system response to consumers with forensic histories.

Workforce planning

Required to ensure adequate workforce supply to support the increasing demand for mental health services. Training, in conjunction with universities and other educational institutions, needs to be tailored to ensure readiness for working with a complex and vulnerable cohort of consumers, including mental health and other associated issues (complex case management, person-centred care, family violence, drug and alcohol, physical health, BPD to name a few).

10. Is there anything else you would like to share with the Royal Commission?

Eastern Health welcomes the Royal Commission into Victoria's Mental Health System as an opportunity to review and improve the services that we provide to our consumers, their families and carers.

We look forward to hearing further from the Commission, and welcome any feedback or requests for further information in relation to this Submission.

For further information contact:
Lisa Shaw-Stuart
Program Director, Mental Health, Eastern Health
5 July 2019

Glossary

ABS	Australian Bureau of Statistics
AIPU	Adolescent Inpatient Psychiatric Unit
APMHS	Aged Persons Mental Health Service
BETRS	Body Image & Eating Disorders Treatment & Recovery Service
BPD	Borderline Personality Disorder
CALD	Culturally and Linguistically Diverse
CATT	Crisis Assessment and Treatment Team
CEED	Centre for Excellence in Eating Disorders
CRM	Collaborative Recovery Model
CYMHS	Child Youth Mental Health Services
DHHS	Department of Health and Human Services
EACH	Extended Aged Care at Home
ECT	Electroconvulsive Treatment
EDAC	Eating Disorders Assessment Clinic
EDVOS	Eastern Domestic Violence Service
EFT	Equivalent Full Time
EHPHN	Eastern Metropolitan Primary Health Network
EMCHN	Enhanced Maternal and Child Nurse
EMHSCA	Eastern Mental Health Service Coordination Allianz
GP	General Practitioner
HARP	Hospital Admission Risk Program
HoNOS	Health of Nations outcomes Scale
HOPE	Hospital Outreach Post suicide attempt Engagement
ICA	Intensive Care Area
ICTiR	Initial consultations and Treatment in Recovery
LGBTIQ+	Lesbians, Gay, Bisexual, Transgender, Intersexes, Queer
MHaP	Mental Health and Police
MSIR	Medically Supervised Injecting Room
NDIS	National Disability Scheme
NPS	National Psychosocial Support
NSQHS	National Standards for Quality and Safety and Healthcare

PAPU	Psychiatric Assessment and Planning Unit
PARC	Prevention and Recovery Care
PEHS	Perinatal Emotional Health Service
PHN	Primary Health Network
SECU	Secure Extended Care Unit
TAC	Transport Accident Commission
Tier 1	**Services including** primary care, general practitioners, school-based nurses and community health
Tier 2	**Services including** private psychiatrists, not-for-profit mental health and psychology services (i.e. Headspace)
Tier 3	Tertiary mental health services as provided by Eastern Health
VAGO	Victorian Auditor-General's Office
YETTI	Youth Engagement and Treatment Team Initiative

Eastern Health is accredited by the Australian Council on Healthcare Standards in recognition of the achievement of minimum performance standards in the provision of healthcare services and demonstrated through an independent external peer assessment.

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Royal Commission into Victoria's Mental Health System

ATTACHMENT DJP-3

This is the attachment marked 'DJP-3' referred to in the witness statement of David John Plunkett dated 24 July 2019.

easternhealth

s p e c t r u m
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Submission to the Royal Commission into Victoria's Mental Health System

About Spectrum Personality Disorder Service for Victoria
Spectrum, the Personality Disorder Specialist Service for Victoria, is auspiced by Eastern Health. Spectrum provides services to people with Personality Disorder (PD) treated within the Victorian Public Mental Health Service.

During its 20 year history, Spectrum has accumulated extensive knowledge and experience in the delivery of care for people with PD.

PD has a prevalence of around 5% in the general population. Amongst people with PD, it is those diagnosed with Borderline Personality Disorder (BPD) who seek care most actively from Mental Health Services. There is a 1% prevalence of BPD in the community; this implies that around 60,000 Victorians experience BPD in Victoria today. It is reported that the prevalence of BPD in psychiatric inpatient facilities is about 20%.

A recent Spectrum study (yet to be published) that was conducted in collaboration with the Coroner's Court of Victoria has demonstrated that PD is the underlying cause in an estimated 10% of all suicides. The study also found that, on average, there were 50 BPD-related suicides in Victoria per year, amounting to one BPD suicide per week. Of those with BPD who died by suicide, 99% had presented to mental health services in the preceding 12 months and 88% had presented to mental health services in the preceding six weeks.

Spectrum has conducted a recent audit of BPD consumers presenting to Emergency Departments (ED) and it is estimated that approximately 10,000 ED presentations over a one-year period in Victoria are for people with BPD. However, a clear finding from Spectrum's extensive clinical work across the Mental Health Sector in Victoria, is that access to evidence-based treatments for people with BPD is extremely limited.

The current care for people with PD is chaotic, uncoordinated and may unintentionally contribute to mental illness. There is no clearly articulated care pathway or model of care for people with PD. When care is provided, it is frequently in response to a crisis, leading to expensive and, in most cases, unnecessary hospitalisations, polypharmacy and ED care. People with PD are, at best, *managed* rather than *treated* with evidence-based psychological interventions that have proven to result in remission and recovery for most people.

Spectrum recommendations for consideration by the Royal Commission

Addressing stigma and promoting help-seeking

- Develop and implement public awareness campaigns about PD, and BPD in particular, akin to the campaigns by organisations such as Beyond Blue in its raising of awareness about depression.
- Implement school-based programs that would build awareness and resilience about Mental Health in general and PD more specifically.
- Fund and task consumer-carer organisations such as the BPD Foundation, to undertake community awareness campaigns across Victoria.

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- Develop a 24/7 Victorian specialist telephone helpline and online chat service for consumers, carers and clinicians that can offer specific assistance to suicidal PD populations, their families and carers, as well as the clinicians working with them. Existing telephone support systems are inundated with calls from people with PD and the clinicians working at these helplines often find the complexities of these calls do not adequately match their skill levels.

Building workforce capacity in managing PD and other co-occurring mental disorders

- The Victorian government has recently funded ($2.45 million per year) a Personality Disorder Clinical Specialist Initiative that will initially enhance the capacity of six Victorian Mental Health Services to better service the needs of people with PD. Additional resourcing of $10 million per year will enable this initiative to be expanded to cover all Victorian Mental Health Services. This would ensure that the entire Victorian mental health sector is better trained and supported to address the treatment needs of people with PD.
- All mental health clinician training programs should teach and assess core competencies relevant to PD. These core competencies should include the skills to detect, diagnose and provide psychotherapeutic clinical interactions during every clinical interaction, even in the absence of formal long-term psychotherapeutic interventions.
- Clinicians across the Victorian Health Sector, and specifically the Mental Health Sector, must be trained to diagnose and treat people with PD. The training need not be extensive or expensive. One of the barriers to offering treatment is the expense of popular treatments for BPD, such as Dialectical Behaviour Therapy (DBT), which costs up to $25,000 per patient. This would amount to a cost of $1.5 billion to treat the Victorian BPD population. A viable alternative proposed by Spectrum is to adopt a stepped-care model that would comprise:
  (i) Brief and less expensive, common factors-based psychological interventions for mild severity PD populations;
  (ii) A core competencies-based treatment approach for moderate to severe PD populations; and
  (iii) The use of specialist treatments (e.g. DBT or Mentalisation Based Therapy) for severe and complex PD populations.

  A stepped-care approach would be less expensive, require less extensive clinician training and would vastly improve the accessibility of appropriate treatment for people with PD.

Developing suicide prevention strategies for at-risk populations

- As stated above, most people with Personality Disorder who die by suicide access mental health services within both six weeks and one year prior to death. This provides a real opportunity to detect 'at risk' people with PD and implement suicide prevention strategies.
- Spectrum has treated about 2500 consumers with PD over the last two decades and the suicide rate for this treated population of PD consumers has been extremely low (eight deaths out of 2500 treated patients). If Victorian Mental Health Services were to implement treatment strategies that are currently provided at Spectrum, this would greatly enhance the effectiveness of suicide prevention efforts in relation to PD.

Building integrated service responses for co-occurring PD and other mental disorders

- Victoria requires a well-articulated clinical care pathway and a clear Model of Care within Mental Health Services to coordinate and deliver evidence-based psychological treatments to people with PD alongside treatment for co-occurring mental illness.

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- A panel of expert clinicians, consumers and carers is needed to develop care pathways within a comprehensive model of care. Such pathways may include caring for BPD consumers in Psychiatric Assessment and Planning Units (**PAPU**) and Prevention and Recovery Care (**PARC**) settings rather than in ED and psychiatric inpatient facilities.
- Victoria needs to adopt a population health approach that utilises a stepped-care model to treat Victorians with PD. This would involve the delivery of services to people with PD by the Primary and Public Sectors.
- To address the high cost and long treatment duration associated with specialist psychotherapy, Spectrum has developed several brief and cost-effective interventions that can be readily taken up by Mental Health Services. Doing so will enhance the capacity of Victorian Mental Health Services to provide access to care for a larger number of consumers with PD. These brief interventions have been specifically developed to suit the needs of the Victorian Health Care Sector.

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4. Newton-Howes, G., Clark, L. A., & Chanen, A. (2015). Personality disorder across the life course. Lancet, 385(9969), 727-734. doi:http://dx.doi.org/10.1016/S0140-6736(14)61283
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9. Paris, J. (2008). Treatment of borderline personality disorder: A guide to evidence-based practice: Guilford Press.

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5 July 2019

Royal Commission into Victoria's Mental Health System

ATTACHMENT DJP-4

This is the attachment marked 'DJP-4' referred to in the witness statement of David John Plunkett dated 24 July 2019.

Turning Point

TREATMENT · RESEARCH · EDUCATION

SUBMISSION: ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Turning Point
July 2019

easternhealth

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

About Turning Point

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling, integrated with world-leading research and education. Turning Point is auspiced by Eastern Health and is formally affiliated with Monash University.

Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that

1. Increases access to support and evidence-based practice through the use of innovative technologies.
2. Delivers high quality evidence-based practice.
3. Supports healthcare professionals nationally and internationally to provide high quality evidence-based practice.
4. Delivers workforce and community education programs to a broad range of populations
5. Undertakes policy and practice relevant research and provides key national population level data.
6. Provides policy advice to state and federal governments as well as expert comment.

Turning Point's Recommendations for consideration by the Royal Commission

Addressing stigma and promoting help-seeking

- Develop public health campaigns that counter persistent negative stereotypes about consumers with alcohol and other drug (AOD) use disorders, as well as community myths about addiction that act as barriers to accessing treatment.
- Widely promote free, confidential 24/7 helpline and online services for AOD use disorders as well as stories of recovery.
- Implement school-based intervention programs that build mental health literacy skills among young people and facilitate early help-seeking.

Building workforce capacity in managing alcohol and other drug use and other co-occurring mental illness

- Improve AOD training opportunities, including undergraduate and postgraduate clinical placements for doctors, nurses, psychologists, allied health professionals and paramedics.
- Address structural and organisational barriers to providing alcohol and other drug use disorder assessment and treatment by ensuring adequate workplace support, career development, leadership, and mentoring.
- Build capacity in the AOD sector to enable the management of co-occurring mental illness by increasing the availability and accessibility of postgraduate training opportunities in addiction psychiatry, psychology, and mental health nursing through accredited training posts.
- Invest in addiction medical specialist and accredited training positions within each public health service to ensure appropriate treatment for individuals with complex alcohol and other drug use and co-occurring mental illness.

Developing suicide prevention strategies for at-risk populations

- Develop suicide prevention responses that target consumers with AOD use disorders and/or those on long-term pharmaceutical opioids.
- Ensure AOD services are adequately skilled to identify individuals at risk of suicide, and that prevention and intervention strategies are sufficiently resourced within these settings.
- Utilise coded ambulance data, and other timely administrative datasets, to monitor emerging trends, magnitude, patterns, characteristics, geographic and temporal mapping of acute mental health and self-harm.

Building integrated service responses for co-occurring alcohol and other drug use and other mental ill-health

- Promote service integration and continuity of care across AOD and mental health services, by ensuring treatments for mental illness and co-occurring alcohol and other drug use disorders are provided at the same service (as opposed to in parallel or sequentially at separate services).
- Expand access to (and duration of) programs that provide evidence-based psychological treatment for consumers with complex co-occurring mental illness and alcohol and other drug use disorders.
- Ensure that integrated care is included within service specifications of commissioning bodies, is adequately funded, and spans the entire health system (including hospitals and emergency services).
- Develop a new integrated model of care for consumers with the most severe mental illness and alcohol and other drug use disorders.

Establish robust governance of AOD treatment responses

- Appoint a Chief Addiction Medicine Specialist, analogous to the Victorian Office of the Chief Psychiatrist, to guide and govern Victorian AOD practice.
- Establish an expert panel (aligned to Safer Care Victoria) to review complex pharmaceutical opioid and other drug dependence, as well as provision of oversight for critical incidents or near misses.

Responses to the Royal Commission's questions[1]

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Over the past two decades, there has been considerable success in increasing the community's understanding of anxiety and depression, through the work of government, Beyond Blue and others, which has led to reductions in stigma and increased levels of help-seeking and community support[2,3]. However, despite alcohol and other drug use disorders being categorised alongside other forms of mental illness within international diagnostic classification systems (e.g. the World Health Organisation's International Statistical Classification of Diseases (ICD); the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) for many decades, alcohol and other drug use disorders remain highly stigmatised and misunderstood within the community. It is therefore imperative that they are considered through the lens of a Royal Commission into Victoria's Mental Health System, to ensure that they receive similar levels of critical review and investment in terms of public policy and system design, funding allocations, service models, workforce planning, research initiatives and treatment responses.

Stigma significantly delays help-seeking, treatment and recovery

Research shows that stigma can lead to substantial delays in help-seeking (up to two decades for alcohol and other drug use disorders), as well as treatment noncompliance, reduced self-esteem, social exclusion, discrimination, and relapse[4,5]. It is therefore not surprising that the costs associated with alcohol and other drug -related harms to Australian society are estimated to exceed $55.2 billion annually, due to impacts on healthcare, crime, productivity and road crashes[6]. Individuals with alcohol and other drug use disorder and/or co-occurring mental illness face considerable stigma and a range of structural barriers to accessing treatment[7]. Indeed, the prevailing community thinking about addiction is that it is a moral condition that is self-induced, and this damaging paradigm is also applied to consumers with mental illness and co-occurring alcohol and other drug use.

Protracted delays in treatment-seeking directly contribute to poor clinical outcomes[8,9], including recurrent relapses and multiple complications (e.g. poor physical and mental health, fractured relationships and social instability). This highlights the importance of creating an accessible and effective treatment system for people who need treatment for their alcohol and other drug use, as well as earlier intervention for this group once problems manifest.

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[1] This submission does not include responses to questions 5, 6, 7 and 8 for the Royal Commission into the Victorian Mental Health System.

[2] Jorm, Christensen, and Griffiths, 'Changes in Depression Awareness and Attitudes in Australia: The Impact of Beyondblue: The National Depression Initiative', *Australian and New Zealand Journal of Psychiatry,* 40/1 (2006), 42-46.

[3] Mok et al., 'Stimulating Community Action for Suicide Prevention: Findings on the Effectiveness of the Australian Ru Ok? Campaign', *International Journal of Mental Health Promotion,* 18/4 (2016), 213-21.

[4] Balhara et al., 'Stigma in Dual Diagnosis: A Narrative Review', *Indian Journal of Social Psychiatry,* 32/2 (2016), 128-133.

[5] Evans-Lacko and Thornicroft, 'Stigma among People with Dual Diagnosis and Implications for Health Services', *Advances in Dual Diagnosis,* 3/1 (2010), 4-7.

[6] Collins and Lapsley, *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05* (Department of Health and Ageing Canberra, 2008).

[7] Priester et al., 'Treatment Access Barriers and Disparities among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review', *Journal of Substance Abuse Treatment,* 61 (2016), 47-59.

[8] Dennis et al., 'The Duration and Correlates of Addiction and Treatment Careers', ibid.28/2 (2005), S51-S62.

[9] Dawson et al., 'Estimating the Effect of Help-Seeking on Achieving Recovery from Alcohol Dependence', *Addiction,* 101/6 (2006), 824-34.

However, delivery of interventions within primary and acute care settings remains extremely low[10], even when alcohol and other drug use is directly related to the presentation, and is associated with higher rates of re-presentation and/or re-injury post-discharge[11,12]. Indeed, there are many primary care settings within Victoria that refuse to treat consumers with alcohol and other drug use disorders, even if they present with other mental illness, as they see this group as too difficult or complex to manage.

Failure to provide consumers with effective and timely intervention for their alcohol and other drug use disorder is a critical missed opportunity to engage a typically difficult-to-reach population at an earlier stage[13], and is symptomatic of a healthcare service system where AOD treatment is often siloed and ignored. It is also consistent with evidence that healthcare professionals feel under-skilled in managing alcohol and other drug use disorders, and actively discriminate against this population[14].

While engagement between health services and consumers is improving, persistent negative stereotypes about consumers with alcohol and other drug use disorders can influence how they are treated within the primary care, acute health, and mental health systems. These include the belief that individuals with AOD use disorders lack motivation, and are likely to be violent and aggressive[9]. This view has been reinforced by expensive advertising campaigns in recent years that depict alcohol and other drug users as either indolent, volatile and/or dangerous, while neglecting discussion of the positive responses to treatment experienced by the majority of alcohol and other drug users.

A recently released national study of ambulance responses to men's mental health (*Beyond the Emergency*) found that paramedics were less likely to correctly identify mental illness when they co-occurred with alcohol or other drug use. Moreover, they were more likely to hold stigmatising attitudes towards people experiencing mental illness when alcohol and other drug use was present, particularly the belief that these individuals were dangerous and unpredictable. This finding is consistent with negative societal attitudes towards individuals with alcohol and other drug problems, and is likely to act as a barrier to the provision of appropriate, high-quality support by frontline emergency services to those with co-occurring mental illness[15].

The need to address stigma through informed public campaigns and clinical training placements

Public discourse and policy typically separates alcohol and other drug use disorders from other mental health conditions, subserving and perpetuating stigma. This segregation makes it difficult for those with co-occurring issues to seek effective professional help for their problems, as a lack of

[10] Muench, 'Screening and Brief Intervention Practice Systems and Implementation', *Addressing Unhealthy Alcohol Use in Primary Care* (Springer, 2013), 171-88.
[11] Gacouin et al., 'At-Risk Drinking Is Independently Associated with Icu and One-Year Mortality in Critically Ill Nontrauma Patients', *Critical Care Medicine,* 42/4 (2014), 860-67.
[12] Clark et al., 'Alcohol Screening Scores and the Risk of Intensive Care Unit Admission and Hospital Readmission', *Substance Abuse,* 37/3 (2016), 466-73.
[13] Van Boekel et al., 'Stigma among Health Professionals Towards Consumers with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review', *Drug and Alcohol Dependence,* 131/1-2 (2013), 23-35.
[14] Teesson et al., 'Alcohol-and Drug-Use Disorders in Australia: Implications of the National Survey of Mental Health and Wellbeing', *Australian & New Zealand Journal of Psychiatry,* 34/2 (2000), 206-13.
[15] Turning Point, 'Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health', (Richmond, Victoria, 2019).

integrated strategies and funding models results in commonly comorbid conditions being triaged and treated by separate departments and workforces[16].

In Victoria, this separation of services has developed in the decades following the deinstitutionalisation of the mental health system and recommissioning of services. Previously, mental health and AOD treatment had been integrated within large public psychiatric hospitals, which provided training opportunities for health workforces as a core part of their career development. Following deinstitutionalisation, acute mental health services were integrated with hospitals, while AOD services were recommissioned to non-government organisations[17].

While the mental health system has been configured to allow for training of health workforces through undergraduate and postgraduate training placements and university curricula, the recommissioned AOD system was not supported to provide clinical placements for undergraduate and postgraduate students. Thus, for the past 20 years, nurses, doctors, psychologists and allied health workers trained in Victoria have had limited access to accredited AOD training placements and supervision, meaning that the bulk of the Victorian health workforce have limited skills and knowledge in assessing and managing alcohol and other drug use disorders.

This knowledge and skills gap within the health system has been further exacerbated by the absence of funding for a Victorian tertiary specialist workforce, with no statewide investment in addiction medical specialists and associated addiction training positions for general practitioners, psychiatrists and physicians. The resulting knowledge gap is at the core of why individuals with alcohol and other drug use disorder and/or co-occurring mental illness are highly stigmatised and face multiple barriers to effective care.

As stigma and discrimination are some of the biggest problems facing people with alcohol and other drug disorders and mental illness, education for the general community, families and employers is vital for recovery. Recent Australian campaigns targeting suicide, depression and anxiety have increased community awareness of mental illness and had a positive impact on attitudes towards seeking help[18,19]. This is a promising outcome, but efforts need to broaden, as campaigns that intentionally work towards reducing stigma are currently lacking in the AOD space.

Campaigns to reduce alcohol and other drug -related stigma should be evidence-based and developed in consultation with consumer organisations, and avoid drug prevention messages[20]. They should also promote the benefits of early help-seeking and treatment (including the availability of 24/7 helpline support) and address community myths about addiction (such as no-one improves and treatment does not work). As alcohol and other drug use disorders are less likely to be considered as mental illness and more likely to be considered self-induced compared to other mental health conditions[21,22], focusing on social inclusion/human rights and emphasising that people are not to blame for their problems may be most effective in reducing prejudice[23].

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[16] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?', *Drugs and Public Health: Australian Perspectives on Policy and Practice* (Oxford University Press, 2008), 127-38.
[17] Whiteford and Buckingham, 'Ten Years of Mental Health Service Reform in Australia: Are We Getting It Right?', *Medical Journal of Australia,* 182/8 (2005), 396-400.
[18] Jorm, Christensen, and Griffiths, 'Changes in Depression Awareness and Attitudes in Australia: The Impact of Beyondblue: The National Depression Initiative', *Australian and New Zealand Journal of Psychiatry,* 40/1 (2006), 42-6.
[19] Mok et al., 'Stimulating Community Action for Suicide Prevention: Findings on the Effectiveness of the Australian Ru Ok? Campaign', *International Journal of Mental Health Promotion,* 18/4 (2016), 213-221.
[20] Lancaster, Seear, and Ritter, 'Reducing Stigma and Discrimination for People Experiencing Problematic Alcohol and Other Drug Use: Final Report', (A report for the Queensland Mental Health Commission, 2017).
[21] Schomerus et al., 'The Stigma of Alcohol Dependence Compared with Other Mental Disorders: A Review of Population Studies', *Alcohol and Alcoholism,* 46/2 (2010), 105-12.

2. *What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?*

Similar to other mental health conditions, alcohol and other drug use disorders commonly co-occur with other mental illnesses. Indeed, it has been estimated that more than one-third of individuals with an AOD use disorder in the community have at least one additional co-occurring mental illness, and among those in treatment for alcohol and other drug use disorders, the rate of comorbidity is considerably higher[24], estimated to range between 70%-90%.

Conversely, the prevalence of alcohol and other drug use disorders in people attending mental health services ranges between 11%-70%[25]. Depression, anxiety (including post-traumatic stress disorder) and borderline personality disorder are common among people attending AOD treatment services, with high rates of alcohol and other drug use disorder also evident among individuals accessing mental health services, particularly among those with serious mental illness, such as bipolar disorder and schizophrenia[26,27,28,29,30].

There are numerous factors that are believed to underlie this comorbidity. Some individuals with mental illness may self-medicate with alcohol or other drugs in an attempt to manage or cope with their symptoms. Regular alcohol and other drug use can also lead to mental illness, either directly (e.g. through neurochemical changes) or indirectly (e.g. through exposure to traumatic situations, or the creation of ongoing problems with finances, relationships, and/or physical health). There is also evidence that shared vulnerabilities can underlie the development of both AOD use and mental health problems. These can include common genetic factors, as well as environmental triggers (e.g. childhood abuse, trauma or poverty)[31,32].

Receiving a different response from mental health providers can lead to individuals with co-occurring alcohol and other drug use disorders and other mental illness being disadvantaged when seeking help. Outcomes can include consumers being turned away by mental health services[33,34], or

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[22] Angermeyer and Dietrich, 'Public Beliefs About and Attitudes Towards People with Mental Illness: A Review of Population Studies', *Acta Psychiatrica Scandinavica,* 113/3 (2006), 163-79.
[23] Clement et al., 'Mass Media Interventions for Reducing Mental Health-Related Stigma', *Cochrane Database of Systematic Reviews,* 7 (2013).
[24] Slade et al., '2007 National Survey of Mental Health and Wellbeing: Methods and Key Findings', *Australian and New Zealand Journal of Psychiatry,* 43/7 (2009), 594-605.
[25] Deady et al., 'Comorbid Mental Illness and Illicit Substance Use: An Evidence Check Review', (NSW Mental Health and Drug and Alcohol Office: Sax Institute, 2015).
[26] Kranzler and Rosenthal, 'Dual Diagnosis: Alcoholism and Co-Morbid Psychiatric Disorders', *The American Journal on Addictions,* 12 (2003), s26-s40.
[27] Xiong Lai et al., 'Prevalence of Comorbid Substance Use, Anxiety and Mood Disorders in Epidemiological Surveys, 1990–2014: A Systematic Review and Meta-Analysis', *Drug and Alcohol Dependence,* 154 (2015), 1-13.
[28] Nesvåg et al., 'Substance Use Disorders in Schizophrenia, Bipolar Disorder, and Depressive Illness: A Registry-Based Study', *Social Psychiatry and Psychiatric Epidemiology,* 50/8 (2015), 1267-76.
[29] Mortlock, Deane, and Crowe, 'Screening for Mental Disorder Comorbidity in Australian Alcohol and Other Drug Residential Treatment Settings', *Journal of Substance Abuse Treatment,* 40/4 (2011), 397-404.
[30] Regier et al., 'Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Results from the Epidemiologic Catchment Area (Eca) Study', *JAMA,* 264/19 (1990), 2511-18.
[31] Mueser, Drake, and Wallach, 'Dual Diagnosis: A Review of Etiological Theories', *Addictive Behaviors,* 23/6 (1998), 717-34.
[32] Kendler et al., 'The Structure of Genetic and Environmental Risk Factors for Common Psychiatric and Substance Use Disorders in Men and Women', *Archives of General Psychiatry,* 60/9 (2003), 929-37.
[33] Roberts and Maybery, 'Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services', *Journal of Dual Diagnosis,* 10/3 (2014), 139-44.
[34] Searby, Maude, and Mcgrath, 'The Experiences of Clinicians Caring for Older Adults with Dual Diagnosis: An Exploratory Study', *Issues in Mental Health Nursing,* 38/10 (2017), 805-11.

being told to address their alcohol and other drug use before any mental health treatment can be offered, even when other services do not have the skills or capacity to offer suitable treatment.

Accredited undergraduate and postgraduate training placements within AOD services, as well as targeted education and training are likely to aid health professionals in responding appropriately to co-occurring alcohol and other drug use disorders. Effective strategies to change individual clinician behaviour include regular educational meetings, educational outreach, prompts and reminders, and auditing and feedback[35]. However, it is important to note that the effectiveness of these strategies is likely to be influenced by the prevailing organisational culture. Workforce development approaches should therefore have a 'systems focus' that targets organisational and structural factors in addition to addressing the education and training of individual workers. This perspective emphasises the importance of ensuring adequate workplace support, career development (including clinical supervision), leadership and mentoring, among other key areas[36].

Additional training opportunities may be of particular benefit for general practitioners, as they are typically the first (and sometimes only) point of call for people with alcohol and other drug use disorder and co-occurring mental illness, and are well-placed to aid in early intervention efforts. However, training GPs in opioid pharmacotherapy has been far more challenging than engaging this group in mental health treatment. Nevertheless, any attempt to address the community impact of alcohol and other drug use disorder and co-occurring mental illness should aim to improve its diagnosis and management within general practice. Ideally, this would involve building on knowledge and skills that are taught at the undergraduate level, and reinforced during intern and fellowship training.

While alcohol and drug training was implemented across medical schools in Australia in the 1990s, many universities lack the funding to continue offering this material in depth, which warrants review[37], especially given the prevalence and impact of these disorders in the community. Active learning (e.g. interactive case studies and clinical scenarios) and authentic tasks (e.g. tasks that involve the experiences of general practitioners already involved in AOD work) should be prioritised over the passive dissemination of information[38]. However, it is increasingly recognised that efforts need to go beyond simply offering individualised education and training programs. In general practice, this may involve addressing structural barriers in order to increase confidence and perceptions of role legitimacy, and reducing isolation and perceptions of a lack of specialist support[39].

While early treatment is widely recognised as a protective factor for alcohol and other drug use and mental illness[40], adolescents are often reluctant to seek professional help, preferring to rely on their

[35] Bywood, Lunnay, and Roche, *Effective Dissemination: A Systematic Review of Implementation Strategies for the Aod Field* (National Centre for Education and Training on Addiction, 2008).
[36] Roche and Nicholas, 'Workforce Development: An Important Paradigm Shift for the Alcohol and Other Drugs Sector', *Drugs: Education, Prevention and Policy,* 24/6 (2017), 443-54.
[37] Lubman et al., 'Health Professionals' Recognition of Co-Occurring Alcohol and Depressive Disorders in Youth: A Survey of Australian General Practitioners, Psychiatrists, Psychologists and Mental Health Nurses Using Case Vignettes', *Australian & New Zealand Journal of Psychiatry,* 41/10 (2007a), 830-35.
[38] Roche, Hotham, and Richmond, 'The General Practitioner's Role in Aod Issues: Overcoming Individual, Professional and Systemic Barriers', *Drug and Alcohol Review,* 21/3 (2002), 223-30.
[39] Skinner et al., 'Health Professionals' Attitudes Towards Aod-Related Work: Moving the Traditional Focus from Education and Training to Organizational Culture', *Drugs: education, prevention and policy,* 16/3 (2009), 232-49.
[40] Lubman et al., 'Intervening Early to Reduce Developmentally Harmful Substance Use among Youth Populations', *Medical Journal of Australia,* 187/S7 (2007b), S22-S25.

peers for support[41]. However, research indicates that many young people demonstrate poor mental health literacy[42], as indicated by a limited ability to recognise specific disorders, knowledge and beliefs about help-seeking that act as barriers to seeking professional help, stigma, fears about lack of confidentiality, reliance on oneself and concerns about helper characteristics[43]. These help-seeking beliefs and preferences highlight the importance of building the mental health literacy and help-seeking skills of adolescents, including ensuring that they know when and how to assist their peers to access support.

Importantly, by equipping young people with the skills to help their peers, there is strong evidence that such knowledge also assists young people to seek professional help for themselves, ensuring timely access to effective care. In this regard, school-based intervention programs have been found to play an important role in facilitating early help-seeking for mental illness. For example, a recent NHMRC-funded Victorian trial of the *MAKINGtheLINK* intervention[44] demonstrated that the program effectively improves the help-seeking behaviour, attitudes and intentions of young people experiencing mental illness, and equips them to not only support their peers, but also themselves. Programs such as *MAKINGtheLINK* make a significant contribution to early intervention and prevention efforts by equipping adolescents with effective help-seeking skills, and highlight the need for such programs to be embedded within the Victorian school curriculum.

3. What is already working well and what can be done better to prevent suicide?

Alcohol and other drug use presents one of the strongest modifiable risk factors for suicide prevention. The absence of strategies to specifically address substance use represents a critical missed opportunity in suicide prevention policy. As highlighted in a recent article that Turning Point published in the Australian and New Zealand Journal of Psychiatry[45], the risk of suicidal behaviour is particularly elevated in those diagnosed with an alcohol and other drug use disorder. Globally, alcohol and other drug use disorders were responsible for almost one-fifth of suicide-related disability-adjusted life years in 2010, with 13.3% of this burden attributable to alcohol use disorders alone[46], second only to depression. Although research consistently estimates that between one-quarter to one-third of suicide decedents meet diagnostic criteria for alcohol use disorder, there has been little conversation regarding the potential value of policies aimed at reducing alcohol availability as a way of further reducing the suicide rate in Australia. In terms of other use disorders, the risk of suicide in people with other drug use disorders, relative to the general population is also substantial, ranging from 6.9 (opioid dependence), to 8.9 (stimulant dependence) and as high as 16.9 (cocaine dependence)[47].

A recent systematic review of international suicide prevention policies identified only three countries globally that identified strategies specifically targeting alcohol and other drug use

[41] Gulliver, Griffiths, and Christensen, 'Perceived Barriers and Facilitators to Mental Health Help-Seeking in Young People: A Systematic Review', *BMC Psychiatry,* 10/1 (2010), 113.
[42] Jorm, Wright, and Morgan, 'Where to Seek Help for a Mental Disorder?', *Medical Journal of Australia,* 187/10 (2007), 556-60.
[43] Jorm et al., '"Mental Health Literacy": A Survey of the Public's Ability to Recognise Mental Disorders and Their Beliefs About the Effectiveness of Treatment', *Medical Journal of Australia,* 166/4 (1997), 182-86.
[44] Lubman et al., 'A School-Based Health Promotion Programme to Increase Help-Seeking for Substance Use and Mental Health Problems: Study Protocol for a Randomised Controlled Trial', *Trials,* 17/1 (2016), 393.
[45] Witt and Lubman, 'Effective suicide prevention: Where is the discussion on alcohol?', *Australian and New Zealand Journal of Psychiatry*, 52/6 (2018), 507-508.
[46] Ferrari et al., 'The Burden Attributable to Mental and Substance Use Disorders as Risk Factors for Suicide: Findings from the Global Burden of Disease Study 2010', *PloS One,* 9/4 (2014), e91936.
[47] Kalk et al., 'Addressing Substance Misuse: A Missed Opportunity in Suicide Prevention', *Addiction,* 114/3 (2019), 387-88.

disorders[48]. The Australian National Suicide Prevention Strategy (**NSPS**), first introduced in 1999, formalised and coordinated suicide prevention activities, as well as provided for greater funding and investment in suicide prevention research. Complementing the NSPS, most states and territories also outline their own responses.

Yet despite the increased risk of suicidal behaviour in those diagnosed with an alcohol and other drug use disorder, specific suicide prevention strategies focusing on individuals with such disorders remain notably absent, with this population infrequently identified as an important 'at risk' group within suicide prevention strategies and initiatives. This is particularly relevant in the context of male suicide, given that men are less likely to seek help for suicidal ideation and/or behaviours until they reach a crisis point. Indeed, the recent Beyond the Emergency[49] report identified that over 65% of ambulance attendances for male suicide attempts across the country involved alcohol and other drug use. This is consistent with research showing that males with depression are more likely to report problems with alcohol use, whereas females are more likely to report 'classical' symptoms of depression[50]. Therefore, when males do seek help, given their focus on alcohol, they are more likely to be referred for AOD treatment in the first instance. It is therefore important that AOD services and helplines are adequately skilled to identify individuals at risk of suicide, appropriate prevention and intervention strategies are sufficiently resourced within these settings, and effective partnerships are in place with local mental health providers to provide support and referral pathways.

Increasing rates of drug overdose in Victoria also need to be considered through the lens of suicide prevention. These deaths have raised public and professional concern about the prescription of potent opioid medications for chronic non-cancer pain and led to the recent implementation of a real-time prescription monitoring system (*Safescript*) in Victoria. However, it is important to note that studies of consumers who are prescribed opioids for chronic non-cancer pain report high rates of depression, suicide attempts and suicidal ideation[51], highlighting the need for suicide prevention initiatives to broaden the scope of populations that they target.

Given that only around one-third of suicide decedents were in contact with mental health services in the year preceding their death, other public health initiatives are also required to meaningfully reduce suicide rates. At the population level, rates and patterns of alcohol consumption have been consistently associated with suicide rates across a number of countries, particularly for males. Data from a number of eastern European countries suggest increasing per capita alcohol consumption is associated with an increase in overall suicide rates, with the proportion of suicides attributable to alcohol as high as 66.4% in countries that predominately consume spirits and 34.5% in countries that predominately consume non-spirits-based alcoholic beverages[52]. Such findings highlight the need for a more robust public discussion about the relationship between alcohol and suicide in Australia and that, similar to the current community conversations concerning the link between alcohol and cancer, future suicide prevention strategies must advocate for policies that effectively reduce alcohol consumption, such as increasing the price of alcohol through taxation and limiting marketing and promotion.

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[48] Ibid.

[49] Beyond the Emergency A National Study of Ambulance Responses to Men's Mental Health, Beyond Blue, 19/5 (2019)

[50] Cavanagh et al., 'Differences in the Expression of Symptoms in Men Versus Women with Depression: A Systematic Review and Meta-Analysis', *Harvard Review of Psychiatry,* 25/1 (2017), 29-38.

[51] Campbell et al., 'The Pain and Opioids in Treatment Study: Characteristics of a Cohort Using Opioids to Manage Chronic Non-Cancer Pain', *Pain,* 156/2 (2015), 231-42.

[52] Landberg, 'Alcohol and Suicide in Eastern Europe', *Drug and Alcohol Review,* 27/4 (2008), 361-73.

Effective intervention and policy development requires detailed understanding of the magnitude, characteristics and patterns of the intersection between acute mental health, suicide and alcohol and drugs over time and across regions. Few population based datasets have the capacity to capture that detail in a timely and consistent way. For example, emergency department and hospital data only includes those who present to hospital and are admitted and the coding systems cannot capture suicidal ideation, specific substance types and nuances between self-harm and suicide attempt.

For over 20 years, Turning Point has been providing a Victorian alcohol, illicit and pharmaceutical drug surveillance system using coded paramedic data in partnership with Ambulance Victoria. This world-first surveillance system has recently applied the same methodology to mental health, as part of the recently released Beyond the Emergency study. Beyond the Emergency found national morbidity data appears to significantly underestimate the burden of self-harm in Australian men, and the coded ambulance data (for only six Australian jurisdictions) indicated rates amongst men almost three times higher than hospitalisation data[53]. These data could be utilised as an ongoing surveillance system to inform policy responses, reduce suicide and self-harm behaviours and evaluate existing interventions.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

The separation and fragmentation of the AOD and mental health service sectors is a significant barrier in access to effective care. Individuals frequently present to AOD services with complex mental health issues that can interfere with alcohol and other drug use treatment. Indeed, those with co-occurring alcohol and other drug disorder and mental illness are also more likely to rely on emergency services (including police and ambulance services) for mental health responses[54,55], be dependent on welfare benefits, have limited social supports and financial resources, and be at high risk of relapse, suicide, aggression, medical comorbidity, homelessness and incarceration. They frequently present with underlying trauma that may be masked by the use of alcohol and other drugs as a coping strategy. Because of these issues, they are generally less able to navigate between, engage with, and remain in treatment.

The separation of treatment for alcohol and other drug use disorders from treatment of other mental illnesses can result in pressure to place consumers in the 'correct' system based on a primary diagnosis, which can, in turn, lead to treatment of one disorder at the expense of the other. In reality, the relationship between alcohol and other drug use disorders and mental illness is bidirectional, with both conditions serving to maintain or exacerbate the other[56]. The boundaries created by treating co-occurring disorders in separate systems can also impede consumer progress and prognosis[57]. Often, consumers are passed back and forth between AOD and mental health

[53] Turning Point (2019). Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health. Richmond, Victoria.

[54] Dickey and Azeni, 'Persons with Dual Diagnoses of Substance Abuse and Major Mental Illness: Their Excess Costs of Psychiatric Care', *American Journal of Public Health,* 86/7 (1996), 973-77.

[55] Graham et al., 'How Much Do Mental Health and Substance Use/Addiction Affect Use of General Medical Services? Extent of Use, Reason for Use, and Associated Costs', *The Canadian Journal of Psychiatry,* 62/1 (2017), 48-56.

[56] Teesson, 'Mental Health and Substance Use: Opportunities for Innovative Prevention and Treatment', (Mental Health Commission of New South Wales, 2014).

[57] Baker, *Coordination of Alcohol, Drug Abuse, and Mental Health Services* (US Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1991).

services, inevitably falling through the gap over time. These outcomes can lead to the perception that treatment is ineffective, or that consumers are responsible for poor treatment outcomes, when in reality they have received disparate care that failed to adequately address their individual needs.

The need for a 'no wrong door' policy that is equipped to work

A common aim of models of service delivery is that all consumers will be provided with appropriate treatment services or referral regardless of where they enter the treatment system, the 'no wrong door' approach. This concept needs to be further consolidated, with the needs of consumers being addressed in the services they access, rather than requiring referrals to multiple agencies.

The implementation of 'The Orange Door' initiative within Victoria, which represents a shift in the way services are coordinated to respond to consumer needs within the family violence space, may be informative in this regard. Establishing 'safety hubs' via partnerships between government and community service organisations, which help connect victims of family violence directly to services via a single point of entry, is an important model to consider in addressing issues of integrated and coordinated care for consumers.

In 2017, Turning Point was commissioned by the Victorian Department of Health and Human Services to conduct a review of AOD service planning across the state. The review identified key elements of an effective AOD service system, in particular one that increases the availability of specialist treatment services whilst taking into account the varying needs of a complex population where consumers require varied level of care. As part of the review, the Victorian treatment-seeking population was segmented into tiers, in order to match consumers with differing levels of addiction severity and complexity to 'packages' of care[58]. Using a 5-tier model, most consumers were classified as Tier 3 or above (i.e. presenting with alcohol and other drug dependence plus one or more complexity factors), with approximately 20-25% percent of these classified as Tier 5 (the most complex consumers in the system). Within each Tier, the presence of complexity factors, which included comorbid mental illness, was critical in determining the level of care a consumer was to receive.

Managing consumers with co-occurring alcohol and other drug use disorder and mental illness requires a highly skilled AOD workforce. Within the AOD service system, high prevalence mental health disorders (in particular, mood and anxiety disorders) are common. Indeed, it has been estimated that the rate of co-occurring mental illness among consumers accessing residential AOD treatment within Australia ranges from 64%-71%[59]. In contrast, public mental health services typically provide care to individuals with 'serious mental illness' (i.e. the low prevalence conditions of schizophrenia and bipolar disorder) that are frequently accompanied by alcohol and other drug use disorders[60]. Differences in consumer profiles mean that neither service sector is ideally equipped to deal with the issue of co-occurring disorders.

However, simply improving referral pathways may not necessarily result in improved outcomes. There are inherent differences in the AOD and mental health sectors, including differences in the language and service philosophies, as well as a general lack of understanding among workers of the different models of care and service constraints[61]. Efforts have been made at Commonwealth and

[58] Lubman, Manning, and Cheetham, 'Informing Alcohol and Other Drug Service Planning in Victoria', (Turning Point, 2017).
[59] Mortlock, Deane, and Crowe, 'Screening for Mental Disorder Comorbidity in Australian Alcohol and Other Drug Residential Treatment Settings', *Journal of Substance Abuse Treatment,* 40/4 (2011), 397-404.
[60] Hall, Lynskey, and Teesson, 'What Is Comorbidity and Why Does It Matter', *National Comorbidity Project,* (2001), 11-17.
[61] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?' In Moore and Dietze. *Drugs and Public Health: Australian perspectives on policy and practice (2008),* 127-138.

State levels to improve approaches to co-occurring disorders through 'Dual Diagnosis' initiatives, and these have largely focused on building workforce awareness and knowledge. While these approaches have been well-intentioned, they have struggled to advance the clinical capacity required by the treatment sector to manage the levels of complexity seen in individuals with co-occurring mental illness and alcohol and other drug use disorder.

There is a need to build capacity in the AOD sector to enable the management of co-occurring mental illness. Currently, the minimum qualification for delivering AOD treatment in Victoria is a Certificate IV in Alcohol and Other Drugs, meaning that clinicians have limited experience or expertise in managing co-occurring mental illness. A lack of skills and experience necessary to appropriately assess and manage co-occurring mental illness within the AOD sector has been identified as a key barrier to effective service provision, and building workforce capabilities has been identified as a priority for the Victorian Government[62]. In order to address this gap in service provision, there is a need for greater support of postgraduate training opportunities in addiction to psychiatry, psychology and mental health nursing within the AOD sector. Effective capacity building also requires the recruitment of clinicians experienced in managing co-occurring disorders, who can assist in training and service development[63].

An example of a program that incorporates a skilled workforce is *Making Waves*[64], a specialist service provided by Turning Point that offers evidence-based treatment for co-occurring alcohol and other drug use disorders and complex mental health presentations. Making Waves delivers 12 individual face-to-face treatment sessions with a focus on learning new strategies for making alternative choices, particularly around alcohol and other drug use, as well as building skills in better managing and tolerating emotional stress and improving interpersonal relationships.

Evidence-based psychological treatment for this level of complexity (in particular, for complex trauma) dictates continuity and consistency in care, as considerable time is required to forge a therapeutic alliance, with consumers requiring more than 12 sessions to achieve successful recovery. Indeed, expanding access to, and the duration of programs, such as *Making Waves*, could reduce chronicity and relapse, particularly as referrals to new services are difficult to action on discharge because few other services exist in the public sector to support individuals with this level of complexity.

The importance of effective service integration

There is strong evidence that an integrated response, whereby treatments for mental illness and co-occurring alcohol and other drug use disorders are provided at the same service (as opposed to in parallel or sequentially at separate services), is necessary to adequately treat such disorders[65,66].

Commonwealth initiatives through the National Comorbidity Initiative and the National Action Plan on Mental Health (2006-2011) have targeted this issue, and have included funding to enhance mental health capacity within the AOD sector. However, while such strategies are to be

[62] Department of Health and Human Services, 'Victoria's Alcohol and Other Drugs Workforce Strategy', (Victoria, 2018).
[63] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?'. In Moore and Dietze, *Drugs and Public Health: Australian perspectives on policy and practice (2008),* 127-138.
[64] Hall et al., 'Emotional Dysregulation as a Target in the Treatment of Co-Existing Substance Use and Borderline Personality Disorders: A Pilot Study', *Clinical Psychologist,* 22/2 (2018), 112-25.
[65] Torrens et al., 'Psychiatric Co-Morbidity and Substance Use Disorders: Treatment in Parallel Systems or in One Integrated System?', *Substance Use & Misuse,* 47/8-9 (2012), 1005-14.
[66] Morisano, Babor, and Robaina, 'Co-Occurrence of Substance Use Disorders with Other Psychiatric Disorders: Implications for Treatment Services', *Nordic studies on alcohol and drugs,* 31/1 (2014), 5-25.

commended, the segregation of the AOD and mental health sectors remains a fundamental issue in Victoria, and Australia as a whole[67]. Implementing effective integration responses necessitates improved models of integration between mental health and AOD directorates within the Victorian Department of Health and Human Services in their policy and funding priorities.

Ensuring that integrated care is included within service specifications of commissioning bodies and is adequately funded is critical in effective integration[68], and funding AOD and mental health system design and policy separately is likely to be contributing to an ongoing fragmented system[69]. Currently, both sectors face considerable demand for services and are significantly under-resourced.

An integrated response also needs to span the entire health system, including hospitals and emergency services. Appropriate treatment and a holistic approach to meeting consumer needs will reduce the pressure on public health services, including ambulance attendances, emergency department presentations, and admissions to acute mental health facilities. The extent of this issue was highlighted by the recent *Beyond the Emergency* project, where the volume and complexity of presentations and re-presentations to ambulance services (where 78% were transported to hospital, with >60% of attendances occurring after hours) reinforced the need for a comprehensive review of service responses and a more flexible and integrated service system[70]. *Beyond the Emergency* interviews with men who had accessed ambulance services as well as paramedics consistently highlighted problems associated with a mental health sector in which long wait times, financial costs, and difficulties accessing appropriate services are extra barriers to ongoing professional support. Alternative models of delivering emergency care for those experiencing acute mental illness should therefore be explored, and investment is needed in systems and responses that reduce the many barriers to accessing timely support.

The importance of funding models that promote continuity and service integration is further highlighted by the results of the *Patient Pathways* study, which found treatment outcomes were influenced by continuity in AOD treatment[71]. The study also found that treatment reduced emergency service use[72]. As with other chronic health problems, alcohol and other drug use disorders appear to be best managed through continuing care models, involving ongoing monitoring and coordination between different services, rather than by an acute episodic treatment approach.

A strong evidence base also exists around linkage to peer and community 'aftercare' support (i.e., ongoing follow-up and support post-specialist AOD treatment, which may include telephone or online counselling as well as linkage with peer support and mutual aid, such as 12-step groups). While most studies on the benefits of mutual aid have been conducted in the US and UK, in the Australian Patient Pathways study, consumers with alcohol but not illicit drugs as their primary drug of concern were two-and-half times as likely to be abstinent or to have reliably reduced their drinking if they attended mutual aid (e.g. Alcoholics Anonymous) or other recovery meetings following AOD treatment. There was also a trend for higher rates of treatment success among those attending more meetings in the previous 12 months, with more than 31-50% of those attending

[67] Lubman, Hides, and Elkins, 'Dual Diagnosis: Dual Disorders or a Dual System?'. In Moore and Dietze, *Drugs and Public Health: Australian perspectives on policy and practice (2008),* 127-138.
[68] Savic et al., 'Strategies to Facilitate Integrated Care for People with Alcohol and Other Drug Problems: A Systematic Review', *Substance Abuse Treatment, Prevention, and Policy,* 12/1 (2017), 19.
[69] Canaway and Merkes, 'Barriers to Comorbidity Service Delivery: The Complexities of Dual Diagnosis and the Need to Agree on Terminology and Conceptual Frameworks', *Australian Health Review,* 34/3 (2010), 262-68.
[70] Turning Point, 'Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health'.
[71] Manning et al., 'Substance Use Outcomes Following Treatment: Findings from the Australian Patient Pathways Study', *Australian & New Zealand Journal of Psychiatry,* 51/2 (2017), 177-89.
[72] Lubman et al., 'A Study of Patient Pathways in Alcohol and Other Drug Treatment', *Fitzroy: Turning Point,* (2014).

meetings at least monthly on average responding to treatment[73]. Overall, there is robust evidence that peer support/mutual aid improves treatment outcomes and linkage to these programs as a form of aftercare needs to be a core part of any service delivery model[74].

9. *Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?*

The need for a sustainable addiction medical workforce

There is an urgent need to build a tertiary specialist workforce within the AOD system. Up to a quarter of Victorians in the AOD treatment system can be considered Tier 5[75], presenting with levels of clinical complexity concomitant with tertiary sector opinion and management. However, mainstream care within the Victorian AOD sector is typically provided without ready access to medical or psychiatry support, dependent on private GPs or emergency departments for their most at-risk cases. The relative absence of a tertiary AOD sector, and associated evidence-based multidisciplinary team management, has a critical impact on recovery and outcomes for individuals with complex alcohol and other drug use and co-occurring mental illness.

Currently, there is overwhelming demand for provision of assessment and treatment in areas of medical and psychiatric complexity, such as co-occurring pain, anxiety and addiction, heroin and depression, prescription opioid and other pharmaceutical misuse, complex trauma, alcohol and liver disease, methamphetamine and psychosis. There is also high demand from residential rehabilitation settings that require specialist assessment and management of consumers with co-occurring alcohol and other drug use disorder and mental illness prior to admission.

The roll-out of mandatory real-time prescription monitoring (*SafeScript*) in Victoria over the coming year will increase the visibility of prescribing of high-risk medications, including a range of psychotropic drugs such as opioids, benzodiazepines, sleep medications and quetiapine, further contributing to demand for addiction medical specialist opinion and management both within the AOD treatment system, and from mental health and primary care. Through this lens of high-risk prescription medications, it will become increasingly difficult to inform safe and effective withdrawal, stabilisation, treatment and recovery plans without access to addiction medicine and psychiatry expertise.

Training for doctors specialising in the treatment of addiction is provided by the Chapter of Addiction Medicine (under the Royal Australasian College of Physicians or RACP) and the Royal Australian and New Zealand College of Psychiatry (**RANZCP**), however barriers to entering addiction medicine and psychiatry in Australia have contributed to a shortage of clinicians in this field. (The 2017 RANZCP Victorian Branch workforce report estimated only 3.0 EFT of funded addiction psychiatry positions in the public AOD sector across the state.)[76]

The numbers of trainees and qualified addiction specialists are particularly low in Victoria due to a chronic lack of investment in training and specialist positions: New South Wales, by way of contrast, has almost six times the numbers of addiction doctors in training as Victoria, as well as funded addiction specialist positions within each health service. Careers in addiction medicine were given

[73] Manning et al., 'Substance Use Outcomes Following Treatment: Findings from the Australian Patient Pathways Study', *Australian & New Zealand Journal of Psychiatry,* 51/2 (2017), 177-89.
[74] Lubman, Manning, and Cheetham, 'Informing Alcohol and Other Drug Service Planning in Victoria', (Turning Point, 2017).
[75] Ibid.
[76] Royal Australian and New Zealand College of Psychiatrists (Ranzcp), 'Psychiatry Attraction, Recruitment and Retention Needs AnalysisProject', (Victoria, 2017).

some momentum in recent years due to changes in Medicare Benefits Scheduling that recognised the specialty by allocating physician type item numbers. However, this has not been enough to attract adequate trainees to replace those specialists lost through the attrition or retirement.

The lack of a career pathway for doctors interested in pursuing a career in addiction medicine or addiction psychiatry, including consultant positions within the public system, means that Victoria is facing a future without such expertise, with an exodus of specialists to funded positions interstate in recent years, and many of the remaining cohort of addiction specialists nearing retirement. As addiction psychiatry and medicine provide the tertiary specialist support needed to develop a workforce capable of treating co-occurring disorders, as well as providing appropriate clinical expertise to consumers in Tier 5, appropriate funding of addiction medical specialists within the health system remains an urgent priority for Victoria[77].

Oversight and governance models for managing co-occurring disorders in the Safescript era

Contrasts between the mental health and AOD sectors are necessary given approaches to mental illness and alcohol and other drug use disorders often require different emphases and strengths. However, the AOD sector can also learn from established models within mental health, such as the statutory clinical governance provided by roles such as Victoria's Chief Psychiatrist.

Some jurisdictions have adopted such roles for addiction medicine, with Victoria trialling such a role before discontinuing it some years ago. The role of a Chief Addiction Medicine Specialist, analogous to the Chief Psychiatrist position, has the potential to guide and govern Victorian AOD practice. Given the recent launch of the *Safescript* real time prescription monitoring system, most clinicians in the sector predict increasing numbers of complex clinical challenges will become visible in primary care. Without appropriate governance, general practitioner management of pharmaceutical drug use disorders, including those complicated by mental health comorbidity, will potentially lead to GPs discharging (or abandoning) consumers with comorbid prescription medicine dependence, pain and mental illness or referring them to services with limited expertise in such conditions or significant access barriers, such as public pain clinics.

A structured governance system in addiction medicine would complement the Chief Psychiatrist role. The position would be well placed to lead innovative approaches such as an expert panel (aligned to Safer Care Victoria) to review complex pharmaceutical opioid and other drug dependence, as well as provision of oversight for critical incidents or near misses. Currently, there is no clinical governance model that oversees non-hospital high-risk medication prescribing, nor review of critical clinical incidents in the AOD sector, including deaths. Models of incident review are well established in public health services.

However, no systematic review of serious events related to medication misuse are applied to the private fee-for-service general practitioner and non-government AOD settings (including rehabilitation services) that deliver the majority of care for alcohol and other drug use disorders and mental illness in Victoria. Translating a system of clinically governed expert committee risk review to the state-wide level would be an ideal way to reduce the harm related to inappropriate use of medication through stewardship of the prescribing of opioids, benzodiazepines, stimulants and sedating psychiatric drugs.

New model of care for consumers with the most complex needs

[77] Frei and Clarke, 'Meeting the Challenge in Care of Co-Occurring Disorders', *Medical Journal of Australia,* 195/3 (2011), S5.

Currently, there is no effective service model in place for consumers with the most severe mental illness and alcohol and other drug use disorders within Tier 5, with many of these individuals falling through the gaps in existing service provision. Given the nature of their complexity, which often involves repeated presentations to emergency services, risky behaviours and poor adherence to treatment, these consumers cannot be managed through simply improving referral pathways between services, particularly as they are unable to navigate one system let alone multiple. Instead, these consumers require an integrated model of care and multidisciplinary clinical expertise that is qualitatively different from what is currently offered across existing services. Ideally, this integrated service model would incorporate tertiary specialist expertise from both the AOD and mental health sectors working within one team and one philosophy, spanning both outpatient and inpatient care, with access to community housing, employment support, peer support and integrated long-stay residential rehabilitation.

In terms of outpatient models of care, assertive community treatment (**ACT**) is an intensive mental health program involving a multidisciplinary approach to consumer care that differs conceptually and empirically from traditional case management. A team of professionals support consumers who are at risk of psychiatric hospitalisation, but who do not readily use clinic-based services, with contact typically occurring in community settings. In 2001, Bond and colleagues[78] noted that ACT was one of the most comprehensively researched models of treatment in regard to mental illness, with 25 randomised controlled trials evaluating its effectiveness. The results of these trials indicate that ACT can substantially reduce psychiatric hospital use, increase housing stability, engage consumers in treatment, and result in a moderate improvement in symptoms and quality of life. While costly, this is offset by the reduction in hospital use amongst high-needs consumers.

Although implemented primarily in the mental health field, assertive community treatment has been recommended for consumers with serious mental health and co-occurring AOD use disorders, particularly when integrated with other treatments or interventions. In particular, it is a potential treatment model for consumers with severe co-occurring alcohol and other drug use disorders and medical disorders who are difficult to engage in treatment (such as those with alcohol dependence and liver cirrhosis). Indeed, a recent randomised controlled trial found that alcohol dependent consumers who received ACT had better treatment engagement and less unplanned healthcare use than those who received treatment as usual[79] .

Drake and colleagues argue that assertive outreach is a critical component of treatment given that many consumers with serious mental illness and alcohol and other drug use disorders struggle to manage linkages between services and maintain participation in treatment[80]. As such, assertive outreach is arguably of most benefit to a subgroup of consumers who are severely ill and difficult to engage. A review of Australian mental health stakeholders' (mental health service providers and mental health non-government organisations) views on such clients revealed that over 80% believed assertive outreach to be moderately to very effective[81] .

A study comparing assertive case management and standard case management amongst consumers with serious mental illness and co-occurring alcohol and other drug use disorders found that participants in both conditions improved over time, with greater decreases in substance use than would have been anticipated without treatment. They concluded that integrated treatment can be

[78] Bond et al., 'Assertive Community Treatment for People with Severe Mental Illness', *Disease Management and Health Outcomes,* 9/3 (2001), 141-59.
[79] Drummond et al., 'Assertive Community Treatment for People with Alcohol Dependence: A Pilot Randomized Controlled Trial', *Alcohol and Alcoholism,* 52/2 (2016), 234-41.
[80] Drake et al., 'Implementing Dual Diagnosis Services for Clients with Severe Mental Illness', *Psychiatric Services,* 52/4 (2001), 469-76.
[81] Cleary et al., 'Views of Australian Mental Health Stakeholders on Clients' Problematic Drug and Alcohol Use', *Drug and Alcohol Review,* 28/2 (2009), 122-28.

delivered successfully by either method of care[82] . However, qualitative evidence suggests that building trust through ongoing involvement as well as a feeling of personal responsibility for taking part in treatment may be crucial elements of successful ACT amongst consumers with co-occurring serious mental illness and alcohol and other drug use disorders[83] .

Concluding comments

Turning Point recommends a move away from the concept of a standalone 'mental health system' and towards an integrated 'system of care.' Building capacity in the AOD sector to enable the management of co-occurring mental illness within AOD services will provide a better quality of care and, over time, reduce the burden on health and emergency services, including ambulances, police, emergency departments and public mental health inpatient beds, as well as correctional and welfare services. Proposed improvements need to be informed by consumer voices from the initial planning stages, with iterative co-design and ongoing consultation shaping development. This applies to the AOD service sector as much as it does the mental health system. Whilst AOD consumer peak bodies are occasionally consulted for input into service delivery, there remains a lack of a systematic and co-ordinated consumer movement in AOD recovery, in comparison to the progress made by mental health consumer bodies. Individual consumers in the AOD system, faced by substantial stigma, may not feel empowered to advocate for change. The requirement of consumer representation on all AOD-related commissioning bodies can help redress this.

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[82] Susan M Essock et al., 'Comparison of Act and Standard Case Management for Delivering Integrated Treatment for Co-Occurring Disorders', *Psychiatric Services,* 57/2 (2006), 185-96.
[83] Pettersen et al., 'Engagement in Assertive Community Treatment as Experienced by Recovering Clients with Severe Mental Illness and Concurrent Substance Use', *International Journal of Mental Health Systems,* 8/1 (2014), 40-52.