



WITNESS STATEMENT OF PAUL MICHAEL DENBOROUGH

I, Dr Paul Michael Denborough, Clinical Director of Alfred Child & Youth Mental Health Service (**CYMHS**) and headspace at Alfred Health of 55 Commercial Road, Melbourne, in the State of Victoria, say as follows:

1. I am authorised by Alfred Health to make this statement on its behalf.
2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

A. BACKGROUND AND EXPERIENCE

(i) *Please describe your background, qualifications and expertise.*

3. I have the following qualifications:
 - 3.1. Bachelor of Medicine, Bachelor of Surgery, University of Melbourne (1985);
 - 3.2. Master of Medicine, University of Melbourne;
 - 3.3. Royal Australian and New Zealand College of Psychiatrists FRANZCP; and
 - 3.4. Certificate of Child and Adolescent Psychiatry.
4. I started at Alfred Health in 2002 as the Clinical Director of Alfred CYMHS and headspace and this is my current position.
5. I am a child and youth psychiatrist with extensive experience working in the public health system. I have been working in a senior management role for 17 years and am responsible for over 100 staff and a budget close to \$20 million.
6. Attached to this statement and marked 'PMD-1' is a copy of my current Curriculum Vitae.

(ii) *Are there any entities (other than the Alfred Health) that you are associated with, employed by or receive funding from?*

7. There are no entities, other than Alfred Health, with which I am associated or by whom I am employed or from which I receive funding.

B. ALFRED HEALTH AND HEADSPACE

(iii) **Please describe:**

(a) **your role as Director at Alfred Health's Child and Youth Mental Health Service;**

8. As the Director of CYMHS at the Alfred, I am responsible for:

- 8.1. ensuring the optimal functioning of CYMHS/headspace;
- 8.2. improving linkages with outside agencies;
- 8.3. improving quality of management and supervision in CYMHS;
- 8.4. developing innovative and effective treatment programs;
- 8.5. improving carer participation in CAMHS as well as family sensitive practice; and
- 8.6. developing an effective outcome measurement system.

9. Essentially I am responsible for the CYMHS, headspace primary and headspace youth early psychosis. My job is to implement recovery oriented practice. A 'recovery oriented approach' represents:

'a movement away from a primarily biomedical view of mental illness to a holistic approach to wellbeing that builds on individual strengths... Recovery-oriented practice emphasises hope, social inclusion, community participation, personal goal setting and self-management. Typically...recovery-oriented practice promotes a coaching or partnership relationship between people accessing mental health services and mental health professionals, whereby people with lived experience are considered experts on their lives and experiences while mental health professionals are considered experts on available treatment services'.¹

(b) **the nature of the Child and Youth Mental Health Service (Service)**

10. The CYMHS at Alfred Health provides a 'coordinated mental health service for young people and their families'.² The CYMHS offers an integrated service in the sense that persons are treated such that they avoid "bouncing" around the mental health system.

¹ Mental Health, Drugs and Regions Division: Victorian Government Department of Health, *Framework for recovery-oriented practice* (August 2011), 2; also see Davidson L, *Recovery: concepts and application*, Recovery Devon Group (2008) UK.

² Alfred Health, *Child & Youth Mental Health Service* <<https://www.alfredhealth.org.au/services/child-youth-mental-health-service>>.

(c) who the service is designed for (including ages);

11. The CYMHS is designed for families and young people (between the ages of 0-25) that are located in the municipalities of Port Phillip, Stonnington and Glen Eira, and for families and young people (between the ages of 0-18) located in the municipalities of Bayside and Kingston.³
12. The CYMHS is often engaged by referral for the following symptoms:
 - 12.1. 'not wanting to go to school;
 - 12.2. trouble controlling temper or tantrums;
 - 12.3. potential or actual harm to self or others;
 - 12.4. feeling sad, depressed, angry, stressed, anxious;
 - 12.5. feeling shy or withdrawn;
 - 12.6. not getting along with family, friends or others;
 - 12.7. bullying or being bullied;
 - 12.8. difficulties with co-ordination, social skills, learning and attention and concentration;
 - 12.9. difficulties with play, speech and language;
 - 12.10. eating and sleeping problems;
 - 12.11. feeling or acting suicidal;
 - 12.12. unusual experiences such as hearing voices, seeing strange things, having beliefs that seem out of touch with reality;
 - 12.13. mental health and alcohol or drug problems; and
 - 12.14. experience of trauma or abuse'.⁴

(d) how long the Service has been operating;

13. The CYMHS has operated since the early seventies, primary headspace has operated since 2007, and the headspace Youth Early Psychosis Program (hYEPP) has operated since 2013.

³ Alfred Heath, *Child & Youth Mental Health Service* <<https://www.alfredhealth.org.au/services/child-youth-mental-health-service/>>.

⁴ Alfred Heath, *Child & Mental Health Service* <<https://www.alfredhealth.org.au/services/hp/child-youth-mental-health-service/>>.

(e) what services are provided, and how (i.e. outpatient, free, low cost, etc);

14. The CYMHS can provide support to general practitioners, school counsellors, community health centres and headspace but also takes direct referrals from the public'.⁵ The following clinics are part of the CYMHS:
- 14.1. *Infant and Preschool Program* – provides direct clinical support along with consultation to caregivers and other services for infants and young children who are yet to start primary school and who have difficulties in emotional, social, and developmental areas, or who are at risk of having difficulties in these areas.⁶
 - 14.2. *Eating Disorders Program* – a CYMHS program which assists young people with eating disorders. Individual family programs include Brief family intervention, Clinic-based family intervention and Intensified Family Based Treatment. Group family programs include the Multi-Family Therapy Group for Adolescent Anorexia Nervosa which is 'an intensive, 4 day group treatment which is attended by the family and the young person experiencing anorexia nervosa'⁷. The Eating Disorders Program has changed considerably over the last 7-8 years. In particular, we have eschewed the practice where young persons with eating disorders are first sent for physical assessment with a general practitioner or paediatrician, resulting in a parallel treatment regime for physical health on one hand, and mental health on the other. CYMHS now manages the entire treatment of young persons irrespective of the severity.⁸
 - 14.3. *Single Session Family Consultation* – a CYMHS clinic which offers families 'one off' appointments with a team of clinicians. Single Session Therapy (**SST**) was developed at the Alfred CYMHS in 2004 and builds on worldwide data on SST practice. SST is 'an effective tool in improving both self and parent-rated individual, interpersonal, social and overall wellbeing for young people presenting to a mental health

⁵ Alfred Heath, *Child & Youth Mental Health Service* <<https://www.alfredhealth.org.au/services/child-youth-mental-health-service>>.

⁶ Alfred Health, *Infant and Preschool Team* <<https://www.alfredhealth.org.au/services/infant-program>>.

⁷ Alfred Heath, *Eating Disorders Program* <<https://www.alfredhealth.org.au/services/hp/eating-disorders/>>.

⁸ Alfred Heath, *Single Session Family Consultation* <<https://www.alfredhealth.org.au/services/single-session-family-consultation>>.

service'.⁹ Young people, parents and families either enter SST at their first point of contact with the service or by referral from a CYMHS clinician.¹⁰

- 14.4. *Early Intervention Mobile Outreach Service (EIMOS)* – a specialist, multidisciplinary group of CYMHS clinicians who provide intensive outreach mental health case management to clients, their carers, and families struggling with, or at high risk of, mental or behavioural disturbance.¹¹
- 14.5. *Neurodevelopmental Program* – a service for people aged 0-25 years incorporating neuropsychiatry, developmental assessment and management service, and Mental Health Intellectual Disability – Youth Initiative that provides multidisciplinary assessment and case management for children and young people with delays and impairments in several areas of development with additional emotional, social and behavioural problems.¹²
- 14.6. Generalist sector teams - these teams see the broad range of child and youth mental health problems.
- 15. CYMHS is staffed by a multidisciplinary staff group including psychiatrists, peer workers, psychologists and allied health professionals. It is a free service.

(f) *how many people access the Service on a yearly basis;*

- 16. Over 800 young people access the CYMHS each year. Over 2000 young people access our headspace primary service each year and around 700 the hYEPP and these numbers grow each year.

(g) *what benefits the Service offers; and*

- 17. The CYMHS can assist children and young people that:
 - 17.1. 'feel excessively anxious, worried, unhappy or shy;
 - 17.2. are having difficulty controlling impulses and/or anger, mood swings or depression;

⁹ Alfred Health, *Single Session Family Consultation* <<https://www.alfredhealth.org.au/services/single-session-family-consultation>>.

¹⁰ Alfred Health, *Single Session Family Consultation* <<https://www.alfredhealth.org.au/services/single-session-family-consultation>>.

¹¹ Alfred Health, *Early Intervention Mobile Outreach Service* <<https://www.alfredhealth.org.au/services/eimos>>.

¹² Alfred Health, *Neurodevelopmental Stream* <<https://www.alfredhealth.org.au/services/neurodevelopmental-stream>>.

- 17.3. have problems with sleeping or eating regularly;
 - 17.4. experience physical complaints that could be caused by emotional stress;
 - 17.5. are having difficulties with relationships;
 - 17.6. are having difficulties with learning, concentration, thinking clearly or remembering things;
 - 17.7. are distressed from a traumatic incident or have experience of abuse;
 - 17.8. have unusual experiences such as hearing voices, seeing strange things or things seem different;
 - 17.9. have thoughts of self-harm or suicide;
 - 17.10. experience a loss of enjoyment or motivation;
 - 17.11. notice changes in personality; and
 - 17.12. have family or friends who have expressed concern about behaviour changes'.¹³
18. Through a combination of psychological social and biological interventions CYMHS is able to improve the functioning and wellbeing in the vast majority of young people referred. CYMHS is able to achieve this in partnership with families.

(h) any challenges faced by the Service.

19. The CYMHS struggles to meet demand (like most mental health services in Victoria). Although we are able to maintain a 'no waiting list' policy, this is becoming increasingly challenging, and does come at the expense of true early intervention and the ability to properly support our tier 1 and tier 2 partners. We are more reactive than proactive and hence can be a little invisible to the general community as there is little promotion of the service in primary care, schools etc. The catchment area issue for us also makes it difficult to offer a continuous and effective service for the young adults in the middle south area of our catchment. We also have a much younger workforce often with limited mental health experience before they start with us which means a lot more time is spent by our more experienced staff in supervision and training than in the past.

¹³ Alfred Heath, *Child & Youth Mental Health Service* <<https://www.alfredhealth.org.au/services/child-youth-mental-health-service/>>.

20. headspace faces the following challenges:

- 20.1. as a fee for service Medicare model applies, there are some limitations in how flexible clinicians are able to be in terms of the response afforded to patients, particularly in terms of the number of sessions, but also family work and groups are more difficult to run;
- 20.2. headspace (primary) does not have a catchment area, however the state service operates on a catchment basis. Although this is manageable there is a lot of work needed to manage the interface between the different services;
- 20.3. a report prepared for the Department of Health and Human Services identified three options to resolve the catchment issue:
 - Option 1 was a minimal change option but would add the youth and adult clients to our middle south catchment;
 - Option 2 was to have 600,000 all age catchments which would mean that Alfred would take all ages in its CYMHS catchment; and
 - Option 3 was dividing the metropolitan area into three large areas.

My opinion is that Option 1 would have been reasonably easy for the Alfred to implement. Option 2 was more complicated to implement but in my opinion would offer the best options for families as it meant a hospital was responsible for the mental health care for their entire population across the age span. Attached to this statement and marked 'PMD-2' is a copy of the report.

(iv) ***Please describe what headspace is, the services it provides, and to whom.***

- 21. headspace is a free, confidential service provided by the CYMHS for people between the ages of 12-25 which can assist with 'general health, mental health, education, employment, alcohol and other drug problems'.¹⁴
- 22. headspace provides a range of general services including:
 - 22.1. medical services;

¹⁴ Alfred Health, 2019 (<https://www.alfredhealth.org.au/services/headspace>)

- 22.2. counselling services provided by psychologists, social workers and occupational therapists;
 - 22.3. drug and alcohol counselling;
 - 22.4. school and work assistance;
 - 22.5. services to families/friends; and
 - 22.6. youth early psychosis services.¹⁵
23. We also run the hYEPP across five headspace centres. The program focuses on early intervention, aiming to prevent disruptions in a young person's life and lessen the duration of untreated psychosis. We offer intensive integrated services including case management for young people and their families for up to five years.
24. There are four community care teams located in headspace centres in Bentleigh, Narre Warren, Dandenong and Frankston.
25. headspace also offers a Recovery Program which includes group program, peer workers, youth participation, exercise physiology, neuropsychology and vocational workers.
26. headspace also provides:
- 26.1. a *Mobile Assessment and Treatment Team (MATT)* – the MATT provides an out of hours service 'for young people and families that find it difficult to attend the centre or are in need of more intense services in the evenings or weekends'.¹⁶ The objective of MATT is to intervene early with young people at risk of their first episode of psychosis to prevent hospitalisation. The MATT also aims to 'work with families and young people who are hard to engage and have difficulty attending clinic based services'.¹⁷
 - 26.2. headspace *Discovery College* – headspace Discovery College is about learning from each other, sharing experiences and ideas to explore who we are, what works for us, what we want and what we can do. Discovery College values all different kinds of knowledge and experiences.
27. headspace primary first opened in 2007 and we took over the management of the Elsternwick site in 2010. This gives us a unique opportunity as a state funded hospital to provide an integrated system of mental health care in partnership with hYEPP and CYMHS.

¹⁵ Alfred Health, headspace <<https://www.alfredhealth.org.au/services/headspace>>.

¹⁶ Alfred Health, headspace <<https://www.alfredhealth.org.au/services/headspace>>.

¹⁷ Alfred Health, headspace <<https://www.alfredhealth.org.au/services/headspace>>.

- (v) ***Please describe the relationship between Alfred Health and headspace. What is the 'no wrong door' joint entry model to headspace and the Service and associated single session planning?***
28. The intake team at headspace works collaboratively with the intake team at CYMHS which ensures that patients are directed to the appropriate service. This collaboration is facilitated by the fact that both intake teams are employed by the Alfred and under the direction of unified management.
 29. The 'no wrong door' joint entry model means that no matter whether a person contacts headspace or CYMHS, the person will receive help. In other words, the entry point into the mental health system should not matter in order for a person to get help or obtain treatment. We operate by asking questions like "when", "where" and "who" as opposed to assessing eligibility. It is important to provide a "full" service to ensure that people do not "bounce" around the system. The effectiveness of this model is dependent on the assessment and judgement of the intake clinicians of both intake teams (that is, CYMHS and headspace). The initial call must be prioritised and the allocation must be trusted and accepted.
 30. Single Session Program (**SSP**) is where the patient and family and/or friends attend a two hour session with CYMHS clinicians as one group. We try to encourage as many as possible of the people that care about the young person to attend.
 31. We use a one way mirror during the session and after an hour of talking with the family, the participants swap places. The family watches as the clinicians brainstorm strategies and this is very powerful because the family, and the patient, has the opportunity to see people caring for and thinking about them. We operate on the assumption that the family is best placed to help the patient.
 32. The SSP model was based in the United States where a clinician decided to follow up on patients that did not attend their second session. The patients advised they did not attend a follow up session because they had received the intended benefit, and this was not a clinical or treatment failure as assumed. The most common number of sessions that people attend is one, therefore the idea behind the SSP model is to make the most of the initial session.
 33. Most mental health services are focused on detailed assessments. In contrast, the SSP is beneficial because it focuses on trying to fix the problem (that is, outcome focused) rather than delving into the "skeletons" in the closet. For example, clinicians at SSP ask questions like "what is the main problem you want to work on", "what questions would you like answered". In my experience, many

parents who attend a mental health service are worried about being blamed. Focusing on outcomes and solutions somewhat relieves this concern.

34. Teenagers are often reluctant to attend a session to discuss their mental health so another advantage of SSP is that the model only requires them to attend one session. People are hesitant to engage if they think that they have to return on multiple occasions over a long period of time.
35. It is often the case that before they have been referred to us, a psychologist will have seen a young child on their own, even as young as 8, yet the family has not been seen. My view is that for most children and teenagers, the sessions should involve the family because intensive intervention with the family often achieves a better outcome.
36. Approximately 20% of young people at the CYMHS start with a single session which helps approximately 70% of those people in the sense that the family is satisfied with the outcome and they do not request additional help. In respect of the other 30% of young people who require further services and return for more help, we try to ensure that returning patients are seen by the same clinician so that they do not have to retell their story.
37. The Eating Disorders Program also utilises targeted initial sessions which focus on finding solutions and delivering outcomes rather than doing detailed problem saturated assessments unless absolutely necessary.
38. The Early Youth Psychosis Program is another example of a service which utilises the principles of making the most of the first appointment by involving as many members of the network in the first meeting and making sure there is time to listen to the different perspectives of family members and develop a collaborative treatment plan.
39. The single session model is a vital ingredient in helping us maintain no waiting list. It is also outcome and family focused and recovery oriented which helps orient our service in this direction.

(vi) *Describe the headspace Youth Early Psychosis Program, including:*

(a) *your role in that program;*

40. In 2013, the Federal Government awarded a grant to set up the hYEPP. The Alfred is one of six providers in Australia and at the present the only provider of the hYEPP in Melbourne.

41. The Program comes under the headspace program of which I am, and have been, the Clinical Director since 2002. We implemented the youth early psychosis service at the Alfred with innovations such as Discovery College and Collaborative Adapted Network Approach (**CANA**). CANA is an adaption of open dialogue developed overseas and is a model we are using to ensure that all young people get off to a good start with us and receive outcome orientated and recovery oriented practise. My role is to provide clinical leadership to the program and ensure we offer an integrated system of care where young people and their families do not fall through gaps.
42. My key responsibilities involve managing the interface between Alfred, the Primary Health Network (**PHN**), headspace National and Orygen in regards to accreditation and quality control. We are funded directly from the PHN and are accountable to them for our outputs and outcomes. In partnership with my Operations Manager, we are responsible for the optimal functioning of the HYEPP, ensuring we are operating with high fidelity to the Early Psychosis Prevention and Intervention Centre model and providing safe and effective services.

(b) the nature of the program;

43. The Program at the Alfred focuses on early intervention of mental illness and aims to 'prevent disruptions in a young person's life and lessen the duration of untreated psychosis'.¹⁸

(c) who it is designed for (including ages);

44. The Program is designed for people who are experiencing their first episode of psychosis (or at risk of developing psychosis) between the ages of 12-25.¹⁹ The Program may also include people that have a family history of psychosis, have a decline in functionality, and/or have transient psychotic symptoms.²⁰

(d) how long the program has been operating;

45. The Program has been operating since 2013.

¹⁸ Alfred Health, *headspace Early Youth Psychosis Program* < <https://www.alfredhealth.org.au/services/headspace-youth-early-psychosis-program/> >.

¹⁹ Alfred Health, *headspace Early Youth Psychosis Program* < <https://www.alfredhealth.org.au/services/headspace-youth-early-psychosis-program/> >.

²⁰ Alfred Health, *headspace Early Youth Psychosis Program* < <https://www.alfredhealth.org.au/services/headspace-youth-early-psychosis-program/> >.

(e) what services are provided;

46. The Program provides:
- 46.1. 'evidenced based early treatment with a multidisciplinary team;
 - 46.2. psycho education;
 - 46.3. psychiatry support;
 - 46.4. GP services;
 - 46.5. comprehensive recovery programs;
 - 46.6. outreach services;
 - 46.7. after hours and crisis support; and
 - 46.8. support for family and friends'.²¹
47. The outreach team operates after hours and seven days per week.

(f) how many people access the program on a yearly basis;

48. Around 700 young people access the Program per year.

(g) what benefits the program offers; and

49. The Program offers holistic, comprehensive and collaborative care to young people and their family at the most vulnerable and challenging period. The model is based on evidence of effectiveness developed here in Melbourne at Orygen. The outcomes for young people and their families using the Program have been extremely positive.

(h) any challenges faced by the program.

50. The main challenge for the Program has been the lack of certainty of funding and, although we are funded until June 2021, the relatively short contracts for staff can leave our workforce vulnerable.

C. INTERVENTION EARLY IN LIFE

²¹ Alfred Health, *headspace Early Youth Psychosis Program* < <https://www.alfredhealth.org.au/services/headspace-youth-early-psychosis-program/>>.

(vii) What do you understand to be meant by the terms ‘early intervention’ and ‘intervention early in life’?

51. Early intervention means different things to different people, but I understand it as helping people as soon as possible once mental distress is identified.
52. Intervention early in life means helping people in childhood and adolescence.

(viii) What are the early signs or symptoms of mental ill health in the following groups?

(a) Infants

53. Babies do not exhibit the classic symptoms of mental illness, but babies do demonstrate through, for example, poor sleep patterns, difficulties with feeding, restlessness and gastric disturbance, that they are anxious and tense, distressed or fearful.

(b) Children aged 2 – 5 years

54. The early signs or symptoms of mental ill health in children aged 2-5 years include anxiety, sadness, behavioural disturbance and developmental problems.

(c) Children aged 6 – 12 years

55. The early signs or symptoms of mental ill health in children aged 6-12 years also include anxiety, sadness, school reluctance or avoidance and behavioural disturbance. Anorexia nervosa is uncommon under the age of 12, but does occur and psychosis is extremely rare under the age of 12.

(d) Children aged 13 – 18 years

56. The early signs or symptoms of mental ill health in children aged 13-18 years include anxiety and depression and behavioural problems. It is also the time of life when anorexia nervosa presents most commonly, and some people present with psychosis in this age group.

(ix) Are those signs and symptoms easily detectable, and if not, what can be done to ensure early detection?

57. Young people with more externalising symptoms are often easily detected in the school setting, but the problem is often lies in identifying who is best placed to provide the help and will that help involve supporting the whole family. Young

people with anxiety, depression and eating disorders can “fly under the radar” which can delay help seeking and lead to secondary morbidity, such as school refusal and anorexia nervosa.

(x) *What are the benefits of intervening in mental health early in life? What is the impact of not intervening?*

- 58. Early intervention in mental health is beneficial because it treats the illness now and prevents or minimises the impact of mental illness in the future.
- 59. Anorexia, in particular, is the most important condition for early intervention because, if caught at an early stage, it is 100 percent treatable. The longer the condition is left without treatment, the more difficult it becomes to treat.
- 60. For children, it is especially important to get them back on a “normal path” where they have a peer group, are making friends, going to school, learning, etc.
- 61. The children that end up in youth justice are generally surviving, but struggling at primary school and then find the transition to high school extremely challenging. The struggle is exacerbated due to a lack of community structure which often results in early offending.

(xi) *What are the types of early intervention strategies or services that exist in Victoria, Australia and in the world?*

- 62. In Victoria, there are several early intervention strategies or services of which I am aware.
 - 62.1. Compared to other parts of the world Victoria has a pretty comprehensive state funded CYMHS service which is quite innovative but struggles to meet demand.
 - 62.2. We have also pioneered the 0-25 age service structure (otherwise known as Child and Adolescent Mental Health Service (**CAMHS**) plus) which in my opinion offers much better care for young adults. This model however is not across the whole of Victoria.
- 63. In Australia, there are several early intervention strategies or services of which I am aware.
 - 63.1. There are many different innovations in parts of Australia that Victoria could learn from. The mental health support to young people in youth justice is much more evolved in Queensland. There is a very innovative program in Adelaide working with child protection to help parents get

their kids back following removal. In Sydney, Coral Tree Family Services provides a family intervention model for NSW which I believe we could replicate in Melbourne. The Foyer model is something that could be expanded to different parts of Victoria as a response to youth homelessness and mental illness.

64. There are a number of international examples of early intervention strategies or services.

64.1. Open dialogue is a model of care which has shown a lot of promise in other countries as a way of effectively treating early psychosis - this could be rolled out more in Australia.

(xii) *What are the most effective services or strategies of early intervention?*

65. Services that are integrated with their local community so referrals are received as early as possible. Families are welcomed in and empowered to support their young person to alleviate their mental distress. Services that are most effective are the ones that involve families from the very beginning, collaborate with them and are flexible enough to adapt their treatment to the needs of the family.

(xiii) *What is Victoria doing well in terms of early intervention, and what could it do better?*

66. We have a talented workforce and there are examples of world leading innovation in certain areas (such as eating disorders and first episode psychosis). The CAMHS plus model of extending CAMHS up to age 25 and the headspace system are the envy of many other countries. The main issues are the lack of consistency across the state and in places a lack of co-ordination or integration between state and federally funded services.

67. Early intervention could be improved in Victoria if the following changes are implemented:

67.1. headspace could be expanded to cover 0-25 years rather than 12-25 years. My view is that this would be beneficial for general practitioners and maternal health nurses to be involved in headspace for children aged 0-12 years in order to provide holistic treatment/service. Although CYMHS offers services for children aged under 12, the percentage of these children being treated has decreased because children aged above 12 years old are being prioritised. As long as interventions in

headspace for 0-12 years were family focused this could be an efficient way to improve access for this age group.

- 67.2. The general mental health system should manage eating disorders like anorexia as opposed to specialist services. This would allow for a much greater chance of earlier intervention, which is the key to treating this disorder.
- 67.3. People must be welcomed into the mental health system. Presently, in many instances, people are asked a lot of questions designed to determine eligibility, rather than assisting engagement and instilling confidence that they have found the right people to help them.
- 67.4. The methodology of “root cause analysis” to review suicide has many unintended consequences which have a major negative impact on the quality and effectiveness of many mental health services. A culture of blame and fear can develop in services which is insidious. Clinicians can be afraid to make decisions or to collaborate with families. A much more modern approach is required (of which there are several examples). These approaches involve the clinicians involved in the death and focus on learning and retrospectively looking at the quality of care provided including whether the family was welcomed in and care provided was recovery oriented rather than trying to uncover a “root cause”.

(xiv) *What are the difficulties faced in Victoria improving its services in terms of early intervention?*

- 68. The difficulties faced in Victoria include the following:
 - 68.1. The state system is unable to adequately meet the demand. This is partially due to lack of resources, but also because families are often not involved, welcomed in to the service or offered very “front ended” treatment which is intensive, collaborative and outcome focused. All too often inefficiencies are created by families having to tell their story to multiple people before they are even offered any sort of help. When they do finally get help they are often put through long problem saturated assessments. Help is often “on top” rather than “on tap” and the focus tends to be more on “what is wrong with you” rather than “what has happened to you”. A truly effective treatment system would be one that is recovery oriented and outcome focused. This does exist in some places but is not widespread.

- 68.2. The public system does not go looking for people because they do not have capacity or funding to take on more patients. In my opinion, public mental health services have an extremely rudimentary online presence because of a fear that if public mental health services are more welcoming and accessible we will be overrun. There are many opportunities missed because of this approach, in terms of early intervention and utilising online support and treatment. Most mental health services' websites are hidden within a bigger general hospital which perpetuates our invisibility to the broader community, and fails to address the mystery and lack of transparency which the community experiences about the system.
- 68.3. There is a lack of integration between state and federally funded services: we are the exception at Alfred Health Child and Youth, but this lack of integration causes tremendous frustration for families in terms of being "bounced around" the system.
- 68.4. The catchment system could definitely be improved based on previous advice.

PART IV: YOUTH EARLY PSYCHOSIS

(xv) *Can you describe what a psychotic episode or illness is?*

69. Psychosis is a collection of symptoms rather than a disease.

(xvi) *What are the signs and symptoms of a psychotic episode or illness?*

70. An individual is suffering from hearing voices or having unusual beliefs. In other words, they are having sensory experiences that do not exist, or having beliefs with no basis in reality.

(xvii) *What percentage of young people are at risk of experience a psychotic episode or illness?*

71. As many as 3 in 100 people will have a psychotic episode at some point in their lives.

(xviii) *How does this compare to young people who experience other mental health issues such as anxiety or depression?*

72. Psychosis is less common. Some surveys, in particular Sawyer et al., suggest that up to 14% of young people suffer from other mental health issues.

(xix) *Is there any risk of a person being falsely diagnosed as having a psychotic illness? If so, can you please explain?*

73. This is not really an issue if psychosis is seen as a collection of symptoms rather than a “disease”.

(xx) *What is the critical period after the onset of the first psychotic episode that you believe treatment needs to occur?*

74. Treatment really should occur as soon as identified. The critical misunderstanding here can be that treatment implies medication. Not all people with psychotic experiences need, or require, medication but respond well to psychosocial interventions.

(xxi) *Is there any data or evidence to suggest that early treatment for psychosis in young people is beneficial? If so, what does that data or evidence say?*

75. There is a large amount of evidence that early treatment is beneficial both locally and internationally. The TAPS study in Norway, the Raise study in USA, and Orygen research are among a few as well as several studies on the Open Dialogue model.

(xxii) *Are there any criticisms or controversies associated or directed to early treatment for psychosis in young people? If so, can you explain what those criticisms or controversies are?*

76. Yes, some criticisms or controversies are associated or directed to early treatment for psychosis in young people, because of the risk that young people are given drugs and labelled with a disease unnecessarily. These should be easily mitigated against if the service is recovery oriented, and psychosis is viewed as a collection of symptoms rather than disease. There is ample evidence which demonstrates the benefits of early intervention for young people who are suffering from acute mental health concerns. In my opinion, there is no justification for why these services should not be offered as early as possible.

sign here ► 

print name Paul Michael Denborough

date 9 July 2019



ATTACHMENT

PMD-1

This is the attachment marked '**PMD-1**' referred to in the witness statement of Paul Denborough dated 9 July 2019.

Dr PAUL DENBOROUGH

SUMMARY

I am a youth psychiatrist with extensive experience working in the public health system. I have been working in a senior management role for 17 years and am responsible for over 100 staff and a budget close to \$20 million.

I have a successful record of leadership, clinical work, teaching, research and working closely with community agencies. With strong leadership qualities and a clear sense of purpose and direction, I have a commitment to outcome evaluation and quality improvement as well as best practice, particularly in the youth psychiatry field.

I have excellent communication, analytical and conceptual skills and am equally as comfortable with young children, teenagers and adults. I am well recognized for implementing innovative practice and culture change within the mental health system as well as implementing ground breaking youth early psychosis service with innovations such as Discovery College and client-led needs-adapted practice.

Significant achievements include improving a CAMHS service with particular emphasis on enhancing teamwork, clarifying accountability, improving relationships with key stakeholders and working with carers to improve family sensitive practice.

CAREER OBJECTIVE

A senior management position within the psychiatric profession with an opportunity to achieve best practice and the highest standard of patient care.

CAREER HISTORY AND ACHIEVEMENTS

ALFRED HOSPITAL

Clinical director of Alfred CYMHS and Headspace

2002-current

Key Achievements:

The CAMHS service has gone from a budget of 2.8 million dollars in 2002 to now the budget being close to 20 million dollars in 2019. The service has a growing reputation for innovation and excellent clinical practice.

2007-Awarded first Headspace centre in Australia in Elsternwick.

2009-Awarded the “demonstration project” via competitive tender where Alfred CAMHS became CYMHS as the first child and adolescent service to extend their age range from 18 up to age 25 which is now acknowledged as the way to the future.

2013-awarded Federal funding of \$12 million to implement HYEPP (Hearspace youth early psychosis program) in the Southern Region. This service has delivered many innovative programs including Discovery College, peer work and ground breaking work on client led dialogical practice.

2015-awarded competitive tender for the new mental health and intellectual disability-youth team.

2018-awarded the service to implement the new youth forensic service for eastern half of Victoria.

Key Responsibilities:

1. Optimal functioning of CYMHS/Hearspace

March 2005 – Alfred Psychiatry In Depth Review ACHS:

“CAMHS is to be commended on the significant improvements around clarity of structure, alignment of staff to enhance multidisciplinary team functions and the clarification of lines of accountability promoting an integral learning organization culture. This was demonstrated by clear reporting processes by teams in the CAMHS Executive, transparent management of strategic alliances and a corporate history of change documented in the Executive minutes. An extremely comprehensive orientation manual clearly stipulated roles and responsibilities within this component of Alfred Psychiatry”.

March 2009 as part of state-wide vision for service redesign in child and youth mental health Alfred CAMHS was awarded a demonstration project to lead the way in redeveloping the service within a 0-25 years framework that improves continuity of care, fosters age appropriate responses for children and young people and builds partnerships with primary health, early childhood services, schools and a range of community services.

To date there have been multiple achievements including a broader range of clients (particularly young adults) being seen, increase in number of single sessions, much greater system of care for anorexia nervosa clients, as well as for all client groups.

2. Improving linkages with outside agencies

- Developed an enhanced intake service to successfully build a system of care in our catchment area.

- Greatly improved relationship with Child Protective Services via regular liaison and development of Southern Consultancy Panel. Alfred CAMHS now has a reputation for excellence in this area.
- Able to deliver on no waiting list policy to minimise access problems to CAMHS.

3. Improving quality of management and supervision in CAMHS

- Introduced an effective performance management system with enhanced ability to deal with performance issues.
- Ensured all staff have regular clinical supervision.
- Developed a strategic and business plan for Alfred CAMHS.

4. Developing innovative and effective treatment programs

- Lead and implemented an effective Single Session Intervention Service.
- Lead formation of effective Family Therapy Teams.
- Lead and coordinated effective and innovative Group Therapy Program.
- Enabled shared work to occur without impacting on access to CAMHS for clients.

5. Improving carer participation in CAMHS as well as family sensitive practice.

- Promoting and ensuring family sensitive practice by multiple means:
 - successfully implementing Friends of Alfred CAMHS,
 - improving documentation,
 - clarifying and modeling best practice in terms of assertive and effective case management,
 - improving information for carers.

6. Developing an effective outcome measurement system

- Introduced and developed a culture of client directed outcome based treatment.
- Operationalised a clinically useful outcome measurement system.

Consultant Psychiatrist CEED(Centre of Excellence in Eating Disorders) 2007-2019

Part-time role assisting mental health services develop a system of care in managing eating disorders state wide.

Supervision of CEED staff who are providing primary, secondary and tertiary consultation to area mental health services.

A&RMC

Consultant Child and Adolescent Psychiatrist 1997 – 2002

(Team Leader, Central North East Community Outpatient Team and Consultant in charge of Paediatric Liaison Psychiatry at A&RMC)

Key responsibility for optimal functioning of community team and department

- Achieved very stable and effective staff team and led team to introduce innovative practices by working closely with all members to develop a cohesive team culture.
- Improved the standing of A&RMC CAMHS in the community by developing strong links with local community agencies and by taking a leadership role in the formation of the Banyule Youth Services Network.
- Developed and maintained strong morale and minimized disruption among the outpatient team staff by proactively managing recent structural changes.
- Enhanced patient outcomes and provided stimulation for team members by developing a single session family intervention structure with built in evaluation.
- Designed and implemented a research project to evaluate our family therapy to inform clinical practice and highlight the importance of evaluation of our work.
- Played a leading role in implementing a system of outcome measures for CAMHS.
- Promoted the continuity of care and reduced conflict over referrals by establishing closer communication/liaison between inpatient and outpatient staff.
- Provided clinical leadership and strong supervision and support to the multidisciplinary staff of the outpatient team.

Liaison psychiatry of children and teenagers in the paediatric, spinal and neurology wards of A&RMC

- Achieved excellent outcomes in the treatment of Chronic Fatigue Syndrome by pioneering a multidisciplinary approach to the illness (currently unique in the world).
- Currently playing a leading role in the improved treatment of such illnesses as Anorexia Nervosa by fostering excellent relationships and a strong collaborative approach between paediatricians and CAMHS.
- Conducted joint presentations with rehabilitation physicians on common areas of interest at the spinal injuries conference.

EARLIER PROFESSIONAL DEVELOPMENT

1995-96 Senior Registrar A&RMC

Psychiatry Registrar:

1994	Chronic Psychiatry, N.E.CATT
1993	Acute Psychiatry, Larundel Geriatric Psychiatry, Wildarra
1992	Acute Psychiatry Repatriation Hospital Liaison Psychiatry, Austin Hospital
1991	Child and Adolescent Psychiatry, Austin Hospital Acute Psychiatry, Bendigo
1990	Acute Psychiatry, Larundel Hospital Chronic Psychiatry, Larundel Hospital
1989	Senior House Officer, Princess Alexandra Hospital, London
1988	General Medical Locums, London
1987	Junior RMO, Box Hill Hospital
1986	Intern RMH, Parkville

RESEARCH

2001	Evaluation of Chronic Fatigue Program (published in Australasian Psychiatry)
2000	Evaluation of Single Session family therapy intervention (ongoing)
1999	Evaluation of Central Team family therapy program

POSTGRADUATE QUALIFICATIONS AND AWARDS

1990-96	Royal Australian and New Zealand College of Psychiatrists FRANZCP (1996)
1995-96	Certificate of Child Psychiatry (1996)
1990-96	Master of Medicine, Melbourne University
2000	Quality Award Psychiatry CSU A&RMC

TEACHING

Fifth Year Medical Students
 Intern and HMO training A&RMC
 DPC Training
 Graduate Diploma of Child Psychiatry
 Co-ordination of liaison training at child psychiatry training program



ATTACHMENT

PMD-2

This is the attachment marked '**PMD-2**' referred to in the witness statement of Paul Denborough dated 9 July 2019.



Victoria's Clinical Mental Health System Plan

Discussion Paper

***Design, Service and Infrastructure Plan for Victoria's
Clinical Mental Health System***

Department of Health and Human Services

August 2016

Executive summary

This discussion paper relates to the development of a high level Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System (the Plan). With one in five Victorians expected to experience a mental health condition each year and almost half of Victorians expected to experience a mental health condition in their lifetime, it is important that Victoria's clinical mental health system is designed to adequately respond to the future needs of the Victorian community.

The Victorian clinical mental health system provided services for close to 66,000 registered clients in 2014/15 as well as a much larger number of unregistered individuals for which the system provided support and treatment. In 2014/15 there were over 27,000 mental health related admissions and over 2,000,000 mental health community contacts. Recognising the importance of system design and planning in ensuring sustainable care provision for Victorians, the Plan will take a long term, aspirational view providing direction at the systems level.

Informed and aligned to the goal and outcomes articulated in Victoria's 10 Year Mental Health Plan, are the following clinical mental health system planning principles that will support the development of this Plan. These are underpinned by the notion that system design of the clinical mental health system should be led by the unique needs of individuals with a focus on individuals most vulnerable and at risk.

- individual choice and co-production
- access to appropriate mental health care is equitable, responsive and timely, providing care in a community setting where possible
- services are person and family-centred, and organised around maintenance of an individual's functioning - through both management of illness (mental and physical) and the process of recovery
- role delineation should facilitate system design that aims to develop a complementary capability and service mix with a focus on safety and quality
- earlier, more connected individualised care and support.

In planning the design of the overall clinical mental health system across Victoria the following key considerations will need to be addressed.

Capacity planning for the future - with population characteristics and the nature of demand changing it is important to consider the optimal mix of service models as well as approaches to forecasting demand to facilitate alignment of future supply and demand. Principles of recovery and co-production should underpin the design and planning of capacity and service models.

Age based service configuration – with age based service offerings being a key element of the current system architecture, there is a need for clarification of the definition and provision of child and youth based services, acknowledging that the 10 to 29 year age group is a critical time for early intervention given the significant onset of mental health conditions during this period. Further, with demographic trends clearly showing an ageing population there is a need to consider whether the definition for aged mental health services should be changed.

Catchment based service configuration - the catchment structure in Victoria has been unchanged since the 1990s. Review of this structure should consider: the appropriateness of maintaining existing fixed catchment areas for service delivery; suitable governance arrangements and enhanced alignment across age based services.

Integration across service providers - given the multifaceted nature of individuals' health care needs, integrated and interdisciplinary care approaches are necessary. Taking a holistic view of health care is encouraged given the often poorer overall health status of individuals with mental health conditions.

This discussion paper begins to identify some of the planning challenges for Victoria and emphasises the need to make clear choices regarding the future direction and configuration of the system.

We welcome your feedback and views on the questions raised throughout this discussion paper which can be provided via [Clinical Mental Health Service Plan survey](#).

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1 Introduction

The focus of this discussion paper is on developing a Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System (the Plan). Development of this high level systems focussed Plan provides an opportunity to review the structure and architecture of Victoria's clinical mental health system which has not been comprehensively reviewed since the mid-1990s. The Plan is a key element of the implementation of Victoria's 10 Year Mental Health Plan and will take a long term view aiming to be aspirational and develop a world leading clinical mental health system for Victoria.

30 years ago the clinical mental health system was structured around the need for deinstitutionalisation - that is, moving support and care for people out of standalone psychiatric hospitals toward care that is based in the community. Victoria's population growth in the 1990s was concentrated in the south eastern suburbs of Melbourne with suburbs such as Caroline Springs being undeveloped green space.

Fast forward 30 years, Victoria is a very different place, with population growth over the last 20 years being greater than the size of Adelaide's entire current population (growth of 1,400,000 people since 1996). Growth corridors and centres have emerged and are expected to continue growing, especially in the north, west and inner Melbourne areas. Rapidly changing population, service provider and care characteristics are contributing to, and exacerbating, the misalignment between supply and demand across Victorian clinical mental health services. With one in five Victorians now expected to experience a mental health condition each year and almost half of Victorians expected to experience a mental health condition in their lifetime, it is important that the system adequately responds to the future needs of the Victorian community. Through development of Victoria's 10 year Mental Health Plan and previous consultations with health services regarding catchment structures, there is both the vision and a solid platform of existing information upon which the future architecture of Victoria's clinical mental health system can be built. To realise the goal and outcomes of the 10 Year Mental Health Plan, the design and configuration of Victoria's clinical mental health system needs to be reconsidered, to ensure the right types of services are accessible in the right places at the right time for those who need them.

1.1 Scope and purpose

The purpose of this discussion paper is to outline key service design and planning considerations for the Victorian clinical mental health system. It aims to stimulate discussion about clinical mental health service planning approaches, providing insights that will contribute to developing an informed and innovative final Plan.

The Plan aims to provide high-level direction for the design, capacity and configuration of the clinical mental health system, including public inpatient, sub-acute and other bed-based and community-based settings across Victoria. The Plan will articulate the system architecture needed to support achievement of the outcomes articulated in Victoria's 10 Year Mental Health Plan, and will provide the foundations and direction for clinical service planning over the initial five years of that plan.

Informed and aligned to the goal and outcomes articulated in Victoria's 10 Year Mental Health Plan, are the following clinical mental health service planning principles that will support the development of this Plan. These are underpinned by the notion that system design of the clinical mental health system should be led by the unique needs of individuals with a focus on individuals most vulnerable and at risk.

- **Individual choice and co-production** – are built into service design with shared influence, choice and decision making between individuals, their families, carers and service providers.
- **Access to appropriate mental health care is equitable, responsive and timely providing care in a community setting where possible** - aiming for equitable access to appropriate and safe clinical mental health services. Access should be underpinned by the fair and sustainable distribution of service capacity that is able to flex up and down in response to periodic changes in the volume or complexity of mental health needs.
- **Services are person and family-centred, and organised around maintenance of an individual's functioning - through both management of illness (mental and physical) and the process of recovery.**
- **Role delineation should facilitate system design that aims to develop a complementary capability and service mix with a focus on safety and quality** – ensuring services have the clinical capabilities required to safely perform their role enabling people with mental illness to receive the level of care and support they need in the most appropriate setting.
- **Earlier, more connected individualised care and support** – orientating the mental health system around the earliest point of need for an individual with integrated services designed for the health and wellbeing needs of the individual.

These planning principles support and compliment the statewide health system design principles as agreed by the Ministerial Advisory Council for the Statewide Design, Service and Infrastructure Plan for Victoria's Health System, to which this plan will contribute. The agreed design principles for Victoria's health system include:

- Victoria's public hospitals have clear role delineations, are geographically coordinated and are well connected to the broader health system.
- Where safe and cost effective to do so, services will be delivered outside of the hospital setting.
- Enhanced system design and service planning and performance management will release existing capacity in our public hospitals and better distribute new capacity.
- An appropriate balance will be considered so that designated tertiary/specialist health services are able to provide access to their local community, while also ensuring access to patients from across Victoria who require specialist care.
- The causal relationship between the volume of services being provided and the quality of these services will be reflected in system design and service planning.
- The prioritisation and distribution of high cost medical equipment across the system will be undertaken by the department.

This discussion paper focuses on key considerations for Victoria's clinical mental health system over the next 20 years, including the broad areas of: age based service configuration, catchment configuration, integration across service providers, ensuring sustainable capacity and service models, individual choice and governance arrangements.

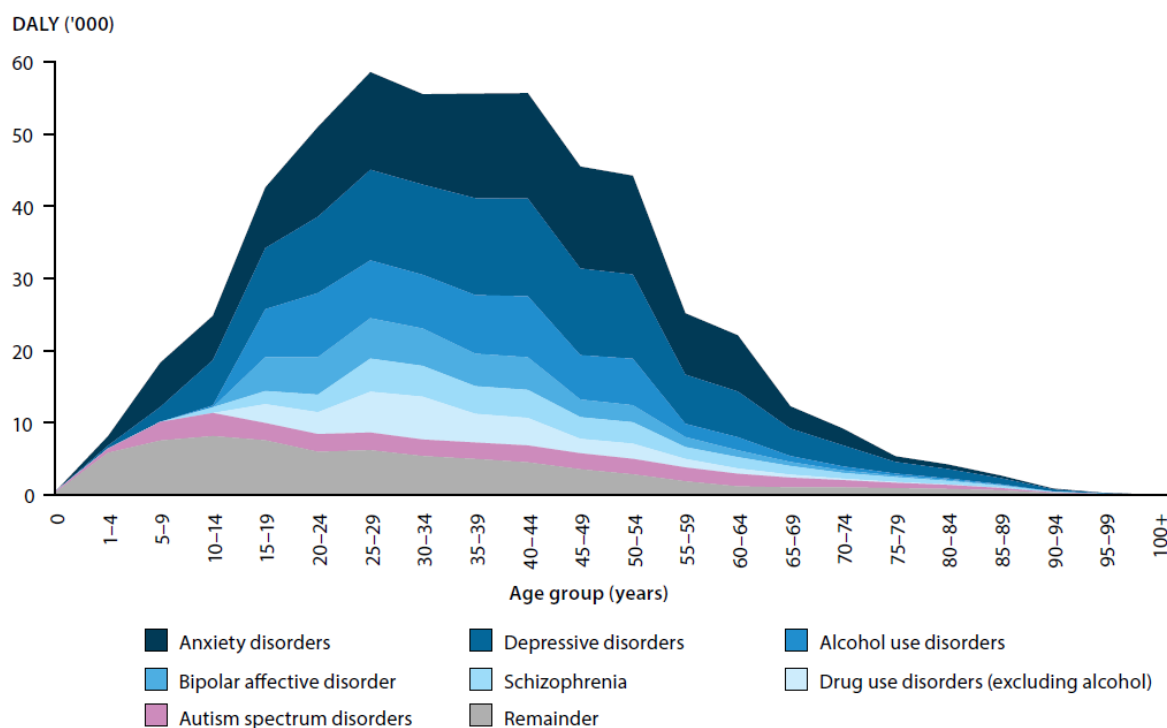
2 Mental health profile

2.1 Burden of disease

Mental and substance use disorders are the third highest burden of disease category (12 per cent of Australia's burden of disease and 24 per cent of Years Lived with a Disability (YLD)), contributing significantly to Australia's burden of disease profile. Women contribute a higher proportion of the non-fatal burden for mood, anxiety and eating disorders, whereas men appear to have a higher proportion for substance use disorders, schizophrenia and disorders that begin in childhood. Exploring trends over time, it appears that people are living for longer with illness, with the age standardised rate of total burden due to mental and substance use disorders decreased for fatal burden and increased slightly for the non-fatal burden across 2003 to 2011ⁱ.

Figure 2-1 below illustrates that the 10 to 29 year age group is a critical time for early intervention given the significant onset of mental health conditions during this period. The National Mental Health Commission (The Commission) acknowledge that early intervention is important for people of all ages, especially those with first time mental health issues or those for which mental health difficulties are becoming more complex. The Commission suggests that best practice encourages holistic, proactive and non-stigmatising approaches for timely identification of early warning signsⁱⁱ.

Figure 2-1: Mental and substance use disorders burden (DALY), by age and disease - Australia

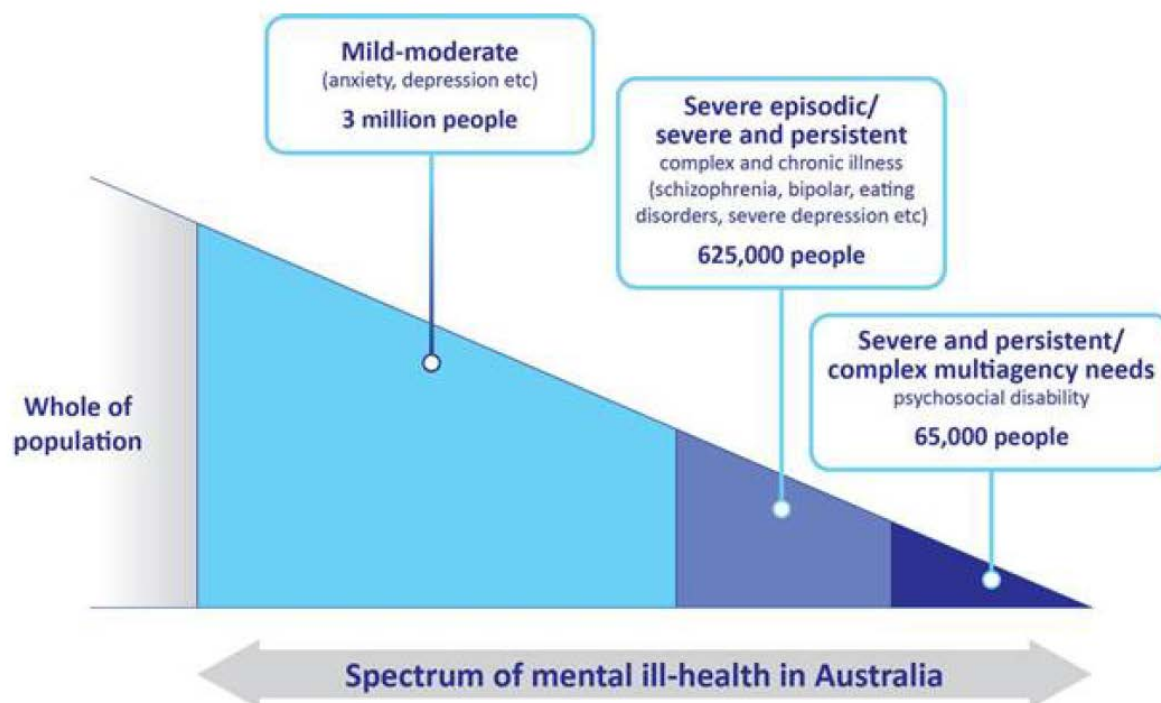


Source: Australian Institute of Health and Welfare, Australian Burden of Disease Study, 2011.

2.2 Continuum of mental ill health

Around three per cent of the Australian population experience mental illness with the severity spread across a spectrum of mental ill-health as shown in Figure 2-2 below.

Figure 2-2: Distribution of severity of mental ill health in Australia



Source: National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 2014.

Given only 46 per cent of individuals currently seek services per year, taking a holistic view of health care is encouragedⁱⁱⁱ. This is important given the often poorer overall health status of individuals with mental health conditions and the need to encourage individuals, their families and carers to access services. The stark reality is people with severe mental disorders on average tend to die earlier than the general population with there being a 10 to 25 year life expectancy gap^{iv}.

2.3 Mental health system architecture

The structure of the clinical mental health system - the system architecture – should be aimed at providing resources and effort in the most appropriate form, in the right places, at the right time. Mental health architecture should consider the following groups and their unique care needs (Figure 3-2)^v:

- Family and child health – acknowledging lifelong health approaches, developmental years and the need for early intervention.
- Youth and young adults – acknowledging a period of significant onset of mental illness and the need for early intervention.
- Adults – acknowledging chronic mental health difficulties and the need for provision of holistic health care.
- Older people – acknowledging the need for appropriate services that consider holistic aged care needs.

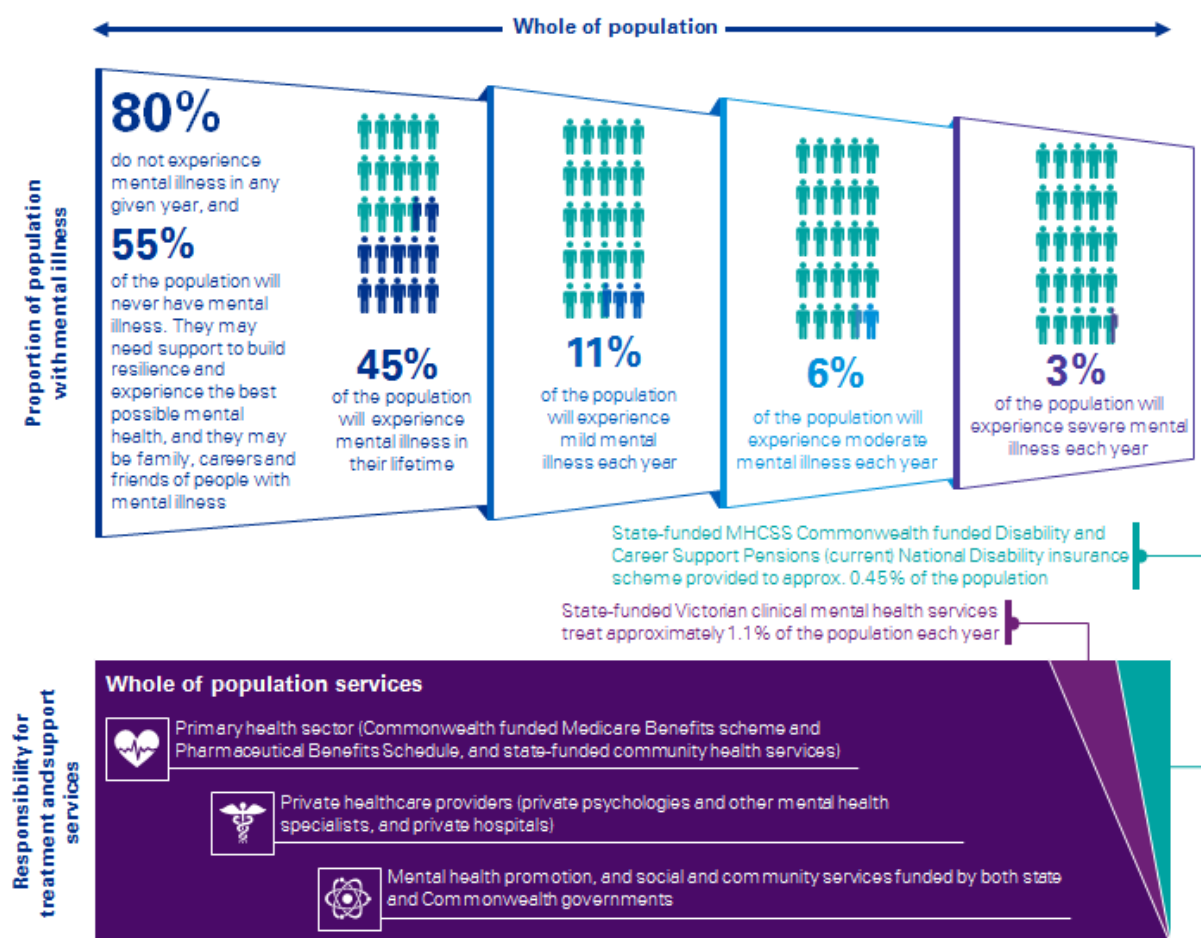
3 Victorian mental health system

Victoria's clinical mental health system comprises acute, subacute and community services with acute services providing care for those with complex and severe needs, for example those who would sit closer to the tip of the triangle shown in Figure 3-1. At the other end of the spectrum, community services support people with a mental illness to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment^{vi}.

The Victorian public clinical mental health system provided services for close to 66,000 registered clients in 2014/15 as well as a much larger number of unregistered individuals for which the system provided support and treatment. In 2014/15 there were over 27,000 mental health related admissions and over 2,000,000 mental health community contacts. Over the last seven years mental health service activity in terms of community contacts has remained stable and average contact hours per client have been falling (Figure 8-1).

Total admissions and client numbers have slowly increased and average length of stay per client have slowly decreased for children, youth and adults, however have increased for individuals aged over 65 years (Appendix Figure 8-2 to 8-4). Over the past 10 years the severity of problems that individuals present with on admission has increased as measured by the Health of the Nation Outcome Scale (HONOS) scores). The age standardised separation rate has increased at an uneven rate in the 10 years to 2015, illustrating an increasing utilisation of admitted patient services (Figure 8-5)^{vii}.

Figure 3-1: Services and prevalence of adult mental illness in Victoria



Source: Victorian Department of Health and Human Services, 2016.

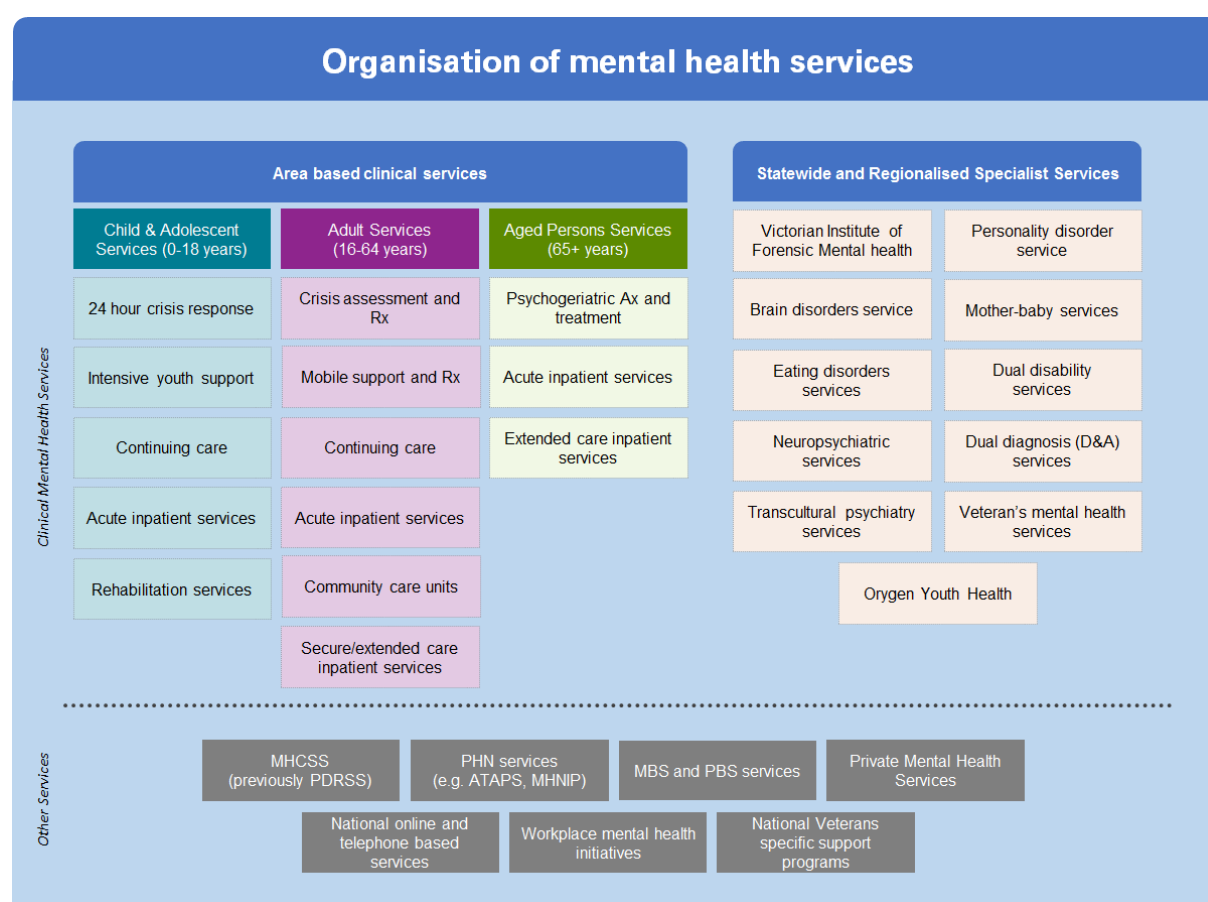
3.1 Service types and locations

Clinical mental health services are provided in a number of settings including acute inpatient services, community based services, residential care and non-government support services. The architecture of Victoria's system includes elements around: acuity, population type and geographic catchments, with overlap across these system layers that can lead to complexity.

Public mental health funding in Victoria is relatively evenly split across acute (52 per cent) and sub-acute, outpatient and community services (receiving 48 per cent)^{viii}; consistent with public mental health funding at a national level. The profile of inpatient services has changed significantly over time, with a changing balance between community and inpatient bed based services.

The Clinical Mental Health System Plan will focus on area based clinical services and specialist services (Figure 3-2). In developing a Plan for clinical mental health services the interfaces and relationships between other services sitting below the line in Figure 3-2 will also be considered.

Figure 3-2: Organisation of mental health services



Source: KPMG, 2016 based on information from Victorian Department of Health and Human Services.

Figure 3-3 below shows the various public admitted mental health services across Victoria, showing that rural and regional units are located in the major regional towns. In metropolitan Melbourne there is a distribution across the major hospital sites.

Figure 3-3: Map of health services offering admitted mental health services



Source: KPMG, 2016 based on information from Victorian Department of Health and Human Services.

4 Capacity planning for the future

Population characteristics and the nature of service demand is changing. Being able to reliably estimate future demand across different consumer cohorts, service types and locations is important for developing appropriate capacity planning approaches and clinical service models.

4.1 Consideration – Optimal demand modelling approach

Demand and bed modelling

Nationally, a range of approaches have been used to estimate demand for services. Historically, the use of normative population based benchmarks have been used to estimate total bed requirements for a state for a range of program areas.

The Mental Health Clinical Care and Prevention (MH-CCP) model was developed in New South Wales in the early 2000s. A key feature of MH-CCP is that the population prevalence of mental illnesses is stratified by age group and by defined levels of severity, described as mild, moderate and severe. Appropriate average care packages (bed based and community) are assigned to groups within each level of severity.

This approach has been adopted and further developed by the Commonwealth Department of Health into the National Mental Health Service Planning Framework (NMHSPF). This project aims to achieve a population based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments.

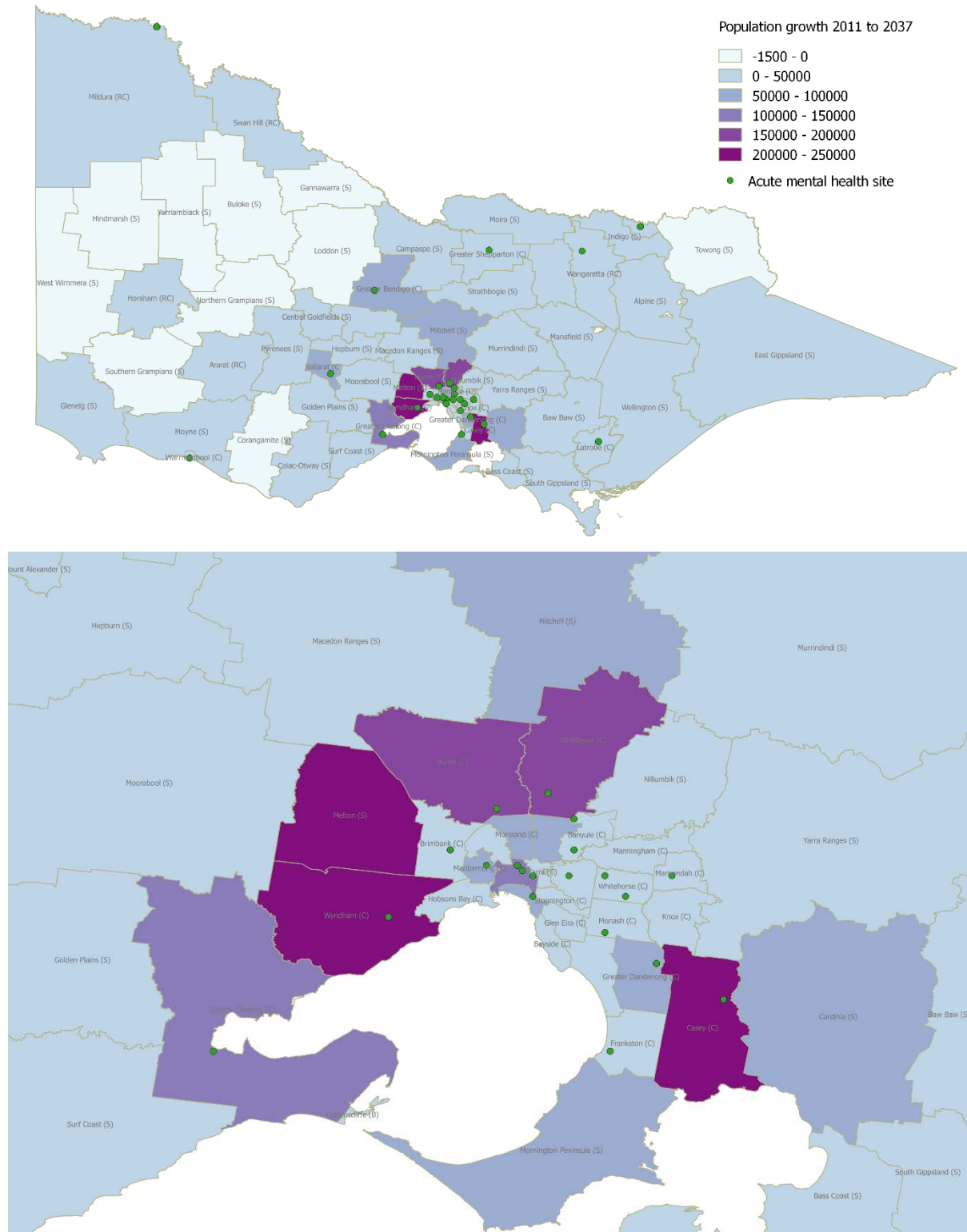
Impacts of population growth on supply and demand

The 2015 version of Victorian government population projections estimate a 1.8 per cent annual average growth rate to 2037. This will result in 40 per cent growth in Victoria's population to a total of 8.3 million by 2037^{ix}.

The concentration of population growth is dynamic and as such drives demand trends and the need for targeted service supply. The Wyndham, western, south east and northern growth planning areas are expected to experience a compound annual average growth rate exceeding 2.3 per cent between 2015 and 2037. The rapid emergence and continued growth of these corridors has led to a general misalignment between supply and demand for health services, including mental health services (Figure 4-1). This is particularly evident in the local government areas of Casey, Wyndham, Melton, Whittlesea, Hume and Greater Geelong that are all set to experience significant population growth, but appear to have limited access to public local clinical mental health services.



Figure 4-1: Projected population growth 2011 to 2037 and the current placement of acute mental health services



Source: KPMG, 2016 based on information from Victoria In Future, 2015.

4.2 Consideration – Enhancing the mix and sustainability of service models

Striking a better balance between community and admitted services and developing innovative service models is important in managing demand and in underpinning the design of the system.

Service type and model mix

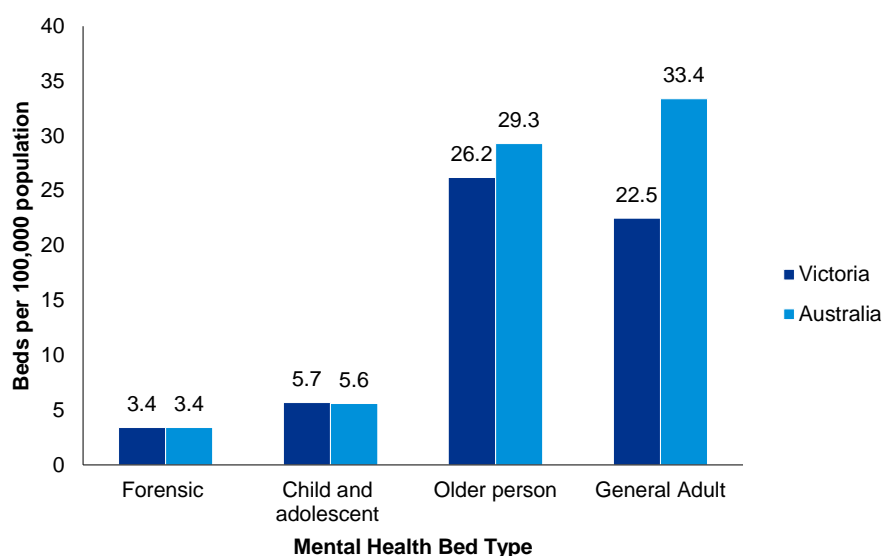
Victoria has moved beyond policy directions focused around deinstitutionalisation, to those based on patient choice and recovery^x. While some mental health service systems have progressed further than others, Victoria has one of the lowest mental health bed bases across Australia and globally (Figure 4-2). Those with fewer beds per 100,000 population tend to reserve hospital care for emergency type care, as a ‘last resort’, or for a brief period to stabilise mental health during an acute episode of illness. Australia has progressively moved away from hospital care towards community-based mental health services.

Capacity across a wide range of individuals’ needs, taking into account community services, acute care, emergency care, subacute care and long term support needs to be explored. Suitable pathways for individuals following an emergency presentation should not be confined to an acute admission, and rather may be able to be supported in a subacute short stay facility or community based service setting.

As an example, in Queensland, South Australia and Victoria short stay mental health crisis care services that are collocated with emergency departments provide care for individuals requiring short term acute care. Importantly these models are not consistently available throughout Victoria. Further, some services in the Netherlands have reconfigured existing mental health emergency department resources to establish mental health urgent care services that provide follow-up support for individuals, their families and carers following an emergency department visit. Both of these examples of enhanced emergency mental health pathways have produced reductions in mental health related emergency department presentations and length of stay.

In planning the design of the overall clinical mental health system across Victoria, a decision should be made about further investment into increasing the admitted mental health bed base, considering the interplay between supply and demand in the system as a whole and on a catchment basis.

Figure 4-2: Public sector specialised mental health hospital beds per 100,000 by target population and program type



Source: Australian Institute of Health and Welfare. National Mental Health Establishments Database, 2013-14.

Design for recovery and co-production

Victoria's 10 Year Mental Health Plan embraces recovery and co-production as both essential design features and outcomes of the service system, along with universal access to public services and access to specialist mental health services which are needed and chosen by people with mental illness, their carers and families. How the fundamental architecture of the clinical mental health system should be designed to support and give expression to recovery and co-production is a critical but challenging question for all stakeholders.

Victoria's Framework for Recovery-Oriented Practice describes recovery-oriented practice as encapsulating healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship.

Victoria's 10 Year Mental Health Plan has noted that we are just beginning to understand how co-production can transform the way government and public services do business, by involving service providers and service users (people living with mental illness and their families and carers) in the design, development and delivery of services. The Expert Panel established by the Minister for Mental Health has been tasked to explore what co-production can and should mean for Victoria's mental health and other services.

Demand management

Whilst demand management strategies that include opportunities to shift demand are intended to lead to a reduced reliance on acute bed based care they have not previously had significant impacts on changing the trajectory of demand. Subsequently future demand management strategies will need to be innovative in order to elicit change. Specific initiatives responding to clinical demand are currently being established under Victoria's 10 Year Mental Health Plan, aiming to ensure early access to services, plan additional services to meet demand, ensure safe and effective care and increase options for earlier discharge and preventing readmission.

Technology

The use of technology in service delivery is increasingly being used as an alternate platform for service delivery. As an example, in the Netherlands there is a treatment platform for e-mental healthcare, facilitating blended service delivery (face to face and online) and flexibility in timing and pacing of treatment. The platform currently has treatment modules including, but not limited to, depression, social anxiety, burn out and panic disorders. There are similar approaches available across Australia (e.g. Blackdog Institute NSW), however these are not well integrated into state based mental health services^{xi}.

Ensuring sustainable specialty service delivery

Ensuring sustainable and effective delivery of specialty mental health services is important given the limited number of specialist services providing specialised services to the entire state.

Across Victoria there are over 97 dedicated specialist acute beds including those dedicated to: eating disorder services, Psychiatric Assessment and Planning Unit (PAPU), psychiatric intensive care, spectrum, neuropsychiatry, Koori, perinatal services and brain disorder services^{xii}.

In designing a clinical mental health system that responds to forensic service capacity and sustainability, key design issues and opportunities include consideration of avenues to:

- divert people with a mental illness from the criminal justice system by strengthening pathways to early community treatment and support,
- reduce initial and deepening contact with the criminal justice system by people with a mental illness through improvements to the range and availability of services,
- strengthen specialist mental health service capability to manage high-risk clients in the community and criminal justice workforce capability, and
- improve mental health treatment for high-risk offenders leaving prison.

If you could change one part of the clinical mental health system in the next 12 months, what would it be and why would changing this aspect be so important?

What can be done to reduce reliance on acute beds (consider alternative service models and types)?

How do you think the principles of recovery and co-production should be reflected in the way Victoria's clinical mental health services are designed?

5 Age based service configuration

Clinical mental health services are configured around age, with three broad categories recognised across the state, including: children and adolescent, adult and aged mental health services. In some regions a fourth category dedicated to young adult mental health services has also emerged. Appropriate definition and configuration of age based services is important to ensure a user friendly system which promotes partnership and complementary service provision, especially in times of consumer transition between age based services. This represents a commitment to achieving universal access to public mental health services as outlined in Victoria's 10 Year Mental Health Plan.

5.1 Consideration – Definition of children and youth based services

Currently there are particular catchments that have multiple providers of child and youth mental health services. Additionally, where there are multiple providers of services for children and adolescents, the definition of age groups does not align with the generally recognised state norm.

Specifically, across Victoria child and youth mental health services usually provide care for those aged from 0-18 years, however specific youth services such as those provided by Orygen Youth Health and *headspace* provide care for individuals aged 16 to 25 years. Age based service configuration definitions across jurisdictions vary, with the Netherlands providing care for children and youth up to the age of 23 years as an example. Ensuring appropriate definition of the child and youth cohort is important given that this life stage represents significant developmental milestones and onset of mental health issues as demonstrated by the data presented above in section 2.

In planning the design of the overall clinical mental health system across Victoria, a decision should be made around the appropriateness of separating child from youth service provision and further should ensure consistency of definition and service provision across child and youth services. A consistent approach based around the three age groups (children and youth, adult and aged) could focus on:

- streamlined access for individuals, their families and carers, health professionals and referrers
- equality of service provision and access
- reduced disruption during times of transition between child and adolescent services.

It is however important not to lose sight of having age appropriate service settings to cater for youth.

5.2 Consideration – Definition of aged services

Aged clinical mental health services are currently defined as those servicing individuals aged 65 years and over. With recent demographic trends clearly showing an ageing population and increased life expectancy, numerous changes at a broader level have been made including increasing the age requirement for age pensions from 65 to 67 years by 2023 and with the Commonwealth aged care planning benchmarks increased to the proportion of the population aged over 70 years.

In defining the most appropriate age based service definitions, the degree of flexibility should be considered. Jurisdictions such as New South Wales, Canada, New Zealand and the Netherlands allow significant flexibility relating to age definitions, choosing to focus instead on the unique care needs of each person. These approaches are in line with one of the major focus areas of Victoria's 10 Year Mental Health Plan, having a service system which is accessible, flexible and responsive to people of all ages, their families and carers. In planning the design of the overall clinical mental health system across Victoria, a decision should be made around whether the age definition for aged mental health services should be increased to reflect changing population characteristics. Impacts of this change may extend to assisting with the development of more appropriate service options for this group.

Should Victoria's clinical mental health system be configured by age based services?

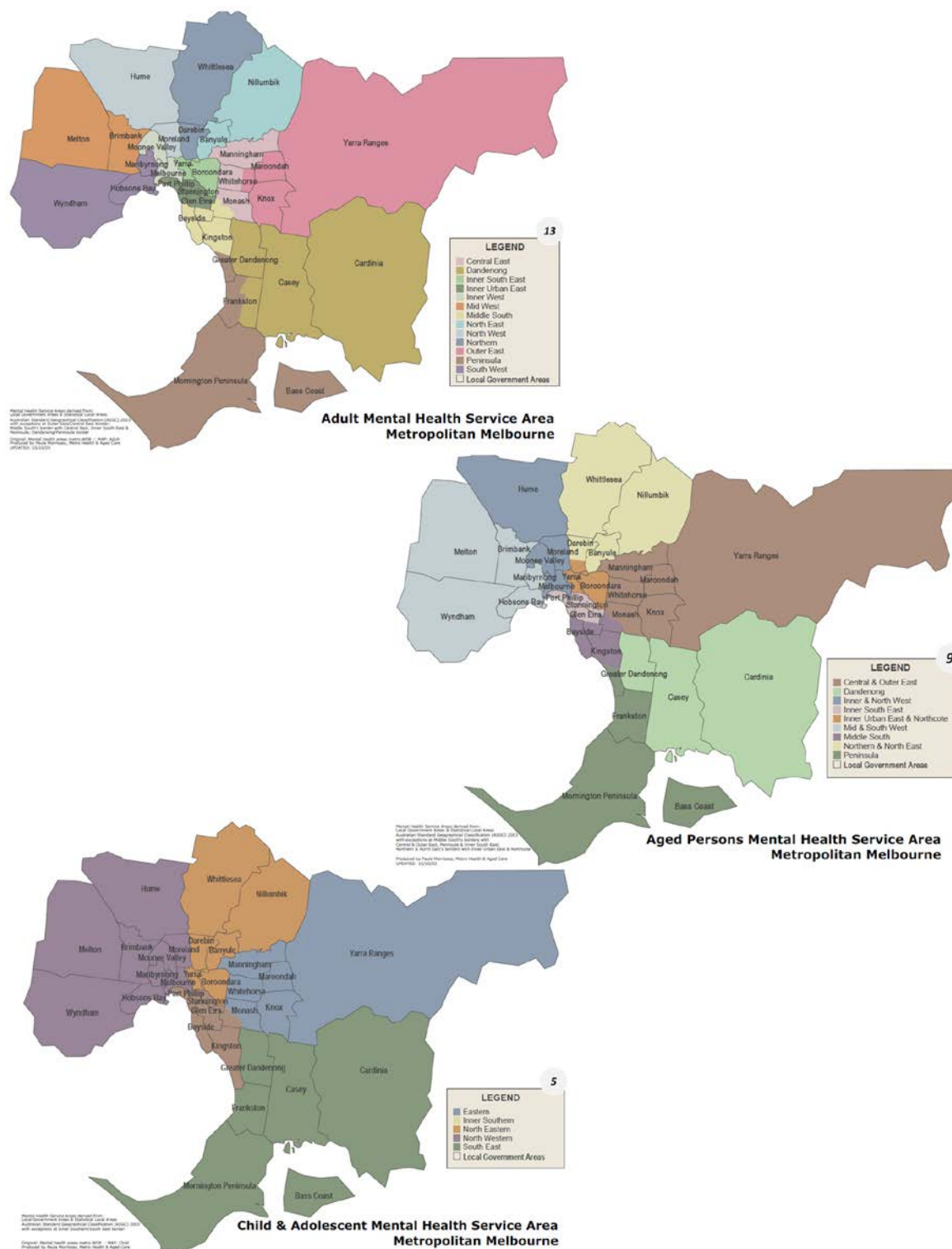
Should clinical mental health services continue to be based around the three age based components of Child and Adolescent, Adult and Older Person?

What alternative age based service configurations could be used in Victoria (consider how youth based services can be consistently integrated across Victoria)?

6 Catchment based service configuration

The current Victorian clinical mental health system is structured around fixed geographic catchments for service delivery. Figure 6-1 below demonstrates that the current catchment structure varies across the catchments for different age groups.

Figure 6-1: Metropolitan Melbourne mental health catchments (top: adult, middle: aged, bottom: child and adolescent)



Source: Victorian Department of Health and Human Services, 2015.

In 2013 the Victorian DHHS gathered feedback from stakeholders regarding enhancing catchment design. Consultation revealed divergent views across stakeholders, with a general acceptance that the current configuration was complex and fragmented.

Stakeholders have acknowledged that action in this area needs to consider broader issues and criteria, including:

- continuity of care
- individual choice
- funding reform
- quality
- safety
- service linkages
- area self-sufficiency
- demographic trends
- transition planning
- demand management
- care pathways
- adoption of a whole of life coverage approach
- improved and consistent service provision for people that are homeless
- alignment and service integration across the broader sector
- access to highly specialised mental health services
- a clear single managing health service in each catchment.

6.1 Consideration – Fixed catchments for service delivery

Fixed catchments are used for planning and service delivery in clinical mental health; this contrasts with the broader Victorian health system which only uses catchment areas for planning. The appropriateness of fixed catchments should be considered as should the impacts this architecture has on individual choice. Removing fixed catchment areas for service delivery could facilitate more individualised consumer movements, likely changing the balance of demand as individuals choose providers.

Making significant changes to the fixed catchment approach for service delivery presents challenges associated with:

- the risk of services ‘cherry picking’ clients
- forecasting and managing consumer flow (impacting on infrastructure and workforce planning)
- increased complexity of interagency partnerships with a broader array of services needing to collaborate.

6.2 Consideration – Catchments, alignment and governance

As discussed above, the DHHS has previously explored options to change mental health catchments, largely focused around the following three options:

1. Existing model with minor change: Selected realignment of some catchments and health service management arrangements.
2. Consolidated whole-of-life area mental health services: Nine whole-of-life Area Mental Health Services (AMHS), with further reconfiguration of catchments and possible changes to managing health services.
3. New two-tier model: Four whole-of-life area mental health services and separately defined arrangements for accessing highly specialised providers.

Stakeholders have previously expressed a diverse range of preferences relating to catchment configuration, with some suggesting entirely different options to those listed above.

When considering ideal catchment configuration it is important to consider the alignment of mental health catchments and provision with that of the broader health sector. Across Victoria there are five

local government areas (LGAs) in which multiple mental health catchments are placed. Further, as an example, New South Wales has clinical mental health service boundaries that align with Primary Health Network boundaries. This facilitates service linkage, partnerships and ease of navigating the clinical mental health system.

In planning the design of the overall clinical mental health system, a decision should be made around whether catchment areas should be revised. The following benefits may result from such changes:

- The introduction of consistent governance across catchments and age based services resulting in enhanced continuity of care (i.e. an individual would not need to transition to a different service provider as they move between age based service categories).
- Distribute catchment areas in alignment with current population and demand trends, ensuring that catchments have an appropriate population base.
- Reduced system complexity – simple navigation for individuals, their families, carers and referrers.

Changes to the catchment areas would not be without short term challenges such as continuity of service provision, the need for new service agreements and resource implications.

Should Victoria's clinical mental health system have catchment areas at all (i.e. currently individuals must access clinical mental health services within the regional catchment in which they reside)?

If catchment areas were removed from Victoria's clinical mental health system, how would the system achieve continuity of care for the most complex and vulnerable individuals?

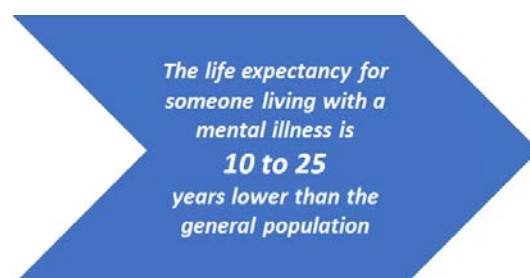
Conversely, if Victoria's clinical mental health system continues to have catchment areas, should they be:

- ***Configured differently?***
- ***Consistent in population size?***
- ***Aligned with primary health network catchments?***
- ***Aligned to acute health service regions?***
- ***Fixed for service delivery?***

7 Integration across service providers

Integration between clinical mental health providers and wider health service providers is required. Individuals with mental health conditions commonly have comorbidities and experience higher rates of coexisting physical health conditions. Alarming the life expectancy for someone living with a mental illness is 10 to 25 years lower than the general population^{xiii}. Given the multifaceted nature of individuals health care needs, integrated and multidisciplinary care approaches are necessary. Integration between the mental health and wider health sector needs to involve:

- consistent and aligned policies and legislation
- establishment of inter-agency partnerships and a high level of organisational buy in
- consistent structures and funding arrangements
- information sharing as supported by common IT and data systems across mental health and wider health providers
- a focus on an individual's journey continuity to ensure individuals are not lost in the system.



There are multiple examples of where integration is working well, as listed below.

- The Ottawa Inner City Project in Canada supports integration across health and social care for the homeless population that have significant care needs within the subacute space. The project has seen multiple service providers come together to develop population health approaches that reduce reliance solely on hospitals and emergency departments.
- The Milwaukee Wraparound Model in the United States offers a comprehensive system of care for children and youth who have serious emotional, behavioural and mental health care needs. The model offers integrated mental health and support services to the individual and their family organised into a coordinated network covering the holistic needs of the individual, their family and carers.
- New Zealand has a strong interface between mental health and primary care supported by the five year 'Our Health and Mind' plan that aims to enhance the engagement and mental health capability of primary care, acknowledging that broader health system engagement is required in order to ensure future sustainability of mental health service delivery.

What needs to be changed in the system to facilitate integration, allowing individuals to better navigate the system and drive their care decisions?

8 Survey link and next steps

The development of the Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System offers a unique opportunity to advance the goals of Victoria's 10 Year Mental Health Plan by designing a better clinical mental health system for Victorians.

This discussion paper begins to identify some of the key service planning challenges that need to be resolved for Victoria and emphasises the need to make clear choices regarding the future direction and configuration of the system. Building on these initial discussions, there will be further exploration of mental health service planning considerations not raised in this discussion paper, including: technology, role of the private sector, infrastructure and service type requirements, workforce planning, governance and intersections with the broader health sector and reform (including National Disability Insurance Scheme, Victoria's Roadmap to Reform).

We welcome your feedback and views on the questions raised throughout this discussion paper which can be provided via [Clinical Mental Health Service Plan survey](#).

ⁱ Australian Institute of Health and Welfare, Australian Burden of Disease Study, 2011.

ⁱⁱ National Mental Health Commission. Approaches that support recovery, including early intervention, 2016.

ⁱⁱⁱ National Mental Health Commission, Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, 2014.

^{iv} World Health Organisation, Information sheet - Premature death among people with severe mental disorders, 2016.

^v The National Mental Health Commission, 2014.

^{vi} Victorian Department of Health and Human Services, Mental Health Community Support Services, 2015.

^{vii} Victorian Department of Health and Human Services, 2015.

^{viii} Victorian Department of Health and Human Services, 2015.

^{ix} Victorian Department of Transport, Planning and Local Infrastructure. Victoria in Future data, 2015.

^x Organisation for Economic Co-operation and Development (OECD), Making Mental Health Count. 2014.

^{xi} Karify, 2016.

^{xii} Victorian Department of Health and Human Services, 2015.

^{xiii} World Health Organisation, Information sheet - Premature death among people with severe mental disorders, 2016.

Appendix: Activity data summary

Figure 8-1: Community contacts

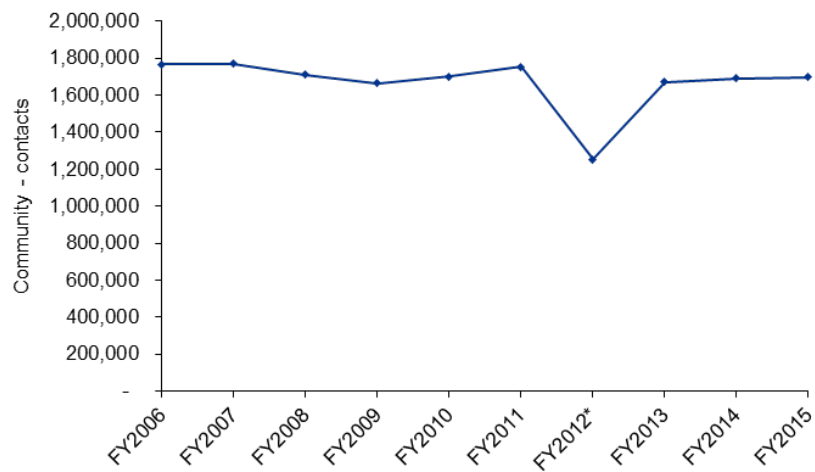


Figure 8-2: Admitted separations by client type

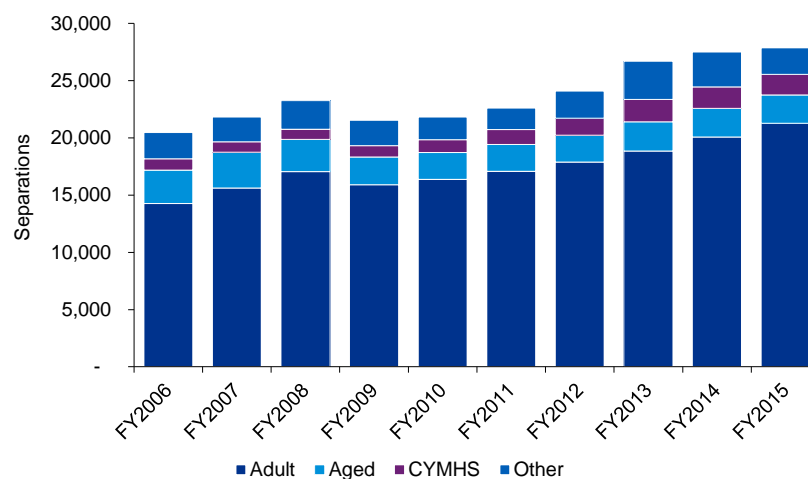


Figure 8-3: Admitted bed days by client type

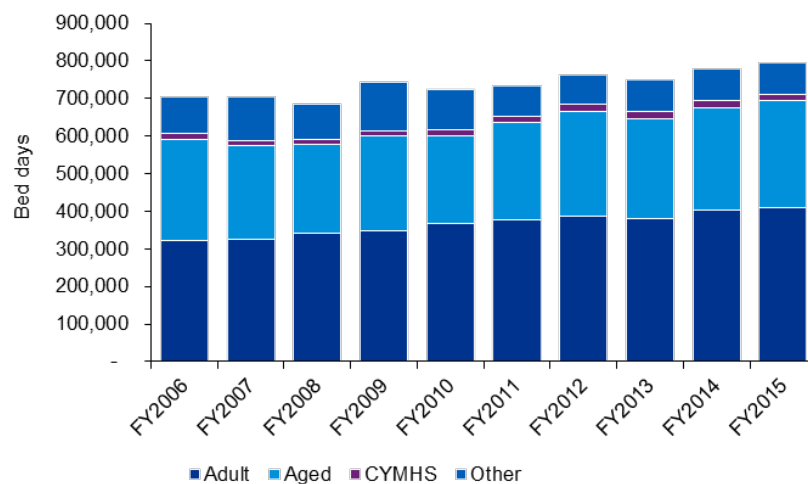


Figure 8-4: Average length of stay by program type

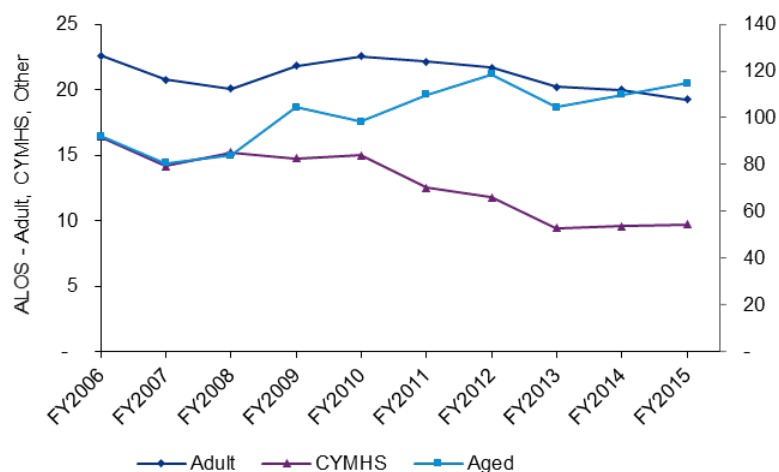
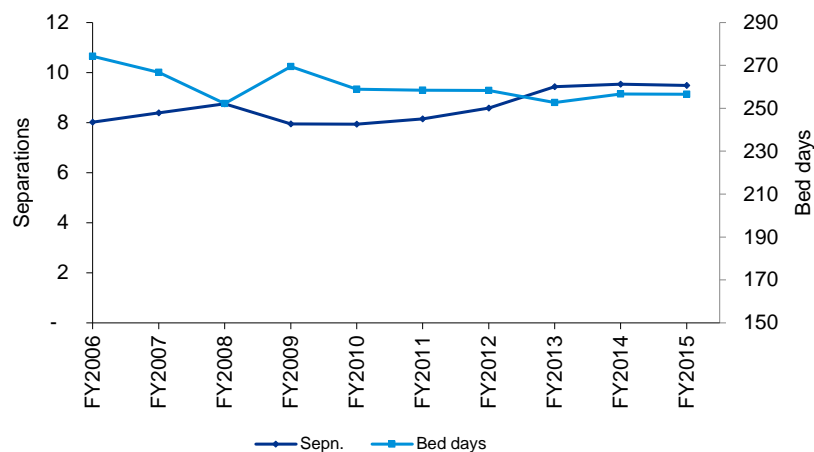


Figure 8-5: Direct aged standardised rate - separations and bed days



Source: DHHS CMI-ODS, ABS, VIFSA.

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The findings in this discussion paper have been formed on the above basis.



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