2019 Submission - Royal Commission into Victoria's Mental Health System

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

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?

What is already working well and what can be done better to prevent suicide?
"Goal: The HOPE and Zero Suicide Framework support a suicide safer health system and these programs should be implemented in all services and regions. HOPE The aim of the HOPE initiative is to reduce suicide attempts, repeated intentional self-harm, suicide deaths and associated psychological distress for clients, their carers and families, and provide better services for people leaving hospital following a suicide attempt. The program has been designed to prevent avoidable suicide attempts and suicide by providing people with assertive, tailored postvention support in the community for a period of up to three months' post discharge from hospital.   The program also supports the person's carer(s) and family to identify and build the protective factors that reduce the risk of suicide attempt/completed suicide. Research has found that the provision of assertive and coordinated care post-discharge can reduce the risk of suicide re-attempts and completed suicide. The HOPE initiative tests a model of continued care and coordinated service referral for people that are at-risk of suicide and leaving hospital, that are not referred to specialist clinical mental health services for ongoing care. These are the people that fall through the gap in the current service system.   Zero Suicide ZS in health and behavioural healthcare is an international approach seen as a best-practice, systematic and programmed response to reducing sentinel events for patients in health systems. The foundational belief of ZS is that suicide deaths for individuals under care within health and behavioural health systems are preventable. This is an approach that is consistent with reducing road or airline deaths. For health care systems, this approach represents a commitment to patient safety, the most fundamental responsibility of health care and to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.   The programmatic approach of ZS is based on suicidal individuals falling through the cracks in fragmented health care systems. A systematic approach to quality improvement in these settings is necessary. The challenge of ZS is not solely borne by practitioners providing clinical care, but uses a system-wide approach to improve outcomes and close gaps.   LRH has been implementing the ZS approach over the last 18 months and has actively engaged with and visited sites in the USA, New Zealand and the Gold Coast to support our work. Since implementation we are seeing changes in clinical practice such as increased safety planning for patients and follow up and treatment for people who ordinarily would have fallen through the gaps in the health care system.   Essential Elements of Suicide Care Seven essential elements of suicide care for health and behavioural health care systems to adopt within

the ZS framework are: 1.Lead ? Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles. 2.Train ? Develop a competent, confident, and caring workforce. 3.Identify ? Systematically identify and assess suicide risk among people receiving care. 4.Engage ? Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means. 5.Treat ? Use effective, evidence-based treatments that directly target suicidal thoughts and behaviours. 6.Transition ? Provide continuous contact and support, especially after acute care. 7.Improve ? Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk. The Victorian government in its document Victorian Suicide Prevention Framework 2016-25 has committed to halving the rate of suicide deaths by 2025: This target is guided by a broader vision, similar to the Vision Zero approach to road safety and the international Zero Suicides in Health Care approach. We aim to keep working on suicide prevention until there are no suicide deaths. The ZS approach was developed from the work done on Perfect Depression by the Henry Ford Health System in Michigan, USA, and incorporated into the 2012 National Strategy for Suicide Prevention. This is an approach that has been implemented across the USA, the Gold Coast Hospital in Australia, Canterbury Health in New Zealand and Merseyside in the United Kingdom. It is well suited to broader use across Victoria. Summary of evidence ZS has developed an overview and recommendations linked to an evidence base for each of the seven key focus areas above. This can be located at: http://zerosuicide.sprc.org/search/node/research%20base "

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.
"Goal: Invest in the implementation of a stepped model of care that supports early intervention, prevention, community treatment, alternatives to hospitalisation and reduces crisis and ED presentations through: oFunding, designing and implementing a stepped model of care through Community Mental Health Hubs; oSupporting Consultation Liaison Psychiatry in all acute health services; oExpanding psychosocial supports and system navigator roles; oDelivering therapeutic treatment and care; oFunding, piloting and testing innovative and new approaches; and oFunding telemedicine and e-mental health approaches to care in rural regions. Stepped Model of Care The fragmentation and lack of coordination of the mental health service system is widely known. This impacts on people being able to find and access services, with rural and regional areas particularly disadvantaged. Establishing a Stepped Care approach has been identified as a fundamental objective for mental health service planning and commissioning by both state and federal governments. It is anticipated that the Stepped Care approach will help facilitate improved access to treatment, ensure a range of services are available to meet the needs of individuals and population groups, and make the best use of available workforce and technology. The primary aim of a Stepped Care model is to simplify consumer pathways and provide more tailored care in accordance with self help and recovery approaches. The Stepped Care model provides a framework for organising mental health care by adopting a whole systems approach in matching presenting need with the least intensive evidence-based intervention that is still expected to provide significant person centred health benefit outcomes. A Stepped Care model is designed to ensure that the transition between the levels of care according to the person's needs are complementary and a classification system is based on a person's level of need, not on diagnosis. For Stepped Care to be successful, all stakeholders, including community members and health professionals, need to be aware of the available service options and levels of

intervention, and be committed to participation in the stepped care processes. Implementing Stepped Care needs to be recognized as a complex change process which will challenge established expectations and processes. Stepped Care is a system of delivering and monitoring treatments, so that the most effective yet least resource intensive, treatment is delivered to patients first; only stepping up' to intensive/specialist services as clinically required. The Stepped Care process is predicated on having the right service in the right place, at the right time delivered by the right person. The implementation of a Stepped Care model requires consideration from two overarching but overlapping levels: 1.Service and population planning level ? taking into account how care is planned and delivered in   relation to all services and providers; and 2.Individual treatment level - this includes how a Stepped Care model is experienced by the patient/consumer through access points, care planning and measurement of treatment outcomes. Community Mental Health Hubs designed using a stepped model of care can deliver a range of services such as mental heath care, primary health, alcohol and drug services, aged care, care for children and young people, housing, vocational services, etc. ? designed by the local community and service providers to match population growth and demand and deliver care and treatment in innovative ways. Implementation of a stepped care model would need all service providers to work in collaboration across the stepped care levels of interventions.   The model should integrate access to expanded dual diagnosis services and links to community and residential detoxification and rehabilitation. Access to good practice models with integrated drug/alcohol service provider engagement is a current gap. This gap between mental health and alcohol and other drug (AOD) providers has led to fragmented and siloed service delivery. Consumers and carers find the system difficult to navigate. A community mental health hub model must integrate alcohol and drug treatment and funding reform must support the development of a shared mental health and AOD approach.   Investment in alternative community mental health options will reduce the huge current pressure and demand on acute mental health response teams and mental health triage staff. Services cannot adequately respond in a timely manner to the volume of calls and referrals for acute responses. This is made much more difficult across large regional areas with numerous emergency departments and urgent care centres with limited on call and re-call mental health services available. With limited funded mental health services within these acute hospitals and unclear pathways of managing care within the local community, significant pressure is placed on the clinical service to respond to people with mild to moderate illness, leading to those with more severe needs being unable to access the specialist service required. Responding to the complex needs of young people with mental health issues is a significant issue that can be addressed with an adequately funded and resourced stepped care approach that integrates services. Working in silos can no longer be the way forward.   The Regional Mental Health and Suicide Prevention Planning positions are a key resource that can drive and lead this process with the Primary Health Networks and Area Mental Health Services. Each Local Government Area (LGA) can develop their own stepped model of care to suit their region ? with a range of early intervention and prevention services, system navigators to assist people to access the right part of the service for their needs, e-health and telemedicine approaches (e.g the Royal Flying Doctor Service Mental Health program in rural Gippsland is a good model for teleheath approaches), psychosocial pathways, consultation liaison psychiatry across all acute health services as a less intensive pathway to care, evidence based treatments such as cognitive behavioural therapy, dialectical behvaviour therapy, treatment for eating disorders and consideration of treatments that are having benefits internationally e.g. Open Dialogue.   This stepped care model can support access to mental health care across all ages and stages of life. The system navigator roles can enable people to access the integrated mental health hub system, understand what services are available, improve service and treatment co-ordination and reduce the fragmentation of care. This role (and developing a

workforce for these roles) will free up time to enable the mental health clinicians to focus on providing treatment for mental health concerns.   "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
N/A

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Goal: Increase numbers of specialist mental health clinicians through innovative approaches to university training, placements, and graduate programs in regional areas. One of the most difficult and challenging roles for LRH is the recruitment and retention of a specialist mental health workforce.   The impact of the complex nature of the work, occupational violence and stress is significant. The ongoing inability to recruit in rural and regional areas continually compounds these issues. In basic terms, there are not enough health professionals being trained to fill the current or future vacancies in clinical mental health services. In order for broader service reform to occur, a deeper understating of workforce demographics, needs, numbers, targets and a particular focus on rural and regional services is needed. Once the data is clear, targeted investment can occur to build a specialist workforce. This work should be led through the Regional Planner roles so workforce and service planning are inextricably linked to the particular regions. This will require a genuine commitment from DHHS, universities, TAFE, organizations and health services to support clinical and organisational placements to develop a mental health workforce across all age groups. This can be achieved through several means such as: shared placements across service providers to build capability (e.g. Child and Youth Mental Health and Child Protection or Adult Mental Health and Community Managed Mental Health), rural Universities offering peer work and allied health courses to recruit and attract local people, graduate programs for allied health and peer work being established and funded state-wide, funding for rural scholarships to support university/TAFE costs and linked with a rural health service contract post-graduation and offering the Bachelor of Mental Health at all rural and regional university campuses with health services offering the clinical placement rotations.   In addition, clinical supervision for all mental health services state-wide must be funded and implemented to support staff due to the complex psychological nature of the work. The Office of the Chief Mental Health Nurse has undertaken a large body of work relating to Clinical Supervision for Mental Health Nurses. This framework must be financially supported and a state-wide approach taken to training, implementation and evaluation. The Centre for Mental Health Learning is suggested as a resource to deliver on this work for all disciplines including peer workers.   The lack of private psychiatrists in rural areas is of particular concern. The time taken from offering positions to potential applicants to APHRA registration and RANZCP approval, ranges from 12 ? 18 months. This is totally unacceptable for our community. Urgent action needs to be taken to address this gap to ensure services can recruit medical staff into regional areas and for an equitable allocation of mental health staff to regional areas through incentives aligned to registration and training. Nurse practitioners (NP) are a critical component of mental health care provision in rural and regional areas. LRH has actively supported, trained and mentored six Nurse Practitioners and we currently have four Nurse

Practitioner candidates undertaking their training. This has been a significant investment in the future of mental health care and for the leadership and advanced practice career opportunities for our nurses. Key barriers still remain for access to prescribing and diagnostics within the community mental health setting. NPs still require an agreement with a medical practitioner. Medicare rebates are significantly less for NPs than for other disciplines. Consumers cannot access a full scope of services from the NP. This needs to be urgently addressed to enable the NP workforce to practice within their full scope and support access to mental health care in rural areas.   Finally, the undergraduate curriculum for all health professional courses needs to be reviewed in relation to mental health content. A critical gap exists in being able to recruit undergraduates from health courses into postgraduate mental health study and graduate positions. The work being undertaken by the Australian College of Mental Health Nurses in this area should be expanded to all undergraduate health curricula. "

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?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"Goal: Develop and implement a new funding model that fully costs clinical mental health service delivery in rural and regional areas, sets meaningful performance targets and delivers an associated infrastructure plan The National Mental Health Commission (2014) conducted an extensive review into funding models within the mental health sector. It is well reported that funding in Australia is moderate compared with international standards and funding in Victoria is the lowest per capita in the country. This review articulated the key issues as: the funding of costly acute and crisis services rather than early intervention, prevention and treatment in the community setting; a fragmented and uncoordinated system across service providers and settings; and inequitable access to mental health care for those living in rural and remote regions.   A funding model needs to support the delivery of care, be targeted equitably based on need and severity of illness and break down silos to support providers to work in a coordinated way. The funding reform also needs to deliver an associated infrastructure plan and considerable energy is required to map out what infrastructure (e.g. physical locations, e-health, telemedicine, equipment) will be needed over the next 5-10 years to deliver reform in a proactive way. The reform needs to address the rural and regional context of service delivery and support innovation to provide access to those hard to reach populations who are not receiving service. A truly reformed model would target the needs of each geographic region as a unique entity rather than being a one size fits all approach. In addition, current services funded as state-wide services which are all metropolitan based (e.g. eating disorders, borderline personality disorder, child and youth inpatient services), are to be included in a new rural funding model. Rural people have a right to access specialist clinical care from their regional service provider.   This funding model can then be mapped to workforce needs, care models, geographic needs, population, patient demographics and service demand. The case management model of the 1980s is outdated, inefficient, expensive and does not demonstrate enhanced clinical outcomes. The current funding still reflects the old system and is based on volume of contacts rather than any therapeutic, evidence informed or high- quality health system.   The CMI/ODS system must also be urgently reviewed to enable timely access to data and linkage to electronic medical records. The inefficiency of this system contributes to overall

inefficiencies within the mental health system.   Finally, a review of the current key performance measures is required to ensure Victoria has meaningful data on clinical and patient outcomes and service efficiency and effectiveness. The funding, infrastructure and performance target work will set a core platform on which to build the next phase of the mental health service system.   "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"As stated, the critical areas of funding models, workforce and infrastructure planning need urgent attention to prepare the service system for proactive reform. Any serious reform to the system will be impacted if there are not enough skilled and capable mental health professionals to deliver the services in regional areas. An evaluation framework will be required from the start to ensure patient and service outcomes are being met as designed. This should include meaningful targets that are linked with clinical performance and outcomes and promote high value evidence-based care. Legislative barriers for NPs must be removed and urgent changes made to address the shortage of medical and other specialists in rural areas.   The impact of occupational violence and aggression (OVA) on wellbeing impacts the recruitment and retention of mental health staff. Ongoing investment in evidence based programs such as Safewards across all inpatient units should be addressed. Safewards is a model that aims to improve safety for both patients and staff, with a focus on reducing conflict (anything that could be harmful for a patient, other patients, or staff) and containment (restrictive interventions). Safewards was developed in the UK. It has a strong and growing evidence base from around the world and here in Victoria. It includes an exploratory preventative model and ten interventions. Staff and patient modifiers in the Safewards model identify opportunities to prevent conflict and containment or reduce its impact. The Safewards interventions provide practical ways to use these modifiers. The interventions are actions that are taken to increase safety and mutual support for staff and patients.   (extract from https://www2.health.vic.gov.au/~/media/Health/Files/Collections/Research%20and%20reports/E/ed-safewards-overview-model-and-interventions-trial)   Standardized state-wide OVA prevention and management training must be progressed as a matter of priority and funded OVA prevention programs and wellbeing programs should be included in the funding reform package.   Some services have actively reduced their seclusion rates and LRH has been leading this patient safety work for over 10 years. There is a clear body of evidence that supports seclusion reduction and this must be funded and led to drive practice change to ensure all services work towards seclusion reduction targets.   Finally, the mortality and morbidity rates for people living with serious mental illness are unacceptable. A standardized best practice approach to managing this aligned with patient safety indicators and performance measures should be developed with Safer Care Victoria.   "

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

"Executive Summary Latrobe Regional Hospital (LRH) is pleased to provide a written submission to the Royal Commission into Victoria's Mental Health System (Royal Commission). The Royal Commission is a once in a lifetime opportunity to make recommendations which will lead to a complete overhaul and redesign of the clinical mental health service system. Our staff, patients and families are optimistic that the Royal Commission will make big, bold decisions that will change the face of mental health service delivery forever. Our submission is provided within the context of our great hope for meaningful change.   Proposed Recommendations LRH urges the Royal Commission to consider the following recommendations: Develop and implement a new funding model that fully costs clinical mental health service delivery in rural and regional areas,

sets meaningful performance targets and delivers an associated infrastructure plan; Expand the Hospital Outreach Post-Suicidal Engagement Program (HOPE) trials across all clinical mental health services; Implement the Zero Suicide (ZS) Framework across all clinical mental health services; Invest in the implementation of a stepped model of care that supports early intervention, prevention, community treatment, alternatives to hospitalisation and reduces crisis and Emergency Department (ED) presentations through: oFunding, designing and implementing a stepped model of care through Community Mental Health Hubs; oSupporting Consultation Liaison Psychiatry in all acute health services; oExpanding psychosocial supports and system navigator roles; oDelivering evidence informed therapeutic treatment and care; oFunding, piloting and testing new and innovative approaches; oFunding telemedicine and e-mental health approaches to care in rural regions; and Increase numbers of specialist mental health clinicians through innovative approaches to university training, placements, and graduate programs in regional areas including urgently addressing registration and college endorsement timelines for medical specialists and removing barriers for nurse practitioner led models of care. Introduction LRH is the clinical mental health service provider for Gippsland, a large rural and regional catchment covering over 44,000 sq.km of Victoria.   Our catchment includes large urbanised centres, regional towns and tiny remote communities. LRH provides specialist mental health care across 10 sites in Gippsland and delivers inpatient, residential, acute, sub-acute and community mental health care. We also provide in-reach services to more than 10 acute hospitals and rural health services across the Gippsland catchment. Last year LRH had over 1100 mental health admissions and delivered over 60,000 service hours of community contacts, making us one of the busiest services in the state. We employ over 300 equivalent full time (EFT) staff across the disciplines of nursing, medical, allied health, peer workers, consumers and carers.   Around 3% of the population require treatment for a serious mental illness. LRH is currently only able to reach about 1% of the population. Mental Health is in the top five causes of disability in each of the six local government areas of Gippsland. Our catchment has high rates of alcohol and other drug use, child protection notifications, family violence, intergenerational trauma, community mental health contacts and suicide rates when compared with many other areas of Victoria. It is a challenge to deliver care across a large geographic area in a community with many complex social and health care issues. Our submission highlights key areas for action and attention by the Royal Commission.   "