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# Mercy Mental Health

# Royal Commission into Victoria's Mental Health System: Submission

5 July 2019

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# Abbreviations

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| AIHW | Australian Institute of Health and Welfare |
| AHMAC | Australian Health Ministers' Advisory Council |
| CALD | Culturally and Linguistically Diverse |
| CDHB | Canterbury District Health Board |
| CMBS | Commonwealth Medicare Benefits Scheme |
| DELWP | Department of Environment Land Water and Planning |
| DHHS | Department of Health and Human Services |
| DoH | Department of Health |
| EISPR | Early Intervention Psychosocial Support Response |
| HoNOS | Health of the Nation Outcome Scale |
| MHCSS | Mental Health Community Support Services |
| MMH | Mercy Mental Health |
| NDIS | National Disability Insurance Scheme |
| NWAMHS | North West Area Mental Health Service |
| NWMPHN | North Western Melbourne Primary Health Network |
| RANZCP | Royal Australian and New Zealand College of Psychiatrists |
| SECU | Secure Extended Care Unit |
| SWAMHS | South West Area Mental Health Service |
| VAGO | Victorian Auditor General's Office |

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# Executive summary

Mercy Health welcomes the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System.

Mercy Health believes the Royal Commission provides a once-in-a-generation opportunity to reimagine and redesign Victoria's mental health service system.

The effective prevention and treatment of mental illness requires a system that acknowledges and responds to the social determinants of mental illness, which include physical health, disability, housing, economic participation, education and social inclusion.

Mental health cannot be looked at solely through a health lens. A redesigned system should be person-centred and provide a cohesive network of services that deliver holistic support to people living with a mental illness throughout their life.

There are significant challenges facing the current system.

It is fragmented and complex. For example, in the south-western metropolitan catchment there are multiple providers of mental health services, with different providers serving different cohorts. This fragmentation makes the system difficult for consumers and their carers and family to navigate and undermines effective service provision.

The lack of a whole-of-life service system makes planning for long-term care difficult. It also creates risks for consumers as they transition from one service to another at significant times of life (for example, from a youth to adult service).

The system is not well aligned with other service systems that support people living with a mental illness.

The lack of integration with community-based support services contributes to prolonged stays in inpatient mental health units and relapse post-discharge. Problems with the transition to the National Disability Insurance Scheme and the lack of housing for people living with a mental illness are significant issues for the mental health services system.

The system is significantly under-resourced and funding has failed to keep pace with population and growth in demand. Lack of funding results in a focus on crisis responses and underinvestment in prevention and early intervention, and in service planning and capital investment. Most importantly, it means people cannot get the services they require when and where they need them.

A new funding model is needed that is input-based, flexible and removes the inequities in the availability of services between areas, particularly in relation to the metropolitan growth corridors and regional and rural Victoria.

The system has significant workforce challenges, with a shortage of trained and skilled staff. The absence of effective sector-wide workforce planning undermines workforce recruitment and retention, skills development and staff engagement as service providers compete with each other for scarce skilled resources and staff have little time devote to professional development and skills enhancement.

A redesign of the mental health service system, including how it is funded and its intersection with the health and social support systems, is required. This will require prolonged investment and sustained effort if it is to result in a person-centred mental health services system that is capable of effectively preventing and treating mental illness.

This submission recommends nine principles that should inform the design of a reimagined system.

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# Recommendations

That the Royal Commission recommend that Victorian Government adopt the following design principles for the Victorian mental health service system:

1. ***Person-centred service is prioritised***
   This means mental health services are designed and delivered around the needs of the consumer, and their families and carers, so that service system is easy to navigate, provided close to home and available when required.

2. ***Services are evidence-based, adaptable and tailored for specific consumer cohorts***
   This means mental health services are designed using evidence of what works and is appropriate for the particular needs of each cohort.

3. ***There is only one mental health service provider in a catchment***
   This means only one catchment-based mental health service provider works with consumers, their families and other service providers to provide specialist mental health care that is accessible, coordinated, person-centred and clinically efficacious.

4. ***Each service provider services all cohorts***
   This means that each service provider provides mental health services to all cohorts throughout the life cycle, including perinatal, child and youth, adult and aged persons services.

5. ***Partnerships and cooperation between mental health service providers and other providers are encouraged and valued***
   This means developing new ways of working with other health services and providers of social supports (such as housing and employment) to better support consumers, including those with comorbidities.

6. ***Each catchment is large enough to provide economies of scale and efficiency***
   This means area mental health services are of sufficient size to create operational economies of scale and service delivery efficiencies, and to permit services to respond to the changing needs of the catchment population and the developing clinical evidence base.

7. ***Funding is population-based, flexible and adequate to meet the needs of the catchment population***
   This means funding reflects demand and consumer complexity, is flexible enough to allow for innovation and meets the true costs of service delivery.

8. ***Service and infrastructure planning is proactive and future-facing***
   This means that investment in infrastructure anticipates future needs and ensures that the service system is able to respond to changing demand.

9. ***There is sufficient planning to ensure the mental health workforce is skilled and available***
   This means there is a systemic and coordinated approach to workforce planning across all disciplines (including psychiatry, nursing, allied health and lived experience).

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# About Mercy Mental Health

Mercy Health operates MMH. Mercy Health is a Catholic organisation founded by the Sisters of Mercy and is grounded in a 2,000-year tradition of caring for others. Through its mission Mercy Health is committed to the common good, human dignity and serving the poor and disadvantaged.

Mercy Health employs over 9,000 people who provide acute and subacute hospital care, aged care, mental health programs, maternity and specialist women's health services, early parenting services and home care services.

MMH is the tertiary provider for adult mental health services in Melbourne's south-western metropolitan catchment. MMH's adult mental health services are delivered across multiple sites located in Hobsons Bay, Wyndham and Maribyrnong. Services include acute in-patient, acute community and community services (South West Area Mental Health Service).

MMH is the tertiary provider for perinatal mental health services for south-western Victoria and provides a unique suite of services that include in-patient consultation liaison, outpatient and in-patient services. MMH also provides perinatal consultation liaison and perinatal outpatient services at Mercy Hospital for Women located in Heidelberg.

The MMH portfolio is based on a recovery-orientated approach, which involves working collaboratively with and for the consumer, carers and family to encourage the restoration of the consumer's self-confidence, self-esteem, self-awareness and acceptance (Australian Health Ministers' Advisory Council, 2013).

The current service delivery profile of MMH includes:

- **Acute Mental Health Points of Care:** The Mercy Mental Health bed profile includes 54 beds available in the Clare Moore Building (50 operational as at June 2019) and 16 beds at the Ursula Frayne Centre at the Footscray Hospital campus of Western Health. MMH also has access to two beds at Wyndham Private Clinic Hospital, subject to availability until the end of June 2019.
- **Community Care Unit (CCU):** A 20-bed unit located in Werribee, which provides medium term residential rehabilitation and treatment, and recovery support services for people with serious mental illness and significant psycho-social disability.
- **Prevention and Recovery Care (PARC) Unit**: A 10-bed unit located in Deer Park, outside the MMH catchment area. The PARC unit is operated in collaboration with a non-clinical MHCSS partner and aims to prevent acute admission ('step up') or 'step down' following an acute admission.
- **Community Mental Health Team:** Based in Wyndham and Maribyrnong, MMH's two community-based clinics provide assessment, treatment and support via a clinical case management model.
- **Mother Baby Unit:** A six-bed unit on the Werribee Mercy Hospital site. The Mother Baby Unit has an extended catchment, including western metropolitan, regional and rural localities.
- **Perinatal Mental Health Services**: This team includes perinatal mental health outpatient services at Werribee Mercy Hospital and Mercy Hospital for Women, perinatal consultation liaison at Mercy Hospital for Women, and perinatal mental health research.
- **Secure Extended Care Unit (SECU):** MMH consumers have access to five SECU beds at Sunshine Hospital. These are managed by Midwest Area Mental Health Service (North West Area Mental Health, Melbourne Health).

- **Emergency Mental Health Services:** Telephone triage; emergency crisis assessment and treatment team (ECATT) response in two emergency departments (Werribee Mercy Hospital and Footscray Hospital); and crisis assessment and treatment team (CATT) in the community.

The MMH workforce currently comprises 347 equivalent full-time staff (headcount 590), including consultant psychiatrists, junior medical staff, registered psychiatric nurses, clinical psychologists, social workers, occupational therapists, lived experience workers and administration.

In 2017-18 there were 1,235 MMH acute adult discharges. The primary diagnosis for these admissions was schizophrenia, unspecified (15.1%), followed by emotionally unstable personality disorder, borderline (6.5%) and paranoid schizophrenia (6.1%).

| Primary diagnosis | Discharges | Percentage of total |
|---|---|---|
| Schizophrenia, unspecified | 187 | 15.1 |
| Emotionally unstable personality disorder, borderline type | 80 | 6.5 |
| Paranoid schizophrenia | 75 | 6.1 |
| Schizoaffective disorder, unspecified | 73 | 5.9 |
| Adjustment disorders | 70 | 5.7 |
| Severe depressive episode without psychotic symptoms, not specified as arising in the postnatal period | 67 | 5.4 |
| Depressive episode, unspecified, not specified as arising in the postnatal period | 55 | 4.5 |
| Other symptoms and signs involving emotional state | 45 | 3.6 |
| Acute and transient psychotic disorder, unspecified, without mention of associated acute stress | 43 | 3.5 |
| Mental and behavioural disorders due to use of other stimulants, including caffeine, psychotic disorder, methylamphetamine | 41 | 3.3 |
| Other Primary Diagnosis | 499 | 40.4 |
| **Total** | **1,235** | **100.0** |

*Table 1.0 Top 10 Primary Diagnosis MMH, 2017-18 (Mercy Health, 2017-18)*

# 1. Current mental health service system challenges

This section sets out Mercy Health's views on the challenges facing Victoria's clinical mental health service system.

The challenges are discussed around four key themes:

- system complexity and fragmentation
- partnerships in care
- funding
- the mental health workforce.

These themes, while not new, were identified during the co-production of the MMH Service Plan 2019-32 (Mercy Health, 2019a) however the challenges exist across the whole of the Victorian mental health system. A copy of the MMH Service Plan is at Appendix 2.

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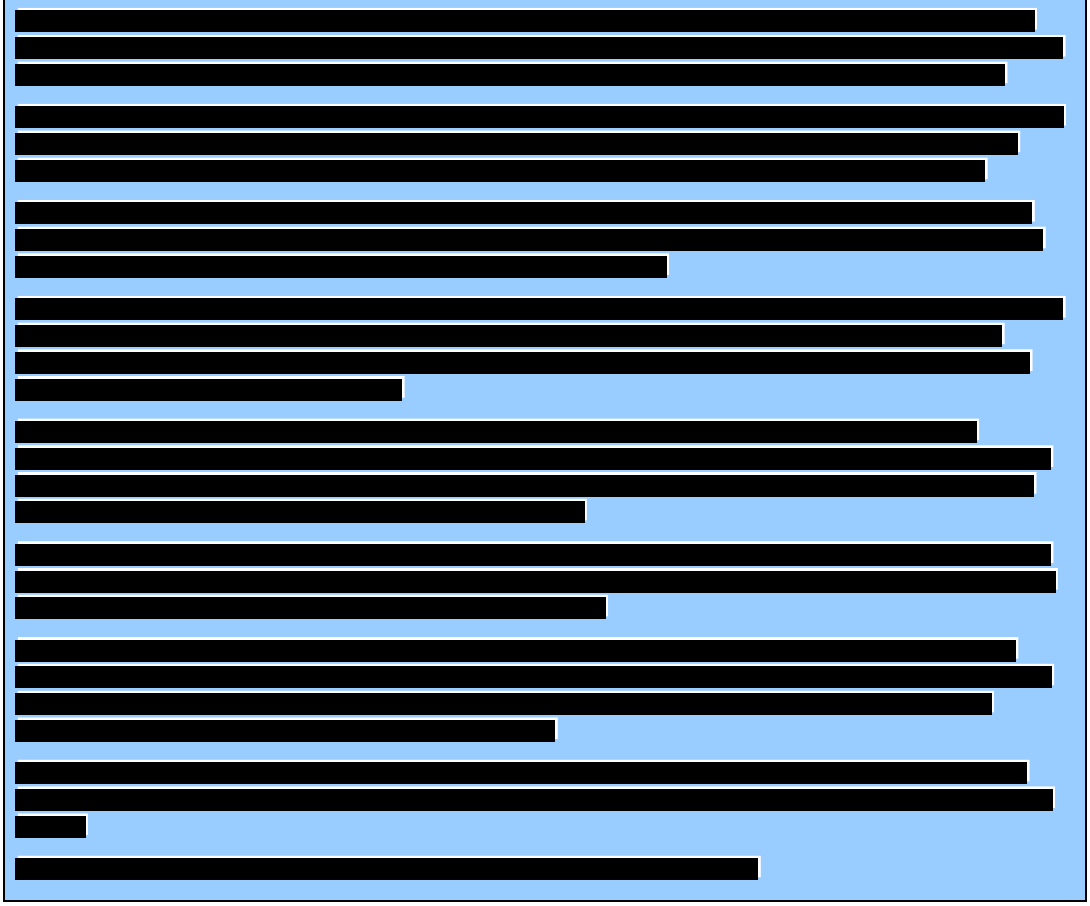
## 1.1 System complexity and fragmentation

Victoria's system of area-based clinical mental health services is complex and fragmented (DoH, 2013). It challenges the notion of person-centred care by creating barriers to system entry and is hard for consumers, carers, referrers and providers to navigate.

***Case study: System complexity and fragmentation***



### *Multiplicity of providers*

In Victoria, area mental health services are provided by catchment-based service providers. However, in some areas there are multiple service providers servicing different age cohorts. For example, in metropolitan Melbourne there are 13 providers of adult services, nine providers of services for aged persons and five providers of child and adolescent services. In some cases, the services provided by the different providers are not well aligned or integrated.

This multiplicity of providers makes navigating the system hard for consumers and their carers and families. It also can create tension between service providers. Most importantly, it means the system fails to provide seamless, timely and optimal care.

Further, the current catchments for area mental health services are based on the catchments of the acute hospitals, rather than the needs of the consumers. A person-

centred approach to the design of the mental health service system would mean that the needs of consumers are paramount and services are designed accordingly. This would also require the development of genuine partnerships between area mental health services and the acute hospitals.

***Lack of a 'whole-of-life' approach***

Due to the multiplicity of providers, each of which services a different cohort, consumers can be required to move from one service provider to another over their life cycle.

The absence of whole-of-life service provision creates risks and frustrations for consumers and their carers and families. Of particular concern is the risk for the consumer at key transition points (for example, moving from youth services to adult services) as their care may be disrupted or they may be lost to the system. The evidence shows that there is an increased risk of suicide at the transition from acute in-patient care to community care.

Contrary to a whole-of-life approach to mental health care, clinical perinatal mental health services are not seen as a key component of mental health service provision. The Inquiry into Perinatal Services noted "the ad hoc and unintegrated nature of perinatal mental health services" (Parliament of Victoria, 2018, p. 111).

While a whole-of-life approach is favoured, as it would reduce risks and frustrations for consumers, there may still be a case for the provision of some specialist providers that work across catchment boundaries. These specialist service providers would work with and support area mental health services. Care would need to be taken in the design of the interface between the specialist providers and the area mental health providers in order to avoid replicating the complexities that exist in the current system.

***Lack of alignment with other support systems***

In some regions, the service catchments are not well aligned with the broader health and human service systems, which is detrimental to holistic care. This is particularly the case in relation to comorbid physical health needs and social determinants that can have a serious impact on mental health and wellbeing, such as employment and housing.

Mental health should not be looked at from a siloed perspective or through a health-centric lens. An appropriate person-centred response requires a social determinant perspective across health, disability, housing, economic participation, education and social inclusion.

The fragmentation of the clinical mental health service system has been exacerbated in recent years by the reforms in key partner sectors, such as the non-clinical mental health system transition to National Disability Insurance Scheme and the Primary Health Networks and Drug and Alcohol Treatment Services Reform.

MMH and the south-western metropolitan service system: an example of system complexity and fragmentation

System complexity and fragmentation can be seen in the MMH's catchment area where:

- there are multiple clinical mental health service providers (Mercy Mental Health for adults, Royal Children's Hospital for children, Orygen Youth Health for youth and Mid West Area Mental Health Service for aged persons)
- there is insufficient funding to provide consultation liaison perinatal services at Werribee Mercy Hospital, which is a level 4 maternity service delivering 3,800 babies per annum) (DHHS, 2016a)

- DHHS has located MMH's Prevention and Recovery Care service out of the catchment which affects consumer and carer willingness to access this service; a problem exacerbated by public transport deficits in what is a growth corridor region
- there are a lack of providers in key partner sectors to support people with mental health issues in the community, including a lack of private mental health providers (for example, consultant psychiatrists, clinical psychologists, occupational therapists, social workers), drug and alcohol services, NDIS providers, employment services, housing services, etc. Where these providers do exist, they too are often poorly resourced to cope with the needs of the catchment.

## 1.2 Partnerships in care

The clinical mental health service system sits within the broader non-clinical mental health, health and social support services systems.

Key partners for clinical mental health service providers include specialist mental health services; community based non-clinical mental health providers (particularly the NDIS); drug and alcohol services; acute, community and primary care health services; education, disability and justice services; and housing and employment services.

A person-centred mental health service system requires a cohesive network of services that supports a person in all aspects of life, including health, disability, housing, economic participation, education and social inclusion. This is particularly vital given the significant levels of comorbidity and homelessness present in people living with a mental illness.

***Comorbidities***

The data on comorbidities for Victorians with mental health issues is sobering and highlights the importance of effective partnerships in care. For example, more than 10 per cent of adult mental health consumers have type 2 diabetes, almost twice the rate of the general Victorian adult population. Three per cent of those admitted to public hospitals and four per cent of people using hospital emergency departments were mental health consumers admitted for a physical health condition, although mental health consumers represent less than one per cent of the general population. The crude death rate for mental health consumers in 2015 was almost 50 per cent higher than for other Victorians (DHHS, 2019e).

DHHS's report *Equally well in Victoria* (DHHS, 2019e) highlights the disparity in health outcomes for Victoria's mental health consumers, noting eight priority areas for focus (smoking, metabolic health, alcohol and substance use, sexual and reproductive health and blood borne viruses, medicine optimisation, dental and oral health, reducing falls). This data reinforces the need for mental health and physical health care providers (including acute, community and primary health care) to work in partnership to improve the physical health of people living with a mental illness.

***Homelessness***

A similar need exists in relation to housing and homelessness. Each year in Victoria more than 100,000 people access homelessness services (DHHS, 2019c). People with mental health issues are particularly vulnerable to homelessness and are one of the fastest growing groups using specialist homelessness services, growing at an average of 12 per cent per year since 2012-13 (ABS, 2018). These consumers need more, and more frequent, support from housing service providers and require support for longer than other service users (ABS, 2018).

In 2016-17, 50 per cent of those seeking support from a specialist homelessness service were already homeless. Of people with mental health issue seeking assistance, most had

already received homelessness services at some time during the previous five years. Over half had additional vulnerabilities, including family violence and problematic drug or alcohol use. One in 10 reported all three vulnerabilities (family violence, problematic drug or alcohol use, and mental health issues) (ABS, 2018).

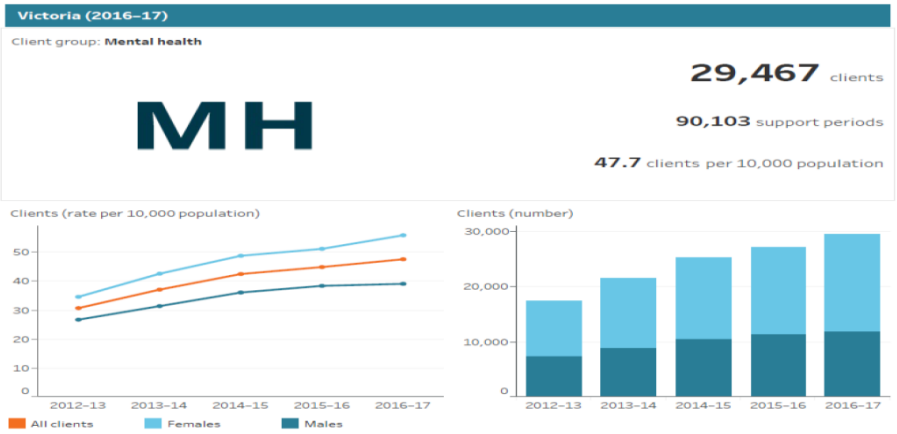



*Figure 1.1: Mental Health consumers accessing Specialist Homelessness Services, 2012-13 to 2016-17 (AIHW, 2018)*

*Case study: Person-centred service access*

[redacted]

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***Working with partners: system challenges***

The coordination of services and practitioners across the various service systems is challenging in the current system, in which complexity and fragmentation is a hallmark and where services and clinicians are stretched and time-poor.

Further, misaligned catchment boundaries, different funding models across federal, state and local governments, and multiple funding sources impede the coordination of effective care for consumers of mental health services with other community-based support services.

Recent Commonwealth and state-initiated reforms in primary health networks, the drug and alcohol sector and the Mental Health Community Support Services (MHCSS), as well as the transition to the NDIS, have all had a major negative impact on the ability of clinical mental health services to negotiate the delivery of seamless services to support people in the community.

The key challenges in the complex matrix of providers that support people living with a mental illness include:

- the varying quality, availability, type and access to support services (within and between catchments)
- proactive and robust information-sharing between partner agencies
- transfer of care at key transition points between partner agencies
- development of relationships between agencies, including between service management and clinicians to enable information-sharing and the development of eligibility criteria, referral pathways and protocols
- increasing pressure on area mental health services to provide services that have previously been provided by specialist providers, without the allocation of resources that are necessary to build capability across a large network.

The multiplicity of providers and ongoing system reform has had a direct impact on people who access clinical mental health services. It challenges their ability to navigate and access the services they require.

It also affects the service sector's ability to deliver seamless and integrated care for vulnerable people, including those with mental health, physical health and social comorbidities such as economic disadvantage or homelessness. The difficulties associated with the transition to the NDIS is an example of this challenge.

Another significant challenge for area mental health services is discharge planning for people who are homeless or at risk of homelessness. The lack of housing options for people with a mental health condition is at crisis point in some areas. This impacts on acute bed-based services, subacute bed stock and emergency department presentations. Mental health services often face the dilemma of having to discharge a person who has no housing, thereby discharging the consumer to homelessness, which in turn is likely to have negative consequences for the person's mental health.

The lack of a forum to support partnership development and dissemination of learnings among providers of clinical mental health services is keenly felt by area mental health services. This was noted by VAGO (2019b) in relation to child and youth services as "… a missed opportunity to share lessons and challenges to address … system issues" (p. 105). The Safer Care Victoria Clinical Network platform has been successfully utilised as a vehicle for learning and partnership development in physical health, while the recently convened Mental Health Clinical Network provides an opportunity to support the engagement of the mental health workforce and share innovations and best practice (Safer Care Victoria, 2019).

The opportunity to utilise workforce development approaches (for example, shared training sessions) to strengthen the capacity of the broader health, education, justice, and community and family services workforces to better support people with mental health issues and their families and carers has been well documented (DHHS, 2016).

MMH and the south-western metropolitan service system: the challenge of holistic care

In the MMH catchment, the navigation of partnerships is challenging for all providers of care to people living with a mental illness. This is exacerbated by the multiplicity of clinical mental health stakeholders in the region and a paucity of private psychiatrists, allied health providers and NDIS providers.

Building and maintaining partnerships across mental health, physical health and social service sectors is difficult, especially in a catchment with a rapidly growing and diverse population and increasing demand.

In order to deliver an appropriate service to mental health consumers, a regional response requires the integration and coordination of support services across mental health, health, disability, housing, economic participation, education and social inclusion.

An example of the challenges in this regard is the transition to the NDIS. In the south-western metropolitan region, the transition to NDIS has been slower than anticipated, particularly for those with a psychosocial disability related to their mental health condition. People are experiencing delays in assessments and the initiation of support services.

In the past, when a person treated by a clinical mental health service had multiple and complex needs, there was a regional approach whereby the clinical and non-clinical providers would work together to develop a service offering best tailored to meet the person's needs. While this was challenging, there was, nonetheless, a known regional approach to support the care of individuals who presented with complex mental health needs. If one agency was 'stuck', DHHS (either regional or central) was able to assist as DHHS funded both clinical and non-clinical mental health services.

A large amount of non-clinical funding is now provided through federal funding streams (for example, Primary Health Networks or NDIS). This means that it is more difficult to resolve issues because of the involvement of multiple levels of government and because the pathway for resolving issues is now less direct and less responsive. This means there are delays in accessing non-clinical support and people are not receiving the care they need. This places an increased burden on carers and clinical mental health services.

Another example relates to interactions between MMH's perinatal service and the child protection system regarding the most vulnerable children in our community. MMH's perinatal mental health clinicians report that there is an inconsistency in approach among child protection workers, who will often have conflicting advice or take different action in relation to mandatory reporting for the same family. This creates substantial difficulties for providers and, more importantly, for family members.

Homelessness is a pressing issue in the south-west of Melbourne and secure housing is of critical importance to optimal mental health outcomes. The Council to Homeless Persons has an Interactive Homelessness Heat Map, which gives a picture of homelessness throughout the state (CHP, 2018). Within the MMH catchment, Footscray is ranked third and Werribee 20th in the state for homelessness. St Albans, which falls outside the MMH catchment but is a neighbouring suburb, is ranked fifth (Table 1.1).

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| Metro rank → Location ↓ | Rank 3 Footscray | Rank 5 St Albans | Rank 20 Werribee | Tarneit | Williams-town | Altona | Total |
|---|---|---|---|---|---|---|---|
| Severely Crowded | 426 | 473 | 235 | 251 | 47 | 103 | 1,535 |
| Boarding House | 138 | 24 | 6 | 0 | 50 | 7 | 225 |
| Couch Surfing | 44 | 45 | 46 | 43 | 25 | 37 | 240 |
| Crisis Accom. | 272 | 200 | 66 | 27 | 117 | 60 | 742 |
| Sleeping Rough | 14 | 0 | 18 | 3 | 5 | 5 | 45 |
| **Total** | 894 | 742 | 371 | 324 | 244 | 212 | 2,787 |

*Table 1.1: Incidence of homelessness MMH catchment (CHP, 2018)*

Over the past three years there has been an increase in the number of people admitted to MMH acute in-patient units who are homelessness (MH, 2018).

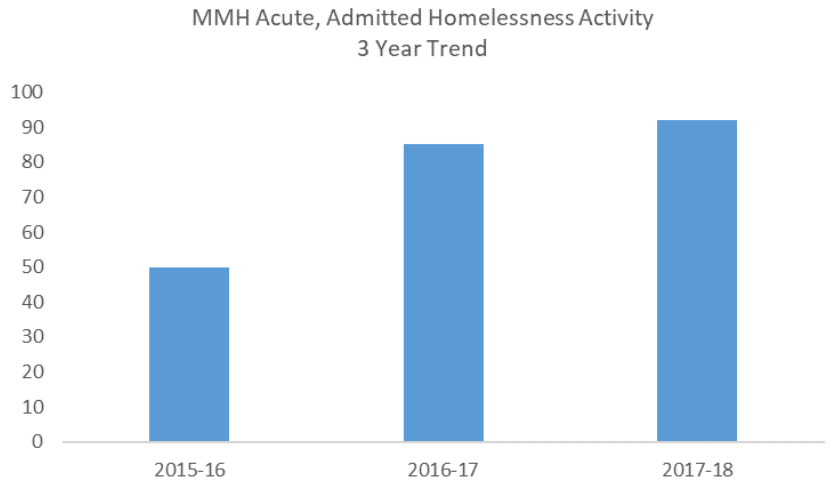


*Figure 1.2 MMH homelessness separations, three-year trend, 2015-16 to 2017-18 (MH, 2018)*

In 2017-18, 92 MMH mental health inpatients (7.5 per cent) identified as homeless (MH, 2018). This is mostly likely an under-representation given the circumstances listed in the definition of homelessness are not always counted. The definition includes living in a boarding house, living in supported homelessness accommodation, living somewhere temporarily, living in severely crowded dwellings, sleeping out and sleeping 'rough'.

On a single day in 2018 when representatives from the Office of the Chief Psychiatrist were visiting MMH's Ursula Frayne Centre at Footscray Hospital, 11 of 16 (69%) MMH inpatients identified as homeless.

MMH is currently implementing a Housing Pathways program for acute mental health inpatient units. This will be similar to initiatives run between community services and St Vincent's Health, Alfred Health, and the Mid West and Goulburn area mental health services.

MMH is a member of H3, a partnership of agencies providing health, housing and homelessness services in western Melbourne. H3 is an example of a cross-agency collaboration, which, if funded, could enable an engaged coalition of agencies to deliver effective and scalable solutions to meet the housing and associated needs of the catchment population.

H3 has identified the need for an adequate supply of social housing that can be quickly accessed when it is identified that a person is homeless or at risk of becoming homeless. The system should provide rapid

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access to transitional supported housing so that people can move out of inpatient units and other care settings. This would enable them to live in a place where the longer-term work of recovery and accessing permanent housing can be supported. Opportunities to develop models that provide transitional housing for people discharged from mental health inpatient facilities would generate substantial savings for the mental health system.

***Case study: Partnerships in care***

## 1.3 Funding and unmet demand

A critical issue facing all Victorian mental health service providers and consumers is inadequate funding, and unmet and growing demand.

In its 2019 audit report, the Victorian Auditor General's Office (VAGO) found that:

- while the number of Victorian with a mental illness has increased significantly, funding for specialist mental health services has declined by 0.3 per cent
- acute admissions grew by 19 per cent between 2009 and 2016
- community mental health contacts decreased by 17 per cent during that same period
- emergency department presentations increased by 9 per cent over the past 10 years
- acute hospital admissions grew by 2.4 per cent annually
- unplanned readmissions were 14 per cent in 2017-18 (VAGO, 2019a).

VAGO also states that "…increasing demand combined with current service shortfalls are placing the whole mental health service under substantial stress" and that little has been done to address the imbalance between demand for, and supply of, mental health services (VAGO, 2019a).

Despite recent budget increases and funding reforms, Victoria still has the lowest recurrent expenditure on specialised mental health services per capita in Australia and one of the lowest number of mental health beds per capita (VAGO, 2019a). All major acute psychiatric units operate at or above 95 per cent capacity, well above the 80–85 per cent that would enable area mental health services to admit acutely ill people in a timely manner (VAGO, 2019a).

A review commissioned by DHHS advised that Victoria's adult bed base needs to grow by a staggering 80 per cent over the next decade to reach the service levels achieved in other Australian jurisdictions (VAGO, 2019a).

***Lack of system planning and investment***

Victoria does not have a transparent and robust population-based approach to funding clinical mental health services, which means that services have not developed to meet the mental health needs of Victoria's growing population.

Funding has been piecemeal and the lack of sufficient and appropriate system-level planning, investment, and monitoring over many years means the mental health system in Victoria lags significantly behind other jurisdictions in terms of available funding and infrastructure, and the percentage of the population supported (VAGO, 2019a).

Mental health funding has failed to keep pace with demand growth and per capita investment has fallen. This has resulted in a reduction in the capacity and reach of the specialist clinical mental health system, such that hours of treatment and care are now below that which best practice guidelines recommend.

***Input-based funding***

Mental health funding in Victoria has been largely based on inputs, such as bed days and community hours, and allocated via an historic block-funding formula, which fails to address the significant unmet demand and the mental health needs of consumers. This is in contrast to other acute physical health inpatient and non-admitted activity, which have case-mix or activity-based funding models.

The current funding arrangements for mental health do not promote efficient use of available resources or support new investment by government on the basis of demonstrable demand and types of service delivered.

***Inequities between catchments***

There is currently no capability framework for Victorian clinical mental health services as there are for other clinical services, for example the *Maternity and Newborn Capability Framework* (2019a) and the *Palliative Care Service Capability Framework* (DHHS, 2016b). This is an impediment to the delivery of a standardised clinical mental health service offering that ensures all consumers can access the care they need.

There is a significant variation in base-level mental health service provision between catchments, including the ability to deliver assessment, interventions and subspecialty care, such eating disorders and perinatal mental health. As noted by VAGO, this has serious equity implications for consumers (VAGO 2019b).

The pressure points in the clinical mental health system are particularly felt in regional Victoria and in metropolitan growth corridors, where access to mental health beds (acute and subacute) and community-based services is difficult.

Access to youth services is also variable across Victoria as highlighted by VAGO (2019b), and is of particular concern in the MMH catchment.

***Lack of flexibility***

Victoria's approach to the allocation of funding for mental health services is inflexible and can result in funds not being directed to those areas of greatest need.

The DHHS approach is based on negotiated targets for volume and throughput. It does not consider consumer outcomes or quality, efficiency and service performance measures. This is particularly problematic in an environment of increasing consumer acuity and complexity (including multiple comorbid conditions).

***Declining investment in prevention and early intervention***

Lamentably, the clinical mental health service system is increasingly focused on crisis response, as scarce resources are drawn from community to higher acuity emergency and inpatient mental health services. One driver of this shift is DHHS' funding of only 62 per cent of the actual cost of providing an acute mental health bed compared to 82 per cent for a general acute hospital bed (VAGO, 2019a). This results in area mental health services subsidising the shortfall from other areas within their service. This is a perverse, inefficient and costly funding model that fails to invest adequately in earlier prevention, intervention and treatment.

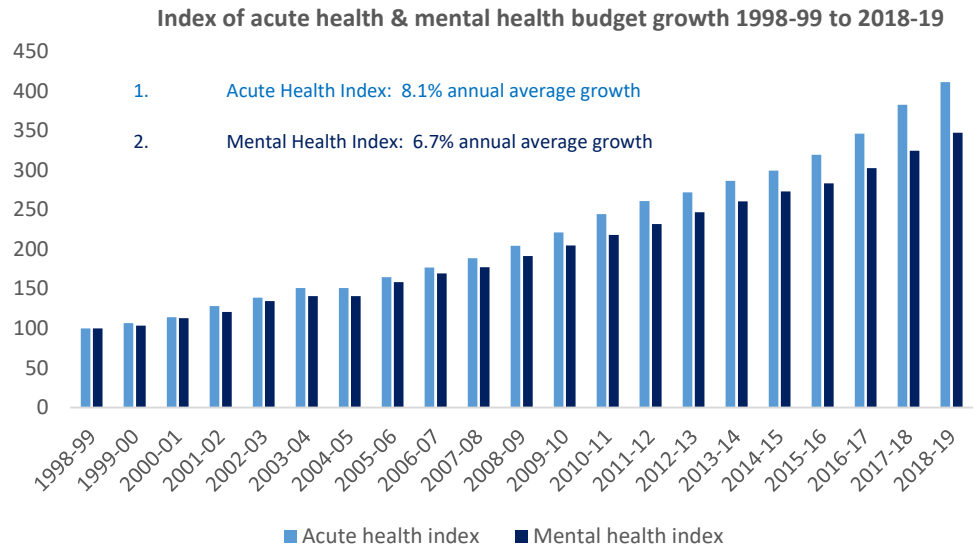


*Figure 1.3: Index of acute health & mental health budget growth, 1998-99 to 2018-19 (Victorian Government, 2019)*

The growth in funding to acute versus mental health clinical streams in Victoria over the past 20 years (1998-99 to 2018-19) is also noteworthy. As demonstrated in Table 1.2 funding for acute health has grown by 371 per cent over the period, while the mental health budget has grown by 267 per cent; a difference of 104 per cent.

| | Mental Health DHHS Funding $M | Acute Health DHHS Funding $M |
|---|---|---|
| **1998-99** | 438 | 2,992 |
| **2018-19** | 1,606 | 14,107 |
| **Growth** | 1,168 | 11,115 |
| **Growth % Change** | **267.0%** | **371.5%** |
| **Difference** | **104.5%** | |

*Table 1.2: Growth (percentage change) acute health and mental health budget, 1998-99 to 2018-19 (Victorian Government, 2019)*

***Reform initiatives***

MMH welcomes recent initiatives by DHHS to improve funding allocations. These initiatives include:

- recurrent funding for adult intensive community packages (DHHS, 2016c) for people with severe mental illness and complex care needs
- fixed-term funding for the early intervention psychosocial support response (ESPIR) framework (DHHS, 2018) which sees a non-clinical NDIS provider work alongside the clinical mental health service to meet a consumer's needs as they transition to the NDIS
- the Clinical Mental Health Funding Reform project led by the DHHS that commenced in 2019.

The Clinical Mental Health Funding Reform project will develop a new activity-based funding model for clinical mental health services, align the funding model to future national funding and reporting requirements, and prepare area mental health services for the adoption of the new model.

The objectives of a new funding model would be to:

- improve equity through funding services based on their consumer mix
- improve efficiency and system capacity through incentives to optimise the use of existing resources and better target new resources to consumers with the highest need and who are at greatest risk
- reduce clinical practice variation by linking the funding provided for specific consumer cohorts or service events to normative care packages or pathways
- improve transparency and accountability in the allocation of clinical mental health funding and in doing so increase the capacity for mental health services to compete for, and sustain essential levels of public funding.

As noted by VAGO, however, a new funding model will fail without an adequate quantum of funding (VAGO, 2019a).

MMH and the south-western metropolitan service system: funding and demand challenges

MMH is located in a growth corridor area. Its population has increased by 21.34 per cent from 2011 to 2016, with forecasts indicating that the catchment's population will increase by 50 per cent by 2031 compared to the Victorian average of 27.8 per cent (Department of Environment Land Water and Planning, 2016).

| *Catchment* | 2011 | 2016 | Change (%) |
|---|---|---|---|
| ***Hobsons Bay (C)*** | 87,395 | 93,577 | 7.07 |
| ***Maribyrnong (C)*** | 75,154 | 85,471 | 13.73 |
| ***Wyndham (C)*** | 166,699 | 220,468 | 32.26 |
| ***Total South West Catchment*** | **329,248** | **399,516** | **21.34** |
| ***Victoria*** | 5,537,817 | 6,048,767 | 9.23 |

*Table: 1.3: Population growth 2011-2016 (Department of Environment, Land, Water and Planning, 2016)*

Funding for mental health services has not kept pace with the catchment's population growth.

Funding for admitted to non-admitted care in the catchment has a ratio of 43.79 per cent to 56.21 per cent, compared to a state ratio of 32.20 to 67.80 per cent (*DHHS Policy and Funding Guidelines, Health*

*Operations* Victorian Government, 2018). This indicates a funding shortfall for community clinical mental health services, which poses a challenge for adequate pre- and post-discharge support for people who were admitted.

| *FUNDING 2018-19* | *Admitted $'000* | *Non-Admitted $'000* | *Total $ '000* | *Admitted (%)* | *Non-admitted (%)* |
|---|---|---|---|---|---|
| **Mercy Public Hospitals** | **$23,917** | **$30,701** | **$54,618** | **43.79** | **56.21** |
| **DHHS Average** | | | | **32.20** | **67.80** |

*Table 1.4: MMH DHHS funding 2018-19 admitted and non-admitted (Victorian Government, 2018)*

The key funding and demand challenges in the MMH catchment mirror those in other Victorian catchments, including in relation to capital infrastructure and the need for population-based planning approaches, service models and funding.

## 1.3 The mental health workforce

The clinical mental health workforce comprises psychiatrists, junior medical staff, registered psychiatric nurses, clinical psychologists, occupational therapists, social workers and lived experienced (peer) workers. The clinical mental health workforce is employed across acute bed-based services, community mental health services, specialist services, and Prevention and Recovery Care and Continuing Care Unit services, and provides triage, assessment, diagnosis, treatment and clinical case management to people with a mental illness.

### *Workforce shortages*

In 2001, the Commonwealth Department of Health warned:

> Australia is experiencing a serious, if not critical, mental health workforce shortage in numbers, poor distribution of providers of all disciplines, and outmoded delivery models in practice and reimbursement that do not achieve the maximum services from the workforce that exists … In terms of the nursing workforce, the overall nursing complement is too limited to fill even current posts. The future is even more daunting as nursing is an ageing work force without sufficient new recruits … The medical psychiatric workforce is poorly distributed and largely sited in the metropolitan areas. Many psychiatric sessions are in private practice, which plays relatively little part in the consultation to primary care services and to rural and remote areas, the conduct of initial (including crisis) assessments, and the training of junior psychiatrists … Psychologists are, by international standards, relatively few within State and Territory mental health services, and too often work as generic case managers. Therefore, their specialist contributions to the delivery of expert psychological therapies are not sufficiently available to people with mental health problems. Rather than addressing the difficult, underlying issues causing the nursing shortage, the current strategy of the States and Territories appears to be efforts to recruit from each other's limited personnel pools. The situation is serious with a high risk of insufficient numbers of trained nurses being available in the foreseeable future to sustain a viable mental health service (Australian Government, 2001).

A decade later, the National Mental Health Workforce Strategy (Australian Health Ministers' Conference, 2011) lamented that ensuring a sustainable, skilled and appropriate mental

health workforce remained a significant challenge across Australia. Moreover, the shortage of psychologists remains and may have worsened.

DHHS (2016d) has noted the need to improve the availability, distribution and sustainability of a qualified mental health workforce, especially in the context growing demand, people presenting with increasingly diverse and complex issues, and an ageing population. The uneven distribution of the Victorian mental health workforce and difficulties recruiting in regional Victoria and growth corridors were also noted (DHHS, 2016d).

The sector-wide shortage of health professionals with mental health qualifications, experience and skills has consequences for service access and the delivery of safe and high-quality care. There remains an undersupply of mental health professionals in all key disciplines and a pressing need to update knowledge, culture and practice of the mental health workforce.

The recruitment of psychiatric medical staff (consultant and registrar) is a sector-wide challenge affecting all area mental health services. Experienced registered psychiatric nurses are in high demand and shortages have required service providers to supplement localised recruitment strategies with national and international campaigns. Interstate and overseas recruitment processes are slow and expensive, and often mean long periods waiting for the required accreditations to be obtained.

***Skills development***

A further workforce challenge affecting the mental health sector is in relation to skills development and specialisation.

Due to overwhelming demand for clinical mental health services, clinical mental health staff are often unable to utilise their full range of skills. Ensuring clinical mental health services are able to support clinicians to develop and utilise their formal training in flexible, consumer-driven models of care is a difficult given the current demand for service, inflexible funding and service structures.

***Allied health and social support***

Victoria also needs to grow the clinical mental health allied health workforce across all disciplines.

The mental health workforce must be familiar with non-discipline specific skills relating to drug and alcohol dual diagnosis, family violence, and cultural diversity including mental health care delivery that is culturally appropriate and tailored to the needs of Aboriginal and Torres Strait Islander peoples. Area mental health services need to develop workforce innovation models, including substitution mode (for example, nurse practitioners, novice community engagement workers) that are tailored to the specific needs of catchment populations.

***Workforce retention***

The retention of mental health professionals throughout their career is important for system sustainability, especially as clinicians seek to alter their work patterns in response to lifestyle changes (for example, young families, older workers, part-time workers). As part of workforce planning, the maintenance of contemporary practice skills is critical, including those of part-time workers.

***Lived experience***

There is growing demand and evidence for increasing the lived experience workforce to provide services such as peer support and advocacy, and to support consumer and carer

engagement (DHHS, 2016d). Lived experience workers provide a unique contribution to the design and delivery of mental health services. The need to boost the role of lived experience workers through greater their integration into mental health services has been noted (DHHS, 2016d).

### MMH and the south-western metropolitan service system: the impact of workforce shortages

In the MMH catchment, workforce shortages pervade all clinical disciplines and MMH is forced to compete with other service providers for skilled staff.

These shortages have meant that even when new beds are introduced into the system they must be opened in a staged manner because the lack of available staff. This was the case with the opening of 23 additional mental health beds at the Clare Moore Building.

The challenges in securing an experienced mental health workforce has required MMH develop innovative workforce development models. An example of this innovation is MMH's use of its experienced clinical workforce (for example, in community-based services and crisis teams) to mentor and support junior staff (for example, in bed-based services).

Another example of a new approach to workforce development and utilisation is the Early Intervention Psychosocial Support Response (EISPR) framework. This involves a partnership between a clinical mental health service provider (MMH) and a National Disability Insurance Scheme provider to deliver non-clinical psychosocial disability supports to consumers of the clinical mental health service.

This program acknowledges that not all the needs of people accessing a clinical mental health service require a clinician and that clinical mental health services have expertise that the non-clinical sector does not, which provides the opportunity to upskill and support non-clinical staff.

Similarly, the non-clinical provider will have expertise in supporting people with the social determinants of mental health including housing and homelessness and assisting people to engage in meaningful occupation and the activities of daily living. This shared care model will reduce the workload of the clinical case managers, which will enable them to deliver more clinical services.

# 2. Victorian mental health system design principles

This section sets out Mercy Health's views on the key areas for reforming Victoria's mental health service system.

Mercy Health believes the Royal Commission provides a once-in-a-generation opportunity to redesign services for people living with mental illness. Overcoming the current service system's shortcomings to create a future state in which the services required by people living with mental illness and their families and carers are provided through an integrated person-centred care system requires a reimagining of the existing systems, significant investment and sustained effort.

Mercy Health has not attempted to provide detailed recommendations on how this could be achieved. The principles suggested in this section are the principles Mercy Health believes should guide the creation of a reimagined mental health service system.

## 2.1 Principles for the design of a new mental health service system

In the future state, a reinvigorated Victorian mental health services system will ensure services are person-centred and individuals and their families and carers can obtain care when and where it is needed.

As pointed out by VAGO, meaningful improvements in clinical service models should meet the changing and dynamic mental health needs of the population (VAGO, 2019a). Individuals, families and the community should be at the centre of the way mental health services are organised and delivered, and they should be intimately involved in the review of existing, and co-production of new, models of care (DHHS, 2015b).

The demand for mental health care will continue to grow due to population growth, a reduction in stigma around seeking help, changes in legal and illegal drug use patterns, and increasing levels of social isolation in our community (VAGO, 2019a, p. 7). In a reimagined system this growth is anticipated and planned for. Funding is transparent and linked to population growth. Both met and unmet demand are recognised and measured (VAGO, 2019). Funding is activity-based and clinical mental health services receive reimbursement for the true costs of service delivery (VAGO, 2019a).

In order to achieve this future state, a fundamental redesign of the mental health service system is required. Such a redesign should be based on the following principles:

**Design principles:**

1. ***Person-centred service is prioritised***

   This means mental health services are designed and delivered around the needs of the consumer, and their families and carers, so that service system is easy to navigate, provided close to home and available when required.

2. ***Services are evidence-based, adaptable and tailored for specific consumer cohorts***

   This means mental health services are designed using evidence of what works, and that they are appropriate for the particular needs of each cohort.

3. ***There is only one mental health service provider in a catchment***

   This means only one catchment-based mental health service provider works with consumers, their families and other service providers to provide specialist mental health care that is accessible, coordinated, person-centred and clinically efficacious.

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4. ***Each service provider services all cohorts***

   This means that each service provider provides mental health services to all cohorts throughout the life cycle, including perinatal, child and youth, adult and aged persons services.

5. ***Each catchment is large enough to provide economies of scale and efficiency***

   This means area mental health services are of sufficient size to create operational economies of scale and service delivery efficiencies, and to permit services to respond to the changing needs of the catchment population and the developing clinical evidence base.

6. ***Funding is population-based, flexible and adequate to meet the needs of the catchment population***

   This means funding reflects demand and consumer complexity, is flexible enough to allow for innovation and meets the true costs of service delivery.

7. ***Service and infrastructure planning is proactive and future-facing***

   This means that investment in infrastructure anticipates future needs and that the service system is able to respond to changing demand.

8. ***There is sufficient planning to ensure the mental health workforce is skilled and available***

   This means there is a systemic and coordinated approach to workforce planning across all disciplines (including psychiatry, nursing, allied health and lived experience workers).

9. ***Partnerships and cooperation between mental health service providers and other providers are encouraged and valued***

   This means developing new ways of working with other health services and providers of social supports (such as housing and employment) to better support consumers, including those with comorbidities.

## 2.2 Removing complexity and fragmentation

A service system designed using these principles would be simpler and less fragmented. It would provide the following positive and measurable outcomes:

- easier system navigation for consumers, families, carers and referrers
- a simplified area mental health service structure to facilitate access to community-based care, treatment and support close to home
- a reduction in the number of people in crisis presenting to emergency departments
- improved clinical outcomes through continuity of care, whole-of-life planning and seamless transition points
- a reduction in risk for vulnerable consumers at key transition points because a single service provides whole-of-life care
- greater certainty for consumers regarding their specialist service provider and interventions
- economies of scale and efficiencies.

## 2.3 Partnerships in care

A service system designed using these principles would improve the system's ability to partner with agencies in the health and social support service systems that provide other services necessary to support those living with mental illness. An adequately funded, person-centred whole-of-life service system would enable greater cooperation and collaboration across health, disability, housing, economic participation, education and social inclusion so that consumers can fulfil their potential.

A partnerships plan would provide the following measurable outcomes:

- improved recovery for people living with a mental illness accessing services from a clinical mental health service
- reduced fragmentation of mental health, physical health and social support care through planning, co-design and service delivery
- a renewed focus on community-based mental health care rather than acute bed-based mental health care, with associated cost savings
- reduced the likelihood of relapse and readmission
- enhanced information and skill-sharing between workers in the various service systems and agencies.

## 2.4 Funding and unmet demand

A service system designed using these principles would provide better services to consumers as well as economies of scale and efficiencies. Funding would be population-based and adequate to meet the mental health needs of catchment populations. The funding model would be transparent and take account of the needs of different cohorts and other catchment-based demographic profiles. It would ensure funding is sufficient to respond to population changes and increasing demand over time.

A new funding model would provide the following measurable outcomes:

- restoration of confidence in the Victorian mental health system as mental health service users are able to access the care they require where and when needed
- a services system that is no longer crisis-driven
- consumers who have equal access to mental health services regardless of where they live and their stage in life
- mental health infrastructure that is planned
- services that meet the needs of the catchment population because funding is sufficient to ensure clinical care models are flexible, regularly reviewed, evidence-based and outcome-focussed
- innovation and agility is encouraged through the application of flexible funding packages.

## 2.5 The mental health workforce

A service system designed using these principles would ensure there is a mental health workforce that is qualified, skilled and available. Workforce recruitment, retention and development would be planned and would anticipate changes in demand and the clinical mental health needs of consumers.

A workforce development plan would provide the following measurable outcomes:

- a sufficient availability of qualified and skilled clinicians, with less need to recruit staff from interstate and overseas
- a workforce that has the skills required to support consumers with drug, alcohol or gambling issues, dual diagnosis, a background of family violence or trauma, and consumers from culturally, linguistically, and sexually and gender diverse communities
- enhanced workforce capability due to a workplace culture that supports staff to develop and maintain their professional skills and advance their careers in the mental health sector
- improved succession planning
- increased involvement of those with lived experience of mental illness in the design and delivery of mental health services and peer support programs
- reduced levels of occupational violence due to improved service delivery models, physical environments and enhanced workforce capabilities
- improved workforce retention and engagement.

MMH and the south-western metropolitan service system: an example of a possible future state

In the future state MMH is the sole provider of whole-of-life care across perinatal, child and adolescent, youth, adult and aged person phases. In addition to a community-centric model of care, MMH's offering includes acute in-patient mental health services tailored to age, sub-acute and residential rehabilitation mental health services tailored to age, mental health consultation liaison into partner hospitals, research and closer collaboration with Mercy Health O'Connell Early Parenting Centre in Canterbury.

MMH provides high-quality, seamless mental health services in partnership with consumers throughout their lives. Access to, and continuity of, care for people accessing MMH services, their families, carers and referrers is dramatically improved with tertiary clinical mental health services consolidated under the clear governance of MMH.

As the sole provider of tertiary mental health services in the catchment, MMH facilitates improved consumer-centric system navigation and partnership with providers of synergistic health, community and social support services in the region. The consolidation of clinical mental health service provision under the governance of MMH provides clarity for support service providers, encouraging additional service providers into the catchment (for example private psychiatrists, private allied health professionals, NDIS providers, etc.).

In the future state, system redesign supports a social determinant recovery focus for mental health consumers, including across health, disability, housing, economic participation, education and social inclusion.

The future state is one of renewed optimism regarding mental health service delivery in the catchment, as complexity and fragmentation is greatly reduced and consumers and their families and carers are able to access the care they need close to home.

MMH is nimble and proactive as it is of sufficient size (DoH, 2013), scope (whole-of-life) and experience, meaning change is anticipated and planned for.

MMH's clinical models are flexible and co-produced with consumers, carers and families. Our models cater to the dynamic needs of the population across the life cycle and to particular cohorts including Aboriginal and Torres Strait Islander peoples, people from a CALD background, people who are sexually or gender diverse, people who are homeless, or at risk of homelessness, people with drug, alcohol or gambling issues, and people with complex comorbidities.

MMH's access to funding improves as a result of the introduction of a robust activity-based funding model for acute and community mental health. The activity-based input model reflects consumer acuity and complexity, service responsiveness and the true cost of delivering clinical mental health services. Funding

allocations are flexible enough to facilitate nuanced approaches to the catchment's demographic requirements, and MMH is able to innovate due to the allocation of funds that can be used in creative new ways.

In the future state, there is an adequate mental health workforce supply to meet the demand needs of the catchment, including across the medical (psychiatric) workforce, registered psychiatric nurses, allied health professionals including occupational therapists, clinical psychologists and social workers, and other health professional such as nurse practitioners. Members of the lived experience workforce support consumers, carers and clinicians, and provide meaningful input into MMH operations and planning. Funding for the MMH mental health workforce is structured at ratio of approximately 30 per cent acute inpatient to 70 per cent community.

MMH's vacancies are filled swiftly and workforce turnover is low. MMH is able to draw from a healthy pool of available and qualified professional mental health workforce, such that recruitment activities focussed on interstate and international resources are much reduced. Clinicians are incentivised to work in growth corridor areas to ensure an adequate and stable supply.

The availability of a trained and experienced mental health workforce ensures that new funding to meet population demand is actualised swiftly. Future state service and capital planning, including in partnership with DHHS, ensures that infrastructure is adequate to meet the requirements of the workforce.

MMH has a robust teaching, training and research portfolio, which is central to the recruitment and retention of a stable psychiatry workforce, including registrars and consultant psychiatrists. Registered psychiatric nurses are recruited as new graduates and are supported to develop and continue their mental health careers at MMH. MMH has a range of other nursing roles, including enrolled nurses in acute settings and nurse practitioners across acute and community settings. There is a higher proportion of allied health professionals employed in the future state MMH and career pathways and clinical governance support retention. MMH also has a range of new workforce types that evolve to meet the needs of the community, which include clinical, non-clinical and lived experience worker roles. Clinicians have the ability to work in roles that they were trained to undertake.

As a whole-of-life area mental health service provider, MMH trains mental health workforce professionals across all life stages. In addition, MMH providers sector-wide leadership in relation to perinatal mental health workforce development. Employees have the opportunity to gain experience and skills with multiple age groups through 'in-house' training programs that are developed by clinical experts.

In the future state, partnerships in care are effective and there is greater clarity of roles and responsibilities between providers. Co-location of synergistic service providers are strategically located in areas such as Werribee that are well served by public transport and enhance service access and utilisation. Role delineation and the promotion of service linkages support the development of shared understandings of service provision in south-western metropolitan region across the spectrum of care and support.

There is an enhanced sense of shared care and the need to provide opportunistic care and interventions for consumers wherever possible to enhance their physical health, mental health and social and economic wellbeing.

Perinatal mental health services are enhanced via funding to develop consultation and liaison services for the growing birthing population in the catchment. All relevant catchment-based regional resources are utilised caring for women with babies through perinatal mental health networks, which including Maternal and Child Health, Early Parenting Services, Early Intervention Services, and maternity service providers.

Catchment-based drug and alcohol services are strengthened through realignment to the MMH catchment boundary. This affords improved consumer care, workforce skills development and economies of scale in service provision. Further, people who require MMH have enhanced access to services to ensure that their physical health needs are met, for example by MMH (acute and community), public acute health providers in the region (including ambulatory and admitted care, as required), and by community health (including dental) and primary care. As a result, there is a decrease in the utilisation of emergency departments by people who are supported by clinical mental health services for physical health crises, and a decrease in potentially preventable hospitalisations for this group.

The current homelessness crisis affecting people living with a mental illness in the MMH catchment is addressed, through increased public housing stock and the funding of additional homelessness services and supports. MMH works closely and collaboratively with homelessness services to ensure that people are not retained in mental health acute beds while waiting for housing support.

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# Appendix 1: MMH catchment profile

The following information provides a profile of the MMH adult catchment, known as the SWAMHS catchment. The catchment for MMH's perinatal services is also presented.

## Community profile

The SWAMHS catchment has a diverse catchment population, with the following characteristics:

- the rate of new settler arrivals per 100,000 population is the highest in the state
- the percentage of people born overseas is among the highest in the state
- the rate of total offences per 1,000 population is the highest in the state
- the gaming machine losses per adult population are among the highest in the state
- the rate of new dwellings approved per 1,000 population is the highest in the state
- higher than average rates of chronic and complex disease and mental illness
- over 100 languages are spoken, and up to eight per cent of the total population having poor or no English proficiency, significantly higher than the national average of 2.6 per cent (DHHS, 2015a).

Table 2.1 demonstrates population and mental health and associated indicators across the three municipalities in the SWAMHS catchment. Drug usage and possession offences and total offences per 1,000 population are higher in Maribyrnong compared to the Victorian average. There are more registered mental health consumers per 1,000 population in Maribyrnong than in Wyndham or Hobsons Bay, and more than the Victorian average.

| | Wyndham (C) | Hobsons Bay (C) | Maribyrnong (C) | Victoria |
|---|---|---|---|---|
| **Population data** | | | | |
| Most populous community | Werribee | Altona Meadows | Footscray | |
| Actual annual population change, 2004 - 2014 | 7.0% | 1.0% | 2.6% | 1.7% |
| Actual annual population change, 2004 - 2014 (rank) | 1 | 38 | 9 | |
| Projected annual population change, 2014 - 2024 | 4.0% | 1.1% | 2.9% | 1.7% |
| Projected annual population change, 2014 - 2024 (rank) | 5 | 31 | 7 | |
| **Mental Health & associated indicators** | | | | |
| Drug usage and possession offences per 1,000 population | 2.7 | 3.1 | 7.2 | 5.1 |
| Drug usage and possession offences per 1,000 population (rank) | 62 | 56 | 18 | |
| Total offences per 1,000 population | 69.2 | 73.6 | 100.3 | 82.6 |
| Total offences per 1,000 population (rank) | 44 | 36 | 16 | |
| People reporting high/very high psych. distress | 8.9% | 9.7% | 11.9% | 12.6% |
| People reporting high/very high psychological distress (rank) | 62 | 52 | 37 | |
| Consumers that received Alcohol & Drug Treatment Services per 1,000 population | 4.4 | 4.4 | 5.6 | 5 |
| Consumers that received Alcohol & Drug Treatment Services per 1,000 population (rank) | 45 | 44 | 29 | |
| Registered mental health consumers per 1,000 population | 9.1 | 10.5 | 12.4 | 11.9 |
| Registered mental health consumers per 1,000 (rank) | 68 | 60 | 48 | |

*Table 2.1: Community Profile, SWAMHS catchment (DHHS, 2015a).*

## Population growth

Victoria In Future (Department of Environment Land Water & Planning, 2016) is an annual analysis of changing economic and social structures and other drivers of demographic trends that are utilised in planning initiatives to indicate possible future populations if the present identified demographic and social trends continue. The Victoria In Future series provides estimated resident population for Local Government Areas by five-year age group and sex, for every fifth year from 2011 to 2031.

Recent Victoria In Future (Department of Environment Land Water & Planning, 2016) data indicates that over the fifteen-year period, 2016–2031, the population of the catchment of the SWAMHS will grow by 50.5 per cent (compared to a Victorian average growth of 27.8 per cent). Population growth figures are provided for each municipality within the catchment in Table 2.2.

| Catchment | 2016 | 2021 | 2026 | 2031 | Difference 2016 to 2031 | Change 2016 to 2031 (%) | Average Growth per Annum (%) |
|---|---|---|---|---|---|---|---|
| **Hobsons Bay (C)** | 93,577 | 98,582 | 104,762 | 109,442 | 15,865 | 17.0 | 1.1 |
| **Maribyrnong (C)** | 85,471 | 101,342 | 119,044 | 130,377 | 44,906 | 52.5 | 3.5 |
| **Wyndham (C)** | 220,468 | 267,356 | 314,054 | 361,394 | 140,926 | 63.9 | 4.3 |
| **Total South West Catchment** | 399,516 | 467,281 | 537,860 | 601,213 | 201,697 | 50.5 | 3.4 |
| **Victoria** | 6,048,767 | 6,605,653 | 7,170,957 | 7,733,259 | 1,684,492 | 27.8 | 1.9 |

*Table 2.2: Population Projections 2016-2031 (DELWP, 2016).*

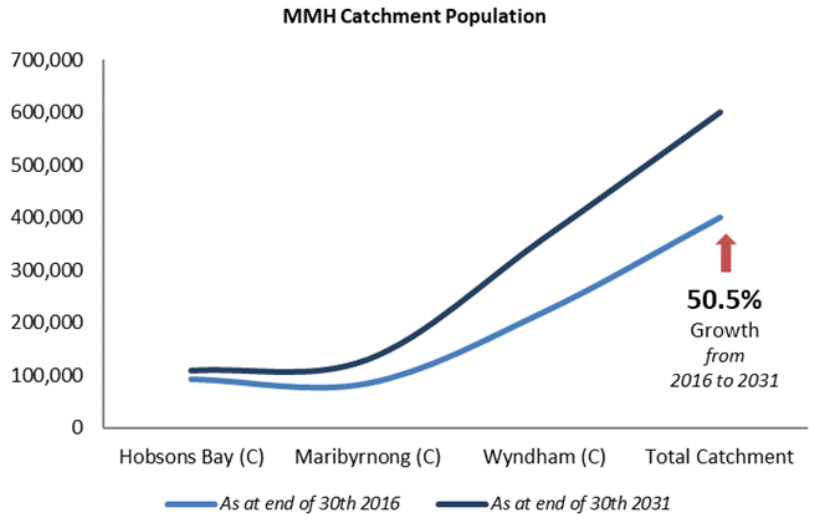


*Figure 2.1: SWAMHS catchment population growth, 2016-31 (DELWP, 2016).*

## Demographic profile

The age profile of the SWAMHS catchment to 2031 is noteworthy, demonstrating varying patterns within municipalities within the catchment.

- In Hobsons Bay, the main age demographic change in the forecast period will be a 51.8 per cent increase in the number of residents over 65 years.
- In Maribyrnong, the number of people aged 0–15 years will increase by 59.2 per cent and the aged population (65+) will grow by 94.4 per cent.
- In Wyndham, growth in each of the three age cohorts is significant; with an increase of 44.9 per cent in the 0–15 age group; an increase of 43.3 per cent in the adult population 16–64, and an increase of 117.9 per cent in those aged over 65 years.

Across the SWAMHS catchment, the adult population, currently served by MMH will grow by 43.3 per cent, as demonstrated in Table 2.3 and Figure 2.2.

| Southwest Catchment | 2016 | | 2031 | | |
|---|---|---|---|---|---|
| **Age Profile** | **Population** | **%** | **Population** | **%** | **Change (%)** |
| **Hobsons Bay** | **93,577** | | **109,442** | | **17.0** |
| **0-15** | 16,782 | 17.9 | 19,891 | 18.2 | 18.5 |
| **16-64** | 63,177 | 67.5 | 68,873 | 62.9 | 9.0 |
| **65+** | 13,618 | 14.6 | 20,679 | 18.9 | 51.8 |
| **Maribyrnong** | **85,471** | | **130,377** | | **52.5** |
| **0-15** | 14,747 | 17.3 | 23,481 | 18.0 | 59.2 |
| **16-64** | 63,035 | 73.8 | 91,951 | 70.5 | 45.9 |
| **65+** | 7,689 | 9.0 | 14,945 | 11.5 | 94.4 |
| **Wyndham** | **220,468** | | **361,394** | | **63.9** |
| **0-15** | 55,857 | 25.3 | 83,280 | 23.0 | 49.1 |
| **16-64** | 149,487 | 67.8 | 234,349 | 64.8 | 56.8 |
| **65+** | 15,124 | 6.9 | 43,766 | 12.1 | 189.4 |
| **Total South West Area** | **399,516** | | **601,213** | | **50.5** |
| **0-15** | 87,386 | 21.9% | 126,651 | 21.1% | 44.9% |
| **16-64** | 275,699 | 69.0% | 395,173 | 65.7% | 43.3% |
| **65+** | 36,431 | 9.1% | 79,390 | 13.2% | 117.9% |

*Table 2.3: Southwest Catchment age profile 2016-2031 (DELWP, 2016).*

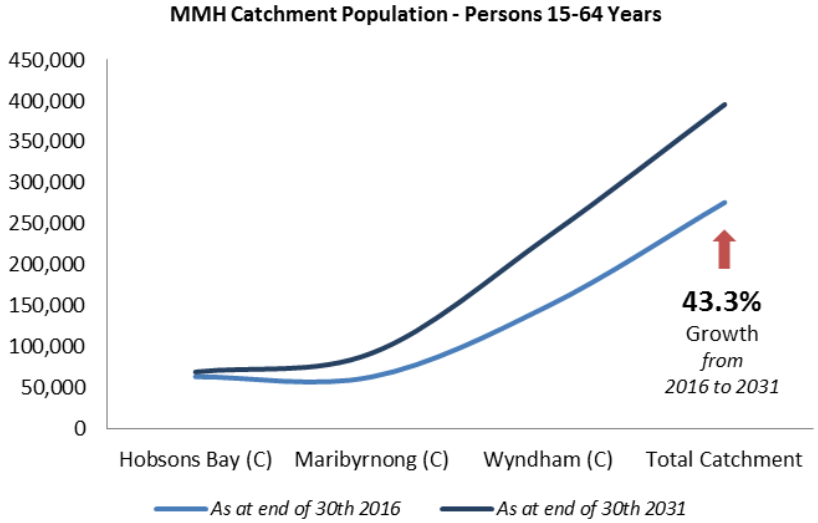


*Figure 2.2: SWAMHS catchment population growth, 2016-31: adult population 16-64 years DELWP, 2016).*

MMH's perinatal mental health services cover the western metropolitan catchment and beyond. The Mother Baby Unit (MBU) has an extended catchment, which covers the western metropolitan region, and regional and rural localities.

MMH's perinatal mental health service also provides perinatal mental health outpatient services at Werribee Mercy Hospital and Mercy Hospital for Women, perinatal consultation and liaison at the Mercy Hospital for Women, and perinatal mental health research. Of note, as per the DHHS capability frameworks for Victorian maternity and newborn services (DHHS, 2016a; 2019a), Werribee Mercy Hospital is a Level 4 maternity service, and Mercy Hospital for Women is a tertiary service at Level 6 (DHHS, 2016a; 2019a).

It is important to note that MMH does not provide Child and Youth Mental Health Services or Aged Person Mental Health Services in the south western catchment. These services are provided by:

- Royal Children's Hospital (RCH) (Child Mental Health 0–14 years)
- Melbourne Health's North West Area Mental Health Service (NWAMHS) Orygen Youth Health (Adolescent Mental Health 15–24 years)
- Melbourne Health's NWAMHS Aged Persons Services (65+ years).

## Appendix 2: MMH Service Plan, 2019-32

In 2018-19, MMH undertook a formal service planning exercise to define the needs of the catchment and service directions over a 10-year+ horizon. The planning exercise was conducted over eight months in 2019 and produced the MMH Service Plan 2019-32 (Mercy Health, 2019a). Service planning analysis included an evidence-based review of service models, policy context overview and consideration of service system challenges. Forecasting for future growth in the catchment utilised data made available to Mercy Mental Health via DHHS and the National Mental Health Service Planning Framework (NMHSPF) (University of Queensland, 2016).

The NMHSPF (University of Queensland, 2019) is an evidence-based framework that provides a population-based approach to strategic planning, and benchmarks for optimal service delivery across the full spectrum of mental health services. The NMHSPF allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population, drawing on available evidence and expert opinion.

The NMHSPF is undergoing a three-year revision to further develop it, which is due to be completed in 2021. Priorities for development include refining the care profiles of the NMHSPF to better account for the needs of special populations including Aboriginal and Torres Strait Islander populations, people living in rural and remote areas; culturally and linguistically diverse groups; forensic populations, and youth.

The development of the *MMH Service Plan 2019-29* also required extensive data analysis of internal and statewide Victorian mental health. Consultation (including interviews, focus groups and surveys) with over 100 MMH staff (including lived experience workforce), consumers, carers, Mercy Health stakeholders and community-based service provider partners was key to informing the co-produced solution based recommendations of the MMH Service Plan (Mercy Health, 2019a). A summary of consumer and care feedback themes is included in Appendix 3.

The *MMH Service Plan 2019-29* took a person-centred and co-production influenced approach to system based planning to meet the future facing clinical mental health needs of MMH's catchment and service portfolio.

The five Service Directions discerned from the MMH Service Plan 2019-29 are noted below. These Service Directions highlight MMH's future facing, system reform oriented, catchment informed aspirations for the mental health service system:

- Operation of whole-of-life cycle mental health service provision across the catchment is pursued; including adequate funding for the provision of services to meet population demand; indexed over time.
- Clinical programs are evidence based, person-centred, recovery focussed and tailored to consumer needs, and adaptable to meet changing demand needs over time.
- Funding for mental health service provision is adequate to provide high-quality clinical mental health services to the area mental health service catchment.
- Current workforce capacity and capability is developed to build a strong, safe and appropriately skilled workforce.
- Partnerships are strengthened through new ways of working with other providers of clinical mental health services, non-clinical mental health services and other health, community and social support services in the catchment to support holistic consumer outcomes.

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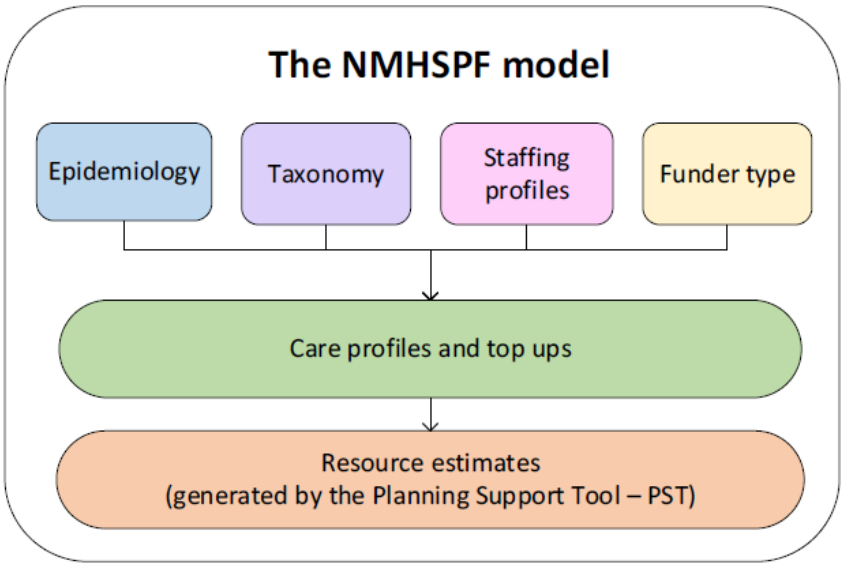
## Appendix 3: National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF) (University of Queensland, 2019) provides a comprehensive model of the mental health services required to meet population needs, and is designed to help plan, coordinate and resource mental health services. It is an internationally unprecedented, evidence-based framework providing national average benchmarks for optimal service delivery across the full spectrum of mental health services in Australia. It provides an agreed national language for mental health services, with a detailed taxonomy and definitions of service types accompanied by national average staffing profiles and salaries. The associated NMHSPF Planning Support Tool (NMHSPF-PST) allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population.

The NMHSPF model (see figure below) combines the best available evidence and expert opinion on the prevalence of mental illness and need for mental health services, the types and levels of mental health care required for different need groups, and efficient standards of mental health service operation to deliver this care. These inputs allow calculation of the resources required to deliver adequate mental health services to a nominal population of 100,000 people in each age group or a selected population region such as Australia, a state or territory, local health network, etc. The NMHSPF model:

- estimates the number of people in a defined population with mental illness in a year, by age and severity, and sets service demand targets for those who will require intervention (epidemiology)
- describes the full spectrum of interventions from self-help, digital and low intensity interventions to primary and specialist clinical treatment, to mental health community support services (taxonomy and staffing profiles)
- describes service needs of age and severity target groups, including types of intervention, intensity, provider and current funder (care profiles and funder type)
- drawing on all of the above, produces resource estimates to deliver those interventions over 12 months.

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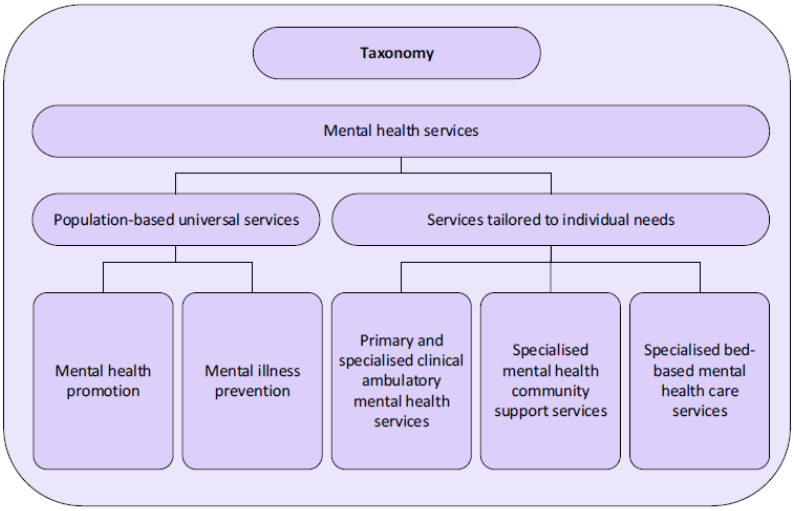
The NMSHPF describes the range of services required in a comprehensive mental health system using an agreed national taxonomy of mental health services across the spectrum of service delivery within five key streams: mental health promotion, mental illness prevention, primary and specialised clinical ambulatory mental health services, specialised bed-based services, and specialised mental health community support services (see figure below). Given that each state and territory delivers mental health services differently, the taxonomy provides a common language and clear definitions of core mental health service components and functions.




The NMHSPF provides a staffing profile tool (see figure below) that allows for a mix of staff across different workforce categories to be assigned to an intervention at a particular ratio. For bed-based and team services (mainly state-funded services but also some team-based community support sector services), there is a separate and unique staffing profile for each service element in the taxonomy, detailing the types and hours of providers involved in that team. Staffing profiles include a roster of the staff mix and hours of service delivery, salaries and administrative overhead costs.

Within the NMHSPF model, estimates of required beds, workforce FTEs, costs and activity are modelled at desirable, efficient operational rates. Outputs are based on averaged national staffing profiles and salaries.