

The Adult Psychiatry Imperative

Achieving parity of care

Submission to the Royal Commission into
Victoria's Mental Health System
July 2019

Consortium members and affiliations

Disclaimer: the views expressed by members of the Adult Psychiatry Imperative consortium represent a chorus of individual psychiatric expert opinion.

We do not imply support or endorsement of the opinions and recommendations contained in this submission by the organisations with which we are affiliated.

Professor David Copolov AO

Pro Vice-Chancellor, Major Campuses and Student Engagement
and Professor of Psychiatry, Monash University
Professor of Psychiatry, University of Melbourne

Professor Tarun Bastiampillai

Professor of Psychiatry
College of Medicine and Public Health, Flinders University
South Australian Health and Medical Research Institute – Mind and Brain Research Fellow

Victorian Psychiatrists (in alphabetical order)

Associate Professor Ravi Bhat

Associate Professor of Psychiatry
Department of Rural Health, Melbourne Medical School
The University of Melbourne

Professor Anne Buist

Professor of Women's Mental Health, Austin Health, University of Melbourne

Dr Paul Cammell

Senior Psychiatrist, Royal Melbourne Hospital
Senior Fellow, Department of Psychiatry, University of Melbourne
Research Lead, BPD Collaborative, South Australia
Chair, Advanced Training in Psychotherapy, Royal Australian and New Zealand College Psychiatrists

Professor Vaughan J. Carr

Adjunct Professor, Monash University and Monash Health
Professor of Psychiatry, University of New South Wales
Senior Principal Research Scientist, Neuroscience Research Australia (NeuRA)

Professor David Castle

Professor of Psychiatry, University of Melbourne
Consultant Psychiatrist

Emeritus Professor Lorraine Dennerstein AO

Department of Psychiatry, University of Melbourne

Professor Maurice Eisenbruch

Department of Psychiatry, School of Clinical Sciences at Monash Health, Monash University
Emeritus Professor, Royal University of Phnom Penh, Cambodia

Professor Carol Harvey

Professor of Psychiatry, University of Melbourne
Secretary, World Association for Psychosocial Rehabilitation – Australian branch

Professor Malcolm Hopwood

Ramsay Health Care Professor of Psychiatry, University of Melbourne
Director, Professorial Psychiatry Unit, Albert Road Clinic

Dr Kym Jenkins

Immediate Past President, Royal Australian and New Zealand College of Psychiatrists

Professor Fiona Judd AO

Department of Psychiatry, University of Melbourne
Menzies Institute for Medical Research, University of Tasmania

Professor Richard A. A. Kanaan

Chair of Psychiatry, Austin Health, University of Melbourne

Professor Nicholas A. Keks

Adjunct Professor of Psychiatry, Monash University
Delmont Private Hospital
Monash Medical Centre

Professor Jayashri Kulkarni AM

Director, Monash Alfred Psychiatry Research Centre

Dr Vinay Lakra

Director Clinical Services, North West Area Mental Health Service
President Elect, Royal Australian and New Zealand College of Psychiatrists

Professor Nicola T. Lautenschlager

Department of Psychiatry, The University of Melbourne

Associate Professor Steve Moylan

Clinical Director, Mental Health Drugs and Alcohol Services, Barwon Health
Clinical Associate Professor, Deakin University

Professor Richard Newton

Adjunct Professor, Department of Psychiatry, Monash University

Professor George Patton

Professor of Adolescent Health Research, University of Melbourne,
Senior Principal Research Fellow, National Health and Medical Research Council

Dr Bill Pring

Member of the Executive, Independent Private Psychiatrists Group
Immediate Past Chair of Council, Victorian AMA

Dr Suzy Redston

Consultant Psychiatrist, Austin Health
Public and Private Mental Health

Professor Emeritus Bruce Singh AM

Emeritus Professor University of Melbourne

Dr Danny H Sullivan

Executive Director of Clinical Services, Victorian Institute of Forensic Mental Health (Forensicare)
Honorary Senior Fellow, University of Melbourne
Adjunct Research Fellow, Centre for Forensic Behavioural Sciences, Swinburne University

Adjunct Clinical Professor Suresh Sundram

Monash University

Professor Emeritus John Tiller

The University of Melbourne,
Albert Road Clinic Associate

Professor Philip Tune

Clinical Director, Mental Health Services, Bendigo Health
 Authorised Psychiatrist, Loddon Campaspe, Southern Mallee DMHS
 Clinical Adjunct Associate Professor, Monash University

Dr Richard Yeatman

Consultant Psychiatrist

Australian (non-Victorian) Psychiatrists

(in alphabetical order)

Associate Professor Stephen Allison

College of Medicine and Public Health
 Flinders University, Adelaide, South Australia

Dr Andrew Amos

Director of Training, Northern Queensland
 Deputy Editor, Australasian Psychiatry

Professor Malcolm Battersby

Head of Psychiatry, College of Medicine and Public Health, Flinders University
 Clinical Director, South Adelaide Mental Health Services, Adelaide, South Australia

Professor Assen Jablensky

Head, Centre for Clinical Research in Neuropsychiatry, The University of Western Australia

Associate Professor Jeffrey C. L. Looi

Acting Head, Academic Unit of Psychiatry and Addiction Medicine,
 ANU Medical School, Canberra Hospital, Canberra, A.C.T.

Professor Gin S. Malhi

Head, Department of Psychiatry, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia

Professor Alexander C. McFarlane AO

Director of the Centre for Traumatic Stress Studies,
 Professor of Psychiatry, The University of Adelaide

Professor Philip Mitchell AM

School of Psychiatry, University of New South Wales

Professor Gordon Parker AO

Scientia Professor of Psychiatry, University of New South Wales

International Advisory Committee

Professor Nancy C. Andreasen

Andrew H Woods Chair of Psychiatry
 University of Iowa Carver College of Medicine, Iowa City, Iowa USA

Professor Dr Mathias Berger

Professor of Psychiatry and Psychotherapy at the Department of Psychiatry and Psychotherapy,
 University Medical Center, University of Freiburg, Germany

Dr John Crichton

Chair, Royal College of Psychiatrists in Scotland, UK

Professor Ian Overall

Executive Dean
 Institute of Psychiatry, Psychology and Neuroscience
 Dean, International Partnerships
 King's College London, UK

Professor Allen Frances

Past Chairman, Department of Psychiatry, Duke University School of Medicine
 Chair of the Taskforce that produced DSM IV

Doris Fuller

Consultant, Mental Illness Research and Advocacy
 Former Chief of Research and Public Affairs, Treatment Advocacy Center, USA.

Distinguished Professor Julio Licinio

Senior Vice President for Academic and Health Affairs
 Executive Dean, College of Medicine
 SUNY Distinguished Professor in the departments of Psychiatry, Medicine, Pharmacology, and Neuroscience and Physiology, USA

Professor Richard O'Reilly

Professor of Psychiatry, Western University, Canada

Distinguished Professor Emeritus Robert T. Rubin

Department of Psychiatry and Biobehavioral Sciences
 David Geffen School of Medicine at UCLA

Professor Steven S. Sharfstein,

President Emeritus, Sheppard Pratt Health System
 Adjunct Professor, School of Medicine, University of Maryland, USA.

Elizabeth Sinclair

Director of Research, Treatment Advocacy Center, USA

Professor Dominic Sisti

Director, The Scattergood Program for Applied Ethics of Behavioral Health Care
 Department of Medical Ethics and Health Policy
 Perelman School of Medicine at the University of Pennsylvania, USA

Professor E. Fuller Torrey

Associate Director of Research,
 Stanley Medical Research Institute, Kensington, Maryland, USA

Supporting organisations

Mental Health Victoria
 The Australian Patients Association
 The Faculty of Adult Psychiatry, Royal Australian and New Zealand College of Psychiatrists

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Executive summary

Our submission focuses on the reforms required to address the specific and unique needs of adults with serious mental illness in order to achieve parity of care. The terms of reference for the Royal Commission ask for a report on “how Victoria’s mental health system can most effectively prevent mental illness...”. We draw an important distinction between primary prevention, and secondary and tertiary prevention of mental illness. There is no evidence-base to direct a population-based approach to the primary prevention of many of the most serious mental illnesses – such as schizophrenia, melancholic depression, and bipolar illness. No intervention proposed to prevent the occurrence of these serious mental illnesses has passed the basic scientific test of being able to generate replicated findings. This is not to deny the value of primary prevention as a core long-term goal; but in this context it is essential that the pressing needs of people with serious mental illness are prioritised and resourced – while ongoing research seeks to better identify the causes of serious mental illnesses in order to prevent them from occurring in the first place. Until such research on primary prevention can be proven to reduce mental health service-needs, we must provision and plan our mental health system based on current demographic and population demands – and based on the principles of parity of care.

Increasing adult inpatient and community mental health capacity to match demand, including establishing new Specialist Mental Health Centres.

We argue that a crucial part of meeting the need for parity will be to increase the number of public, general adult, psychiatric beds in Victoria to the critical rate of approximately 51 beds per 100,000 population (currently ~25.5/100,000). Of critical note: this is a population-relative rate, not a one-time increase. As Victoria’s population increases (from ~6.3 million in 2019 to a projected 10.1 million in 2051) we need to continue to increase the number of beds accordingly. Data on bed numbers show we have failed to do this over the preceding three decades. We will illustrate the value of inpatient care, and show that our numbers of general adult (18-64 age group) public acute, non-acute, and forensic mental health beds are extremely low based on comparative national and international data (well below OECD and World Health Organisation median bed numbers). We recommend an “observed outcomes approach” to calculate optimal psychiatric bed numbers.

These proposed enhancements in mental health care infrastructure are urgent, so they must largely be directed to improving the resources, bed numbers, workforce, and other elements of mental health within existing hospitals and other care facilities. We also recommend establishing new facilities for the longer-term benefits of Victoria’s system, but these facilities would take years to plan and construct, so we need to prioritise improvements to the existing system in the meantime.

In parallel with these crucial improvements to the existing mental health infrastructure, a longer-term strategic approach to mental health care should incorporate specialised, state-of-the-art, mental health infrastructure – just as in other areas of health. We recommend establishing new university-affiliated Specialist Mental Health Centres. These should be modelled on the outstanding international examples of university-affiliated psychiatric centres/hospitals – such as the Maudsley Hospital, and the Institute of Psychiatry, Psychology, and Neuroscience (IoPPN) – that combine the missions of clinical care, education, and research – where patient care comes first, with teaching and research supporting

recovery of patients within and beyond the Centre via highly-skilled care providers and the translation of discovery outcomes into clinical practice.

Regrettably, those who oppose specialised care centres often evoke the outdated notion of asylum – an isolated, cold, and corrupt relic of the past with no data capture, no integration with the research community, and seemingly no likelihood of discharge. But the modern reality is divorced from these examples, with high-quality, recuperative facilities that prioritise patient welfare, safety, health, and wellbeing. Our recommended university-affiliated Specialist Mental Health Centres would be co-located with research centres.

Strengthening mental health research capabilities to support new methods of care and innovation

King's College London and the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) together host the NIHR Maudsley Biomedical Research Centre – an excellent example of the type of co-located research we are recommending.¹ They are researching new tests, treatments, and theories in mental health, neurology, and dementia. They aim to accelerate the translation of the latest scientific discoveries into first-in-human clinical trials and other well-designed studies. The findings from these studies can then be developed and implemented to produce new tests and treatments for people with mental and neurological disorders. Research priorities are focused around novel treatments, precision medicine, translational informatics, and mental-physical health.

Our recommended specialist Centres would be of two types: Mental Health Acute-Care Centres, and Mental Health Rehabilitation Centres. The Acute-Care Centres would function much like the specialised and highly successful Peter MacCallum Cancer Centre, Royal Children's Hospital, and Royal Women's Hospital – embedded within or alongside metropolitan hospitals, attracting high-quality researchers and staff, ensuring best-practice care and outcomes, and serving as hubs for research. The Rehabilitation Centres would support these same functions – though with a more intense rehabilitation focus for those with longer-term needs – in aesthetically designed buildings with access to substantial outdoor spaces for patients and staff.

Enhancing the governance of mental health to improve accessibility, efficiency, effectiveness, and integration with other elements of healthcare

Another core component of our recommendations will be to provide specific suggestions for restructuring mental health governance. Problems we aim to address by reforming governance include inadequate policy and strategy development – especially in terms of long-term planning – and an emphasis on a culture of compliance rather than optimisation of quality and safety enhancement, leading to burdensome regulatory requirements that detract from direct clinical care. There are also insufficient mechanisms for decision-makers to have access to the advice of clinical leaders, subject matter experts, and consumers and carers. For too long Mental Health has stood apart from the broader Health portfolio, offering theoretical "protection" which has not translated into practical benefits for the field – quite the reverse. We will argue that mental health is a part of health, and will benefit from the collaboration, cooperation, and synergies that come from integrating into the existing governance structures for health.

Considering these changes to governance structures, the numerous separate mental health services/entities/organisations already in existence, the new ones that we recommend, and the connected support services (e.g. NDIS, housing, social welfare, legal support), it is very important to integrate these services – standardising a high quality of care, monitoring outcomes, and supporting people with serious mental illnesses to navigate this complex system. To this end we propose new Mental Health Integrated Services Hubs (MHISHs), building on the model of the highly successful Integrated Cancer Services

1 <https://www.slam.nhs.uk/research>

(ICSs) that have been operating in Victoria since 2005.² These Hubs would include a patient navigation function which goes beyond the ICS model.

Developing world-leading clinical information systems to directly improve patient care

The ultimate goal of all these recommendations is to improve delivery of treatment, care, and support. But how will Victoria evaluate whether these reforms are successful? Existing datasets for monitoring the quality (appropriateness and effectiveness) of mental health care are largely stand-alone and not longitudinal. We must improve data linkage and collect longitudinal data to support and enable many of the changes we have recommended, as well as to monitor and evaluate these same changes to ensure they are improving healthcare practice, policy, and stewardship. To that end, a major pillar of our recommended reforms will be to establish clinical-quality registries and other information systems for serious mental illness. This will provide the data necessary for research, and for delivering continuous evidence-based improvements for mental health treatment, care, and support across Victoria on an ongoing basis.

² <https://www.nemics.org.au/>

Recommendations

Prevention

Recommendation 1: Recognition should be given to secondary and tertiary prevention of serious mental illnesses – such as schizophrenia and bipolar disorder – as core foci of mental health services.

Current services

Recommendation 2: Additional funding for mental health care provision should be directed to the existing mental health services associated with general hospitals and care in the community, in order to improve their capacity to cope with growth in demand and to adequately address patients' therapeutic needs in a safe and high-quality clinical environment.

Community mental health

Recommendation 3: Adult community mental health teams should be aligned into subspecialist crisis assessment teams, continuing care teams, and assertive care teams – embedding therapeutic functions within each team and providing significantly more training and supervision resources to improve their overall assessment and therapeutic skills. Staffing levels should be enhanced by at least 20% to build population coverage levels from the current 1.2% toward 3% – the proportion of the Victorian population who have serious mental illnesses requiring public mental health services.

Inpatient care

Recommendation 4: There needs to be a recognition of the value of inpatient psychiatric care that provides a healthy, safe, and enabling physical and social environment for patients with serious mental illness who require full diagnostic assessment and recovery-focused clinical care.

Recommendation 5: The total rate of general adult (ages 18–64) and forensic mental health beds (and concomitant staffing) throughout the public mental health system should be doubled from 25.5 to 51 beds per 100,000 people, and then maintained at that level. The increase should include: 11 general adult acute beds, 12 general adult non-acute beds, and 3 adult forensic beds (all per 100,000 people), giving a total of 30 general adult acute beds, 15 general adult non-acute beds, and 6 adult forensic beds (per 100,000). An increase in general adult residential beds is not regarded as necessary.

Emergency department settings

Recommendation 6: State-of-the-art modern facilities, including special purpose short-stay psychiatry units, should be set up within hospitals, and mental health staffing levels within emergency departments should be increased, in order to address the increasing number of Victorians with serious mental illnesses and with drug and alcohol use disorders who present to emergency department in crisis.

Recommendation 7: Governance and collaboration between emergency departments and mental health services should be improved, and post-Emergency-Department care of people presenting with mental illness should be standardised.

Drug and alcohol services and Clinical Toxicology Units

Recommendation 8: Drug and alcohol services should be integrated at every level of mental health services delivery, and specialised Clinical Toxicology Units should be established in major teaching hospitals.

Forensic mental health services

Recommendation 9: Forensic community and outpatient-clinic capacity should be increased, with six adult forensic beds per 100,000 people which should be distributed across: existing hospital sites, and the new Mental Health Acute-Care Centres (for acute forensic patients) and Mental Health Rehabilitation Centres (for longer term forensic rehabilitation patients).

Recommendation 10: In line with planned service expansion, community and prison services should be scalably developed, along with sector-wide forensic workforce development including training, recruitment, and retention strategies.

Specialist Mental Health Centres

Recommendation 11: Three to six specialist university-affiliated Mental Health Acute-Care Centres should be established over the next 15 years, aiming for the first two within five years.

Recommendation 12: Three to six specialist university-affiliated Mental Health Rehabilitation Centres should be established over the next 15 years, aiming for the first three within five years.

Integrated mental health services

Recommendation 13: Mental Health Integrated Services Hubs (MHISHs) should be established, building on the model of Victoria's highly successful Integrated Cancer Services (ICs), to promote system integration across structural boundaries and to encourage collaborative approaches to evidence-based service development. They should help to coordinate service delivery options across the spectrum of health care providers and enable clearer care pathways between adult community mental health teams, Primary Health Networks, and primary care facilities.

Recommendation 14: Continuity of care – without discharge from the service – should be used as a guiding principle for the small proportion of adults with the most severe forms of serious mental illness, emulating and building on the principles embedded within the current clozapine coordination system.

Clinical information systems

Recommendation 15: A high-quality information infrastructure should be created, including an Electronic Mental Health Record for patients who are served by the public mental health sector, and real-time clinical quality registries. A serious mental illness census should also be undertaken regularly.

Interface between the private and public mental health sectors

Recommendation 16: That energetic steps be taken to foster a greater involvement of private psychiatrists in the public mental health sector by means of detailed conjoint planning by the Department of Health and Human Services, organisations which represent private psychiatrists – especially the Royal Australian and New Zealand College of Psychiatrists and AMA Victoria – and universities.

Research

Recommendation 17: Victoria should aim to be a world-leading centre for serious mental illness research and discovery, significantly increasing serious mental illness research spending and capacity – from bench to the bedside.

Governance

Recommendation 18: The Minister for Health should reassume responsibility for Mental Health, as part of the portfolio responsibility for nearly all other areas of Health.

Recommendation 19: The Mental Health Branch should have greater input of clinical advice to the Branch Director and other senior staff members and have greater interactions with the Directors of Clinical Services in Metropolitan and Regional areas.

Recommendation 20: A Mental Health Quality and Safety Advisory Committee should be established within Safer Care Victoria.

Recommendation 21: Each general hospital health services board should establish a Mental Health Committee that reports to the hospital board. These committees would have strong mental health service enhancement, monitoring, and reporting roles, with reference to the KPIs established by the new Mental Health Quality and Safety Advisory Committee.

Recommendation 22: Because the current responsibilities of the Chief Psychiatrist involve a duality of roles that can be in tension with each other, involving – on one hand regulatory components and on the other quality and safety enhancement components – these sets of responsibilities should be separated. The reconfigured role of the Chief Psychiatrist should be primarily a regulatory one in relation to the *Mental Health Act 2014*. A new position of Chief Mental Health Officer (CMHO) should be created, whose responsibilities would focus on quality and safety enhancement. That role should be located within Safer Care Victoria (SCV) but would be closely associated with the Mental Health Branch.

Recommendation 23: Area Mental Health Services (AMHSs) should be reconfigured to better align their catchment areas with other health and human service areas in order to improve service coordination and to enable within-area whole-of-life mental health care. Groups of AMHSs should sit within six new Mental Health Networks (MHNs), which geographically align closely with the existing Commonwealth Primary Health Networks (PHNs). The incorporation of AMHSs into MHNs would facilitate (1) coordination of services between AMHSs, and (2) integration of mental health services with other health and non-medical services – such as general practice, PHNs, housing, social welfare, and legal aid. There should be three sets of metropolitan and regional MHN pairs.

Recommendation 24: New Specialist Mental Health Centres should be established: one or two Mental Health Acute-Care Centres within each metropolitan MHN (also servicing the regionally paired MHN), as well as one or two Mental Health Rehabilitation Centres within each metropolitan-regional MHN pair.

Recommendation 25: A Mental Health Services Board should be established in each MHN metropolitan and regional pair, to oversee the governance of the new Specialised Mental Health Centres in the area (following the principles and practices of current Health Service Boards) and the Mental Health Integration Services Hubs.

Recommendation 26: A cross-portfolio subcommittee of Cabinet should be established to ensure that the policy recommendations from the Royal Commission are effectively introduced. This subcommittee should be shadowed by an Interdepartmental Committee (IDC) of all departmental secretaries germane to mental health. An Independent Monitoring Officer with statutory powers should be appointed to monitor the progress of the implementation of the Royal Commission's recommendations.

How our recommendations address the Royal Commission's terms of reference

The Royal Commission's terms of reference		Our recommendations as numbered in the text
1.	How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.	1,4,13,23
2.	How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:	4,6,11,12,13,14
2.1.	best treatment and care models that are safe and person-centred;	2,4,6,20,21
2.2.	strategies to attract, train, develop and retain a highly skilled mental health workforce, including peer support workers;	2,3,6,10
2.3.	strengthened pathways and interfaces between Victoria's mental health system and other services;	13,23,24
2.4.	better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements; and	4, 5,6,7,8,9,11, 12,18,19,20,21, 22,25
2.5.	improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms.	15,17
3.	How to best support the needs of family members and carers of people living with mental illness.	2,6,7,12,14
4.	How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian Community, especially those at greater risk of experiencing poor mental health, including but not limited to people:	4, 11,12,23,24

4.1.	from Aboriginal and Torres Strait Islander backgrounds;	We support the goals and aspirations outlined in the document "Mental Health and Aboriginal People and Communities", DHHS, 2015*. Please also see ** below.
4.2.	living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities;	6,13
4.3.	from rural and regional communities; and	23,24
4.4.	in contact, or at greater risk of contact, with the forensic mental health system and the justice system.	5,9,10
5.	How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.	6,9
6.	Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1–5.	16:Engagement with the private mental health sector 26: Post-Royal Commission Subcommittee of Cabinet.

* Mental Health and Aboriginal people and communities – DHHS Technical Paper, 2015
https://www.mhvic.org.au/images/documents/10_year_plan_for_mental_health/Mental_health_and_Aboriginal_people_and_communities_technical_paper_mental_health_plan.doc.

** We have been in discussion with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) with the intention of endorsing its submission (currently in preparation) to the Royal Commission

1.

Introduction – achieving parity of care

1.1. General introduction

The Royal Commission into Victoria's Mental Health System (Royal Commission) represents an important commitment to improving Victoria's capacity to "deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future."

In order to achieve this, the core of our submission is based on recognising the moral and rational requirement for parity of care, which is derived and inspired by the concept of 'parity of esteem', developed by the UK government and enshrined in their *Health and Social Care Act 2012*.

Parity of esteem "is defined as 'valuing mental health equally with physical health', which would result in those with mental health problems benefitting from: equal access to the most effective and safest care and treatment; equal efforts to improve the quality of care; the allocation of time, effort, and resources on a basis commensurate with need; equal status within healthcare education and practice; equally high aspirations for service users; equal status in the measurement of health outcomes."³

We provide evidence and arguments throughout this submission which demonstrate that Victoria's mental health system is currently failing to provide parity of care. Mental health is an inherent and inseparable part of general health, so we must provide equivalent levels of care for both. This is both a moral argument for equality, and a rational argument for effective health care: "poor mental health is linked with a higher risk of physical health problems, and poor physical health is linked with poor mental health."⁴

The recommendations contained within this submission all stem from the fundamental goal of improving parity of mental health care in Victoria – parity with general health, parity across the lifespan, and parity across regions. To this end, we will demonstrate the need for the following systemic reforms:

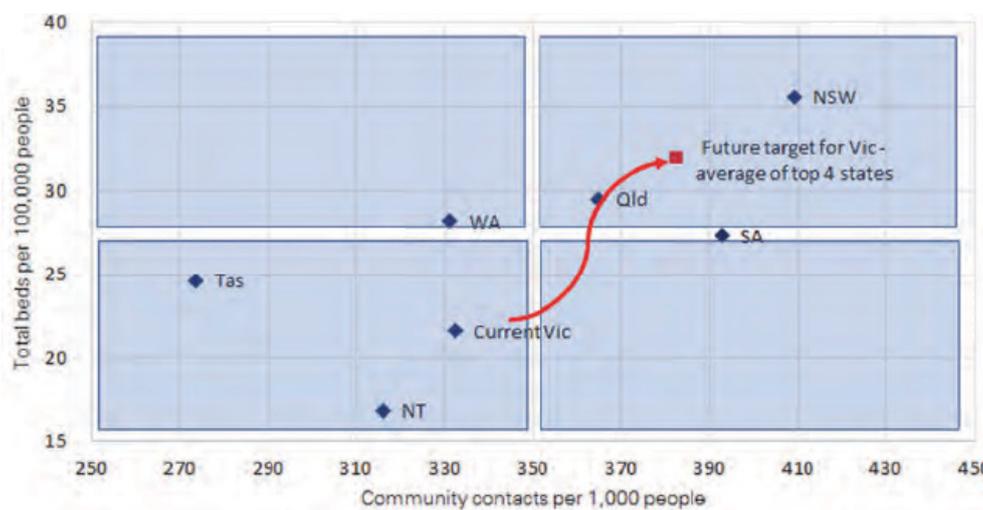
1. Increasing adult inpatient and community mental health capacity to match demand, including establishing new Specialist Mental Health Centres.
2. Developing world-leading clinical information systems to directly improve patient care.
3. Strengthening mental health research capabilities to support new methods of care and innovation.
4. Enhancing the governance of mental health to improve accessibility, efficiency, effectiveness, and integration with other elements of healthcare.

³ <https://www.mentalhealth.org.uk/a-to-z/p/parity-esteem>

⁴ *Ibid.*

While Victoria's Mental Health System currently faces enormous challenges, we also need to recognise its significant strengths. The Royal Commission provides a valuable opportunity for wide-ranging reforms, but we must underpin such reform with a measured and evidence-based approach: retaining what works while fixing what does not. As a consortium of more than three dozen Australian clinical and research psychiatrists (and partner organisations) with deep familiarity and experience in the field of mental health, we have sought to develop a submission to the Royal Commission with the goal of improving Victoria's mental health system for years to come and becoming a worldwide model for others to emulate. Based on careful consideration and analysis of the most current data we will provide a list of detailed recommendations addressing each of the terms of reference for the Royal Commission. We note the complex interactions between diverse elements within the mental health system, and we have striven to develop a cohesive program of recommended reforms that will mutually reinforce each other and work together to enable real systemic improvement.

A recent review by the Victorian Auditor General (see Figure 1) identified that Victoria has significant capacity issues to meet current demand within both the community and inpatient sectors, benchmarked against other states. Victoria had low numbers in terms of both community contacts and overall levels of specialist mental health inpatient beds. An internally commissioned Department of Health and Human Services report using AIHW 2013/14 mental health data identified a target of increasing community contacts by 15% (from 330 to 380 contacts per 1,000 people) and significantly increasing inpatient capacity, excluding forensic beds, by 45% (from 22 to 32 beds per 100,000 – see Figure 1). Importantly, the Victorian Department of Health accepted the findings and recommendations of the Victorian Auditor General.



Note: Excludes forensic mental health beds.

Source: AIHW's *Mental health services in Australia 2013–14*, cited in DHHS-commissioned consultant report, *Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System*, 2017.

Figure 1. Comparison of states and territories on per capita utilisation of mental health beds and community contacts.⁵

However, we are of the view that this target does not go far enough. Australia's mental health system is struggling with capacity issues across the board, so targeting the average of the top four states in Australia is not sufficient. Victoria should be well into the top right sector of this graph, beyond the level of NSW, if it is to meet the systemic demands that we describe in detail in Chapter 4.

⁵ Figure 31, *Victorian Auditor-General's Office, Access to Mental Health Services, March 2019*.

A phalanx of previous reports and reviews

There have been many serious attempts to improve the mental health system in our country – please see below. Yet despite these efforts, and for all its strengths, the Victorian public mental health system also has major shortcomings. The Royal Commission provides an opportunity for major system redesign that will benefit the hundreds of thousands of Victorians with mental illnesses, their families and supporters, and the passionate and caring mental-health workforce working with patients day-to-day. Moreover, such a redesign could enable Victoria to be the primary “engine room” for mental health reform throughout Australia and the world.

In this submission we will be providing recommendations that, to our knowledge, have not been prominent in previous reviews or plans and may contribute to other recommendations that will be submitted to the Royal Commission for consideration.

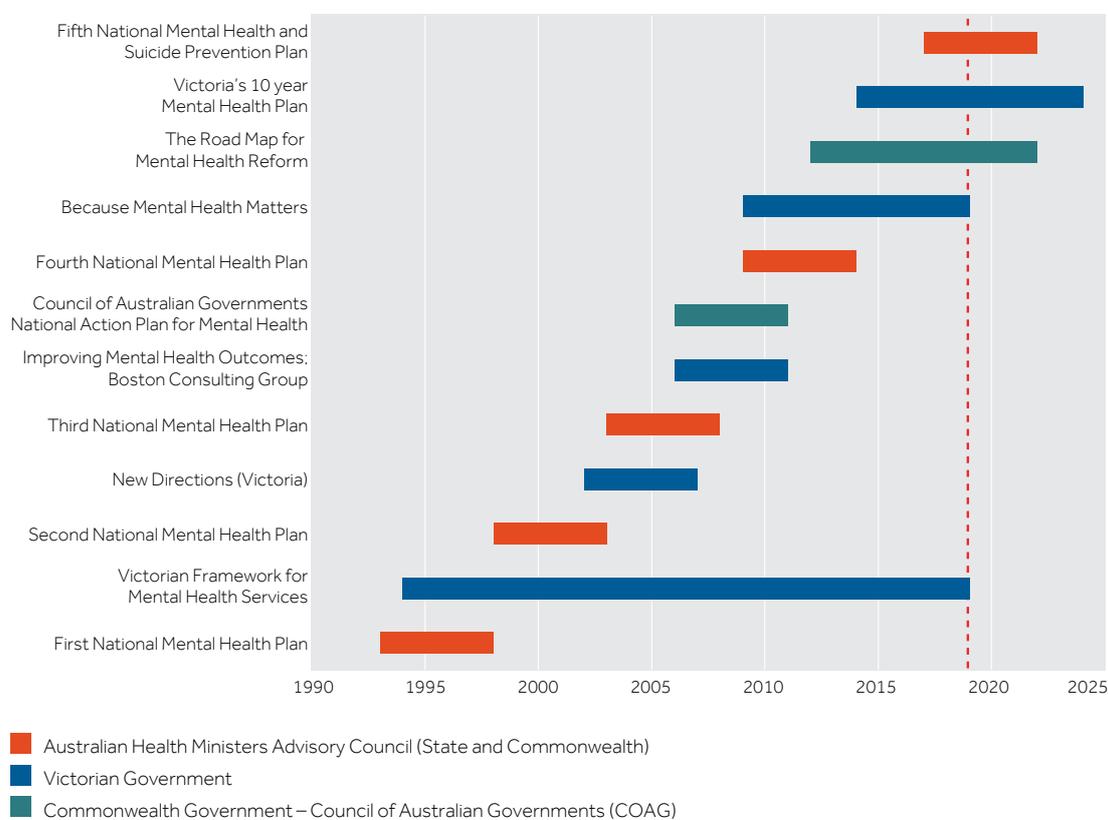


Figure 2. Victorian and National reviews and plans for mental health since 1993.

There have been concerns expressed that many of the reviews and proposed reforms have not significantly improved Australia's and Victoria's mental health systems. Indeed, population levels of mental health are unchanged in terms of overall levels of psychological distress, suicide rates⁶, rising emergency department mental-health-related presentations, and rising levels of transinstitutionalisation for the severely mentally ill.^{7,8}

6 Jorm, Anthony F. "Lack of Impact of Past Efforts to Prevent Suicide in Australia: Please Explain." *Australian & New Zealand Journal of Psychiatry* 53, no. 5 (2019): 379-80.

7 Allison, S., and T. Bastiampillai. "Mental Health Services Reach the Tipping Point in Australian Acute Hospitals." [In eng]. *Med J Aust* 203, no. 11 (Dec 14 2015): 432-4.

8 Allison, S., T. Bastiampillai, J. Licinio, D. A. Fuller, N. Bidargaddi, and S. S. Sharfstein. "When Should Governments Increase the Supply of Psychiatric Beds?" *Molecular Psychiatry* 23 (07/11/online 2017): 796.

Rapid population growth

Whatever recommendations the Royal Commission might make, it must recognise that the need to improve mental health services is a dynamic and ongoing one – Victoria is a very rapidly growing state.

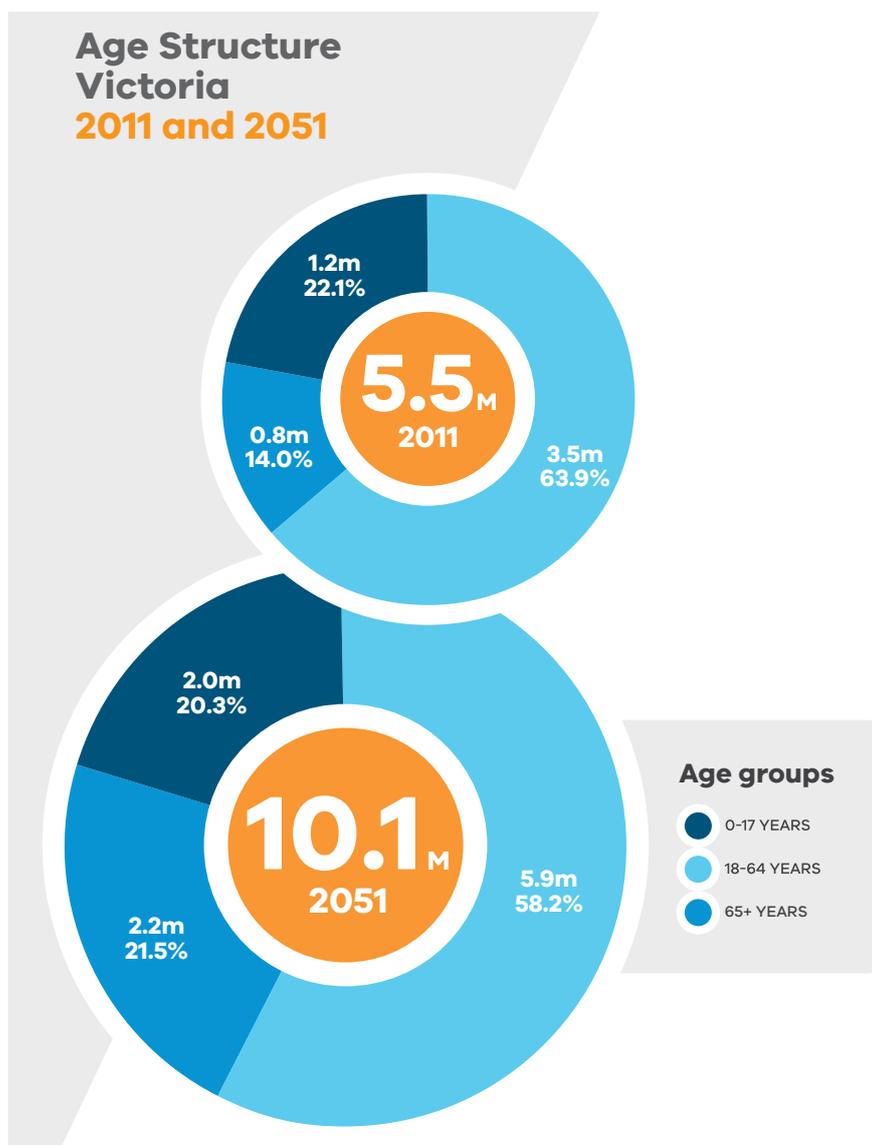


Figure 3. Population projections in Victoria to year 2051.⁹

Victoria is the fastest growing state in Australia, and Melbourne is currently one of the fastest growing cities in the developed world.¹⁰ Melbourne will soon overtake Sydney as Australia's most populous city, possibly by 2031.¹¹ This very high annual population growth of 2.5% between 2011 and 2017 needs to be accompanied by significant public sector investment, including in the healthcare system. Currently there are concerns in Victoria that overall public infrastructure has not kept pace with this high level of population growth. This issue is especially apparent within the mental health sector. Mental health capacity has clearly not matched population growth within both the community and inpatient sectors.

⁹ *Victoria in Future 2016*, Environment, Land, Water and Planning, State Government of Victoria, Australia (based on ABS, 2016 data).

¹⁰ <https://www.theage.com.au/national/victoria/melbourne-is-one-of-the-fastest-growing-cities-in-the-developed-world-20180920-p504zn.html>

¹¹ <https://www.theaustralian.com.au/business/property/melbourne-set-to-become-nations-most-populous-city-by-2030s/news-story/59ab02029829655b7be9e894a0133cbc>

This has led to several problems, which will be discussed in detail within our report, particularly for patients with serious mental illness.

Scope

Central to our overall argument is the need to focus more on adults aged 25–64. Why this age range? One important reason is that they make up the vast majority of people suffering mental health morbidity. The other reason is the following: one of the impressive strengths of Victoria's system is the level of funding and support it directs toward people aged 24 and under, and we are keen to recognise and celebrate this important commitment to the youth of Victoria. Yet we must not allow the substantial outcomes achieved for this age group to absolve us of our responsibilities to the more than 110,000 Victorian adults (aged 25–64) with serious mental illnesses who will continue to make up the bulk of public mental health consumers, but are being left behind by the current system. Victoria's spending on youth (aged 12–24) mental health is the highest in the nation, whereas spending on general adult (aged 18–64) mental health is the lowest in the nation. This overlap of age ranges means that adults aged 18–24 are relatively well supported by Victoria's high (compared to other states) spending on specialist youth services in a way that those aged 25–64 are not.

It is crucially important to improve funding and support for the transition from adolescent/young-adult services to adult services, especially for those individuals whose illness begins prior to age 25, but continues beyond age 25. Without better investment in adult services, we are potentially wasting many of the benefits gained from the earlier investment in youth. This argument is detailed further in section 1.2.2.

We will focus our recommendations on public sector psychiatry as this is the Royal Commission's primary focus. However, where relevant we will draw lessons from private sector psychiatry to inform our recommendations. Private sector psychiatry treats patients with serious mental illness including those who are receiving care in the public sector. Because patients move between the public and private sectors, effective liaison between the sectors is essential for integrated patient care.

We are also choosing to focus on serious mental illnesses. People with serious mental illnesses are the core group of patients treated within the public mental health system: 100% of these patients require ongoing treatment.¹² Moreover, patients with serious mental illnesses spend more time in treatment, further establishing them as the main consumers of public mental health care. This is not to deny the importance of treating patients with mild to moderate mental illness, but to emphasise that the most significant challenge – where the system is currently failing the most – is in supporting the needs of adult Victorians with serious mental illnesses. Australia recognises that State governments have the primary responsibility for funding and providing both inpatient and community mental health services for patients with serious mental illness.

The national context

Although people with serious mental illness represent a relatively small proportion of the population, they experience disproportionately negative impacts of an under-resourced healthcare system.

People with serious mental illnesses experience high unemployment, high emergency department (ED) wait times for admission, high utilisation of hospital beds, high 28-day readmission rates, high suicide rates, and high imprisonment rates compared to those with non-mental-health related conditions. Additionally, only 22% of people with psychotic disorders were found to be in full- or part-time employment in a survey of more than 1,800 representative participants, and this statistic has remained unchanged since 1997.^{13,14}

12 Victorian Auditor-General's Office, *Access to Mental Health Services*, March 2019: 44.

13 Waghorn et al., 'Earning and learning' in those with psychotic disorders: The second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry* (2012) 46(8) 774–785

14 Jablensky, *Epidemiology of schizophrenia: the global burden of disease and disability*. *Eur Arch Psychiatry Clin Neurosci* (2000) 250: 274–285

The enormous health, social, and economic costs of serious mental illness are ramifications of a policy context of reduced spending on mental health beds.

De-hospitalisation has occurred in parallel to high incarceration for people with serious mental illness in Australia, threatening to proceed along the lines of the mass incarceration that followed de-hospitalisation in the US,¹⁵ massively increased burden of care on families with a member with serious mental illness,¹⁶ and poorer care for people with serious mental illnesses – including an escalating emergency department access block crisis.¹⁷

Reduced spending on mental health beds has often been justified by anticipated reduction in demand for mental health services as a result of population health and community care prevention and early intervention strategies and programs. However, increased spending in population health and community-based mental health services has not reduced the prevalence of serious mental illness, nor lessened the demands on our hospital system. In fact, the demand on the hospital system is increasing at a rate four times population growth.¹⁸ This is despite significant investment in Headspace, First Episode Psychosis Services, Better Access programs, and increases in state-funded case management programs.¹⁹

Community care, such as the Australian Government's newly announced expenditure on a trial for community mental health drop in centres,²⁰ is part of the solution but still leaves a gap in specialised psychiatric care for those with more severe and complex disease.

In our experience, care for people with serious mental illnesses in Australia is fractured and disjointed, with fragmented governance and a lack of longitudinal clinical and functional outcome data to provide a robust evidence-base for public health policy and care provision. The treatment of people with serious mental illnesses are overseen by numerous governing organisations – hospital-based acute inpatient care, community mental health centres, non-government organisations, primary care networks, general practitioners, private specialists, federal and state government bodies, and potentially housing, corrections, and other organisations.

There is no common dataset or system, or shared "source of truth" by which to evaluate whether this system is working or to underpin improved integration and evaluation of the effectiveness and efficiency of services. The data that do exist, such as from the Australian Institute of Health and Welfare (AIHW), signal a crisis – with a failure of existing services to keep up with the growing numbers of people presenting to emergency department and needing acute hospitalisation.

An integrated, specialised care network with appropriate bed numbers based on a robust evidence base and an integrated data system is needed to improve care for people with serious mental illness.

A call for Victorian mental health reform

The Background to the Royal Commission states that "of people who experience mental illness in Victoria, only about half receive treatment... For too many Victorians, the care they receive is far too late, when their mental health has deteriorated to the point of a serious crisis. Mental health services in Victoria are under significant pressure from significant population growth, changing patterns of drug use, and greater complexity of need. But there are structural issues in the system that reduce people's access to services too, including funding arrangements and geographic boundaries."

We fully concur with this description of Victoria's challenges and provide further details and analysis in the following chapters.

15 Allison, Bastiamillai and Fuller, Mass incarceration and severe mental illness in the USA. *The Lancet* (2015) Vol 390 July 1, 2017

16 Allison, Bastiamillai and Castle, Victoria's low availability of public psychiatric beds and the impact on patients, carers and staff. *Australian & New Zealand Journal of Psychiatry* (2017) 52(1)

17 Allison and Bastiamillai, Mental health services reach the tipping point in Australian acute hospitals. *MJA* (2015) 203(11)

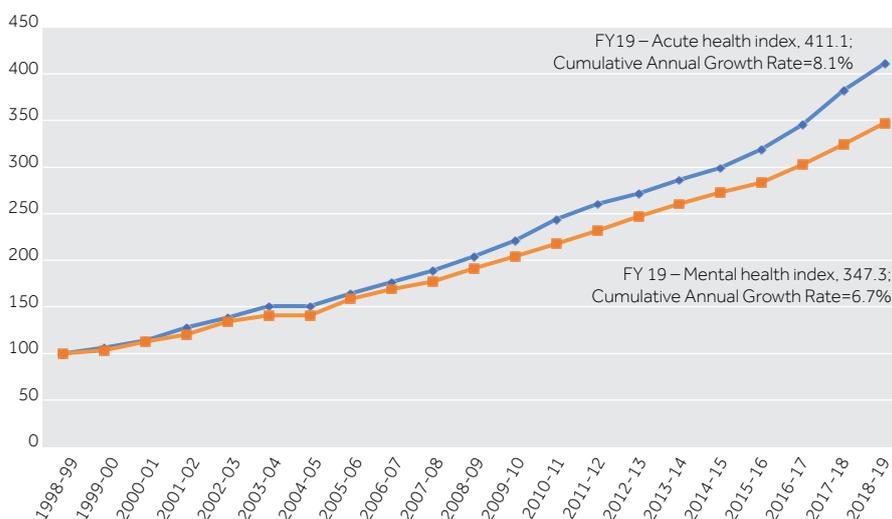
18 Based on AIHW mental-health related Emergency Department presentations

19 Jorm, Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Aust N Z J Psychiatry* (2018) 52(11):1057-1062

20 Australian Government Budget 2019-20

Victorian state government spending on mental health has not kept pace with growth in acute health expenditure (see Figure 4 below). Annual health expenditure has increased by 8.1% annually compared to mental health expenditure having increased by 6.7% annually. This is a relative funding shortfall of 1.4% annually for mental health expenditure compared to acute health expenditure.

Just as mental health expenditure has not kept pace with acute health expenditure within Victoria, so too has Victorian mental health expenditure failed to keep pace with Australia's national growth in mental health expenditure. Victoria began to deviate from the nation in 2006/7 (see Figure 5), corresponding roughly to the time period when divergence with Victorian acute health spending occurred.



Source: Victorian Budget Paper No.3, from 1998-99 to 2018-19

Figure 4. Victorian budget allocation to acute and mental health outputs.

These data are sourced from the Victorian Budget Paper No.3, from FY1999 to FY2019. The Health Index tracks the change in revenue position relative to the starting point. In the Victorian State Budget of FY1999, funding for Acute Health was \$2,991,700,000, while funding for Mental Health was \$437,500,000.

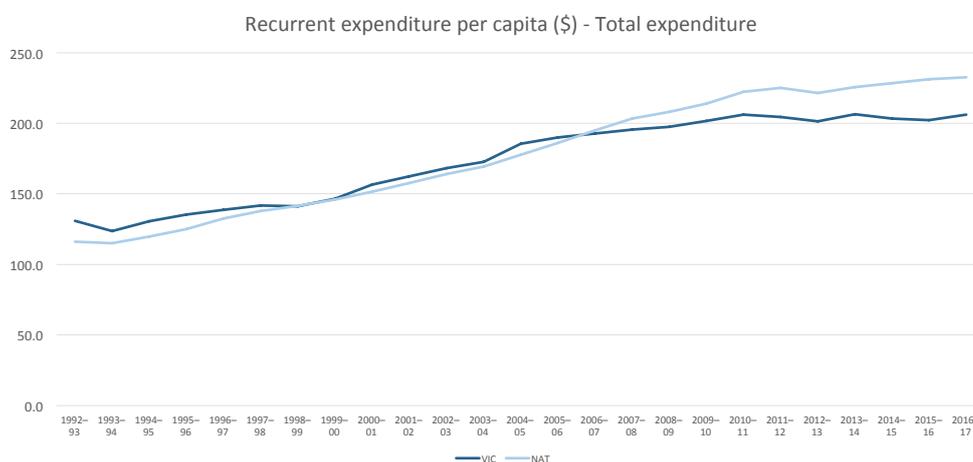


Figure 5. AIHW Expenditure on mental health services from 1993 to 2017.²¹

21 Many of our graphs are derived from Australian Institute of Health and Welfare (AIHW) data, which all come from the following source: <https://www.aihw.gov.au/reports/mental-health-services-in-australia/report-contents/medicare-subsidised-mental-health-specific-services>.

Chapter-by-chapter structure

In Chapter 2 we will provide a detailed, data-driven analysis of Victoria's current provision of care for adults with serious mental illnesses. From this data we firmly demonstrate the significant lack of capacity in inpatient beds for adults in Victoria. In Chapter 3 we discuss various forms of prevention, arguing that we are not yet at the point where we can rely on prevention to reduce the demands placed on the mental health system by the needs of the seriously mentally ill. Chapter 4 examines specific elements of Victoria's existing mental health care system – including community mental health, inpatient care, emergency departments, drug and alcohol services, and forensic mental health – and provide recommendations to enhance these existing services. In Chapter 5 we make the case for establishing Specialist Mental Health Centres as part of Victoria's longer-term strategy for delivering the best quality mental health care into the future. Chapter 6 makes several recommendations for integrating the many disparate elements of mental health services in Victoria – including establishing Mental Health Integrated Services Hubs to unify integration efforts and support patients; developing information infrastructure and clinical quality registries which deliver crucial data to inform the whole mental health system; and better supporting patients who move between private practice care and public sector services. Chapter 7 discusses the important need to prioritise mental health research, which will be supported by the registries and data described in Chapter 6, and by the Specialist Mental Health Centres of Chapter 5. In Chapter 8 we argue that the changes recommended throughout our submission must be underpinned by less fragmented and more effective governance structures – mental health catchment boundaries need to change, mental health needs to be reintegrated with general health at all levels, and numerous changes are needed in executive leadership positions. This overarching vision addresses the four key challenge areas for mental health in Victoria: capacity of services; information to enable and improve services; integration of services; and strategic, bigger-picture leadership and governance.

1.2. Our foci – adults with serious mental illness

1.2.1. Why should serious mental illness be a priority?

This submission focuses on serious mental illnesses (or “severe” mental illness, as the terms are often used interchangeably in the literature) because people with these illnesses represent a significant proportion of the patients seen within the adult public mental health services sector: 57,501 adult clients aged 18–65 (2017–18); a 6.7% increase from the previous year.²² Using data from the Department of Health and Human Services 2017 Review, the Victorian Auditor-General has estimated that 3.1% of Victorians (184,000) have serious mental illnesses, all of whom require treatment, and there were only “72,859 registered users of mental health services”²³ – a significant gap between those who need and those who receive treatment.

Severity of illness	Percentage of Victorians with a mental illness (%)	Number (thousands)	Percentage requiring treatment	Number needing treatment (thousands)	Primary government responsibility
Mild	9.0	537	50	268.5	Commonwealth
Moderate	4.6	272	80	217.6	State/Commonwealth
Severe	3.1	184	100	184	State
Total with mental illness	16.7	993		670.1	

Source: 2017 review, DHHS

Figure 6. Estimated number of Victorians with a mental illness.²⁴

²² Department of Health and Human Services, Victoria's Mental Health Services Annual Report 2017–18, October 2018: 50.

²³ Figure 3D, Victorian Auditor-General's Office, Access to Mental Health Services, March 2019.

²⁴ *Ibid.*

This is evidence that the seriously mentally ill are a marginalised group in Victorian healthcare, as we do not tolerate such gaps in treatment for other areas of health. Moreover, our services see a significantly smaller percentage of people with serious mental illnesses than those of other states.

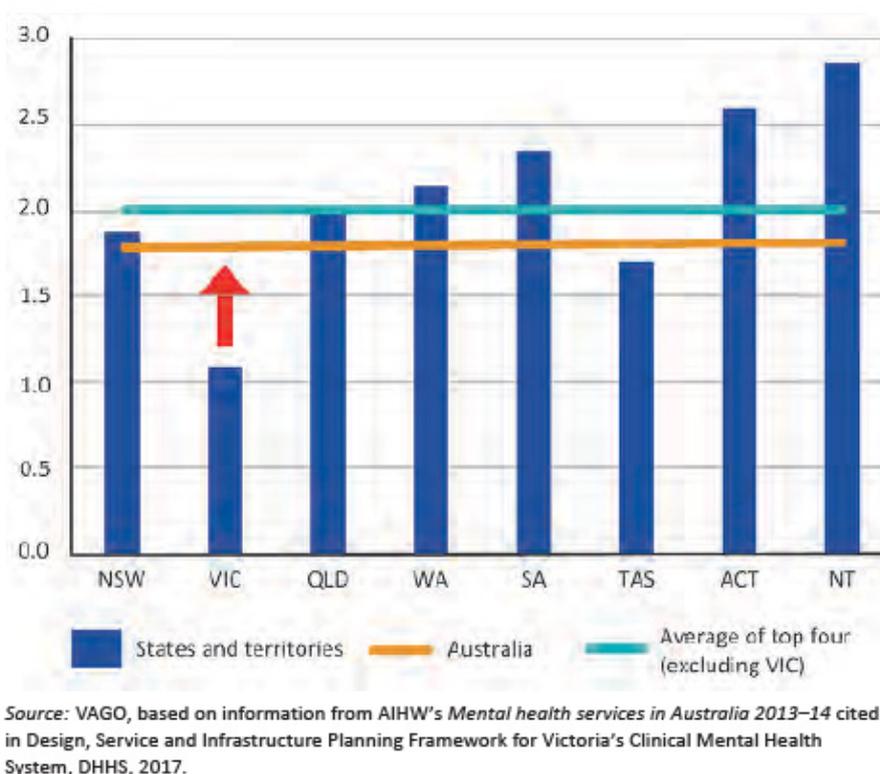


Figure 7. Percentage of Victorian population receiving mental health services compared to other jurisdictions and the national average.²⁵

So serious mental illness makes up a large part of public sector psychiatric care, and Victoria is currently failing to provide treatment for many people with such illnesses. But what is serious mental illness? Although the boundaries of serious mental illness are contestable, we will be using this definition developed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

"While schizophrenia and other psychoses are often regarded as the more serious mental disorders, each disorder can have varying degrees of severity. Here severity refers to the degree of loss in health associated with a condition. ... consideration of serious mental illness should include schizophrenia and other psychoses, bipolar disorder, and severe depression and anxiety..."²⁶ (This RANZCP definition also leaves open the potential for including severe alcohol-use disorder and opioid dependence as part of serious mental illness.)

Unfortunately, although we do intend to include the wide array of serious mental illnesses described above, many of these data relating to mood and affective disorders – such as incidence, prevalence, and outcomes – do not clearly partition these disorders into mild, moderate, and severe. For example, some instances of depression and anxiety are mild, while others are as severe as other types of serious mental illnesses.

On the other hand, as weighted by Whiteford et al.²⁷, both the acute and residual phases of schizophrenia and related psychoses are serious. Almost all schizophrenia falls into the category of

²⁵ Figure 3E, *Victorian Auditor-General's Office, Access to Mental Health Services*, March 2019.

²⁶ *The Royal Australian and New Zealand College of Psychiatrists, The economic cost of serious mental illness and comorbidities in Australia and New Zealand*, 2016: 10.

²⁷ Whiteford et al. – Global Burden of disease attributable to mental and substance disorder ... *The Lancet* 1575-1586, 2013

serious mental illness. For this reason, we believe the data on schizophrenia provide the most accurate and representative picture of serious mental illness in Victoria, and thus many of our references to age onset, prevalence, disability adjusted life years (DALYs), and outcomes will relate to schizophrenia.

Despite this focus on the schizophrenia data, we do mean to include all other forms of serious mental illness in our submission. Our broad approach is this: if a patient requires access to public mental health services they should be provided with the highest standard of care by the State, irrespective of the type of mental illness they have. Focusing on serious mental illness (and then on schizophrenia) – as we are doing in this submission – serves to more precisely articulate some of the biggest challenges for Victoria’s mental health system, without denying the needs of people with less severe mental illness.

As a further reflection of the acuity of illness within the Victorian public mental health system, 55% of inpatients were admitted on a compulsory basis²⁸; most people admitted under compulsory orders have serious mental illnesses. There is no threshold of having to meet the criteria of any of the many definitions of serious mental illness in order to access public mental health services, but a majority of public patients have such illnesses because the private mental health system has limited capacity to treat certain categories of patients with such illnesses. For example, in Australia, 94% of admissions of people with schizophrenia take place in public sector hospital beds, with only 6% in the private sector. By contrast, 55% of admissions for bipolar disorder are within the public sector and 45% in private sector beds. Further, 40% of all occupied bed days in Victorian public sector mental health beds are used by people with schizophrenia.²⁹

We emphasise that we are using a conservative estimate by saying that approximately 3% of Victorians have a serious mental illness. The National Institute of Mental Health has estimated that more than 5% of the population has a serious mental illness, comprising 1.1% with schizophrenia, 2.2% with severe bipolar disorder, and 2% with severe major depression.³⁰

Our recommendations about increasing Victoria’s capacity to care for people with serious mental illness (Chapter 4) must be understood in this context as a bare minimum.

Long-term outcomes of schizophrenia

An overview by Volaka and Vevera³¹ suggested that long-term remission in schizophrenia and related disorders varied between 16% and 38%. Co-morbid substance abuse is also an important factor in reducing positive long-term outcomes for people with schizophrenia and related disorders.

The prognosis of a first episode of psychosis is generally better than the prognosis for later episodes, but research indicates that most young Victorians do not recover after first-episode psychosis. Henry and colleagues³² conducted a 7-year follow-up study of the patients who attended Melbourne’s Early Psychosis Prevention and Intervention Centre (EPPIC) with schizophrenia, bipolar disorders, and related conditions. They found that most young people (75%) did not recover after EPPIC treatment. “Approximately a quarter achieved both symptomatic remission and social/vocational recovery”³³. A recent systematic review of 79 international studies found a recovery rate of 38% among 9,642 individuals with first-episode non-affective psychosis who were followed-up for a mean of seven years.³⁴ Their ‘worst case’ estimate for recovery was 23% with sustained symptomatic and function improvement for more than two years. Hence, the estimated international rate of non-recovery was between 62% and 77%.

28 Department of Health and Human Services, *Victoria’s Mental Health Services Annual Report 2017–18*, October 2018.

29 <https://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/november-2017>

30 <https://mentalillnesspolicy.org/serious-mental-illness-not/>

31 Volavka, Jan, and Jan Vevera. “Very Long-Term Outcome of Schizophrenia.” *International Journal of Clinical Practice* 72, no. 7 (2018): e13094.

32 Henry, Lisa P., G. Paul Amminger, Meredith G. Harris, Hok Pan Yuen, Susy M. Harrigan, Amy L. Prosser, Orli S. Schwartz, et al. “The Eppic Follow-up Study of First-Episode Psychosis: Longer-Term Clinical and Functional Outcome 7 Years after Index Admission.” *The Journal of clinical psychiatry* 71, no. 6 (2010): 716.

33 *Ibid.*

34 Lally, J., O. Ajnakina, B. Stubbs, M. Cullinane, Kc Murphy, F. Gaughran, and R. M. Murray. “Remission and Recovery from First-Episode Psychosis in Adults: Systematic Review and Meta-Analysis of Long-Term Outcome Studies.” *Br. J. Psychiatry* 211, no. 6 (2017): 350–358.

Even with the best early intervention treatment in the world, schizophrenia tends to follow a deteriorating course with ongoing positive psychotic symptoms, and/or negative symptoms (flat affect, loss of interest, emotional withdrawal, and cognitive impairment). A careful 10-year follow-up of 496 patients who had presented to the Danish OPUS early intervention service with first-episode non-affective psychosis found that 28% of the patients continued to experience significant positive symptoms, while 53% continued to experience significant negative symptoms (see figures below). Non-recovery rates could be considerably higher when mental health services are poorly funded, and do not adhere to strict treatment protocols.

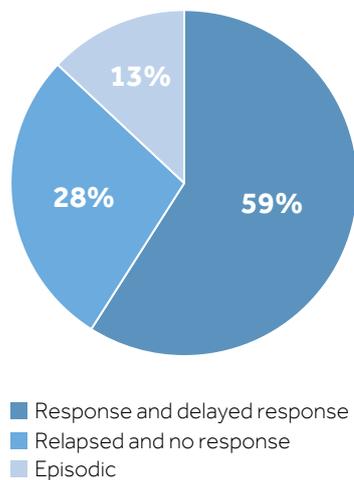


Figure 8. Positive symptom outcomes based on 10 years after OPUS early intervention for schizophrenia spectrum disorder.^{35, 36}

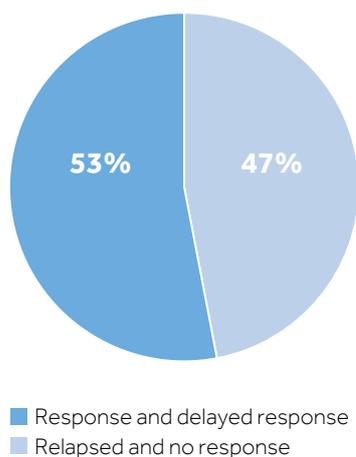


Figure 9. Negative symptom outcomes based on 10 years after OPUS early intervention for schizophrenia spectrum disorder.³⁷

35 Long-term trajectories of positive and negative symptoms in first episode psychosis: A 10year follow-up study in the OPUS cohort. Austin SF, Mors O, Budtz-Jørgensen E, Secher RG, Hjorthøj CR, Bertelsen M, Jeppesen P, Petersen L, Thorup A, Nordentoft M. Schizophr Res. 2015 Oct;168(1-2):84-91.

36 Reprinted Schizophrenia Research, 168. Stephen F. Austin, Ole Mors, Esben Budtz-Jørgensen, Rikke Gry Secher, Carsten R. Hjorthøj, Mette Bertelsen, Pia Jeppesen, Lone Petersen, Anne Thorup, Merete Nordentoft, Long-term trajectories of positive and negative symptoms in first episode psychosis: A 10year follow-up study in the OPUS cohort, 84-91., 2015, with permission from Elsevier.

37 *Ibid.*

In terms of the lifetime prognosis for schizophrenia and related disorders, a systematic review of 50 international studies³⁸ found that only one in seven individuals fully recovered from psychosis. It is important to note that recovery did not mean 'cure'. Recovery was defined as an improvement in both clinical symptoms and social functioning, with the gains in at least one of these two domains being sustained for two years or more. According to a cross-sectional Australian survey of 1,642 adults receiving treatment for a psychotic condition within the public sector, only a minority of individuals with psychosis (6%) had a single episode (see Figure 10), about half experienced multiple psychotic episodes with good or partial recovery (55%), and a significant proportion (39%) had an unremitting course with deterioration.^{39,40}

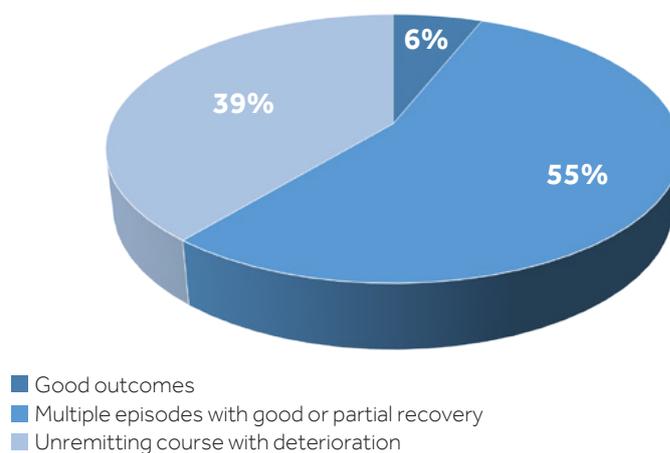


Figure 10. Long term outcomes of schizophrenia from Australian National Survey of Psychosis.⁴¹

As at least half of the new cases of non-affective psychosis begin after age 25 and most patients do not fully recover, the prevalence of schizophrenia continues to rise into midlife – as shown in Figures 14 to 17. Prevalence of schizophrenia is highest in the age range for adult mental health services (82%), compared to only 6% in the child and youth population (aged under 25).

Long-term follow-up studies from the World Health Organisation – following subjects from 15–25 years of age – indicated that 16% of subjects with schizophrenia and 36% of subjects with other psychosis were considered recovered over a 15–25-year timeframe.⁴²

Not only do people with schizophrenia have a life span that is 15–20 years shorter than those in the general population,⁴³ but there is an indication that the mortality gap in the US and Europe has been increasing since the 1970s, with standardised mortality ratios increasing by 37% – from 2.2 in pre-1970 studies to 3.0 in post-1970 studies.

38 Jääskeläinen, E., P. Juola, N. Hirvonen, J. J. McGrath, S. Saha, M. Isohanni, J. Veijola & J. Miettunen, 'A Systematic Review and Meta-Analysis of Recovery in Schizophrenia', *Schizophrenia Bulletin*, 39, 6 (2013), 1296-1306.

39 Morgan, V. A., J. J. McGrath, A. Jablensky, J. C. Badcock, A. Waterreus, R. Bush, V. Carr, et al. "Psychosis Prevalence and Physical, Metabolic and Cognitive Co-Morbidity: Data from the Second Australian National Survey of Psychosis." *Psychological medicine* 44, no. 10 (2014): 2163.

40 Galletly, Cherrie, David Castle, Frances Dark, Verity Humberstone, Assen Jablensky, Eóin Killackey, Jayashri Kulkarni, et al. "Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders." *Australian & New Zealand Journal of Psychiatry* 50, no. 5 (2016): 410-72.

41 Morgan V, McGrath J, Jablensky A, et al. (2014) Psychosis prevalence and physical, metabolic and cognitive co-morbidity: Data from the second Australian national survey of psychosis. *Psychological Medicine* 44: 2163–2176.

42 Jobe, Thomas H., and Martin Harrow. "Long-Term Outcome of Patients with Schizophrenia: A Review." *The Canadian Journal of Psychiatry* 50, no. 14 (2005): 892-900, p.896.

43 Lee, E. E., J. Liu, X. Tu, B. W. Palmer, L. T. Eyster & D. V. Jeste, 'A widening longevity gap between people with schizophrenia and general population: A literature review and call for action', *Schizophrenia Research*, 196 (2018), 9-13.

1.2.2. Why should the treatment of adults be a priority?

The Victorian Government has indicated, "Every person living with mental illness deserves high quality care and treatment, and inclusive support, when, where, and for as long as they need it" (Victorian Royal Commission, Background, Terms of Reference). Our submission places particular emphasis on adults aged between 25–64 based on a focus on severe mental illness age demographics related to the following specific parameters:

- Australian public sector community mental health service use
- Australian public sector specialist mental health overnight inpatient separations
- Schizophrenia incidence, prevalence and disability adjusted life years
- Bipolar disorder incidence, prevalence and disability adjusted life years
- Suicide rates

For the schizophrenia and bipolar disorder incidence, prevalence and disability adjusted life years we have used the internationally recognised Global Burden of disease data⁴⁴ which provide extensive analyses of incidence, prevalence and disability adjusted life year studies in various countries. The principal research organisation is the Institute of Health Metrics and Evaluation based in Washington, Seattle and this organisation specialises in epidemiological research, related to burden of all diseases including mental health. Much of this team's research is published in high impact journals including *JAMA* and *The Lancet* and their research serves as a vital guide for policy planners. This team have developed web interactive tools, that enable calculations of disease burden estimates at the country level, which we utilised for our analysis presented below.

Adults and use of public sector community mental health services

In Australia, 64% of all community mental health contacts are utilised by adults aged between 25–64. The patient demographic with the highest number of patients seen by community mental health is for 25–34 year olds (18.6%) followed by 35–44 year olds (17.1%).

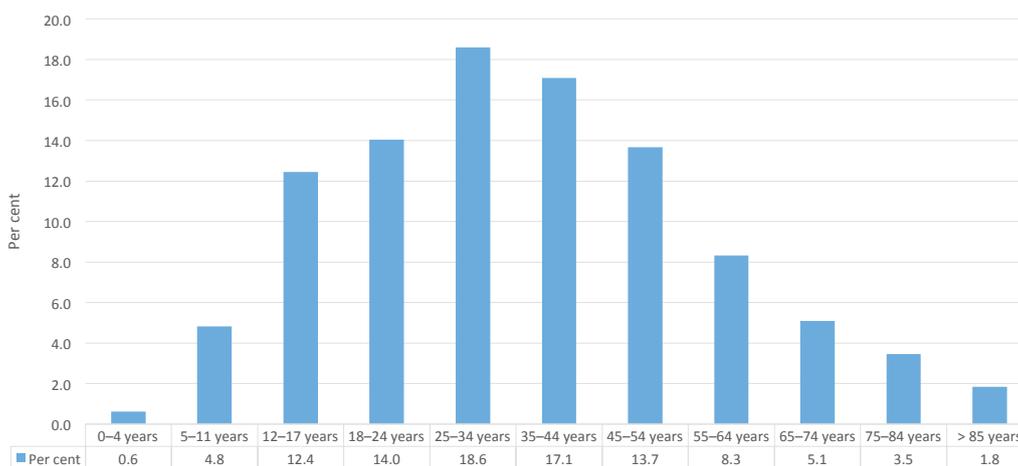


Figure 11. AIHW Interaction with community mental health care service by patient demographic, 2016–17.

44 <http://www.healthdata.org/gbd>

Adults and use of emergency department for mental health related presentations

The use of emergency departments for mental health related presentations is highest for youth aged between 18–24 with 197 mental health related presentations per 10,000 population followed by 35–44 year olds with 166 mental health related emergency department presentations per 10,000 population, and 25–34 year-olds with 159 mental health related emergency department presentations per 10,000 population.

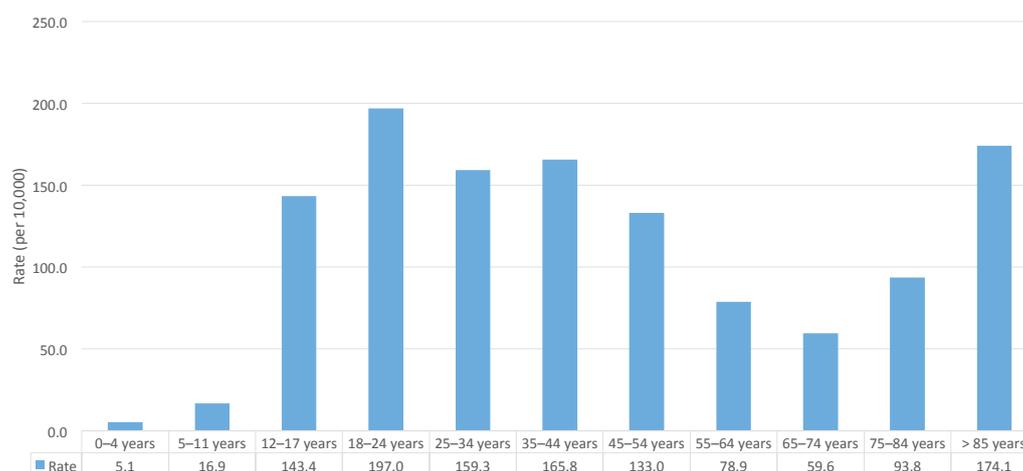


Figure 12. AIHW Mental health-related emergency department presentations by patient demographic characteristics, 2017–18.

Adults (aged 25–64) and overnight specialist mental health inpatient service utilisation

In Australia the highest rate of inpatient separations is for 35–44 year olds with 106 separations per 10,000 populations, followed by 25–34 year olds with 97.6 per 100,000. Overall adults between the ages of 25–64 make up 71% of all overnight specialised care mental health separations. The use of inpatient beds by adults aged between 25–64, reflects upon aspects of incidence, prevalence, and disease burden particularly in relation to severe mental illness.

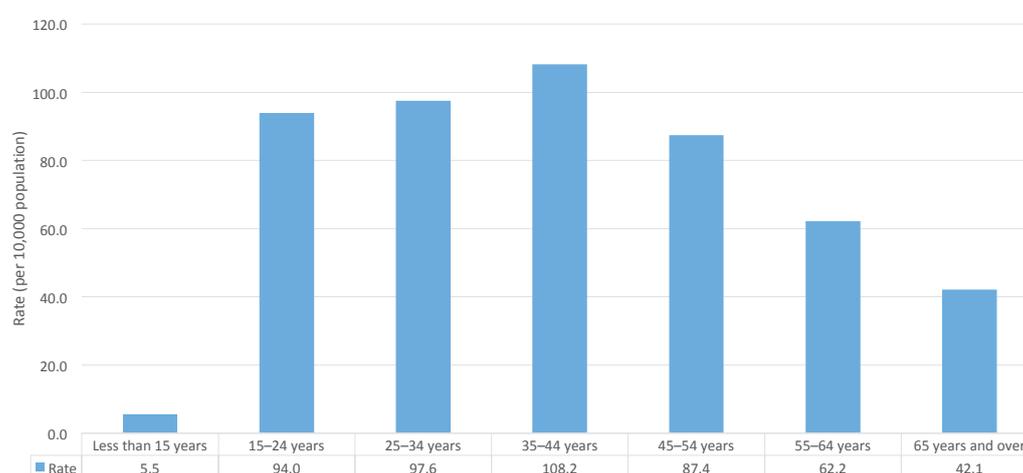


Figure 13. AIHW Overnight admitted mental health related separations, with specialised care, by patient demographic, 2016–17.

Adults (aged 25–64) and Schizophrenia incidence, prevalence, and disability adjusted life-years

The use of inpatient beds by adults aged between 25–64, reflects upon aspects of incidence, prevalence, and disease burden particularly in relation to severe mental illness.

It is important to note that that at least half of the new cases of schizophrenia emerge after the age of 25. Data on the number of individuals who develop schizophrenia annually in Australia (the 'incidence'), drawn from the World Health Organization study of the Global Burden of Disease⁴⁵ in 2017, show that most individuals (63%) first developed schizophrenia between the ages of 25–64.

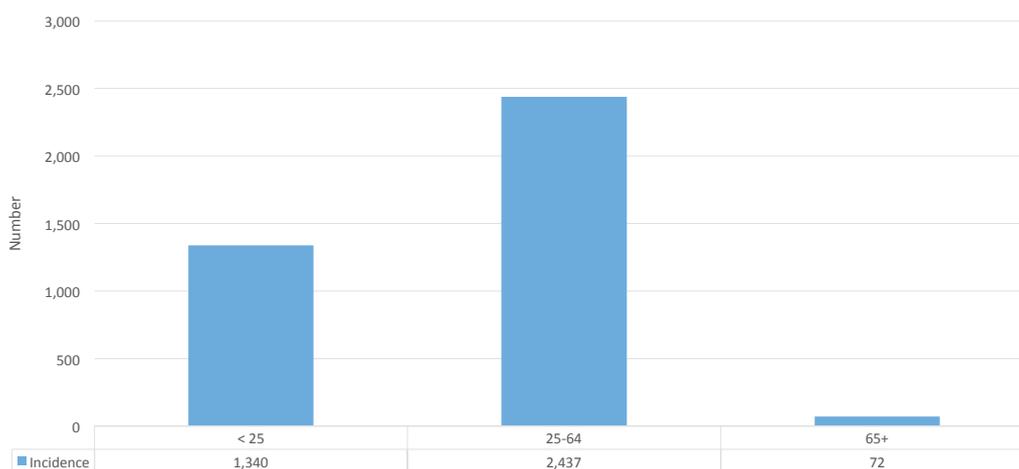


Figure 14. Global Burden of Disease modelled schizophrenia incidence data by age group, 2017.

The Worldwide Global Burden of Disease data for schizophrenia are confirmed by the Thorup et al study⁴⁶, which shows a similar age of onset to the aggregated Global Burden of Disease dataset. Thorup et al conducted their study using the Danish Psychiatric Central register between 2000 and 2012, with a history of contacts dating back to 1969. These schizophrenia incidence data have planning implications, requiring services to consider early intervention informed approaches beyond youth onset services, to also cater for adults who are beyond the age of 25 when they first develop a psychotic illness.

45 <http://www.healthdata.org/gbd/data-visualizations>

46 Thorup A, Waltoft BL, Pedersen CB, Mortensen PB, Nordentoft M. Young males have a higher risk of developing schizophrenia: a Danish register study. 479-84., 2007.

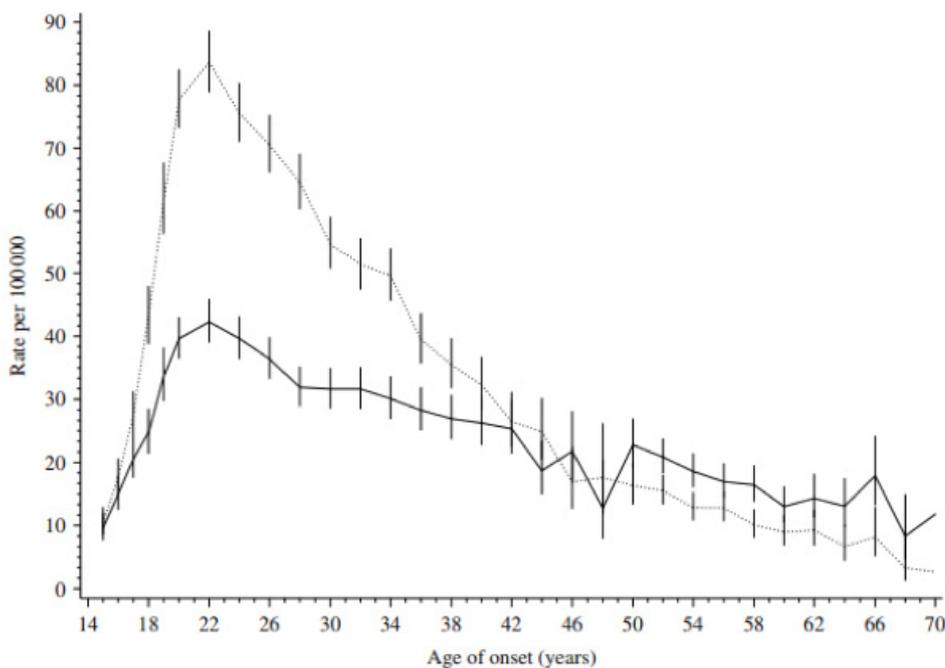


FIG. 1. Incidence rates of schizophrenia by age and gender adjusted for the changes in the diagnostic system (baseline is the ICD-10 period, 1995–2001). —, Females; ···, males.

Figure 15. Gender differences in schizophrenia by age of onset.⁴⁷

The prevalence of schizophrenia is much more prominent in the adult age group than in other age groups, with 82% of schizophrenia prevalence being between the age of 25–64, based on Global Burden of Disease dataset.

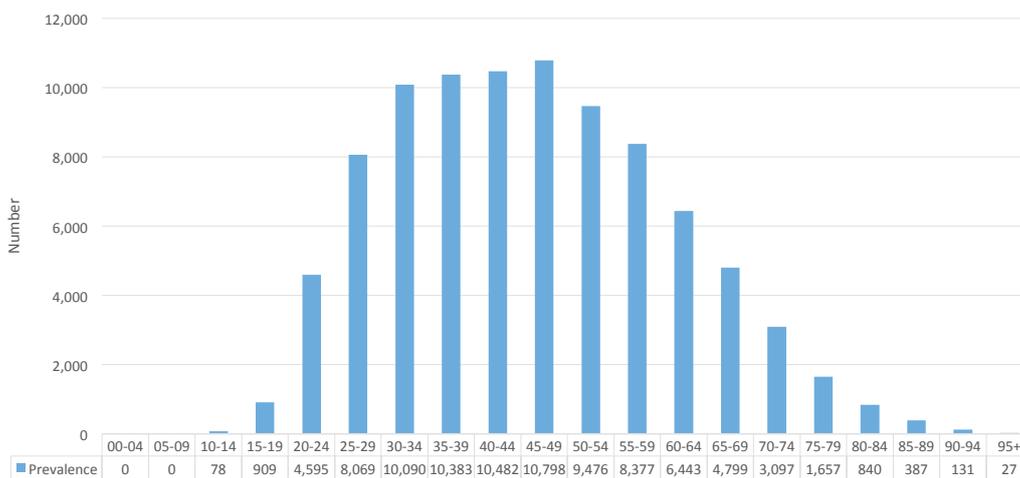


Figure 16. Global Burden of Disease – modelled schizophrenia prevalence data by age, 2017.

47 Thorup A, Waltoft BL, Pedersen CB, Mortensen PB, Nordentoft M. Young males have a higher risk of developing schizophrenia: a Danish register study. 479-84., 2007.

The disability-adjusted life years for schizophrenia are also much more prominent in the adult age group, than in other age groups, with 82% of all DALYs related to schizophrenia being apportioned to adults aged between 25–64.

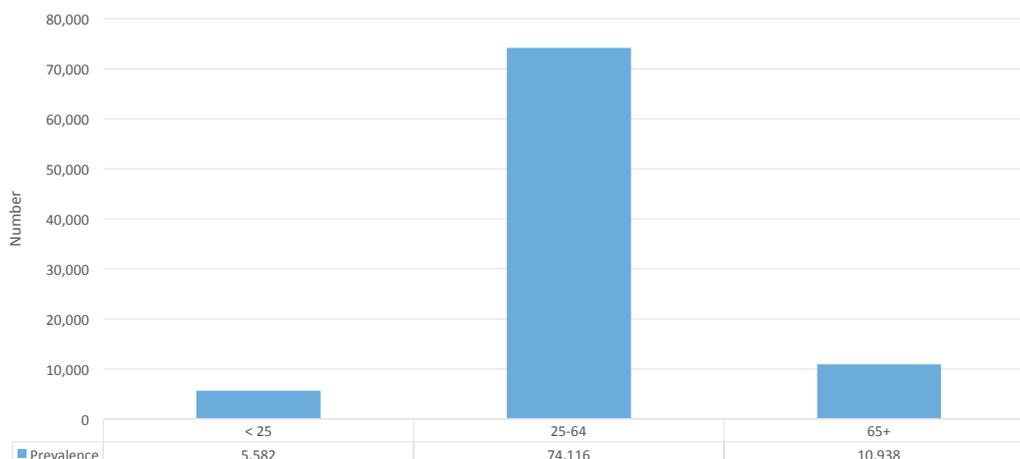


Figure 17. Global Burden of Disease schizophrenia disability-adjusted life years (DALYs) by age group, 2017.

Charlson and colleagues from the University of Queensland specifically noted, “As with prevalence, the peak disease burden is observed at around 30–40 years of age. A comparable burden is seen for males and females”.⁴⁸ The authors continue, “Schizophrenia is also associated with significant impairments in psychosocial function: people with schizophrenia are more likely to be unemployed, homeless, living in poverty, having difficulties keeping up with household and self-care tasks, and relying on ongoing support from family carers and available mental health services. The largest burden from schizophrenia is in the 25–54 year age group”⁴⁹, which is included within the age range for adult mental health services.

Adults (aged 25–64) and bipolar disorder incidence, prevalence, and disability adjusted life-years

The incidence of bipolar disorder is more youth onset when compared with schizophrenia incidence based on Global Burden of Disease dataset, with 44% of bipolar disorder being adult onset (aged 25–64) and 48% having onset before 25.

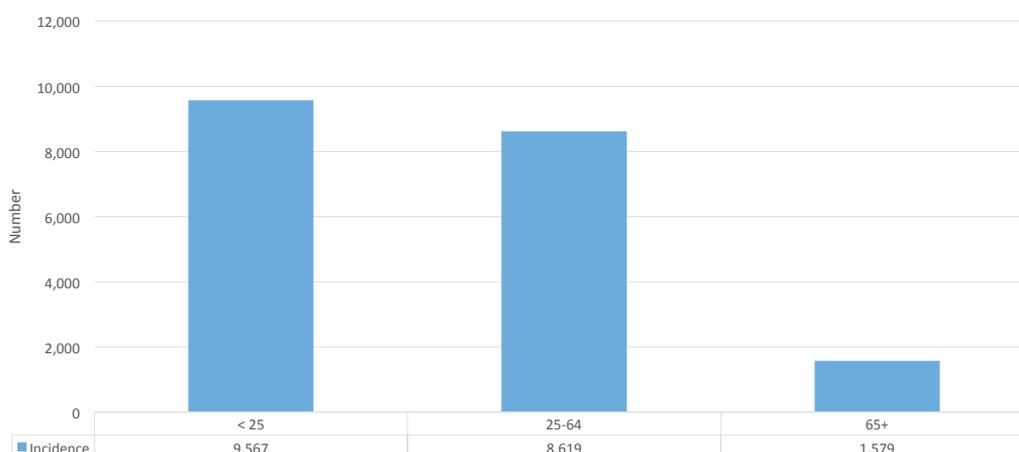


Figure 18. Global Burden of Disease modelled bipolar disorder incidence data by age group, 2017.

48 Charlson, F., A. Ferrari, D. Santomauro, S. Diminic, E. Stockings, J. Scott, J. McGrath & H. Whiteford, ‘Global Epidemiology and Burden of Schizophrenia: Findings From the Global Burden of Disease Study 2016’, *Schizophr. Bull.*, 44, 6 (2018), 1195–1203: 5.

49 *Ibid.* p. 7.

The prevalence of bipolar disorder is 65% for adults aged between 25–64 based on Global Burden of Disease set applied to Australian demography, with 24% being under age 25 and 11% being beyond age 65.

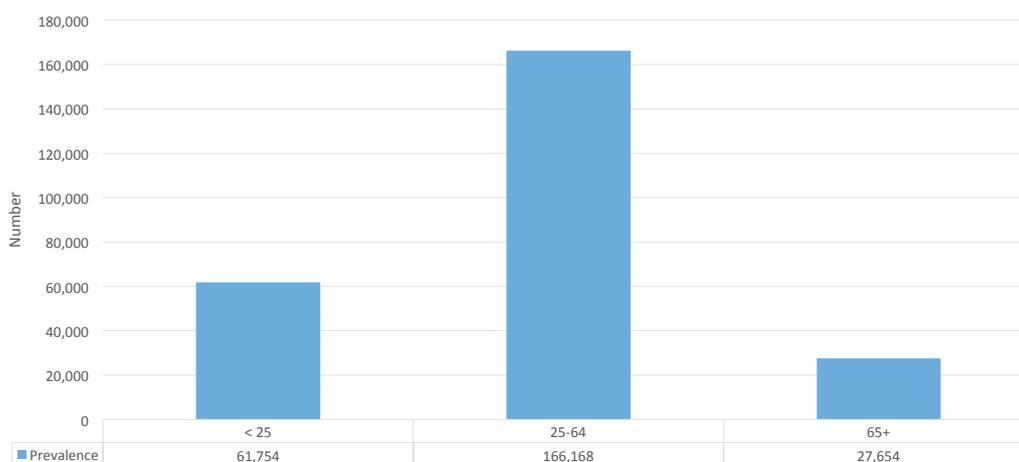


Figure 19. Global Burden of Disease modelled bipolar disorder prevalence data by age group, 2017.

The disability-adjusted life years for bipolar disorder mirror the prevalence data with 65% of disability-adjusted life-years being allocated to adults aged between 25–64.

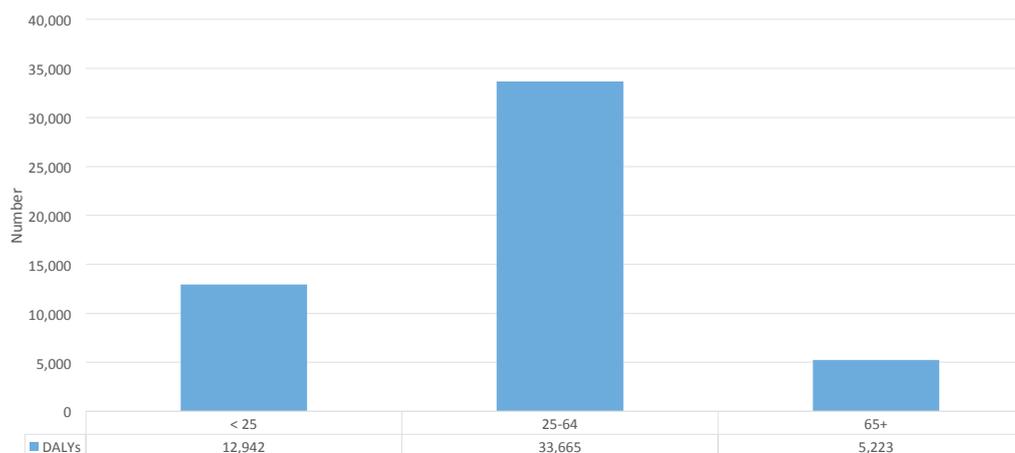


Figure 20. Global Burden of Disease modelled bipolar disorder disability-adjusted life years (DALYs) by age group, 2017.

Adults (aged 25–64) and suicide rates

The highest suicide rate is for adults aged between 45–54 with 18.8 suicides per 100,000 in 2017, followed by adults aged between 35–44 with 17.8 suicides per 100,000 in 2017.

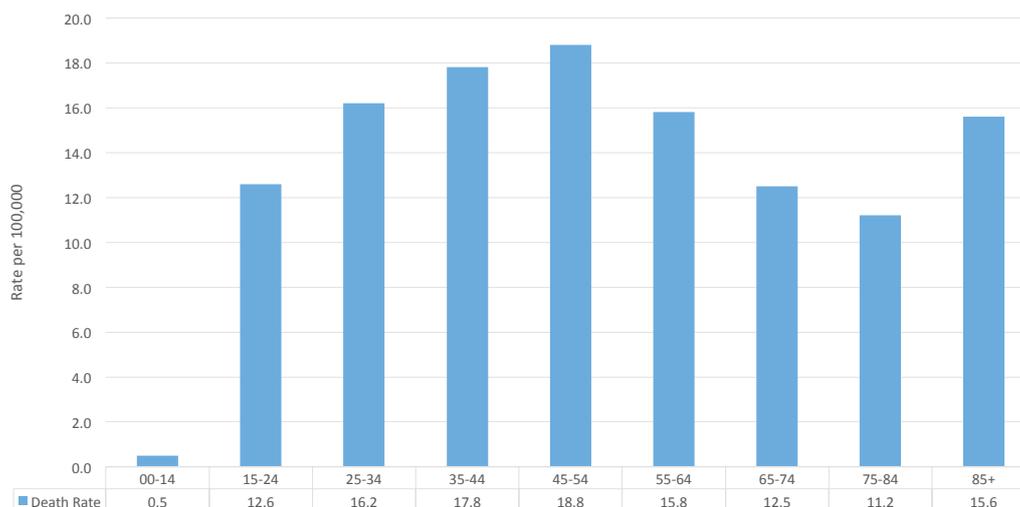


Figure 21. ABS Suicide rates per 100,000 by age group 2017.

ABS Suicides by age group

In Australia there were a total of 3,128 suicides in 2017. In terms of age demographics there were 428 suicides in people aged under age 25; 2,226 suicides in the 25–64 age group; and 474 suicides in the greater than 65 age group. In total 71% of all Australian suicides occurred in the age group 25–64, with 15% of all Australian suicides occurring in people aged over 65 and 14% of all Australian suicides occurring in people aged under 25. The highest number of suicides occurred in the 45–49 age group with 353 suicides, followed by the 40–44 age group with 314 suicides, and the 30–34 age group with 308 suicides.

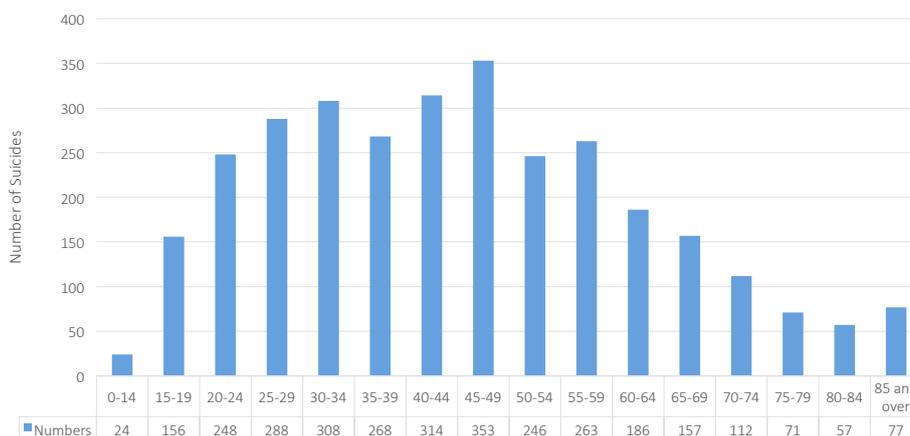


Figure 22. ABS Suicides by age group 2017.

Conclusion

Our data confirm that the highest rate of mental health service utilisation of Australian public sector community and inpatient services is for adults, particularly those aged between 35–44, with secondary peaks of service utilisation between the ages 25–34. There is a primary peak of emergency department mental health service utilisation for youth aged between 18–24, with a secondary peak for adults aged between 35–44.

These service utilisation data within the state public mental health sector strongly align with schizophrenia age distribution of incidence, prevalence and disability adjusted life years, as well as bipolar disorder prevalence and disability adjusted life-years. Suicide is also most prevalent in middle-aged Australians aged between 45–54 with a secondary peak between ages 35–44.

These data have significant planning implications for public sector mental health services, which have primary responsibility for service provision for patients with serious mental illness and also have an important role in suicide prevention. The age demographic data presented above highlight the significant service needs for adults aged between 25–64. Mental health service planners within state governments need to be aware of this whole of system age demographic profiling of service use, in order to meet the required patient demand for severe mental illness and improve patient outcomes.

2.

Victoria's current provision of care for adults with serious mental illnesses

A synoptic overview of the Victorian Mental Health System

This analysis provides a comprehensive overview of mainly Australian Institute of Health and Welfare mental health data, based on the most recent updates. These data are divided into several sections including primary care, community mental health, NGO, residential, inpatient, key performance indicators, and expenditure variables. We have highlighted primarily how Victoria compares with the other states inclusive of national averages, in relation to these service delineations. The primary focus is to concentrate on general adult, forensic, and youth data. In addition to Australian Institute of Health and Welfare mental health data we have also incorporated OECD and WHO psychiatric bed number data comparing this with Victorian and Australian data. A summarised form of this comprehensive analysis follows, with more details contained within the Appendix. We also provide in this section Victorian suicide data from 2013–17.

Overview: what the data show

Victorian mental health expenditure has fallen significantly behind Victorian health expenditure, resulting in Victoria now spending the least per capita on mental health services in Australia. This funding shortfall has led to significant inpatient capacity problems across the Victorian mental health system, mostly related to the lack of available acute and non-acute inpatient capacity for adults aged between 18–64. This particularly affects patients with serious mental illness (schizophrenia and bipolar disorder) who occupy more than 50% of all specialty public sector psychiatric beds.

Victoria has relatively good access to Medicare-funded mental health services, private psychiatric beds in stand-alone hospitals, youth mental health services (community, residential, and beds) and a range of general adult residential facilities. It has general adult community FTE staffing levels roughly equivalent to the Australian average, but with significantly reduced population coverage, likely due to productivity issues. In total, the combined provision of community investment – inclusive of primary care, community mental health, and residential models – in Victoria is above the national average.

However, this above-average (for Australia) investment in non-hospital and community models of care is not sufficient to compensate for the 34% shortage of public sector general adult beds (acute and non-acute) relative to the Australian average. This significant Victorian shortfall must also be placed in an international context: Victoria has 44% fewer beds (public and private) than the OECD median of 62 beds

per 100,000; 30% fewer than European zone World Health Organisation countries; and 27% fewer than high-income World Health Organisation zone countries.

This significant shortage of general adult beds, combined with very high population growth and increases in acuity of mental health patients in Victoria has directly led to prolonged emergency department waiting times for mental health patients needing public sector acute beds, low and declining acute inpatient average length of stay (12 days in general adult), leading to high 28-day readmission rates, negative impact on the inpatient therapeutic milieu, increased burn-out for staff, and increased carer burden. There are specific concerns that patients who urgently need an admission are being denied due to inpatient access block, which in turn increases levels of risk specifically related to suicide and violence. In addition, there are patients who stay for extended periods in acute beds due to the significant shortage of Victorian general adult non-acute beds, contributing to system-wide access block.

There are also increasing concerns that the overall shortage of general adult beds has contributed to the criminalisation of the mentally ill and increased rates of homelessness for this particularly vulnerable population.

Our comprehensive mental health data analysis has been the primary basis for some of our specific planning and service recommendations (later).

Summary of Victorian data for planning and commissioning purposes

Medicare services provision

Victoria has the highest population coverage, total number of service providers, and spending in relation to Medicare-subsidised mental-health-specific clinical services in Australia (2017–18).

Victorian State government mental health expenditure

The Victorian state government spends the lowest per capita on mental health services in Australia, spending \$206 per capita – 11% less than the national average of \$233 per capita in 2016–17.

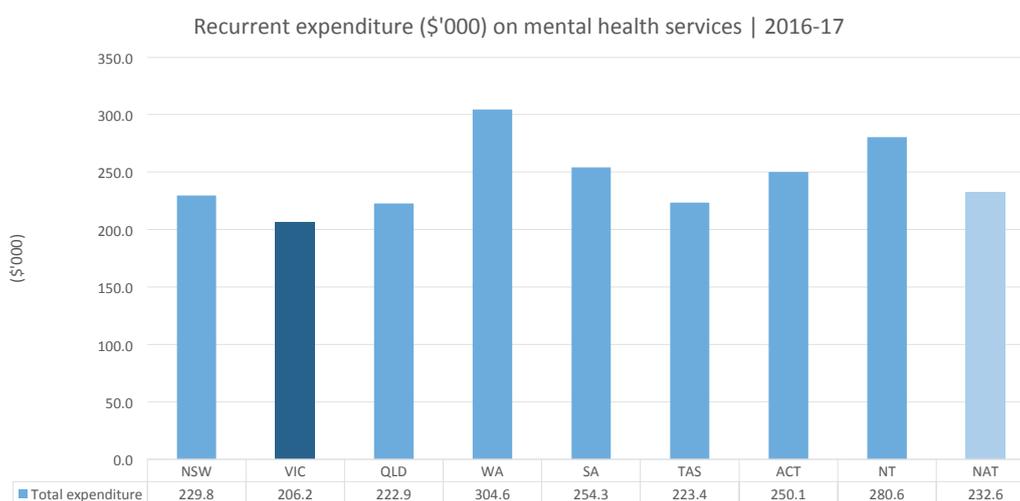


Figure 23. AIHW Expenditure on mental health services.

Most of Victoria's relative lack of expenditure can be attributed to the low spending in the general adult (18–64) population (community, residential, and specialist beds), which is the lowest in the nation, spending \$180 per capita – 27% lower than the Australian average of \$229 per capita.

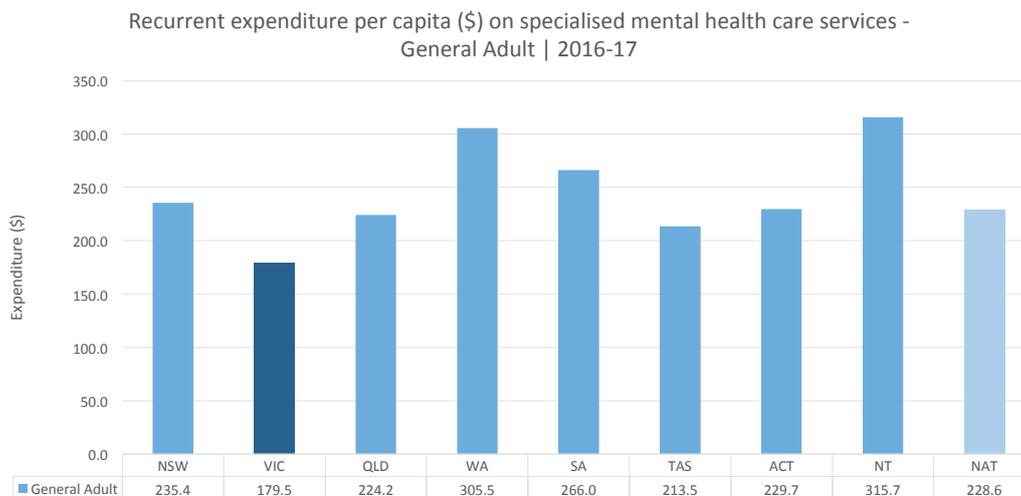


Figure 24. AIHW Expenditure on mental health services.

Community mental health (general adult, forensic, and youth)

Victoria’s population coverage of adult (aged 25–64) community mental health patients is 80% lower than the national average, despite being at the national average for general adult community mental health staffing levels.

Victoria’s population coverage of youth patients is 81% lower than the national average, despite having more than double the youth specialty staffing levels. Victoria’s forensic community mental health staffing levels are among the lowest in the nation.



Figure 25. AIHW Specialised mental health care facilities, full-time-equivalent health care providers by target population, community mental health care services 2016–17.

The overall cost per community treatment day (all age groups) in Victoria is 41% higher than the Australian average, reflecting significant productivity gaps in the state-funded community mental health sector between Victoria and the rest of Australia.

Residential services

Victoria's expenditure on residential beds is significantly higher than the national average (\$31 versus \$12 per capita). Victoria has more than double the number of general adult and youth residential beds, compared to the rest of Australia.

Victorian general adult: 24-hour and non-24-hour residential beds

Victoria has 16 general adult 24-hour residential beds per 100,000 – 128% more residential beds, when compared with the national average of 7 beds per 100,000. The national data do not currently sub-divide these general adult residential beds into short-term sub-acute beds (e.g. Prevention and Recovery Care – PARC beds) or long-term residential beds (e.g. community rehabilitation centres). Victoria has a mix of both short-term PARC (under 1-month length of stay) and community rehabilitation centres (several months length of stay) for the general adult population.

Victoria has 4.5 general adult non-24-hour residential beds per 100,000 – 36% above the national average.

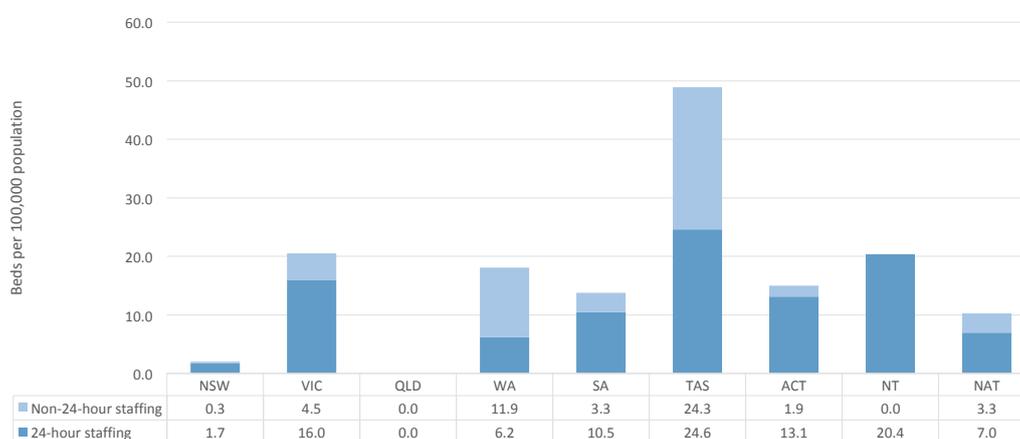


Figure 26. AIHW Specialised mental health care facilities, residential mental health service beds per 100,000 population by staffing – general adult, 2016–17.

NGO services

Victoria's expenditure on NGO services is consistent with the national average and there will be a gradual transition to the NDIS scheme, which will have an impact on this category in terms of expenditure, service delivery, and national benchmarking.

Emergency department (ED)

Mental health presentations to Victorian EDs are increasing annually, but still remain the lowest in Australia and have increased by 55%, rising from 58 presentations per 100,000 in 2004–5 to 90 presentations per 100,000 in 2016–17.

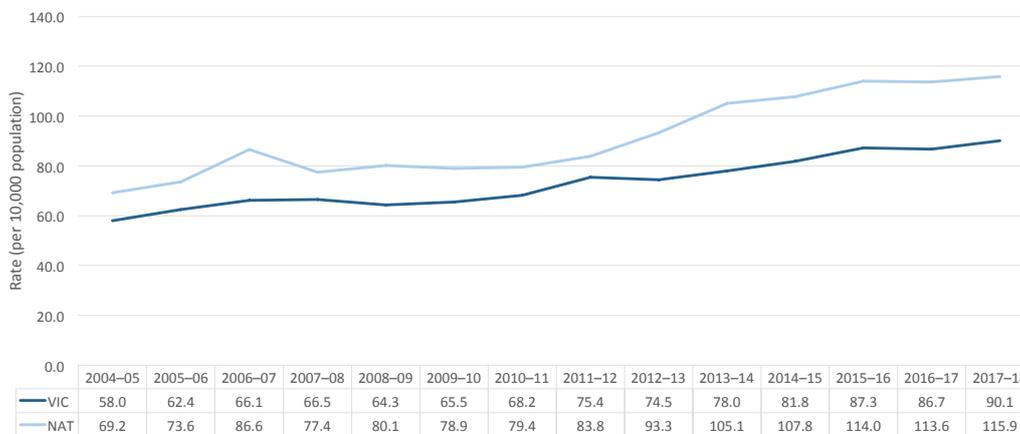


Figure 27. AIHW Mental health related emergency department presentations. Dark blue for Victoria, light blue for Australia.

The rate of schizophrenia-related emergency department presentations is 14% higher than the national average.

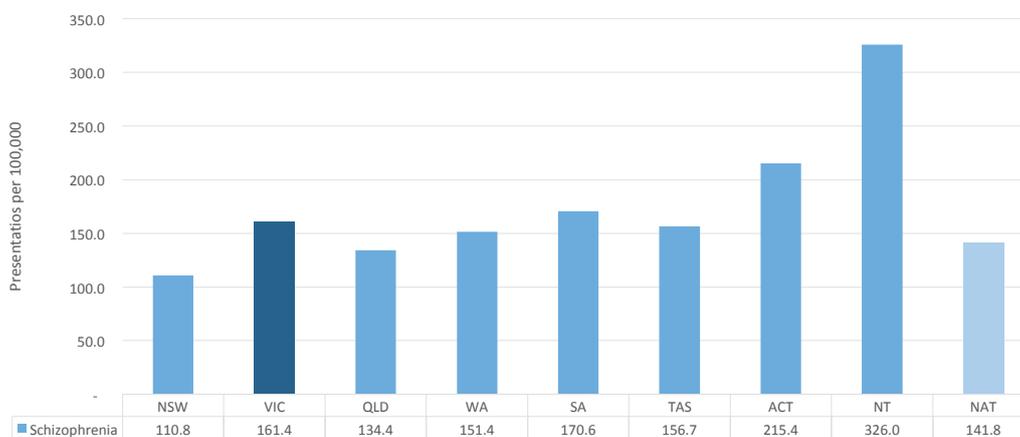


Figure 28. AIHW Schizophrenia presentations to emergency departments per 100,000, 2017-18.

The waiting times in emergency department for mental health patients are significantly higher than for non-mental health patients (90th percentile – 13 hours for mental health versus 7 hours for non-mental health), with many Victorian mental health patients waiting for more than 24 hours in ED.

Specialty psychiatric beds with specific focus on general adult and forensic beds

Victoria has far fewer total psychiatric beds within combined private and public sector (all age groups) than the Australian average: with 35 beds per 100,000, which is 17% below the Australian average of 42 beds per 100,000. If Victoria was a country it would rank only 29th out of 36 OECD countries in terms of overall specialty psychiatric bed numbers. The World Health Organisation average for psychiatric beds is 50 beds per 100,000 people for European zone countries, and 48 beds per 100,000 people for countries categorised as high-income.

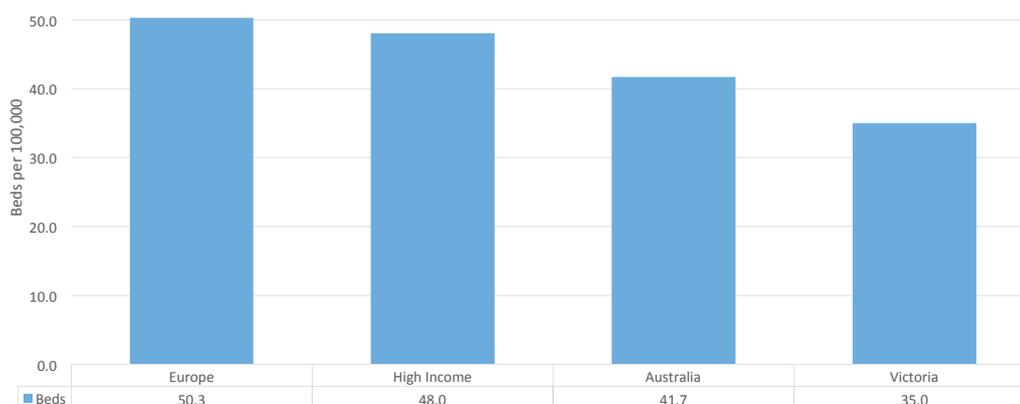


Figure 29. AIHW WHO Mental Health Atlas, mental health beds per 100,000, 2017.

Victoria has a particular scarcity of beds located in the public sector, with only 22 public sector beds per 100,000, 25% lower than the Australian average of 29.4 public sector beds per 100,000 for all age groups.

Victoria's provision of private psychiatry beds is 13 beds per 100,000, which is 6% above the national average of 12.3 beds per 100,000.

Almost all the specialist public sector psychiatric bed shortage in Victoria relates specifically to general adult (18–64) acute and non-acute beds with 22.4 beds per 100,000, which is 34% below the Australian average of 34 beds per 100,000. Victoria has the lowest number of general adult acute beds with 19 beds per 100,000, which is 22% lower than the national average of 24.5 beds per 100,000. Victoria also has significant shortages in general adult non-acute beds with 3.4 beds per 100,000, which is 64% below the national average of 9.5 beds per 100,000.

Victorian costs per general adult acute admitted patient bed day are \$1007, which is 17% below the national average of \$1,206 per bed day, which suggests a high level of productivity within this bed base.

In addition to the shortages of beds within general adult psychiatry, Victoria has fewer forensic beds than the national average: 3.1 compared to 3.5 beds per 100,000.

As a result of the significant increase in emergency department mental health related demand, overnight mental health separations are growing at a rate much faster than both population growth and the growth in health separations.⁵⁰

50 <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf>

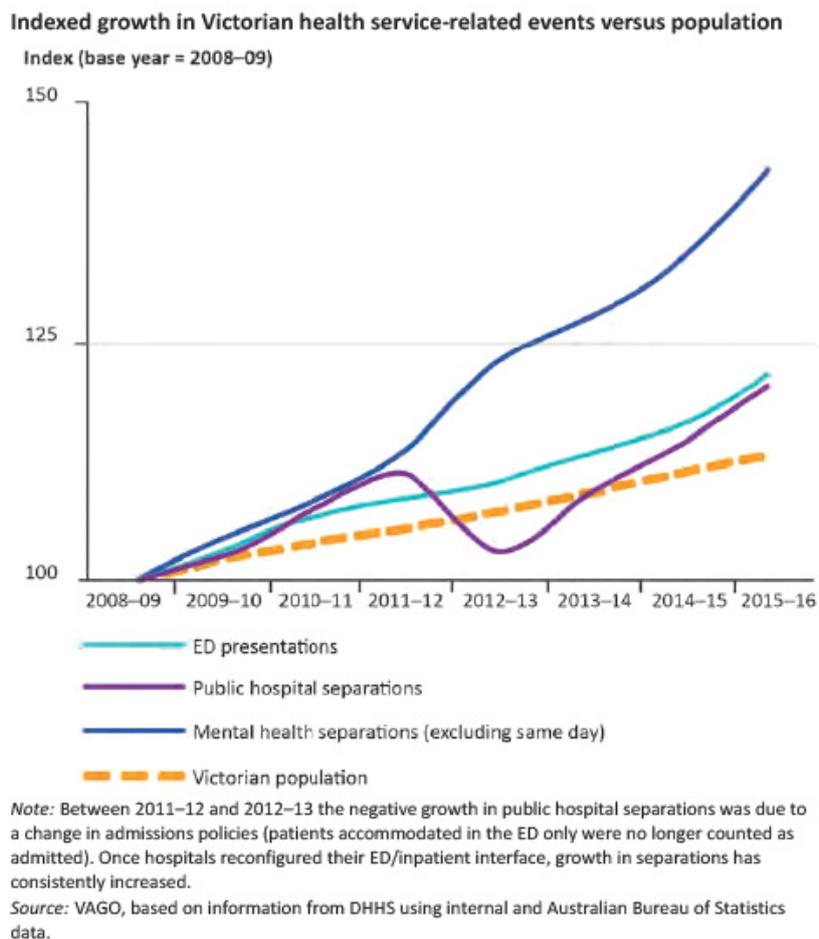
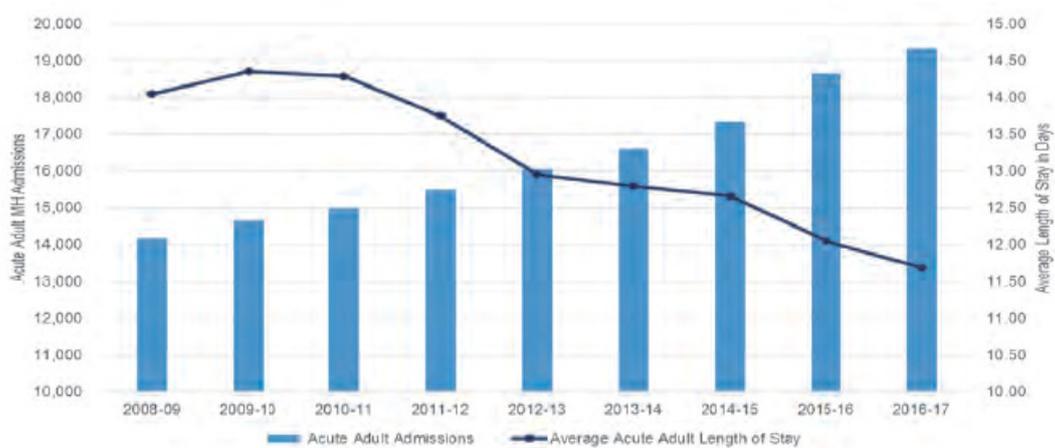


Figure 30. Indexed growth in Victorian health service-related events versus population.⁵¹

However because the general adult acute bed base per 100,000 has reduced over time, due to both the increased emergency department demand and the increase in population, there has been a 16% reduction in the general adult average length of stay since 2008/09 from 14 days to 11.7 days in 2016–17. The number of overnight mental health separations has increased significantly from 14,100 in 2009/10 to 19,200 in 2016–17.⁵²

⁵¹ Figure 3C, *Victorian Auditor-General's Office, Access to Mental Health Services*, March 2019.

⁵² <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf>



Source: Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services, by A.Cockram, S.Solomon, H.Whiteford, 2017.

Figure 31. Acute mental health admissions and average length of stay, 2009–17.⁵³

See Appendix for the full data analysis.

⁵³ Figure 3F, *Victorian Auditor-General's Office, Access to Mental Health Services*, March 2019

3.

The prevention of serious mental illness

Prevention is central to the terms of reference for the Royal Commission, which begin, "You (the Royal Commission) are appointed to inquire into and report on how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment care and support so that all those in the Victorian community can experience their best mental health, now and into the future".

Furthermore, the first term of reference specifies that the Royal Commission will inquire into and report on, "How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services".

Our submission draws an important distinction between primary prevention, and secondary and tertiary prevention of mental illness. According to the World Health Organization, "... the public health concept of disease prevention has viewed prevention as primary, secondary, or tertiary depending on whether the strategy prevents the disease itself, the severity of the disease, or the associated disability."⁵⁴ Building on this definition, New South Wales Health add some further "specific characterisations:

- primary prevention, which reduces the likelihood of developing a disease or disorder
- secondary prevention, which interrupts, prevents or minimises the progress of a disease or disorder at an early stage
- tertiary prevention, which halts the progression of damage already done"⁵⁵

These are the definitions of prevention we use for this submission.

Unfortunately, there is no replicable evidence upon which to base primary prevention measures (to prevent the occurrence) of serious mental illnesses – such as schizophrenia, melancholic depression, and bipolar illness.

Many mental illnesses appear linked to childhood abuse, neglect, bereavement, and trauma, but the nature of this link is complex and in need of much greater clarification.⁵⁶

Given the gaps in our current knowledge and the potential of major benefits for the Victorian community of eventually discovering primary preventative measures, we support further research into primary and pre-illness prevention of psychosis. This research includes: universal prevention (targeting the prevention of psychosis across the whole population), selective prevention (targeting individuals who are

⁵⁴ World Health Organization, *Prevention and Promotion in Mental Health*, (Geneva: World Health Organization, 2002), p. 7.

⁵⁵ South Western Sydney Local Health District, *Providing High Quality Health Services: Secondary Prevention*, (June 2016), p. 1. <https://www.swslhd.health.nsw.gov.au/populationhealth/pdf/news11.pdf>

⁵⁶ Alan S. Brown, The environment and susceptibility to schizophrenia, in *Prog Neurobiol*. 2011, 93(1): 23–58.

at greater risk of psychosis), and indicated prevention (targeting individuals who have early detectable signs of psychosis); see Figure 32. Of these various types of pre-illness prevention, indicated prevention has been the most extensively researched, while research into universal and selective prevention remains in its early phases.

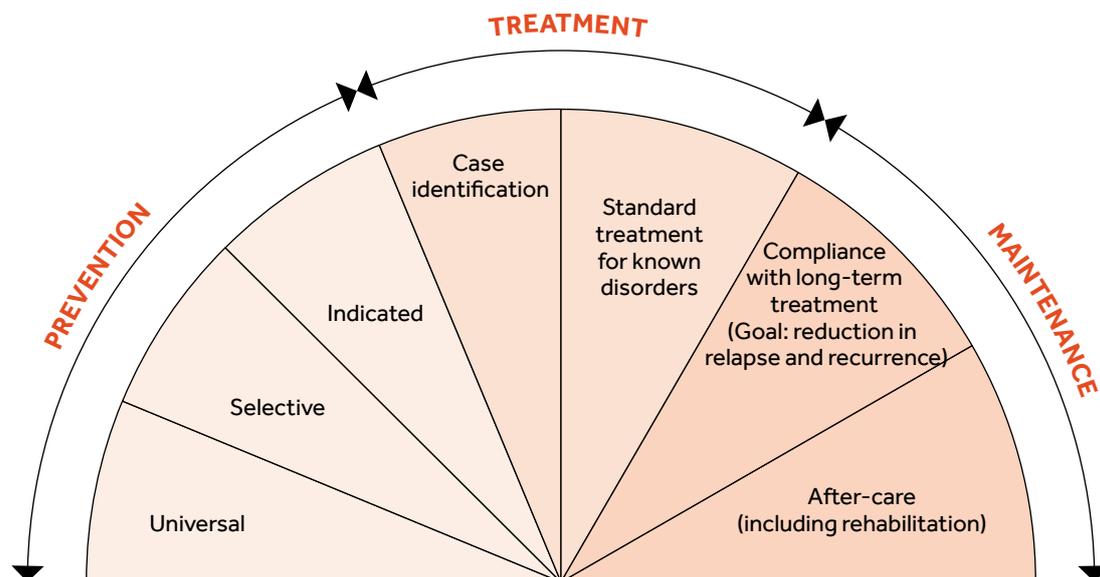


Figure 32. The mental health intervention spectrum for mental disorders.⁵⁷

In a recent review in the highest impact psychiatric journal *World Psychiatry*, leading researchers from Melbourne, London, and New York – Paolo Fusar-Poli, Patrick McGorry, and John Kane (2017)⁵⁸ – noted the pioneering research in universal prevention of psychosis such as dietary phosphatidylcholine supplementation for healthy pregnant women as well as the potential targeting of oxidative stress and aberrant critical period plasticity as primary preventative measures, and recommended that “further research is warranted over the next decade”.⁵⁹

In terms of selective interventions, Fusar-Poli and colleagues detailed the range of potential targets for intervention with parental, perinatal, social, and environment risk factors for psychosis – including later risk factors such as heavy cannabis use – but the authors emphasised, “currently there are no robust and effective preventative strategies to reduce the risk of psychosis in asymptomatic individuals exposed to these environmental risk factors”.⁶⁰

The best-researched type of primary and pre-illness prevention for psychosis is indicated prevention for individuals at clinical high risk who have up to a 20% risk of developing psychosis within two years. “Meta-analysis of randomized controlled trials in CHR-P [‘clinical high risk for the development of psychosis’] individuals suggests that short-term (6–12 months) psychological interventions can halve the risk of illness onset at 12 months. However, the preventative effect is not sustained over a longer period of time (24 months and longer); so, these findings should be interpreted cautiously and may indicate delayed rather than prevented psychosis onset”.⁶¹

57 Republished with permission of National Academic Press from *Reducing risks for mental disorders*, Mrazek PJ, Haggerty RJ, figure 2.1, 1994; permission conveyed through Copyright Clearance Center, Inc.

58 Fusar-Poli, P., P. D. McGorry, and J. M. Kane. “Improving Outcomes of First-Episode Psychosis: An Overview.” [In eng]. *World Psychiatry* 16, no. 3 (Oct 2017): 251-65.

59 *Ibid.* p. 252.

60 *Ibid.* p. 253.

61 *Ibid.*

Fusar-Poli and colleagues also noted, "the three largest studies of preventative interventions in individuals at ultra high risk for psychosis have turned out to be negative, possibly because of low power";⁶² which cast some doubt on the promising early findings of indicated prevention.

No indicated prevention strategy seems better than the others at delaying psychosis. A recent network meta-analysis published by World Psychiatry located 16 randomised controlled trials of indicated prevention with 2,035 patients.⁶³ A wide range of indicated prevention strategies have been trialled: cognitive behavioural therapy, family-focused therapy, omega-3 supplements, and antipsychotic medication. The comparator groups were 'needs based interventions', which focused solely on treating the presenting problems, not preventative efforts.

Davies and colleagues found that there was no evidence favouring the superiority of any particular indicated intervention over others for preventing transition to psychosis. At 6- and 12-months, "almost all the interventions at both time points had estimates favouring them over NBI (needs based interventions)"; however, "the differences were not beyond chance and the 95% CIs (Confidence Intervals) were often large, indicating substantial imprecision".⁶⁴

Overall, the research evidence suggests that a wide variety of indicated prevention programs might have value in reducing distress, improving functioning, and delaying the onset of psychosis for 1–2 years, but do not appear to prevent the longer-term occurrence of psychosis.

Hence, the immediate risks and benefits of the various interventions should be closely examined before indicated prevention programs are widely translated into routine clinical practice. As only about 20% of the clinical high-risk group progress to psychosis, there are risks of harm due to: the high false-positive rates with young people being labelled as being 'at risk of psychosis' when the majority will not develop psychosis; the associated heightened levels of concern for family and carers; the risk of missing alternative diagnoses; additional risks of stigmatisation with the label of psychosis; and most importantly, the potential exposure to antipsychotic medication at a young age – which has a substantial side effect burden among young people.

In contrast to primary prevention, many methods of secondary and tertiary prevention – of relapses, progression of mental illness, and suicide – have been proven effective and reliable: they are a core focus of the clinical work undertaken by psychiatrists and other mental health professionals.

The role of medication in suicide prevention

Patients with serious mental illness (schizophrenia, bipolar disorder, psychotic depression) are at significantly increased risk of suicide compared to the general population, with rates of completed suicide over a lifetime of around 10% (Bastiampillai, Sharfstein, Allison).⁶⁵ Our proposal is to provide comprehensive, expert and ongoing care for patients with severe mental illness, which will have a significant impact on reducing suicide rates for patients with severe mental illness. A combination of approaches is required, including psychosocial support, medication, access to inpatient care, acute community and outpatient aftercare following inpatient discharge and good ongoing community care over the life-course. Lithium and clozapine are gold-standard treatments for bipolar disorder and schizophrenia respectively and are also specific anti-suicidal agents.

A recent systematic review confirmed lithium's role in the prevention of suicide for mood disorders.⁶⁶ Lithium was associated with a significantly reduced risk of suicide (odds ratio, 0.13; 95% CI, 0.03-0.66) when compared with placebo for mood disorders.

62 *Ibid.*

63 Davies, C., A. Cipriani, J. P. A. Ioannidis, J. Radua, D. Stahl, U. Provenzani, P. McGuire, and P. Fusar-Poli. "Lack of Evidence to Favor Specific Preventive Interventions in Psychosis: A Network Meta-Analysis." [In eng]. *World Psychiatry* 17, no. 2 (Jun 2018): 196-209.

64 *Ibid.* p. 203.

65 Bastiampillai T, Sharfstein SS, Allison S. Increasing the Use of Lithium and Clozapine in US Suicide Prevention. *JAMA Psychiatry*. 2017;74(4):423.

66 Cipriani A, Hawton K, Stockton S, Geddes JR. Lithium in the prevention of suicide in mood disorders: updated systematic review and meta-analysis. *BMJ*. 2013;346: f3646.

Clozapine is the gold-standard medication for treatment-resistant schizophrenia and is also approved by the US Food and Drug Administration as an anti-suicide treatment. This is based on the outcomes of a 2-year randomized prospective study comparing the risk for suicidal behaviour in 980 patients with schizophrenia or schizoaffective disorder, all with high risk of suicide, when treated with either clozapine or olanzapine.⁶⁷ Clozapine-treated patients in this trial had significantly reduced suicide attempts, fewer hospitalizations, and required less co-administration of antidepressants compared with the olanzapine-treated group.

The role of medication in relapse prevention

The most recent clinical practice guidelines from the Royal Australian and New Zealand College of Psychiatrists⁶⁸ outline the psychiatric treatments available for the secondary and tertiary prevention of schizophrenia and mood disorders.

Many researchers have emphasised the benefit of antipsychotic medication in preventing relapse after a first episode of schizophrenia. If there are poor responses to two antipsychotic medications, then the Royal Australian and New Zealand College of Psychiatrists' guidelines recommend a trial of clozapine, as clozapine has been shown to improve outcomes and prevent suicide attempts (please see below). As such, the Victorian mental health system should support the clinical use of clozapine in tertiary prevention. However, medication is but one vital part of a comprehensive program of secondary and tertiary prevention that requires community mental health services and acute and rehabilitation inpatient units. These programs can support recovery, and promote employment, education, housing, relationships, and health. Assertive community treatment, family therapy and cognitive-behavioural therapy have significant roles to play in secondary and tertiary prevention of schizophrenia. Family and carer involvement in partnership with mental health services can prevent relapse, improve health, and reduce suicide risk.

The Australian psychiatrist, Dr John Cade, discovered lithium – the oldest and best-researched method of relapse prevention in bipolar disorder – while working at the Bundoora Repatriation Mental Hospital in Melbourne. In the recent Royal Australian and New Zealand College of Psychiatrists clinical guidelines, Malhi and colleagues report on the meta-analysis of the clinical trials of lithium, which can reduce the relapse of mania by 40–60%. While the newer mood stabilisers provide a wide range of therapeutic alternatives for tertiary prevention in bipolar disorder, lithium is able to prevent suicide attempts and suicide over the long term. As such, the Victorian mental health system should support the clinical use of lithium for bipolar disorder. Again, the medical treatment of bipolar disorder is only one vital component of a broad biopsychosocial approach to preventing relapse that includes psychological interventions such as family-focused therapy, interpersonal and social rhythm therapy, and cognitive-behavioural therapy.

Vocational rehabilitation as an exemplar of a preventative intervention in serious mental illness

An important component of the prevention of the negative consequences of serious mental illnesses relates to the strong evidence that increased participation and employment for people with serious mental illnesses enhances their mental health.

Only 22% of people with serious mental illnesses have been shown to be employed on a full- or part-time basis. Yet the vast majority of people with serious mental illnesses report that they want to work.⁶⁹ There is robust evidence to show that participation in community – be it in a workplace, volunteering or participation in community groups – is associated with greater well-being, reduced symptoms of

67 Meltzer HY, Alphas L, Green AI, et al; International Suicide Prevention Trial Study Group. Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT). *Arch Gen Psychiatry*. 2003;60(1):82–91.

68 Galletly, Cherrie, David Castle, Frances Dark, Verity Humberstone, Assen Jablensky, Eóin Killackey, Jayashri Kulkarni, et al. "Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders." *Australian & New Zealand Journal of Psychiatry* 50, no. 5 (2016): 410–72.

69 Waghorn et al., *Australian & New Zealand Journal of Psychiatry* 2012.

mental illness, greater social contact, greater independence, improved self-esteem, lower relapse rates, and better quality of life. Employment can act as a scaffold for personal recovery and restored personal identity by providing structure, purpose, social and economic opportunities, and reinforcing personal values.⁷⁰ Unemployment, on the other hand, is associated with increased likelihood of substance abuse, distress, depression, crime, and suicide.

As highlighted by Waghorn and Lloyd⁷¹, meaningful employment results in significant improvements in many measures including self-concept, self-efficacy, subjective wellbeing, and symptom reduction – as well as resulting in higher levels of functioning.

It has been shown that one of the most evidence-based forms of vocational rehabilitation for people with serious mental illness is Individual Placement and Support (IPS). This has already been demonstrated to be effective for adults and is ready to be implemented, with a systematic review and meta-analysis of international evidence showing it is more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation for people with serious mental illnesses.⁷² Whereas no more than 20% of people will typically return to work without support, IPS can yield rates of 60% or more.⁷³

Conclusion

We strongly support research aimed at uncovering methods to much better understand the underlying causes of serious mental illnesses or to prevent them from occurring in the first place. But until such research on primary prevention has proven successful in clinical trials, we must design our mental health system based on the current evidence that many recovered patients with severe psychotic and depressive mental illness will continue to require – and will benefit from – social, vocational, income, housing, and clinical support for the remainder of their lives.

Symptoms may come and go, and the need for support may vary over the life-course (from none to acute care). But many adults aged 25–64 with serious, non-adjustment-related mental illnesses will be continuous or episodic consumers of specialist or primary mental health care.

Fortunately, secondary and tertiary prevention for serious mental illness has been shown to stop symptom deterioration, illness relapse, and disease progression, and to effectively reduce the risk of suicide.

Recommendation 1: Recognition should be given to secondary and tertiary prevention of serious mental illnesses – such as schizophrenia and bipolar disorder – as core foci of mental health services.

70 Waghorn, Geoff, and Chris Lloyd. "The Employment of People with Mental Illness." *Australian e-Journal for the Advancement of Mental Health* 4, no. 2 (2005/01/01 2005): 129–71.

71 *Ibid.*

72 Modini et al., Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence *The British Journal of Psychiatry* (2016) 2019:14–22

73 Harvey, Modini, Christensen and Glozier, Severe mental illness and work: What can we do to maximise the employment opportunities for individuals with psychosis? *ANZJP Perspectives Australian & New Zealand Journal of Psychiatry* (2013)47(5): 421–424

4.

Enhancing mental health care within the current system

4.1. Current services in Victoria

Victoria's current mental health care system provides many important and valuable services for adults with serious mental illnesses. There are acute community intervention services which provide urgent advice, referral, and treatment to people with mental illness who are acutely ill or in crisis. This is available 24 hours a day, seven days a week, and can be accessed by a simple phone call, where the urgency and nature of the problem is determined. For non-acute cases, there are community mental health services, which often operate from a clinic (rather than a hospital), although they also sometimes see people in their homes. These are offered free of charge to the public.

General hospital emergency departments (EDs) are commonly the entry point to inpatient care for people experiencing acute mental health problems. The emergency department can provide psychiatric triage, to assess the needs of a presenting patient, and determine whether they need to be admitted to an inpatient psychiatric bed or whether other forms of treatment are appropriate. Six sites across Victoria are in the process of developing new emergency department crisis hubs – specially designed 24-hour short-stay units in emergency departments, to treat people during times of crisis. They aim to ensure people presenting with mental health issues receive the right kind of support sooner, aiming to free up crowded emergency departments.

In terms of inpatient care, Victoria has a mix of both acute and non-acute psychiatric beds. The benefits of such inpatient care are described in detail in section 4.3. below.

Victoria has also invested heavily in residential mental health services. These include a mix of short-term prevention and recovery care (PARC) beds – under 1-month length of stay – and community rehabilitation centres designed for patients to stay for several months. Located in the community, rather than the hospital setting, they are designed to encourage patients to keep in contact with their existing supports, and maintain links to their community.

In addition to these general mental health services which aim to be available in all areas, there are various state-wide specialist services (see Figure 33).

Despite all of these crucial mental health services in Victoria, funding for mental health has not been responsive to population growth and increasing acute demand over the last two decades. Funding and resources need to be substantially increased and directed to improving the quality and capacity of existing mental health care. There are many valuable services in place, but no system can cope with increasing demand without a corresponding increase in resources and capacity.

Recommendation 2: Additional funding for mental health care provision should be directed to the existing mental health services associated with general hospitals and care in the community, in order to improve their capacity to cope with growth in demand and to adequately address patients' therapeutic needs in a safe and high-quality clinical environment.

VICTORIA'S CLINICAL MENTAL HEALTH SERVICE SYSTEM



* Delivery of activities varies between areas. Some services have separate teams for the various activities; others operate 'integrated teams' performing a number of different functions.

** Service models for children and young people vary across the state. Some areas have Child and Adolescent Mental Health Services (0–18 years); some have Child and Youth Mental Health Services (0–25 years); and others have specific services for adolescents (12–18 years) or youth (16–24 years).

Figure 33. Victoria's Mental Health Service System.⁷⁴

74 Victoria's Mental Health Service Annual Report, 2017.

4.2. Community mental health

Optimising the functioning of adult community mental health teams

Community mental health is an essential component of an integrated continuum of care which intersects with a range of services and providers – including primary care, private providers (psychologists, allied health, and psychiatrists), NGOs, emergency departments, acute and long-term inpatient specialist units, and forensic services.

In the 1990s, Victoria was a leader in establishing a system of care that allows for differing levels of support and intervention, over different time frames, and across bed-based and community settings. This relied on increased levels of community-based care, with a case-management model, supported by sufficient and timely access to intensive outreach and to inpatient care.⁷⁵ Sadly, while this was a ground-breaking service reform, it was not resourced in a manner to allow its continuation. The model of block funding services which sat within health services funded on an activity basis resulted in some health services taking advantage of the funding model to divert funds from mental health to general health, and the lack of an activity basis meant that mental health funding did not increase at that same rate as acute funding. This, combined with unprecedented and unpredicted population growth, meant that mental health funding in Victoria progressively lagged behind other parts of health and the rest of Australia. The response of health services has been to reduce the staffing in community services – especially medical staffing – and to lessen the intensity of service and after-hours/weekend coverage.

The threshold for entry (in terms of acuity and complexity) to community mental health care has therefore risen through the efforts of mental health services to manage increased demand, thereby limiting opportunities for early intervention (in illness or in episode) and tending to lead to caseloads being dominated by people with multiple complex needs and /or presenting risks to self or others and/or illnesses which are difficult to treat. The March 2019 Victorian Auditor General report confirmed that area public mental health services only see “the most unwell” people, creating significant service problems in other parts of the mental health system.⁷⁶

If services are not available in the community to respond to those whose illness is relapsing, or who are facing a situational crisis, the result is that interventions are delayed. People (patients and their families) are less likely to have their needs met in the community with the result that people are sicker when they do present and more likely to come through the emergency department.

If there is a reduction in bed-based capacity, then the functionality of community-based services is further compromised. Community-based services and inpatient services are mutually dependent. In order for community services to respond appropriately to deterioration in mental state, they need access to inpatient care. For inpatient services to safely discharge patients into the community they need assurance that community and clinic-based services can and will be provided. It should be noted that in line with a ‘stepped model of care’ the bed-based services should comprise acute assessment, acute inpatient, secure- and medium-secure, longer stay, and residential. The community-based services need to include capacity for urgent outreach, clinic-based care, outpatients, and longer term assertive outreach as described by Hoult et al. many years ago.⁷⁷ What we have noticed has been an increasingly dysfunctional system where community services are deficient, treatment is delayed, and in the absence of bed availability those with mental illness either present to or are brought to the emergency department by police or ambulance and have to spend hours of even days in an environment inappropriate to their needs and distressing for staff and other patients.

Adult Community mental health teams should have three essential teams and functions – crisis assessment teams (CAT), continuing care teams, and mobile assertive care teams. Crisis assessment

75 Department of Human Services, Victorian Mental Health Services: the Framework for Service Delivery. 1994, Mental Health Branch: Melbourne, Victoria.

76 Victorian Auditor General’s Office, Access to Mental Health Services, Independent assurance report to Parliament 2018–19: 16. <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf>

77 Hoult, J., A. Rosen, and I. Reynolds, Community orientated treatment compared to psychiatric hospital orientated treatment. *Social science & medicine*, 1984. 18(11): 1005-1010.

teams would specialise in comprehensive assessment and management of patients in crisis who often exhibit suicidal thinking. Crisis assessment teams should have close links with emergency departments and short-stay psychiatry units, in addition to community-based services. Continuing care teams should offer long-term care for people with severe mental illness whilst mobile assertive care teams should offer more intensive case management for those patients with very complex and severe mental illness.

Adult community mental health teams should specifically explore the use of telehealth and digital health interventions as part of their model of care, including use of video and phone conferencing, use of text messaging and mobile health applications. A specific model to consider would be the Improving Access to Psychological therapies model in England, which offers structured phone therapy to patients with anxiety and depression.⁷⁸ In Australia this has been successfully adapted to offer structured phone therapy as part of community follow-up for patients in emergency departments who have presented in crisis.^{79,80}

MyHealth record data should be integrated within community mental health services as it provides current insights into prescription refills and appointment attendance to primary and specialist appointments funded by Medicare. This primary care information will help adult community mental health teams to understand the vital interface between secondary and primary care and assist in the process of accurate information transfer for shared-care patients. Additionally this information can help to offer early intervention opportunities if patients with severe mental illness have not attended primary care appointments or not attended pharmacy for their prescription refills.⁸¹

Workforce

The lack of investment and increased threshold for entry to community mental health care has resulted in increased workloads, staff burnout, and increased turnover in many locations. Additionally, there are challenges to recruiting, training, and retaining staff who are adequately trained to deliver high-quality evidence-based treatment and care. This leads to a lowest common denominator approach to treatment and care with a heavy reliance on psychopharmacology without wide availability of psychosocial and other therapeutic treatments.

Senior staff are also increasingly subject to burnout and have increasingly elected to take on roles without direct service provision to consumers and carers. This leaves the most junior staff working with patients with the most complex needs, thereby increasing pressure on these staff and arguably leading to sub-optimal standards of service delivery.

Incidents of occupational violence experienced by staff have noticeably increased and many community mental health services are ill-equipped to implement the robust systems required to manage and mitigate these significant risks.

Community-based services, psychosocial support, and the NDIS

Numerous reports and commentaries have referred to increasing fragmentation of treatment and care offered to patients and carers through community mental health services and associated community-based treatment and support services. This lack of continuity of care has resulted from the demand pressures, excessive focus on acuity, and workforce turnover outlined above. Continuity of care is a pressing issue, since without it we undermine the therapeutic relationships central to delivery of high-quality personalised care.

78 Lancet. 2018 Feb 17;391(10121):679-686. doi: 10.1016/S0140-6736(17)32133-5. Epub 2017 Dec 7. Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data.

79 Bidargaddi, Niranjana, Tarun Bastiampillai, Stephen Allison, Gabrielle M. Jones, Gareth Furber, Malcolm Battersby, and David Richards. "Telephone-Based Low Intensity Therapy after Crisis Presentations to the Emergency Department is Associated with Improved Outcomes." *Journal of Telemedicine and Telecare* 21, no. 7 (2015): 385-91.

80 Bastiampillai, Tarun, Gabrielle M. Jones, Gareth Furber, Michele Moreau, David Healey, Julianne Watson, and Malcolm Battersby. "The IAPT@Flinders Service: Adapting the Improving Access to Psychological Therapies Model to the Emergency Department Setting in Australia." *Australasian Psychiatry* 22, no. 3 (2014): 277-80.

81 Bidargaddi, Niranjana, Yasmin van Kasteren, Peter Musiat, and Michael Kidd. "Developing a Third-Party Analytics Application Using Australia's National Personal Health Records System: Case Study." *JMIR medical informatics* 6, no. 2 (2018): e28.

In an effort to manage the increasing pressures and demand, community mental health services have increasingly adopted an episodic approach to delivery of care so that patients are often discharged once the acute crisis has diminished. While this approach to care is suitable for patients whose care can mostly be well-managed in the primary care sector, it is inappropriate for patients who are experiencing frequently relapsing mental health conditions and/or those requiring more sustained input to support their recovery (beyond symptomatic recovery). An important partial solution to the current episodic model of care is to re-establish outpatient clinics. Mental health services have over time reduced outpatient clinics as a service model for patients with severe mental illness. However the rest of the acute health care sector, such as physicians and surgeons, continue to maintain high levels of outpatient service provision. Outpatient clinics are vital in providing new assessments and second opinions for general practitioners, to guide a fully informed biopsychosocial treatment plan. Outpatient clinics also provide opportunities for patients to receive ongoing care in the form of combined medication management and supportive psychotherapy to implement evidence-based treatment, prevent acute relapse and improve functional outcomes for patients with severe mental illness. Outpatient clinics could be funded using a Commonwealth-State partnership model based on Medicare funding and use of state-related infrastructure. Outpatient clinics will also likely attract high calibre psychiatrists back into the public system. This in turn will ensure greater educational opportunities for psychiatry registrars, medical students, and multidisciplinary teams. Outpatient clinics will help transform the current episodic model of community care in Victoria, to one that supports a personalised, continuous and evidence based holistic model of care for patients with severe mental illness. Whilst most patients will benefit from an outpatient model, there will be a minority of patients who will not be able to attend an outpatient clinic and they will continue to be supported by crisis assessment, care coordination, and mobile assertive care models delivered by the adult community mental health teams.

Other services fundamental to good and holistic community care have declined or been restricted. Examples include financial administration through State Trustees, access to legal advice (including Legal Aid), financial counselling, access to a range of appropriate accommodation for people who are homeless or at risk of homelessness, and generalist counselling services accessed through community health. This has created even greater difficulties for community mental health services in coordinating and providing a holistic response to people with serious mental illness.

There is strong evidence that psychosocial interventions improve recovery. Most community services provide only patchy and limited psychosocial interventions (such as CBT for psychosis, family psycho-education, life skills training).⁸² For example, less than one quarter of national survey participants reported receipt of an evidence-based level of any intervention: rates ranged from 3.4% (Family Psycho-Education) to 21.1% (Relapse Prevention Planning).⁸³ Further, there are insufficient staff adequately trained to provide these interventions (even if demand pressures allowed) and poor understanding of their value and the change processes and systems necessary to implement and sustain these interventions.

Community rehabilitation services have decreased. These include appropriate and much-needed clinical expertise, for those consumers living with the most complex needs who could benefit from rehabilitation interventions and strategies. Contributory factors include: the introduction of the NDIS, the shrinking of the community-managed mental health sector, and (in some parts of Victoria) the disappearance of Mobile Support and Treatment teams which provide intensive outreach and rehabilitation treatment and support. This situation has led to a neglect of these consumers' needs and, in many cases, experiences of poorer mental health and more frequent relapses.

82 Harvey, C., J. Lewis, and J. Farhall. "Receipt and Targeting of Evidence-Based Psychosocial Interventions for People Living with Psychoses: Findings from the Second Australian National Survey of Psychosis." [In eng]. *Epidemiol Psychiatr Sci* (Jun 12 2018): 1-17.

83 *Ibid.*

Conclusions

Community mental health costs per treatment day need to be brought down to the national average by improving productivity and thereby also increasing population-level coverage of serious mental illness. Adult community mental health teams could use telepsychiatry support systems based on the UK Improving Access to Psychological Therapies program for patients presenting in crisis and consider using available data from the My Health Record system. The intensity of engagement should vary with acuity and severity, enabling smooth transitions between the various levels of care required. This will be facilitated and enabled by our recommended clinical quality registries, telepsychiatry support systems, and My Health Record Data integration. Other services – such as drug and alcohol, employment, and primary care – also need to be integrated and co-located within adult community mental health teams.

Recommendation 3: Adult community mental health teams should be aligned into subspecialist crisis assessment teams, continuing care teams, and assertive care teams – embedding therapeutic functions within each team and providing significantly more training and supervision resources to improve their overall assessment and therapeutic skills. Staffing levels should be enhanced by at least 20% to build population coverage levels from the current 1.2% toward 3% – the proportion of the Victorian population who have serious mental illnesses requiring public mental health services.

4.3. Inpatient care

4.3.1. The importance of inpatient care in psychiatry

Despite the often-prevailing view that inpatient psychiatric care should be seen as a method of last resort – a regrettable necessity – evidence on inpatient care demonstrates that it is critically important and plays a positive and constructive role in mental health care. Inpatient psychiatric care is both life-saving and life-enhancing. Properly supported acute care is invaluable, as expert staff do not just perform crisis resolution (an important first step): they provide therapeutic benefits that support recovery. They provide comprehensive diagnostic formulation (key to understanding and managing mental health problems), assessment, biological and (ideally) psychological treatments, respite, carer and family engagement, and comprehensive discharge planning.⁸⁴ A key component of acute inpatient care is providing care to patients who are acutely suicidal, so inpatient care is a vital component of Victoria's suicide prevention strategy.

There is a clear and compelling need for inpatient psychiatric care. Many serious mental illnesses are relapsing and remitting, so the need for periodic hospitalisation is common. Inpatient care should be seen as an integral and critical part of a continuum of comprehensive psychiatric treatment. Hospitalisation with 24-hour nursing and readily available medical and allied health care provides the opportunity to assess, diagnose, and stabilise complex and comorbid psychiatric illnesses.

Inpatient beds are needed in mental health care just as they are for persons with medical and surgical problems. They are crucial when dealing with problems which are life-threatening. Also, some patients require procedures which can only be done in hospital, or they need a large team – which cannot be assembled in the outpatient setting – to assess or treat their illness. Sometimes patients require long periods of observation while they are receiving treatment, or if they are trying stepwise procedures or alternative treatments.

On top of these similarities with non-mental-health inpatient care, additional difficulties can arise for patients with serious mental illness. For example, often the illness affects their insight or capacity to consent to treatment, due to cognitive impairment: intellectual disability or acquired brain injury. Moreover, there are high rates of non-adherence to treatment when it comes to serious mental illness.

84 Sharfstein, Steven S. "Goals of Inpatient Treatment for Psychiatric Disorders." *Annu. Rev. Med.* 60, no. 1 (2009): 393-403.

Often mentally ill patients lack family or other supports to facilitate treatment, and they often have unstable psychosocial situations – especially unstable housing.

Inpatient treatment enables solving problems like these which cannot easily be dealt with in the community. It is important to ensure that, within the inpatient unit, there are high-quality relationships; minimisation of negative experiences of coercion; a healthy, safe, and enabling physical and social environment; and authentic experiences of patient-centred care. When inpatient facilities are functioning in these ways, they can be truly life enhancing for patients, with much more of a recovery focus. For example, Nuernberg et al. showed that highly significant clinical improvements occurred for patients during their inpatient admissions. "Overall, the present study demonstrated that the intensity of [serious mental illness] symptoms markedly decreased and that patients improved their function and [quality of life] during the hospital stay."⁸⁵

Tasks of inpatient admission must include ensuring the patient is safe, assessment, basic care, rehabilitation, and resolution of personal and social stress. There needs to be sufficient time for a full diagnostic assessment to ensure the patient's care needs are understood. This includes addressing psychosocial aspects of care, the precipitants for worsening of illness, and determining whether there is a need for inpatient admission. Inpatient admission is a unique opportunity to co-ordinate resources, such as alcohol and drug addiction services. There also needs to be time to both assess and address deficits in activities of daily living, such as adequacy of housing, so such deficits do not further exacerbate illness. Key to patient-centred care is for carers to involve the patient in their own recovery plan, ensuring they understand and address the patient's recovery goals, be they interpersonal, residential, occupational, vocational, and/or spiritual goals.

The most obvious task of inpatient admission is to stabilise the illness and, where possible, achieve remission. But there is also a need to identify the issues which lead to destabilisation, and to implement interventions to change the illness trajectory rather than just addressing the specific crisis. This rehabilitative approach is needed to set the patient up for successful reintegration into life outside the hospital.

If this level and duration of care can be provided there is a lower chance of early re-admission, and a greater likelihood the patient will engage in ongoing treatment as their illness is better stabilised.⁸⁶ Hence, length of stay should only be driven by clinical need, not by pressure to discharge the patient because of bed block or bed pressure. Discharge should only occur if the patient has been thoroughly assessed (by a multidisciplinary team if clinically indicated); has received treatment and responded to treatment (again, multidisciplinary treatment if indicated); poses a reduced risk to themselves or others (assuming some initial level of risk); is under less stress; accepts treatment and has appropriate follow-up organised; is adequately self-caring; is not behaving in a socially disagreeable manner; and has suitable and stable housing as a discharge destination.

At the same time, just as acute inpatient care is crucial and should include a recovery focus, some serious mental illnesses require a longer-term rehabilitative approach. Among the 3% of Victorians with serious mental illness, 0.1% (approximately 4,000 Victorians aged between 18–64) have ultra-treatment-resistant schizophrenia – characterised by long-term need for treatment due to ongoing psychotic symptoms, often significant cognitive impairment, and often comorbid drug and alcohol dependence. They are prone to suicide risk, homelessness, incarceration, and repeated re-admission into acute hospital care often staying for several months (leading to acute bed block). Providing them long-term rehabilitation and recovery-focused inpatient care (e.g. the specialised Mental Health Rehabilitation Centres discussed later) would offer optimal psychopharmacological, and psychosocial treatments, risk management, and basic human needs of food and shelter, while significantly reducing

85 Nuernberg, Gabriela L., Fernanda L. Baeza, Marcelo P. Fleck, and Neusa S. Rocha. "Outcomes of Inpatients with Severe Mental Illness: A Naturalistic Descriptive Study." *Revista brasileira de psiquiatria (Sao Paulo, Brazil)* 38, no. 2 (2016): 144.

86 Figueroa, Roberto, Jeffrey Harman, and John Engberg. "Use of Claims Data to Examine the Impact of Length of Inpatient Psychiatric Stay on Readmission Rate." *Psychiatric Services* 55, no. 5 (2004): 560–65. <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.5.560>

the demand on the acute-care setting and carer burden. Ideally, these patients can eventually transition to intensive community-supported housing, but this can often take months or even years.

An important consequence of the bed shortage in Victoria is that patients are spending many hours or even days in the emergency department waiting for an inpatient bed. This pressure has meant the length of time that patients are staying in inpatient beds has reduced significantly. This has contributed to higher 28-day readmission rates as more people have not sufficiently recovered before they are discharged. There is also an increased risk of suicide, and more of these patients are ending up incarcerated in prison or homeless.

Vital role of inpatient care for suicide prevention

A crucial component of suicide prevention is understanding the role of psychiatric inpatient care in reducing suicide risk during acute social crises and the relapse of severe psychiatric illness. Clinical practice is predicated on the principle that inpatient care is a key intervention for addressing the immediate risk of suicide. Suicide risk is a frequent indication for admission, and patients should not be discharged until there is a significant reduction of suicide risk. Inpatient care can provide support, close supervision, respite, monitoring of medication adherence and therapy. There are concerns in the US, which has reduced its psychiatric beds by 35% to only 22 psychiatric beds per 100,000 (from 1998 to 2013) that this may have contributed to the 24% increase in suicide rates from 1999 to 2014. Often when beds are significantly reduced the thresholds for admission are increased for suicidal patients and thresholds for discharge are reduced, which can lead to increased risk of completed suicide in the community. There are also concerns in Australia from various coronial findings that limited access to inpatient care has contributed to suicides.⁸⁷

The critical need for after-care following inpatient admission and ongoing community care

The immediate post-discharge period is a time of marked risk with well-known clustering of suicide shortly after being discharged. This heightened risk is most apparent for 3 months following discharge highlighting the risks involved and the particular importance of the chain of care as patients transition from inpatient care to the community.^{88,89}

The policy implications are that patients should be seen regularly following discharge from hospital settings and that this should be coordinated carefully within the inpatient setting. It is very important that community teams offer a consistent approach to the crucial post-discharge period and that psychiatric outpatient clinics are also provided during this high-risk suicide period. The first three months post-discharge are particularly important for suicide prevention, but it is also important to note that this suicide risk remains elevated (relative to the general population) beyond the three-month period, so access to long-term care inclusive of care coordination, psychosocial support and rehabilitation, outpatient clinics, day hospitals and therapy should be considered for patients with serious mental illness.

Improving safety is of paramount importance

While the valuable and life-enhancing benefits of inpatient care must be recognised, it is also important to acknowledge where such care needs to be improved.

Acute adult wards admit patients with acute psychosis, mania, and intoxication who can present with accompanying behaviours of concern. Often various types of restrictive interventions are used inclusive of chemical restraint, physical restraint, and seclusion. This can be traumatic for an already vulnerable

87 Bastiampillai, T., S. S. Sharfstein, and S. Allison. "Increase in Us Suicide Rates and the Critical Decline in Psychiatric Beds." [In eng]. *Jama* 316, no. 24 (Dec 27 2016): 2591-92.

88 Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. Suicide Rates After Discharge from Psychiatric Facilities: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2017;74(7):694-702.

89 Olfson M, Wall M, Wang S, et al. Short-term Suicide Risk After Psychiatric Hospital Discharge. *JAMA Psychiatry*. 2016;73(11):1119-1126.

group of patients. Victoria has a significantly higher use of restrictive practice compared to the rest of Australia and attempts should be made to minimise its use.

Detailed training and resource provision⁹⁰ to provide systematic responses to reduce the occurrence of behaviours of concern are provided by the Department of Health and Human Services based on Safewards⁹¹ – which was developed in the United Kingdom. Interventions used in Safewards include the development of calming down methods to lower levels of arousal and agitation, and anticipating high-risk situations – such as the delivery of bad news – and taking preemptive steps to reduce the stress associated with them.

A program of de-escalation in psychiatric inpatient settings that is worthy of particular attention is Psy-BOC (Psychiatric Behaviours of Concern), which was developed in the Alfred Hospital. This program involves a rapid response multidisciplinary team approach which is the psychiatric equivalent to a Medical Emergency Team (MET) call. The Psy-BOC intervention was evaluated recently⁹² and resulted in a significant reduction in behaviours of concern, reduction in use of restrictive interventions, and reduction in adverse events.

Programs such as Safewards and Psy-BOC help address safety for all patients and staff, but there are many other specific areas of concern in inpatient wards that require additional detailed attention, including the sexual safety of women. This matter has been the subject of many reports including the 2009 "Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units: Chief Psychiatrist's guideline"; and the 2018 Victorian Mental Health Complaints Commission (MHCC) Report – "The Right to be Safe".⁹³

Both documents highlight the measures that should be considered and whenever possible implemented, to reduce breaches of sexual safety. These include setting clear expectations of required behaviours, and gender segregation (especially in Intensive Care Areas, but also in other areas such as bedroom corridors). If gender segregation is not possible, it is important for there to be a close level of supervision by clinical staff. As an example of policy to address this issue, the Mental Health Complaints Commissioner⁹⁴ reported that since 2016 it has been a requirement by the Chief Psychiatrist that at least one clinical staff member is present within any locked area accommodating two or more patients.

Although there are aspects of inpatient care that must be improved, this section has argued that inpatient care is a vital element of the mental health system. Lack of capacity make safety problems more difficult to address, due to overdemand on the system. The next section will argue for an increase in inpatient capacity.

Recommendation 4: There needs to be a recognition of the value of inpatient psychiatric care that provides a healthy, safe, and enabling physical and social environment for patients with serious mental illness who require full diagnostic assessment and recovery-focused clinical care.

4.3.2. Why inpatient bed capacity needs to be enhanced in Victoria

In the previous section we argued for the value of inpatient care. But why do we need the types of inpatient psychiatric beds that we recommend? And how do we arrive at these rates for each type of bed?

90 <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/training-resources>

91 Bowers, L. "Safewards: A New Model of Conflict and Containment on Psychiatric Wards.(Report)." 21, no. 6 (2014): 499.

92 Exploring the prevalence and impact of behaviours of concern and whether a psychiatric behaviour of concern (Psy-BOC) team improves safety Fiona Whitecross, Hannah Bushell Caitlin Berry, Gamze Sonmez, John Moran, Ilan Rauchberger, Yitzchak Hollander, Ellie Harrison, Catherine Bennett, Stuart Lee. 2018
https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0009/2857527/Fiona-Whitecross-exploring-the-impact-and-prevalence-of-behaviours.pdf

93 Mental Health Complaints Commission, "The right to be safe - ensuring sexual safety in acute mental health inpatient units: sexual safety project report", Victorian Government. <https://www.mhcc.vic.gov.au/resources/publications>

94 *Ibid*

Numerous academic papers in recent years have decried the progressive decrease of psychiatric beds per capita across most high-income countries, and there is significant agreement in the literature that this decrease has gone too far. Sisti et al. clearly articulate the argument in the United States' context, and their view broadly describes the situation for Victoria, for Australia more broadly, and for most other Anglo-sphere countries:

“Deinstitutionalization has really been transinstitutionalization. As state hospitals were closed, patients with chronic psychiatric diseases were moved to nursing homes or to general hospitals where they received episodic psychiatric treatment at significantly higher costs. Others became homeless, utilizing hospital emergency departments for both care and housing... Most disturbingly, US jails and prisons have become the nation's largest mental health care facilities.”⁹⁵

However many western European countries, for example Germany, Switzerland, France and the Netherlands, maintain psychiatric bed numbers well above 80 beds per 100,000⁹⁶ and they do not experience the current problems faced in Anglosphere countries in relation to the humane treatment of patients with severe mental illness (US, Canada, UK, Australia and New Zealand).

As described in the previous section, approximately 4,000 Victorians aged between 18–64 have ultra-treatment-resistant psychosis that is not responsive to clozapine (0.1% of Victorians aged between 18–64). They often go through a destructive and repeated cycle – between hospital, prison, and homelessness – which generally only aggravates serious mental illness. This vicious cycle can only be stopped if we recognise that this sub-group of seriously mentally ill people need the longer-term support and expert care of specialist (non-acute) Mental Health Rehabilitation Centres (see Chapter 5) which are “safe, modern, and humane.”⁹⁷ This is our core argument for increasing adult non-acute bed rates.

On top of significantly reprioritising non-acute beds, we also need to increase acute inpatient beds across the board. The previous section argued that adult acute beds are a key part of Victoria's suicide prevention strategy, among the many other benefits they provide. And adult non-acute beds are crucial for the sub-group of people with long-term ultra-treatment-resistant psychosis. So we are calling for an increase, but how can Victoria determine the appropriate number of inpatient beds to provide?

Deriving the figure of 51 public psychiatric beds per 100,000 people

This number is based on available comparative international data and an “observed outcomes approach” to calculating minimum and optimum bed requirements. Currently across Australia there are 42 mental health beds (29.4 public sector and 12.3 private sector beds) per 100,000 people. As shown in Figure 34, this is significantly less than the OECD median of 62 beds per 100,000. Victoria is 44% behind the OECD median of 62 beds per 100,000 and 17% behind the Australian average. If Victoria was defined as a country, it would rank only 29th out of 36 OECD countries in terms of psychiatric bed provision. This is surprising given the economic wealth of Victoria, compared to other OECD countries,

95 Sisti, Dominic A., Andrea G. Segal, and Ezekiel J. Emanuel. “Improving Long-Term Psychiatric Care: Bring Back the Asylum.” *JAMA* 313, no. 3 (2015): 243-44.

96 Tyrer, P., S. Sharfstein, R. O'Reilly, S. Allison, and T. Bastiampillai. “Psychiatric Hospital Beds: An Orwellian Crisis.” [In eng]. *Lancet* 389, no. 10067 (Jan 28 2017): 363.

97 Sisti, Dominic A., Andrea G. Segal, and Ezekiel J. Emanuel. “Improving Long-Term Psychiatric Care: Bring Back the Asylum.” *JAMA* 313, no. 3 (2015): 243-44.

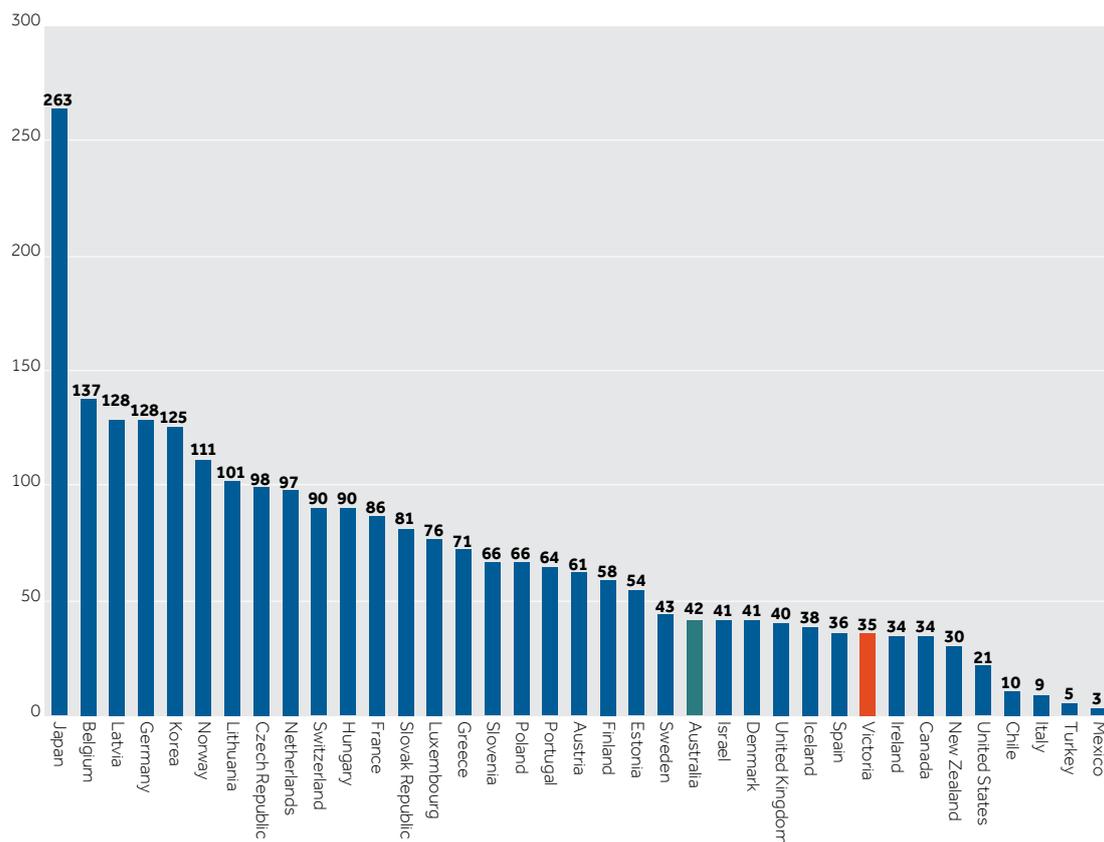


Figure 34. OECD Psychiatric care beds per 100,000 population, 2014–2016⁹⁸

The major psychiatric bed deficit sits within the public sector because in the private sector, Victoria has 13 private sector beds per 100,000, slightly higher than the Australian average of 12 private sector beds per 100,000.

Victoria has consistently underfunded public sector psychiatry beds for all age groups since 1993, spending only \$70 per capita, which is 34% less than the national average of \$105 per capita in 2016–17.

This major funding deficit results in Victoria having only 22 public sector beds per 100,000 (2016–17), which is 25% below the Australian average of 29.4 public sector beds per 100,000 for all age groups.

98 OECD, Hospital beds https://www.oecd-ilibrary.org/social-issues-migration-health/hospital-beds/indicator/english_0191328e-en

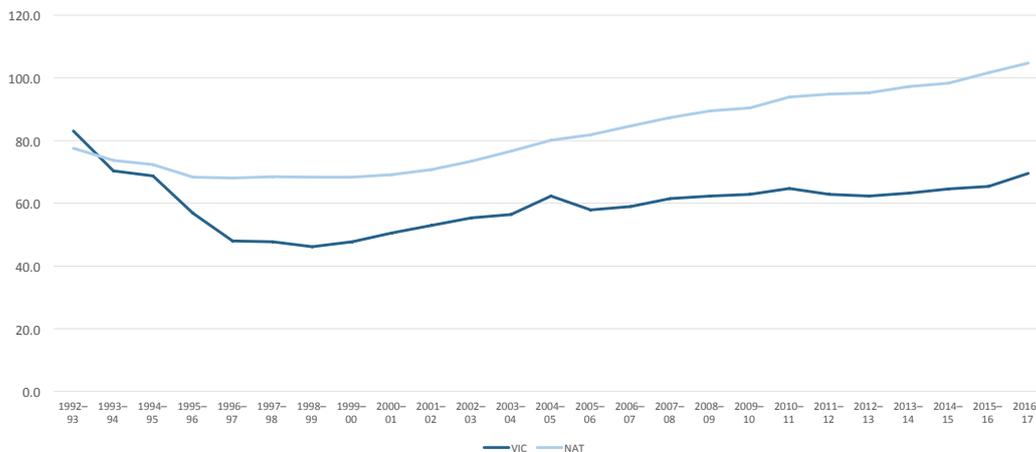


Figure 35. AIHW Recurrent expenditure per capita (\$) – total public psychiatric beds. Dark blue: Victoria. Light blue: Australia.

Most of the deficits in Victoria’s public sector bed numbers relates to inpatient service provision for the general adult population (18–64). Victoria has only 22.4 general adult acute and non-acute beds per 100,000, which is 34% below the national average of 34 beds per 100,000. NSW has the highest number with 41.7 beds per 100,000 and therefore Victoria has 47% fewer total general adult beds when compared directly with NSW.

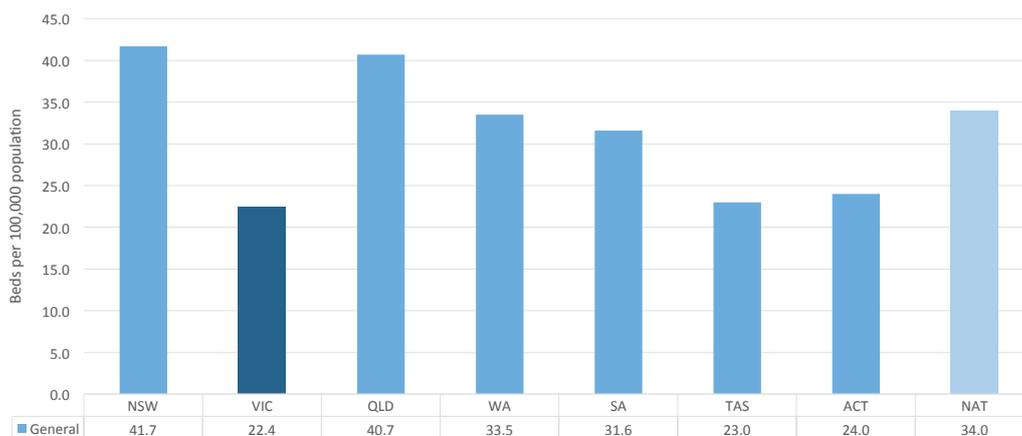


Figure 36. Public sector specialised mental health hospital beds per 100,00 population – general adult total, 2016–2017.

Within the overall general adult bed base, Victoria has significant shortages of general adult acute beds, with only 19 general adult acute beds per 100,000 which is 22% below the national average of 24.5 beds per 100,000 and is the lowest level in Australia.

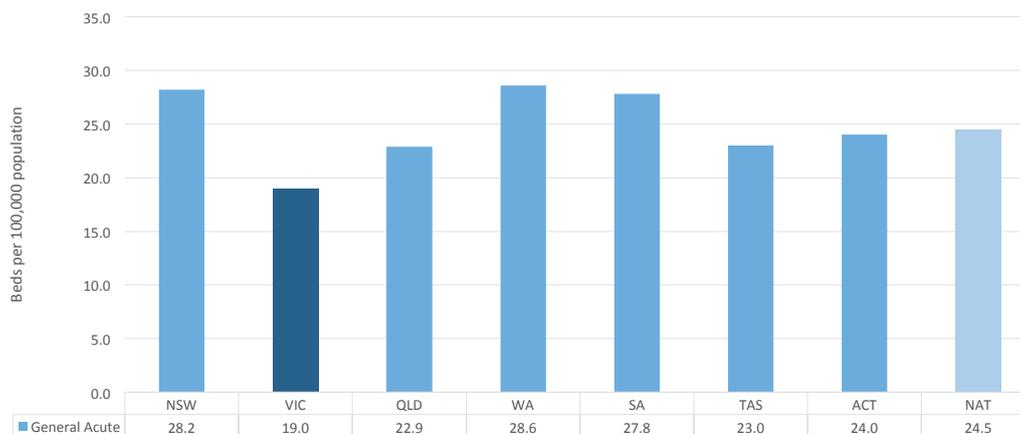


Figure 37. AIHW Public sector specialised mental health hospital beds per 100,000 population – general adult acute, 2016–17.

Within the general adult bed base, Victoria has significant shortages of general adult non-acute beds with only 3.4 general adult non-acute beds per 100,000, which is 64% below the national average of 9.5 beds per 100,000.



Figure 38. AIHW Public sector specialised mental health hospital beds per 100,000 population – general adult non-acute, 2016–17.

Having analysed international comparisons, the OECD expressed concerns about Australia's mental health system amid a strong trend toward de-hospitalisation and reduced proportion of expenditure on public sector mental health beds. We share the OECD's concern that the needs of the whole population should be met, including people with serious mental illness who are at risk of worsening symptoms, more stays in emergency settings, and more hospital readmissions.⁹⁹

Applying the "observed outcomes approach"¹⁰⁰ makes a compelling case for, at minimum, increasing mental health beds to the level we are suggesting. This approach examines the relationship between bed numbers, key performance indicators (KPIs) for hospitals, and population outcomes for people with mental illness. We submit that there are thresholds for the number of psychiatric beds below which adverse clinical and social outcomes begin to appear. As such, developing bed targets based on the

⁹⁹ OECD, Australia at the forefront of mental health care innovation but should remain attentive to population needs, says OECD.

¹⁰⁰ O'Reilly, Richard, Stephen Allison, and Tarun Bastiampillai. "Observed Outcomes: An Approach to Calculate the Optimum Number of Psychiatric Beds." *Administration and Policy in Mental Health and Mental Health Services Research* (2019): 1-11.

observed outcomes approach is positioned to avoid turmoil within hospital and social systems and to ultimately improve the acute and longer-term outcomes for both patients and their families.

Our groups have extensively analysed and reviewed KPIs, and Australia is encountering major quality and safety issues with emergency department boarding, out-of-area admissions, high inpatient occupancy rates, high 28-day readmission rates, increasing rates of incarceration of patients with severe mental illness and an increased risk of suicide in community settings. These adverse effects worsen as total bed numbers fall below a critical range of 50–60 public sector beds per 100,000 people.¹⁰¹ And our data analysis (Chapter 2 and Appendix) reveals that adult acute and non-acute psychiatric beds represent Victoria's largest shortfall compared to the national average and international averages. This is why we have recommended increases in general adult acute and non-acute psychiatric beds to bring Victoria back up over the critical threshold of 50 beds per 100,000. (Note: the argument for increasing adult forensic beds is detailed in section 4.6.)

Additional information is available in the article, 'When should governments increase the supply of psychiatric beds?'¹⁰²

Ideally, the observed outcomes approach would be able to draw on significantly more data sources. This literature review of hospital and population KPIs revealed 16 KPIs that, when used in combination, would be powerful determinants of the adequacy or otherwise of mental health bed numbers. The identified KPIs are listed in the table below, and explained in full within the article, 'Observed outcomes: An approach to calculate the optimum number of psychiatric beds.'¹⁰³

Hospital KPIs

Out of area placements

Boarding in emergency rooms

Involuntary admission

Occupancy rates in psychiatric units

Average length of stay in psychiatric units

Level of acuity on inpatient wards

Discharge to homelessness

Readmission rates

Population outcomes

Rates of homelessness amongst people with SMI

Rates of people with SMI in homeless shelters

Rates of all-cause mortality

Rates of suicide

Rates of crime committed by people with SMI

Rates of incarceration amongst people with SMI

Rates of people with SMI in jails

Burden on carers

Figure 39. Hospital KPIs.

It is important to capture these KPIs as they speak directly to the burden of disease felt by patients, their families, and the community: including long waits for care, sub-optimal care, suicide, crime, incarceration, homelessness, and carer burden. We submit that if a sufficient number of beds were provided there would be significant health, social, and economic advantages both to patients and the broader community – including on these broad KPI outcomes described above.

101 Allison, S., T. Bastiampillai, J. Licinio, D. A. Fuller, N. Bidargaddi, and S. S. Sharfstein. "When Should Governments Increase the Supply of Psychiatric Beds?". *Molecular Psychiatry* 23 (07/11/online 2017): 796-800

102 *Ibid.*

103 O'Reilly, Richard, Stephen Allison, and Tarun Bastiampillai. "Observed Outcomes: An Approach to Calculate the Optimum Number of Psychiatric Beds." *Administration and Policy in Mental Health and Mental Health Services Research* (2019): 1-11.

Establishing clinical quality registries (discussed later) would allow us to include measures to assess performance against each of these KPIs. This would ideally inform acute and non-acute bed numbers on an ongoing basis, allowing a precision approach to determining bed targets.

Future modelling projections for public sector general adult and forensic psychiatric beds

The following table projects the total number of new beds needed over the next decade, based on the bed rates per 100,000 that we are recommending combined with projected population increase.

Table 1. Victorian required bed numbers based on population projections to year 2027.

Bed type	Australian beds/100,000 2016–17	Victorian beds/100,000 2016–17	Victorian bed numbers 2016–17	Recommended Victorian beds/100,000 for 2016–17	Recommended Victorian bed numbers for 2016–17 (% increase)	Recommended Victorian bed numbers for 2027	Recommended Victorian bed number increases from 2016–17 to 2027 (% increase)
General adult acute	24.5	19	747	30	1179 (58%)	1493	746 (100%)
General adult non-acute	9.5	3.4	135	15	596 (341%)	755	620 (459%)
General adult total	34	22.4	882	45	1775 (101%)	2248	1366 (155%)
Forensic beds	3.5	3.1	152	6	294 (93%)	372	220 (144%)

The population estimates for 2027 are based on ABS population projections. The Victorian population is forecast to grow to 7,908,000 from the December 2016 ABS population estimate of 6,244,227. This represents a population growth of 26.7% between 2016–17 and 2027. We have adjusted the projected required bed count for 2017 based on a 26.7% Victorian population growth between 2016–17 and 2027.

On the basis of recommending 30 beds per 100,000 for general adult acute beds, Victoria would need to increase these beds by 58% (based on 2016–17 population), representing the commissioning of an extra 432 beds, to reach the total required level of 1,179 beds. Projecting forward to 2027, general adult acute beds would need to increase by 746 beds (100% increase), doubling the current level of 747 beds to reach the required level of 1,493 beds.

On the basis of recommending 15 beds per 100,000 for general adult non-acute beds, Victoria would need to now increase these beds by 341% (based on 2016–17 population), representing the commissioning of an extra 461 beds, to reach a total level of 596 beds. Projecting forward to 2027, general adult non-acute beds would need to increase by 620 beds (459% increase) from the current levels of 135 beds to reach the required level of 755 beds.

To adequately meet total public sector general adult acute and non-acute bed demand in 2027 an extra 1367 beds (155% increase) will need to be commissioned in a staged manner, to reach the required level of 2249 beds.

On the basis of recommending 6 forensic beds per 100,000, Victoria would need to increase these beds by 94% (based on 2016–17 population), representing the commissioning of an extra 142 beds, to reach the required level of 294 beds. Projecting forward to 2027, forensic beds would need to increase by 220 beds (145%) from the current levels of 152 beds to reach the required level of 372 beds.

The net required general adult acute and non-acute beds and forensic beds in 2027 will be 2,620 beds. This requires a net increase of 1,586 for these types of beds, which is a 153% increase from the current 2016–17 levels. This increase in beds for 2027, is based on adjusting for significant Victorian population growth, as well as increasing the bed per 100,000 ratios for both general adult and forensic beds.

Recommendation 5: The total rate of general adult (ages 18–64) and forensic mental health beds (and concomitant staffing) throughout the public mental health system should be doubled from 25.5 to 51 beds per 100,000 people, and then maintained at that level. The increase should include: 11 general adult acute beds, 12 general adult non-acute beds, and 3 adult forensic beds (all per 100,000 people), giving a total of 30 general adult acute beds, 15 general adult non-acute beds, and 6 adult forensic beds (per 100,000). An increase in general adult residential beds is not regarded as necessary.

4.3.3. Can Youth Mental Health services reduce the need for adult (aged 25–64) specialist psychiatric beds?

The first of the Terms of Reference states that the Victorian Royal Commission into Mental Health will inquire into, “How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness, and early in episode, through Victoria’s mental health system, and in close partnership with other services” (Victorian Royal Commission, Terms of Reference).

Early intervention services, as pioneered in Victoria by Professor Patrick McGorry and his colleagues, are therapeutic and produce better symptomatic outcomes and better functioning, and enhanced engagement with the mental health system over the course of the program. However, these benefits don’t persist into the longer term. Thus, youth early intervention for first-episode psychosis is valuable, but it should not be expected to have a sustained effect of reducing symptoms and improving functioning into adulthood (age 25–64).

A recent systematic review by Correll and colleagues¹⁰⁴ located 10 randomised controlled trials of early intervention for psychosis. These studies included over 2,100 young people. Correll et al. quantified the benefits of early intervention and showed that compared with usual treatment, participants in early intervention programs “had a 12.6% greater likelihood of being in school or employed ... and improved by 24% to 30% more than with treatment as usual on other outcomes, such as remission, ...relapse prevention... , hospitalization,... treatment engagement ... and recovery” (the extracted quote has excluded NNT – number needed to treat – data) ...¹⁰⁵. Hence, early intervention was therapeutic for young people with early psychosis.

However, there is no evidence that the benefits of early intervention continue for a substantial period of time after the intervention stops. The gold standard long-term study of early intervention in psychosis is the 10-year follow-up of the Danish OPUS specialised early intervention treatment for first-episode schizophrenia spectrum disorder, which included 347 individuals¹⁰⁶. They reported both the early intervention services and usual treatment groups had improved long-term outcomes with decreased symptoms (of psychosis, disorganisation, negative symptoms) and better functioning (as measured by the General Assessment of Functioning: GAF). The initial advantage for the early intervention services group did not endure in the long-term after the two-year early intervention program ceased, and young people who received usual treatment had similar outcomes in the long-term at 5 and 10 years. As the authors concluded, “Most of the positive effects of the OPUS treatment had diminished or vanished at this long term follow-up”.¹⁰⁷

104 Correll, C., B. Galling, A. Pawar, A. Krivko, C. Bonetto, M. Ruggeri, T. Craig, M. Nordentoft, V. Srihari, S. Guloksuz, C. Hui, E. Chen, M. Valencia, F. Juarez, D. Robinson, N. Schooler, M. Brunette, K. Mueser, R. Rosenheck, P. Marcy, J. Addington, S. Estroff, J. Robinson, D. Penn, J. Severe & J. Kane. ‘Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis: A Systematic Review, Meta-analysis, and Meta-regression’, *JAMA Psychiatry*, 75, 6 (2018), 555.

105 *Ibid.* This quote excludes number needed to treat (NNT) data as they are too technical for the purpose of this submission.

106 Secher, R. G., C. R. Hjorthoj, S. F. Austin, A. Thorup, P. Jeppesen, O. Mors, and M. Nordentoft. “Ten-Year Follow-up of the Opus Specialized Early Intervention Trial for Patients with a First Episode of Psychosis.” [In Eng]. *Schizophr Bull* 41, no. 3 (May 2015): 617-26.

107 *Ibid.* p. 1.

Conclusion and service planning implications

Well-funded early intervention services are therapeutic during the period in which they are being provided, as a consequence of their ability to deliver high-quality mental healthcare for young people, which highlights the benefits of good-quality care at any point of the illness trajectory¹⁰⁸. Yet the benefits of enhanced care are lost once the programs cease, with no proven long-term benefits compared to treatment as usual.

Youth Mental Health services are crucial to Victoria's goal of providing interventions "early in life". However, mental health services for adults with serious mental illnesses should be provided and planned for on the basis of the prevalence and severity of these disorders, rather than on yet-to-be-realised service-need reductions due to youth mental health early-intervention programs.

Our view aligns with the Royal Commission's terms of reference: that well-funded high-quality mental healthcare (community and inpatient care) should not cease after early intervention, but needs to continue throughout life, as "Every person living with mental illness deserves high quality care and treatment, and inclusive support, when, where, and for as long as they need it".

4.4. Managing increasing mental health demand in emergency department settings

Mental health presentations are common in medical settings such as primary care and emergency departments. Australian data show that these presentations make up nearly 4% of all patients presenting to the emergency department¹⁰⁹. This number is likely an underestimate given the complexity of the initial distinction between organic and psychiatric behavioural disturbance, as well as the difficulty in determining intent of self-inflicted injuries and overdoses. Other studies have estimated that 40% of adults who present to the emergency department with physical complaints have undiagnosed mental illness¹¹⁰. These numbers suggest that mental health presentations are part of the "core business" of the emergency department, rather than a rare occurrence needing only specialist input. At triage, nearly 90% of these presentations are classified as either semi-urgent, urgent, or emergency requiring prompt assessment¹¹¹, similarly suggesting that these are appropriate urgent presentations to the emergency department, not just misdirected from acute psychiatry services.

There is increasing attention being paid to the impact of mental health presentations to emergency departments in the context of numerous issues including rising emergency department mental health presentations, National Emergency Access Targets (NEATs), emergency department access and inpatient bed block, increasing emergency department lengths of stay (LOS), and adverse outcomes¹¹². Lack of access to both psychiatry beds and specialised mental health assessments within the emergency department are commonly cited as causative factors¹¹³. The Australian College of Emergency Medicine (2018) held a summit to acknowledge and address a crisis in mental health service provision to individuals presenting to emergency departments, emphasising that services within emergency departments required improvements, but that no individual should remain in an emergency department for over 24 hours – instead requiring access to a better integrated mental health system with improved access to inpatient beds, emergency drug and alcohol and social support services, and community mental health services¹¹⁴.

108 Dieterich, M., Irving, C., Bergman, H., Park, B., Marshall, M. (2017). Intensive case management for severe mental illness – Review. Cochrane Database of Systematic Reviews, (1), Art. No.: CD007906.

109 Australian Institute of Health and Welfare, 'Mental health services in Australia', aihw.gov.au, 05 Dec 2018

110 Downey LV, Zun LS, Burke T. 'Undiagnosed mental illness in the emergency department'. Journal of Emergency Medicine, 43(5):876-82, Nov 2012

111 Australian Institute of Health and Welfare, 'Mental health services in Australia', aihw.gov.au, 05 Dec 2018

112 Cammell, P. "Emergency psychiatry: a product of circumstance or a growing sub-specialty field?" Australasian Psychiatry, Sept. 2016

113 Allison S, Bastiampillai T, Castle, D. "Victoria's low availability of public psychiatric beds and the impact on patients, carers and staff" Australian and New Zealand Journal of Psychiatry, 52 issue: 1, page(s): 91-92

114 ACEM, "National Mental Health Summit Communique", www.acem.org.au. Accessed 26th May 2019.

60% of emergency department mental health related presentations are currently discharged and 40% are admitted. emergency department psychiatry teams provide an essential consultancy service for this group of patients working in partnership with emergency department physicians. Due to this increasing demand, mental health resources need to be allocated for the assessment and formulation of the appropriate management plan, including the coordination of post discharge follow-up.

It is very important that care following emergency department presentation is also coordinated with primary care and community mental health services (including crisis assessment teams), given the relatively high number of crisis related presentations with accompanying suicidality. The coordination of aftercare from emergency department is a key component of a comprehensive suicide prevention strategy. Mental health presentations should have timely follow-up with a focus on at-risk groups: suicidal, post-self-harm, and personality disorder-in-crisis. Specialised follow-up services that supplement standard Crisis Assessment Teams (CATs) to ensure rapid follow up of all presentations with appropriate evidence-based care models (phone-based and single session interventions, short-term phone and face-to-face care, and effective linking to other community mental health care).

Short stay units and crisis hubs

Approximately 30–40% of admitted patients from the emergency department require short-term crisis related admissions of up to 3 days (with an average of 36 hours). This group of patients would benefit from a specific short-stay unit or crisis hub model. This would be a separate ward from the emergency department but ideally in close proximity, with access to courtyard space.

Throughout Australia, a variety of short stay unit models and consultation liaison models of mental health service provision have been trialled to improve access to mental health care within emergency departments. There is a growing trend of these units being commissioned throughout Australia due to the rising number of crisis related presentations.

A comprehensive model is one that offers a collaborative approach between emergency and psychiatry clinicians, includes access to drug and alcohol services, social workers and care-coordinators, and encourages cross discipline education. Studies looking at the impact of a mental health team based in the emergency department have shown significant positive outcomes¹¹⁵. At the Royal Melbourne Hospital, for example, there is a dedicated Emergency Mental Health (EMH) Team which is based in the Behavioural Assessment Unit (BAU) within the emergency department. The model consists of a flexible mental health multidisciplinary team, available for referrals from the emergency department medical staff. They work across the general emergency department, the Behavioural Assessment Unit, and the general Short Stay Unit. They can perform acute assessments along with the emergency doctor if urgent, assess patients independently, or can provide a consultation service to suggest resources, treatment pathways, or nursing requirements if patients with psychiatric problems are to be admitted to the general hospital. Concurrent assessment of acutely behaviourally disturbed patients in the emergency department allows efficient and effective sedation in a safe environment with access to resuscitation equipment and expertise¹¹⁶.

The future plans for Mental Health and Alcohol and Other Drug (AOD) "Crisis Hubs" in Victoria will extend these models with increased emergency mental health staffing, short stay unit psychiatry beds, and increased dedicated spaces for patients, families, and specialised assessment areas. In 2018 the Victorian Government announced \$100 million of funding for six such "hubs" across Victoria (Royal Melbourne Hospital, Monash, Barwon, St Vincent's, Frankston, and Sunshine). These initiatives are to be welcomed as an appropriate response to rising emergency department demand due to crisis related presentations in Victoria. We would support the expansion of these models to all major hospital emergency departments following a thorough evaluation of their effectiveness. Short stay psychiatry

115 Skopek MA, Francis JL. 'Presentations by ambulance under the NSW Mental Health Act to an emergency department with a 24-hour mental health team'. *Australasian Psychiatry*, 24(5):445–8, Oct 2016

116 Taylor D, Yap, C, Knott J, Taylor S, Phillips G, Karro J et al, "Intravenous midazolam – droperidol (combination), droperidol (only) or olanzapine (only) for the acutely agitated patient: a multi-centred, randomised, double-blind, triple-dummy clinical trial." *Ann Emerg Med*, Oct 2016

units with access to courtyards should be established within all major Victorian emergency departments to manage crisis presentations (average length of stay 1.5 days and maximum stay under 72 hours), governed by mental health services. It is likely that the bed requirements will vary between 4–8 beds depending on emergency department demand requirements for that hospital site.

Recommendation 6: State-of-the-art modern facilities, including special purpose short-stay psychiatry units, should be set up within hospitals, and mental health staffing levels within emergency departments should be increased, in order to address the increasing number of Victorians with serious mental illnesses and with drug and alcohol use disorders who present to emergency departments in crisis.

Recommendation 7: Governance and collaboration between emergency departments and mental health services should be improved, and post-Emergency-Department care of people presenting with mental illness should be standardised.

4.5. Drug and Alcohol Services

Drug and alcohol services run in parallel to mental health services – to the detriment of both. Coexisting mental health and substance use disorders are very common but the primary responsibility for the provision of care is often unclear and also contested, leading to suboptimal outcomes, including symptom exacerbation, multiple relapses, poor long-term outcomes, disinhibited behaviour, and interactions with the criminal justice system.

The integration of mental health and drug and alcohol services should take place at every level of service delivery. This includes integrating Drug and Alcohol Services into the Mental Health Branch, appointing a Chief Addiction Specialist within Safer Care Victoria who would work closely with the Chief Mental Health Officer (please see governance section) who would also work within that Authority, and enhancing provision of drug and alcohol services within community, inpatient community, and inpatient mental health facilities. Strong bridges should be formed between drug and alcohol Services and mental health provision for people with comorbid disorders via the Mental Health Integrated Services Hubs (see Chapter 6).

Across the country there has been increasing concern over substance fuelled violence, particularly the impact on ambulance and emergency department workers, with numerous reports of serious assaults. While the proportion of people who use amphetamines has remained relatively stable, the way in which amphetamines are used has changed. The number of regular users (weekly or more) has increased, with increasing numbers favouring the most potent crystalline preparations¹¹⁷. Both these trends are associated with increased hospitalisations and higher mortality rates¹¹⁸. Of behaviourally disturbed patients presenting to the emergency department, those who test positive for amphetamines have longer lengths of stay but are less likely to be admitted to psychiatric inpatient units¹¹⁹.

Following the model in European hospitals, specially designed Clinical Toxicology Units should be established within major teaching hospitals to care for people presenting with various acute intoxications, intentional and unintentional overdoses, and poisonings. These units would be staffed by specialist physicians, liaison psychiatrists, and drug and alcohol specialists working in collaboration. They would also have secure sections with the capacity to look after acutely behaviourally disturbed patients.

117 Roche A, McEntee A, Fischer J, Kostadinov V. 'Methamphetamine use in Australia', NCETA, nceta.flinders.edu.au

118 Australian Institute of Health and Welfare. 'Mental health services in Australia', aihw.gov.au, 05 Dec 2018

119 Shultz B, Lu B, Onoye J, Toohey T. 'High Resources Utilization of Psychiatric Emergency Services by Methamphetamine Users' Hawaii J Med Public Health, 77(12):312-314, Dec 2018

Many patients who have been admitted to these units would be able to be discharged following stabilisation, but those whose conditions are causing ongoing acute mental health issues will be admitted to psychiatric inpatient wards. One of the clear advantages of the Clinical Toxicology Units would be that patients admitted to such wards – following stabilisation in the Clinical Toxicology Units – would pose a significantly reduced risk to themselves, to other patients, and to staff. In a broader sense the level of stress within psychiatric wards would diminish substantially, which would help address the existing serious occupational and health and safety concerns that arise in relation to patients with serious mental illnesses who are admitted in an intoxicated state.

These units offer an ideal multidisciplinary training environment. They also reduce the stigma associated with suicide attempts or unintentional overdoses since they offer treatment in an acute medical environment rather than a stand-alone drug and alcohol or psychiatric facility. They offer social work support from day one, and importantly, they also keep other patients safe since acutely intoxicated patients can be managed in a secure ward environment.

Recommendation 8: Drug and alcohol services should be integrated at every level of mental health services delivery, and specialised Clinical Toxicology Units should be established in major teaching hospitals.

4.6. Forensic Mental Health

There is a very serious shortage of inpatient forensic mental health facilities in our State – leading on many occasions to mentally ill offenders spending prolonged periods in prison before admission to the Thomas Embling Hospital. The current bed estate is in a 20-year-old hospital which has no high-dependency areas in acute male or female units. The current building is not in line with contemporary standards, and results in increased seclusion rates. Contemporary forensic service planning provides for beds across all levels of security, the majority being in medium secure settings; and enables timely transition to less expensive but appropriately secure settings, which in turn increase opportunity for graded community access which is safe and founded on effective risk assessment and management. There is a current urgent need for increasing forensic beds across all these levels to deal with the current and projected forensic bed shortages.

Elements of the forensic mental health system in Victoria are commissioned by the Department of Health and Human Services and the Department of Justice and Community Safety. Almost all forensic mental health services are delivered by Forensicare, a state-wide public mental health service.¹²⁰ Forensicare includes the following service components: the Thomas Embling Hospital, a 128-bed secure hospital with high-, medium-, and low-secure beds; prison bed-based and outpatient services; and a community forensic mental health service with several specialised programs.

Forensic mental health systems can be parallel to the civil mental health system or integrated.¹²¹ In an integrated system, patients detained under civil mental health laws can be transferred to forensic settings if they exhibit severe behavioural disturbance or are considered exceptionally high risk.

Ideally, forensic mental health services would include state-wide specialised services (such as a single high-secure hospital and a community hub) and would be administered through the Department of Health and Human Services. This would ensure that people in the forensic mental health system or detained in prison could be managed in a distributed network, linked to broader community health services.¹²²

120 See s330 of the *Mental Health Act 2014*

121 See Gunn, J., & Taylor, P., (eds.) (2014). *Forensic psychiatry: clinical, legal and ethical issues*. CRC Press, pp 587–9.

122 To provide holistic health care, as set out in the National Statement of Principles of Forensic Mental Health

We propose that forensic beds be under the governance of a unified forensic mental health service, with high-secure beds located in a single state-wide facility, and medium- and low-secure beds co-located and distributed between Acute-Care Centres and Rehabilitation Centres, with consequent linkages to Mental Health Networks (see Reshaping Governance).

Prison mental health services

Offenders have high rates of mental health problems,¹²³ social problems, substance use, and medical service use.¹²⁴ In recent years, a marked proportional increase in the remand population has increased levels of acuity and detrimentally impacted the capacity of prison mental health services to cope with the caseload or adapt to the specific needs of these populations.¹²⁵

Prison mental health services provide brief interventions for many patients, before they return to area mental health services on bail or after a short sentence of imprisonment. For a small but significant population with severe treatment-resistant illness who cycle between prison and repeated, brief, acute hospitalisation, the issue is of reduced community access to long-term involuntary inpatient mental health settings such as the proposed Rehabilitation Centres.

Forensic hospital

Hospital beds remain an integral part of forensic service systems. Detention in secure hospitals is necessary to provide for long-term treatment of people who have generally committed severe acts of violence. After stabilisation of mental state, processes of graded community leave enable their safe return to the community, which in Victoria takes almost ten years on average.¹²⁶ The prevalence of reoffending among forensic patients is markedly reduced compared to that of prisoners.¹²⁷ Effective forensic mental health services render communities safer.

In Victoria, forensic beds were developed by a scoping process in the 1990s which predicted and modelled the future rise in prison beds. This process was flawed and has proven to have been grossly inadequate. The prison population has almost doubled in the last ten years.¹²⁸ Up to 12 custodial supervision orders are made every year.¹²⁹ Yet there has been a profound lack of service planning since: no planning for future need has provided anything but incremental bed increases.¹³⁰

This widening gap in capacity to meet service needs, and failure of service planning, has been identified in a range of reports (such as the 'Duckett Report'¹³¹, and the 2019 VAGO report¹³²), and has been apparent in recurrent notifications by Forensicare to the Government that bed numbers were insufficient to meet the needs of offenders in prisons or those on forensic orders. Other reports commissioned by the state government have not been released publicly but it is understood that they have all identified grave shortfalls in forensic planning and hospital bed provision.

The waiting list of prisoners certified in prison but unable to be treated until transferred to the Thomas Embling Hospital has at times approached 30 people, and the waiting time has been up to 4 months. These certified prisoners are frequently detained in solitary confinement, unmedicated, psychotic.

123 Offenders have higher rates of mental health service use in the community and tend to use acute services rather than outpatient services (Schilders, M. & Ogloff, J.R.P. (2018) 'Offender mental health' (in press).

124 <https://www.aihw.gov.au/reports-data/population-groups/prisoners/overview>

125 For instance, a snapshot analysis of psychiatrically unwell prisoners at the Melbourne Assessment Prison in late 2015 noted that 54% had had more than five previous inpatient admissions to area mental health services (unpublished data, Forensicare). Contributors to increasing numbers of mentally ill prisoners likely reflect 'tough on crime' initiatives, increases in substance use, reduced access to continuity of care in area mental health services, and reduced access to affordable sustained accommodation.

126 Ruffles, J. (2016). *Review of the Operation of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*. Melbourne, Victoria: Forensicare and Centre for Forensic Behavioural Science, Swinburne University of Technology.

127 *Ibid.*

128 https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2019/04/5f/e048698dc/infocv_prisoner_profile2018.pdf

129 Ruffles, above n X

130 Consequently, the proportion of forensic patients has increased from 45% in 2010 to 76% in 2019; and there are only 23 gazetted beds currently available to the entire prison estate in Victoria.

131 Targeting zero, the review of hospital safety and quality assurance in Victoria

132 Access to Mental Health Services

and posing significant risk to themselves and others. As duration of untreated psychosis (DUP) correlates with treatment resistance and is associated with poor prognosis for future responsiveness to treatment,¹³³ this situation is markedly problematic for prisoners, who cannot access compulsory mental health treatment except at the Thomas Embling Hospital.

Patients found liable to supervision may languish in prison for more than a year, despite having been found not guilty due to mental impairment or unfit to be tried.

Necessary beds

There are no clear benchmarks for the number of forensic beds per head of population.¹³⁴ Professor Bill Kingswell in Queensland estimates that the clinical need among mentally ill offenders is at least 8 high- and medium-secure beds per 100,000 head of population.¹³⁵ Comparative figures developed by the National Mental Health Service Planning Framework in 2018 note that Victoria is under-provisioned when compared to national and international data.

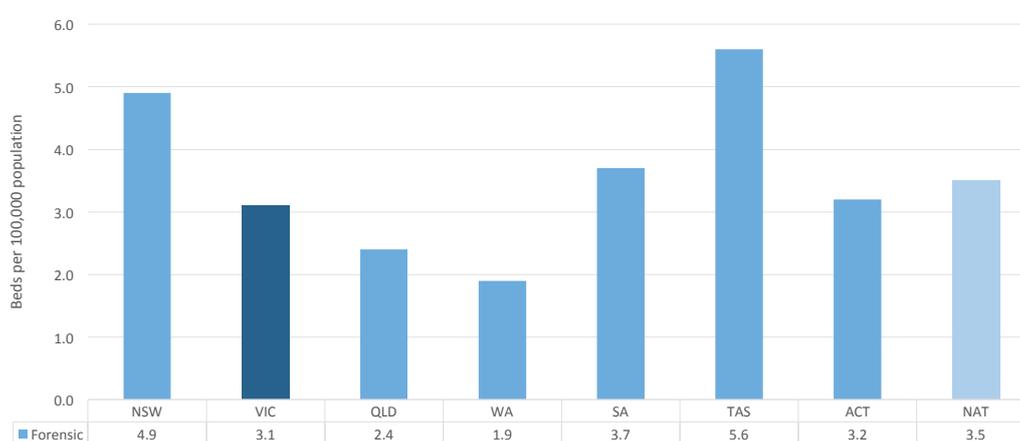


Figure 40. AIHW Specialised Mental Health Care Facilities, Public sector specialised mental health hospital beds per 100,000 population – Forensic, 2016–17.

Table 2. International comparison of forensic bed numbers

International	NZ	BC (Canada)	Quebec (Canada)	Scotland	Ireland*
Population (M)	4.7	1.71	8.46	5.2	4.7
N beds	238	190	292	534	94 (170)
Rate/100K	5.06	3.96	3.45	10.27	2 (3.62)

* soon to open a new forensic hospital with increased capacity.

133 Barnes, T. R., Leeson, V. C., Mutsatsa, S. H., Watt, H. C., Hutton, S. B., & Joyce, E. M. (2008). Duration of untreated psychosis and social function: 1-year follow-up study of first-episode schizophrenia. *The British journal of psychiatry: the journal of mental science*, 193(3), 203–209. doi:10.1192/bjp.bp.108.049718

134 See for example: <https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf>

135 Kingswell, unpublished data, National Mental Health Service Planning Framework, 2018

Specific recommendations

Contemporary forensic service planning provides for beds across all levels of security – the majority in medium-secure settings – and enables timely transitions to less expensive but appropriately secure settings, which in turn increase opportunity for graded community access which is safe and founded on effective risk assessment and management. There is a current urgent need for forensic beds which will only worsen over coming years. What is needed is a long-term vision which includes the redevelopment of the existing facility, and planning and funding of new facilities, including medium- and low-secure services. Ideally, forensic medium- and low-secure beds would be co-located with Acute-Care and Rehabilitation Centres (described later).

On top of the demonstrated unmet service needs across all levels of security, there is a marked need for forensic training; development; sector-wide education; and workforce development, recruitment, and retention. Forensic mental health is a highly specialised area which is more than the provision of mental health services to offenders – it also involves offence-specific interventions, specialised services for comorbidities (including personality disorder and substance abuse), and comprehensive risk assessment and management. The current service has limited capacity to meet these needs for the state of Victoria and requires expanded learning and professional development to meet future service needs. Strong links to research and evaluation will be critical to meet the statutory requirements of the Victorian Institute of Forensic Mental Health.

Prevention of reoffending and opportunities for early intervention will be boosted by state-wide electronic medical records and facilities for specialised research (Recommendations 15 and 17).

Finally, it is imperative that beds are developed in hospital settings. An ongoing government focus on developing prison-bed-based mental health services has occurred at the expense of hospital expansion, diverting staff and resources. Forensic mental health must be provided in hospital settings which enable an equivalent level of care to that offered for community patients with mental illness, and which is in accord with international human rights instruments.¹³⁶

Recommendation 9: Forensic community and outpatient-clinic capacity should be increased, with six adult forensic beds per 100,000 people which should be distributed across: existing hospital sites, and the new Mental Health Acute-Care Centres (for acute forensic patients) and Mental Health Rehabilitation Centres (for longer term forensic rehabilitation patients).

Recommendation 10: In line with planned service expansion, community and prison services should be scalably developed, along with sector-wide forensic workforce development including training, recruitment, and retention strategies.

136 Exworthy, T., Wilson, S., & Forrester, A. (2011). Beyond equivalence: prisoners' right to health. *The Psychiatrist*, 35(6), 201–202.

5.

Specialist Mental Health Centres

5.1. The case for Specialist Mental Health Centres – with comparison to other specialist hospitals in Victoria

In parallel with the above crucial improvements to the *existing* mental health infrastructure, a longer-term strategic approach to mental health care should incorporate specialised, state-of-the-art, mental health infrastructure – just as in other areas of health. We recommend establishing new university-affiliated Specialist Mental Health Centres. These should be modelled on the outstanding international examples of university-affiliated psychiatric centres/hospitals – such as the Maudsley Hospital, and the Institute of Psychiatry, Psychology, and Neuroscience (IoPPN) – that combine the missions of clinical care, education, and research.

The Maudsley Hospital has a close clinical and academic partnership with King's College London through its Institute of Psychiatry, Psychology and Neuroscience (IoPPN). The Institute is Europe's largest centre for research and post-graduate education in psychiatry, psychology, and basic and clinical neuroscience – producing more highly cited publications in psychiatry and mental health (Scopus, 2016) than any university in the world. In the 2014 Research Excellence Framework they were judged to have the second highest research power in the UK for Psychology, Psychiatry and Neuroscience; the impact of their work was 100% world leading or internationally excellent; and its research environment judged as 100% world leading.¹³⁷

South London, Maudsley, and the IoPPN have a joint Research and Development Office, which is committed to ensuring that all research being undertaken is of high scientific quality and of a high ethical standard.

Together with the Institute, King's College London hosts the NIHR Maudsley Biomedical Research Centre, which is researching new tests, treatments, and theories in mental health, neurology, and dementia. Its aim is to accelerate the translation of the latest scientific discoveries into first-in-human clinical trials and other well-designed studies. The findings from these studies can then be developed and implemented to produce new tests and treatments for people with mental and neurological disorders. Their research priorities are focused around novel treatments, precision medicine, translational informatics, and mental-physical health.

¹³⁷ <https://www.slam.nhs.uk/research>

Victoria has a proud history of establishing public sector specialist hospitals with both ambulatory and inpatient foci. A repeated theme throughout this submission is that mental health is a part of health. The Victorian government spends at least \$2 billion annually¹³⁸ on hospitals that provide specialist health care in relation to cancer, women's health, children's health, palliative care, and otolaryngology. And from 2022 will be providing specialised cardiac health care at the Victorian Heart Hospital. There are at least 1,400 beds in these hospitals in which there are inpatient stays and Weighted Inlier Equivalent Separations (WIESs) in excess of 180,000 per annum. There are also at least 600,000 outpatient visits each year to these specialist hospitals.

Specialist public hospitals in Victoria

Data primarily obtained from 2017–18 Annual Reports



The Royal Women's Hospital

Annual expenditure: \$267m
Inpatient beds: ~200
Inpatient activity: 32,113
Outpatient visits: 77,559



Mercy Hospital for Women

Annual expenditure*
Inpatient beds: 314
Inpatient activity: 23,063
Specialist clinics: 47,473



Joan Kirner Women's and Children's Hospital

Opened May 2019
\$200 million facility
Inpatient beds: 237



Monash Children's Hospital

Annual expenditure: \$120m
Inpatient beds: 180
Inpatient stays: 13,162
Outpatient visits: 47,355



The Royal Children's Hospital

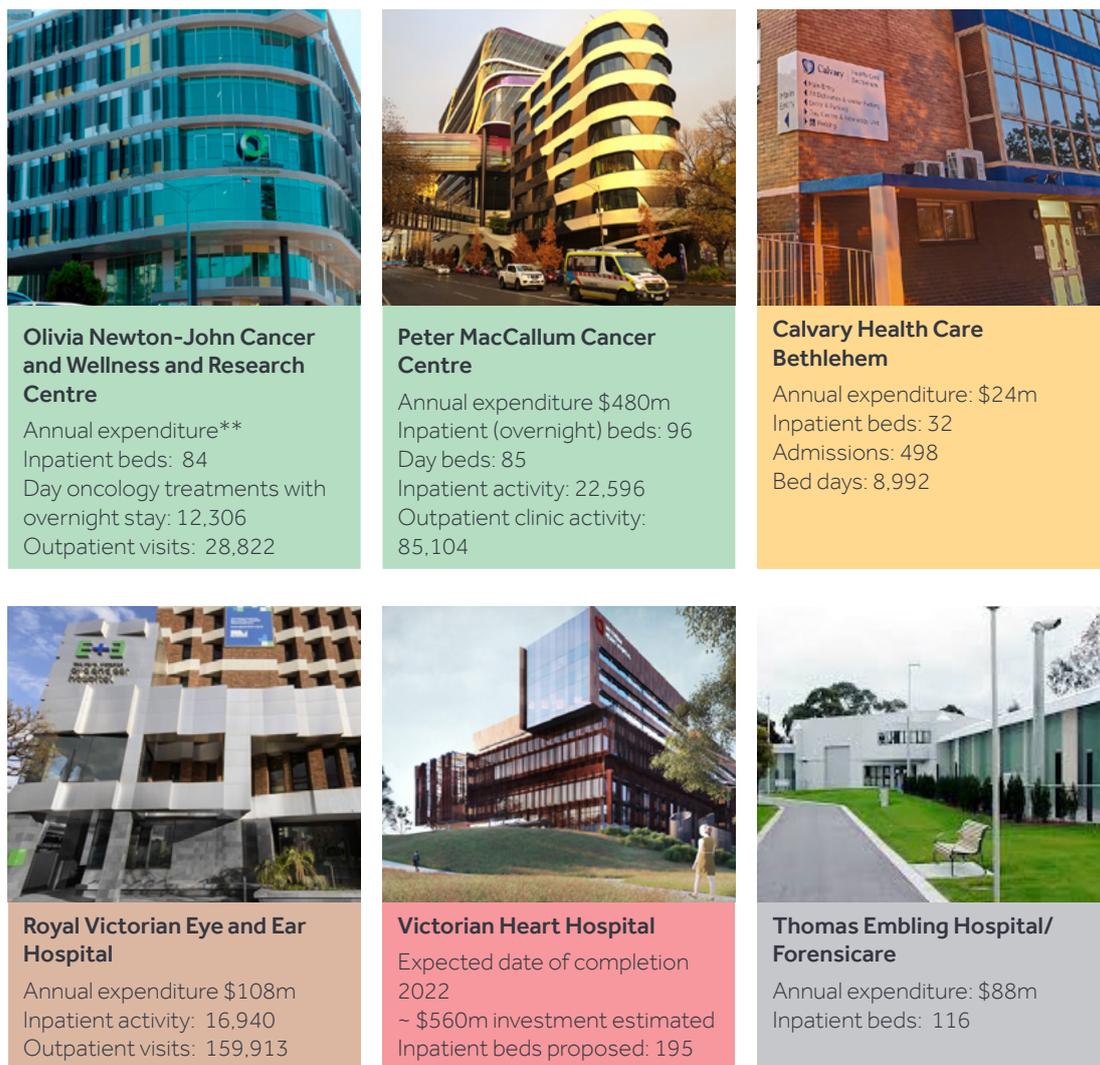
Annual expenditure: \$668m
Inpatient beds: ~250
Inpatient activity: 58,368
Specialist clinics: 143,886

- Women's and babies' hospitals
- Women's and children's hospitals
- Children's hospitals

Inpatient activity is measured as Weighted Inlier Equivalent Separation (WIES) – as defined by Victoria's Department of Health and Human Services.

* The expenditure of the Mercy Hospital for Women is integrated within the total expenditure of Mercy Hospitals Victoria Ltd.

138 Forensic psychiatry is excluded from these non-mental health tallies in this paragraph, with Thomas Embling being provided in the photochart of public specialist hospitals for the sake of completeness.



- Cancer hospitals
- Palliative care hospital
- Eye, ear, nose and throat hospital
- Cardiac hospital
- Forensic psychiatry hospital

** Expenditure of the Olivia Newton-John Cancer and Wellness Centre is integrated within the total expenditure of Austin Health.

Figure 41. Specialist public hospitals in Victoria.

Yet there are no hospitals to which non-forensic adult patients (aged 25–64) suffering from a mental illness can go to get specialist, world-class treatment – as is available in other areas of health.

General hospitals are crucial to the mental health system as a whole, but specialist care is equally important for dealing with the complex and interrelated challenges of psychiatric care.

Regrettably, those who oppose specialised care centres often evoke the outdated notion of asylum – an isolated, cold, and corrupt relic of the past with no data capture, no integration with the research community, and seemingly no likelihood of discharge. But the modern reality is divorced from these examples, with high-quality, university-affiliated, recuperative facilities that prioritise patient welfare, safety, health, and wellbeing.

Advanced training within the Centres would build capacity and capability of the next generation of clinician-researchers – creating a robust network of professionals to support the long-term mental

health of Australians. The excellence of these centres would attract the best and brightest practitioners internationally, further contributing to improved health, growth, and productivity through clinical practice, research, and training.

Momentum has begun with the Professor Marie Bashir Centre (73 inpatient beds) at the Royal Prince Alfred Hospital. This centre is associated with the University of Sydney and the Brain and Mind Centre, and hosts services including an assessment unit, acute mental health unit, and short-stay and inpatient programs, integrated with leading researchers. Please watch the following video for more about the Centre: <https://www.youtube.com/watch?v=iOaKAKjySaE>

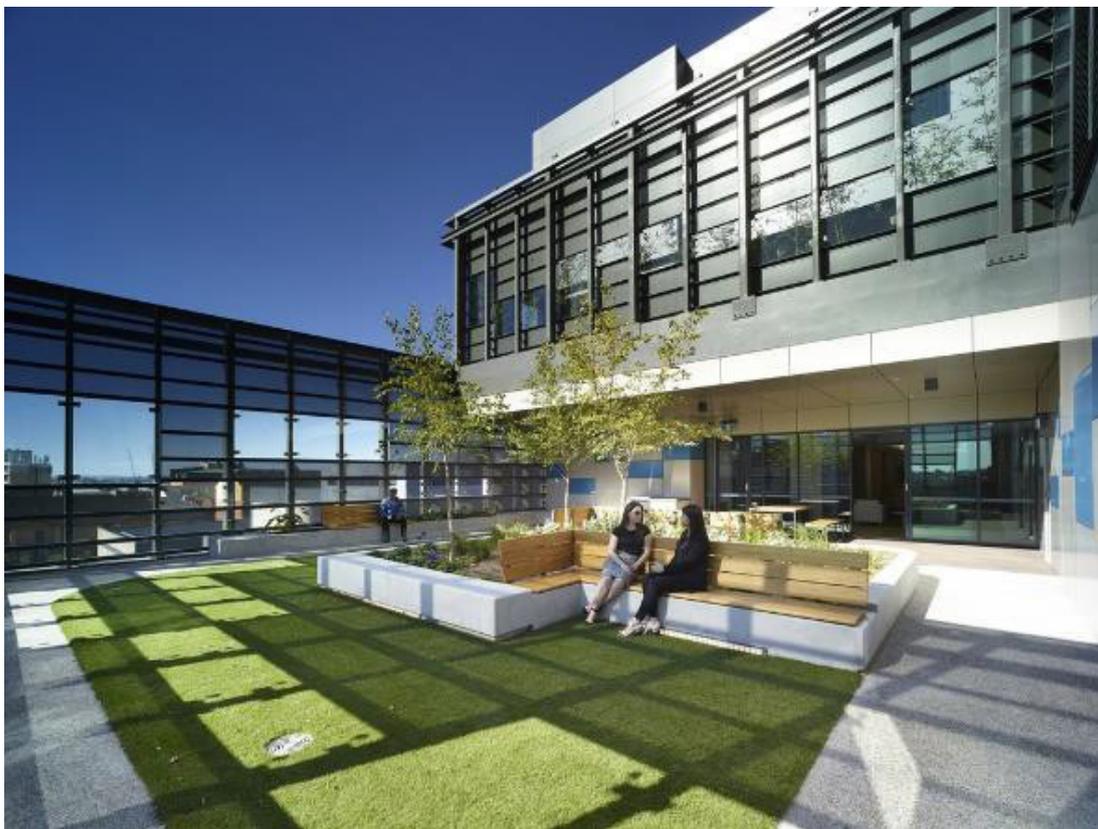


Figure 42. The Professor Marie Bashir Centre, Sydney.

Specialist Mental Health Centres and general hospitals should have very close collaborations, informed by existing Victorian examples of collaboration-enhancing infrastructure and services linking specialist and general hospitals. Two examples are the Parkville electronic medical record, which involves a multi-hospital collaboration between the Royal Melbourne Hospital, the Royal Women's Hospital, and the Peter MacCallum Cancer Centre¹³⁹ and is currently being implemented; and the Victorian Comprehensive Cancer Centre (VCCC) tumour streams – e.g. the Breast Tumour Stream¹⁴⁰ – which are shared and integrated across the Royal Melbourne Hospital, Royal Women's Hospital, and the Peter MacCallum Cancer Centre.

Integration would be further enhanced by transparent, data-driven, clinical governance measures, quality assurance through frequent external review, and regulation in legislation would be essential across these Centres – as is expected for the entire healthcare system. This should be underpinned by clinical quality registries, analysing data from hospitals, patients and population-wide datasets to ensure best practice and continuous improvement.

139 <https://www.thermh.org.au/news/electronic-patient-records-connect-care-parkville>

140 <https://www.thewomens.org.au/health-professionals/oncology/breast-service>

The Centres should be governed by a Board of Directors with oversight of the Centre management teams and with direct line responsibility for performance of services to the state government. We are unaware of anything similar in a non-forensic mental health setting. The model has many strengths, including a dedicated independent board to act exclusively on behalf of the population that it serves as in the case of the Royal Women's Hospital and the Peter MacCallum Cancer Centre.

To further ensure transparency and enhance quality of care, the Centres should be closely linked to general hospitals and universities, and to federal and state health departments, mental health complaints commissions, mental health tribunals, and other regulatory and advocacy bodies.

Social supports, including individual placement and support (IPS) and other community care should be embedded within the centres, so that clinical and functional outcomes are addressed in tandem with close links to community mental health centres and other supports.

The Centres should be closely connected to one another and to other research institutions, creating a powerful network for thought leadership and to attract international investment and talent. These and other connections would facilitate a continuum of care for people with serious mental illnesses so that they do not continue to fall through the current cracks in the healthcare system to incarceration, homelessness, or suicide.

These Centres would generate crucial health, social, and economic benefits:

- Health benefits for individuals – via the care of the Centres themselves, and translation to individuals nationally and internationally, with research outcomes of the Centre generating best practice care standards and novel treatments
- Increased efficiency through targeted, precision patient care – underpinned by registry data, which could include real-time monitoring for adverse outcomes so that swift intervention is possible to restore health
- Increased participation and employment for people with serious mental illness – given the focus of the Centres on both symptomatic and functional recovery and embedded placement services within the Centres to help people get back to work
- Reduced burden for carers – a significant and often overwhelming burden of care for people with serious mental illnesses fall to their families and other carers. Appropriate specialised care centres for people with serious mental illness would reduce this burden, allowing families to participate in the community in other ways, such as employment
- Increased capacity of the healthcare workforce – through training of the next generation of highly skilled staff across psychiatry, psychology, mental health nursing, allied health, social work, and employment services.
- Research and R&D investment from schemes including the Medical Research Future Fund (MRFF) and the National Health and Medical Research Council (NHMRC), as well as philanthropy and commercial sources – driving discovery research that will underpin future innovations in mental health care.
- Commercialisation returns from intellectual property licencing, spin-out, or other commercial outcomes based on research outcomes.

Recommendation 11: Three to six specialist university-affiliated Mental Health Acute-Care Centres should be established over the next 15 years, aiming for the first two within five years.

Recommendation 12: Three to six specialist university-affiliated Mental Health Rehabilitation Centres should be established over the next 15 years, aiming for the first three within five years.

5.2. Mental Health Acute-Care Centres

Each Acute-Care Centre should be medium sized (80–100 beds), and support the following, with all functions on one site to allow for integration, innovation, and collaboration between executives, researchers, and clinicians: emergency department, acute inpatient units, outpatient clinics, and research, data science, and clinical trial infrastructure.

These new centres should be affiliated with universities: they will be research-intensive, allowing opportunities for close interactions between academics and clinicians within the same precinct. They should be modelled on the research integration of the Peter McCallum Cancer Centre and the Hudson Institute of Medical Research/Monash Health. Academic appointments and research laboratories would enable transformative neuroscience, pharmacology, psychological science, and other research, aiding discovery of new knowledge and interventions, in order to improve the quality of lives of people with serious mental illnesses.

5.3. Mental Health Rehabilitation Centres

The Rehabilitation Centres should be a similar medium size to the Acute-Care Centres (approximately 80–100 beds). Their foci would be established within a framework of a strengths-based approach and would involve the enhancement of daily living and self-management skills. Key components of the care model would enable transition to independent living, the optimisation of psychological and pharmacological treatments, and the assessment and management of comorbid physical disorders.

One of the significant advantages of these centres is that they would facilitate much-needed research on treatment-resistant psychiatric conditions, and on optimal psychosocial practices in rehabilitation psychiatry.

Working in a complementary and interactive mode with the mental health rehabilitation centres, serious mental illness accommodation and rehabilitation needs-assessment teams should be established to assess the accommodation and rehabilitation requirements (supported accommodation, 24-hour residential, or rehabilitation beds), and the extent of psychosocial support required within these facilities for patients with serious mental illnesses. This team will be modelled on the processes of the current aged care assessment teams (ACATs), which determine similar level requirements for elderly Australians requiring low-, medium-, or high-level supported accommodation, augmented by varying intensities of care provision.

6.

Integrating mental health services

“For consumers and carers, a lack of integration and agreement on care pathways and service entry thresholds creates frustration and leads to poor treatment continuity, difficulty in maintaining treatment and poorer treatment outcomes. It also leads to a loss of faith in the treatment system.” (The Fifth National Mental Health and Suicide Prevention Plan).¹⁴¹

Mental illnesses are mostly episodic or chronic conditions that vary in severity and associated disability over time, across all developmental stages of human life. Health and related services need to be able to provide continuity of service provision at all developmental stages and ages throughout life, and across the many providers of those services.

It is common for multiple health services to be required at the same time, including physical and mental health and social services. Shifts occur between services as individual needs change, and for different levels of services – primary, secondary, tertiary – to be required, alone or sometimes in combination, at various times. Integrating such services and ensuring seamless transitions between them is a complex matter with plenty of opportunities for individuals to ‘fall between the cracks’.

Integration is complicated by the fact that services are often at different geographical locations and involve different organisations (or different entities within those organisations) that are governed and/or funded separately. Other government services of high importance to mental health include housing, employment, child protection, disability support, education and training, and others. Effective mental health care requires a dynamic integration and coordination of the disparate elements of this complex system to meet individual needs over time. How can this be done?

Two ways of promoting service integration are physical co-location and information technology systems. Physical co-location entails placement of services in one geographical site (with good public transport access). This is not only convenient for service users who consequently need to travel less to disparate locations, but – with good design and strong integration-governance mechanisms – it should facilitate cross-service familiarity, communication, and collaboration.

To ensure that these approaches to integration operate as intended, a strong system of governance and management is required (see Chapter 8). The individual needs to remain at the centre of integrated service delivery, rather than being affected by any competing interests of the organisations or entities involved. Funding incentives should be developed in parallel with the governance system to facilitate and

141 The Fifth National Mental Health and Suicide Prevention Plan, p. 18 <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf>

reward those integrated systems that yield good clinical outcomes and employ best practice models of integrated care.

6.1. Mental Health Integrated Services Hubs

Recommendation 13: Mental Health Integrated Services Hubs (MHISHs) should be established, building on the model of Victoria's highly successful Integrated Cancer Services (ICSs), to promote system integration across structural boundaries and to encourage collaborative approaches to evidence-based service development. They should help to coordinate service delivery options across the spectrum of health care providers and enable clearer care pathways between adult community mental health teams, Primary Health Networks, and primary care facilities.

Mental Health Integrated Services Hubs will be demand and capacity coordination systems. They will use sophisticated software and real-time data-acquisition systems to match people's mental health needs with appropriate care providers in both private and public health systems, and with other service providers – such as housing, social welfare, and legal advice. These Hubs will track and guide vast numbers of patients coming in and out of various mental health services and other related services. At the same time, general practitioners, emergency department staff, and many others in the mental health workforce can use these Hubs themselves to determine where there is outpatient availability, where specialised services are offered, or other key information for supporting their patients.

To support the seriously mentally ill adults who are parents of young children, these Hubs would link them with relevant services including infant mental health, child and adolescent mental health services (CAMHS), and Families where a Parent has a Mental Illness (FaPMI)¹⁴².

Models

The Integrated Cancer Services (ICSs) have been key to implementing the cancer reform agenda across Victoria. They are based on regions – five regional, three metropolitan, and one whole of Victoria (paediatrics). They have a budget and are administered by a leading agency or hospital in their area. They have a clinical directions committee and an executive committee chaired by the CEO of the administrative health service. The budget is managed by one of the hospitals but the chairmanship of the executive committee changes to cover all major entities in the regions. Each ICS has a Director who runs the ICS and a Clinical Director responsible for the professional direction of the ICS.

The ICSs were given four main responsibilities to start with:

1. Introduce multidisciplinary planning for cancer patients
2. Improve coordination of care
3. Increase supportive care for cancer patients
4. Reduce variations in care

The ICSs are given data relating to cancer activity in their region and work to improve understanding of the flow of cancer patients, referral patterns, and information for patients. They have a budget total for all ICSs of approximately \$10M and can support project work in their areas of interest.

They have been very effective in opening the eyes of the major institutions as to what lies outside their doors, and the responsibilities of the institutions to provide services – such as oncology services – peripherally from the hospital, which is particularly important in rural and regional areas.

In addition to providing this kind of service integration – thereby modelling the key functions of Integrated Cancer Services – these Mental Health Integrated Services Hubs should provide lifelong

¹⁴² <https://www.easternhealth.org.au/services/item/204-families-where-a-parent-has-a-mental-illness-fapmi>

monitoring for consumers with serious mental illness, and lifelong support to navigate the numerous components of Victoria's mental health system. Given that people with chronic serious mental illnesses have ongoing (often lifelong) interactions with the mental health system, it is inefficient and confusing to treat each such interaction as a one-off, stand-alone event.

Another model which would be valuable to inform the functions of these Hubs is a project in south-eastern Pennsylvania which instituted a "Wellness Recovery Team" for people with serious mental illnesses which performed a number of roles, including: triage and planning; informing primary carers and behavioural (mental health) carers of any hospitalisations; conducting discharge planning and coordination; providing links to community support and referrals (where necessary); retaining an ongoing relationship with the primary care professionals and psychiatrists; consulting and collaborating with pharmacists; and undertaking preventative care and education.¹⁴³

Long-term care coordination models for severe mental illness – important lessons from clozapine care coordination

There are concerns about the impact of episodic models of care on patient outcomes for serious mental illness. It is accepted that patients with serious mental illness would benefit from continuity of care, but that this is becoming increasingly difficult to achieve in a context of repeated organisational changes and staffing capacity issues. Macdonald and colleagues confirmed that in South London NHS there was declining continuity of care over an 11-year period, which had an independent effect on declining clinical outcomes during this period. In this context we argue that continuity of care is an important service delivery objective for our proposed reform agenda.¹⁴⁴ For people with the most severe forms of serious mental illness – with complex needs that require support from multiple agencies, follow-up, triage, navigation, and more – our proposed Hubs should support these patients with a coordinator for life. We envisage something akin to the clozapine coordination model of care.¹⁴⁵ Clozapine treatment requires monthly blood tests to monitor for neutropaenia and this requires care coordination on an ongoing basis. Indeed patients receiving clozapine have reduced mortality and this is partially attributed to the benefits of the ongoing care coordination role. We envisage that all patients in the public mental health sector with disabling, enduring, and relapsing symptoms, would benefit from ongoing care coordination, regardless of the psychopharmacological and other treatments they might be receiving. It is also possible that such ongoing coordination models could benefit from tele-health peer support models integrated with the MyHealth record system.¹⁴⁶

Antipsychotic medications are the mainstay of treatment for schizophrenia, being particularly effective for relieving acute psychotic symptoms and relapse prevention. However, rates of non-compliance with medication are often higher than 50%, often leading to relapse and subsequent hospitalisation. Patients with schizophrenia die on average 25 years earlier than the general population. A major study published in *The Lancet* in 1999 by Tiihonen et al.¹⁴⁷ identified that long-term treatment with an antipsychotic medication in a nationwide Finland cohort, was associated with reduced mortality compared with no antipsychotic treatment for patients with schizophrenia. Of particular note, clozapine, which is the gold-standard medication for treatment resistant schizophrenia, was associated with the greatest overall reduction in mortality of 26% among all the various antipsychotic medications (olanzapine, risperidone, quetiapine, etc).

There are many reasons as to why clozapine may be associated with a significant lowering of mortality and these include its superior antipsychotic efficacy and its independent anti-suicidal effect. However, another major factor that has been identified as being of relevance is the intensive lifelong mandated

143 Medibank, The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design, p. 93. https://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

144 Alastair Macdonald, Dimitrios Adamis, Tom Craig and Robin Murray *The British Journal of Psychiatry* (2019) 214, 273 -278.

145 <https://health-services.mercyhealth.com.au/service/clozapine-general-practitioner-shared-care-program/>

146 Bidargaddi, Niranjani, Yasmin van Kasteren, Peter Musiat, and Michael Kidd. "Developing a Third-Party Analytics Application Using Australia's National Personal Health Records System: Case Study." *JMIR medical informatics* 6, no. 2 (2018): e28.

147 Tiihonen, Jari, Jouko Lönnqvist, Kristian Wahlbeck, Timo Klaukka, Leo Niskanen, Antti Tanskanen, and Jari Haukka. "11-Year Follow-up of Mortality in Patients with Schizophrenia: A Population-Based Cohort Study (Fin11 Study)." *The Lancet* 374, no. 9690 (2009): 620-27.

monthly monitoring and care coordination that is required when patients are on clozapine, to prevent the small risk of life-threatening agranulocytosis (0.1% of Victorians are currently monitored through this system).¹⁴⁸ It is accepted that this unique lifelong care coordination model has a major role beyond the acknowledged superior antipsychotic effect of clozapine. The lifelong clozapine care coordination and monthly appointments likely help in a number of ways, including general support, addressing psychosocial issues, observing for early warning signs and relapse prevention, lifestyle checks, metabolic monitoring, coordination of appropriate medical interventions, liaison with primary care and family, management of side-effects, and monitoring overall adherence.

The clozapine care coordination system is unique in psychiatry and is a gold-standard monitoring system in medicine, with major positive and enduring impacts on reducing psychotic symptoms, improving social functioning, reducing hospitalisation, reducing suicide, and significantly reducing overall mortality. These benefits are clearly due to a combination of its unique psychopharmacology and its accompanying lifelong monthly care coordination and monitoring system.

Continuity of Care Monitoring and Support System: CCMSS

We would like to propose that the clozapine care coordination system be a primary basis upon which to plan lifelong support for patients with serious mental illness (who are not on clozapine), like other antipsychotic medication and mood stabilising medication. In order to be realistic about resource availability, we suggest a significantly reduced frequency than the monthly mandated monitoring required for patients on clozapine.

Yet there are potential solutions for greater population coverage while still ensuring lifelong support for indicated patients with serious mental illness. We would suggest considering a successful GP shared-care model and/or private psychiatry shared-care model proposed by Filia et al.¹⁴⁹ for clozapine maintenance treatment for clinically stable patients at the Alfred in Victoria. This GP shared-care approach is also available at other centres.¹⁵⁰ The model outlined two alternative clozapine care pathways. The first involved transitioning case-managed patients to private psychiatry care, supported through the appointment of a clozapine coordinator by the private clinic. The alternate model involved the patient's GP who provided primary management supported by a review every six months by the adult community consultant psychiatrist. These two models were able to successfully transition significant numbers of patients on clozapine from sole management within the public system to a GP or private psychiatry shared-care model with adult community mental health teams, while retaining the benefits of structured and ongoing monthly follow-up.

A further refinement to the above protocol would be to integrate the My Health record data system as a key component of the proposed real-time mental health registry¹⁵¹ as part of the ongoing care coordination system for patients with serious mental illness. The My Health Record system importantly enables near real-time information on prescription medication refills, and primary care and specialist appointment attendance. This valuable primary care information could then be integrated within a digital telehealth support service for patients with serious mental illness accompanied by a staged and graded stepped-care protocol which could be outlined as follows:

- Alert generated from My Health Record data, recording prescription refill and appointment attendance
- Text message reminder to patient regarding medication or appointment schedule (if required)
- Peer support phone call to check on overall welfare and psychosocial issues
- Clinical care coordinator phone call to check on mental state, medication issues, and overall safety
- Coordination of adult community psychiatrist or GP appointment

148 *Ibid.*

149 Filia, Sacha, Stuart Lee, Kelly Sinclair, Alyson Wheelhouse, Sally Wilkins, Anthony de Castella, and Jayashri Kulkarni.

"Demonstrating the Effectiveness of Less Restrictive Care Pathways for the Management of Patients Treated with Clozapine." *Australasian Psychiatry* 21, no. 5 (2013): 449–55.

150 <https://health-services.mercyhealth.com.au/service/clozapine-general-practitioner-shared-care-program/>

151 Bidargaddi, Niranjana, Yasmin van Kasteren, Peter Musiat, and Michael Kidd. "Developing a Third-Party Analytics Application Using Australia's National Personal Health Records System: Case Study." *JMIR medical informatics* 6, no. 2 (2018): e28.

The above stepped care protocol, would be sequential steps with most patients responding at earlier stages of the new proposed system of care. In addition to the above we would integrate a 6–12 monthly psychiatrist assessment for this patient group. We would describe this service model as the Continuity of Care Monitoring and Support System (CCMSS).

Conclusion

Our consortium recognises the widely acknowledged value of the unique long-term support system associated with the clozapine monitoring systems, which delivers a range of benefits for patients with treatment resistant schizophrenia. We would like to replicate this successful approach for non-clozapine antipsychotic medications and mood stabilisers (lithium and valproate) for patients with very serious mental illness, who would benefit greatly from this added support. We propose a novel and multimodal solution consisting of the following; digital health using real-time My Health record data with accompanying text-messaging support; peer led tele-support service; GP shared care – prescription and monitoring; and 12 monthly consultant psychiatrist clinical review with case manager.

This proposed innovative approach (CCMSS) has the potential to radically increase our service coverage and continuity of care for Victorians with severe mental illness, using innovative approaches and technologies. Ultimately the solutions proposed have the potential to provide early intervention and prevention, to improve symptomatic and functional outcomes, to reduce avoidable hospitalisations due to non-adherence, to improve side-effect management, and to reduce overall mortality for patients with severe mental illness.

These Hubs should bring together a range of stakeholders – consumers, Mental Health Networks (MHNs – see Reshaping Governance below), Primary Health Networks (PHNs), general practitioners, psychiatrists, psychologists, mental health nurses, occupational therapists, social workers, community mental health care providers, drug and alcohol specialists, NGOs, carers, non-health State and Commonwealth agencies – in order to enhance the development and provision of evidence-based care. They should provide up-to-date data on availability of services across their Mental Health Networks, to enable a matching of demand and capacity across the public and private mental health system.

Recommendation 14: Continuity of care – without discharge from the service – should be used as a guiding principle for the small proportion of adults with the most severe forms of serious mental illness, emulating and building on the principles embedded within the current clozapine coordination system.

6.2. Clinical information systems

Serious mental illness census

It is very important for planning purposes that we fully understand the current situation for patients with serious mental illnesses in Victoria – including how many are homeless, in marginal accommodation, or in correctional settings. We recommend that a comprehensive census of serious mental illness in all locations in Victoria be conducted. This audit will be a cross-sectional census administered over a week, focused on patients with serious mental illnesses in boarding houses, hostels, the homeless population, community mental health teams, residential facilities, acute inpatient units, rehabilitation facilities, and correctional facilities. This extensive census will help to precisely refine Victorian commissioning requirements in order to understand and meet the needs of serious mental illness in a more personalised and contextualised manner. This census should be conducted every four years to monitor the progress of Victorian mental health policy initiatives. It will also be assisted by having a linked serious mental illness registry system (see next recommendation).

Real-time clinical quality registries

Linking health datasets with other national and State datasets is an essential tool for determining factors that contribute to and precipitate mental disorders and outcomes from interventions. Registries are valuable sources of information in many medical fields including cancer, transplantation medicine, intensive care units, and more.

Clinical quality registries are enablers of translational research – they assist in discovery, clinical trial support, health service research and evaluation, monitoring of policy outcomes, operational insights, and personalised medicine. We anticipate that these serious mental illness registries will also enable real-time data linkage between Medicare; community mental health; and hospital, forensic, disability, and social services.

Clinical quality registries are recognised as essential to delivering evidence-based care that is effective, efficient, and innovative. They systematically monitor the quality (appropriateness and effectiveness) of health care by routinely collecting, analysing, and reporting health-related information.¹⁵²

Although clinical administration datasets have been collected over many years, the most important being the Australian Mental Health Outcomes and Classification Network (AMHOCN), these datasets are largely stand-alone and not longitudinal – unlike clinical quality registries.

The data sources incorporated into clinical quality care registries are diverse – such as patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs); clinical scales; and Medicare, emergency department, and hospital data. These provide a basis for identifying benchmarks and areas for improvement in clinical outcomes, including survivorship, health, quality of life, and functional outcomes such as employment.

Data can then be fed back to clinicians to inform clinical practice and decision-making, and also to patients in order to inform behaviours, and to improve health literacy and decision-making capacity. Improvements underpinned by clinical quality registries include health practice via feedback and discovery research, as well as policy and regulation. This feedback loop (Figure 43) is the defining feature of clinical quality registries and leads to significant benefits and reduced costs.

Clinical registries support evidence-based decision-making to improve effectiveness and efficiency of the healthcare system. When Sweden reduced their psychiatric beds to under the OECD average, they were able to evaluate outcomes based on nation-wide patient registries – such as their National Quality Registry for Psychosis Care (PsykosR) – in order to identify that the reduction in beds was likely responsible for a higher mortality rate among patients being treated for serious mental illness.¹⁵³

152 ACSQHC, National arrangements for clinical quality registries <https://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/>

153 Allison, Molecular Psychiatry (2018)

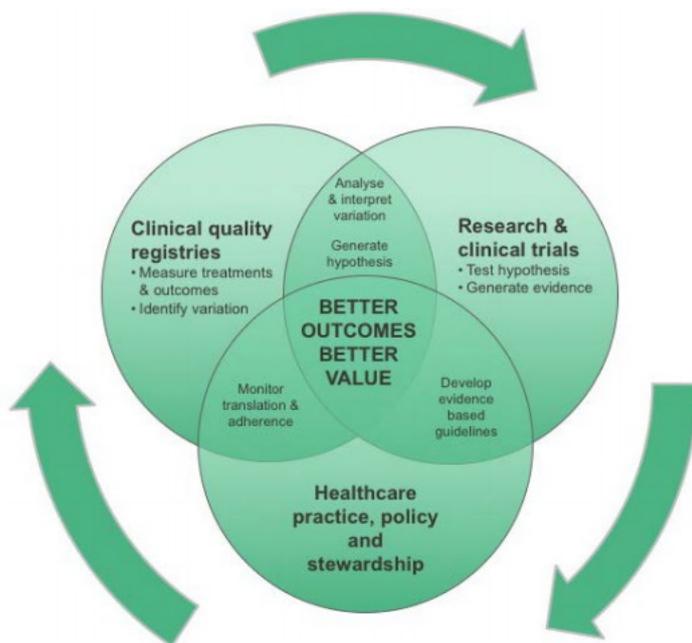


Figure 43. A self-improving synergistic health-care system.¹⁵⁴

Other international examples include the US disease-based schizophrenia registry 'Management of Schizophrenia in Clinical Practice', and similar schizophrenia registries in other countries/regions including Malaysia, Latin America, the Netherlands, and Denmark.

Australia should similarly be able to draw upon robust data sources supporting the broader clinical system, as per Figure 44, in order to determine the impact of treatments for serious mental illnesses, including schizophrenia, on long-term clinical, functional, and adverse outcomes and to determine which programs to support over others based on robust evidence derived from a mental health registry.

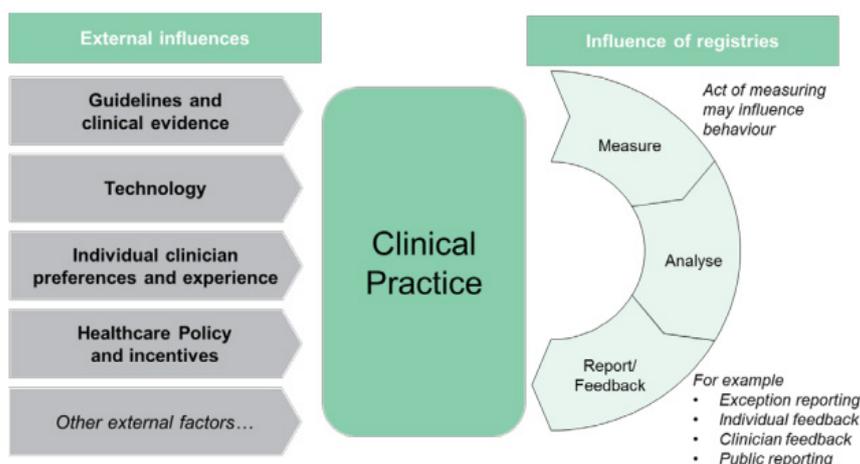


Figure 44. The position of registries within the broader clinical system.¹⁵⁵

The lack of clinical quality registries for serious mental illness in Australia represents a major gap in good quality care. This fact has been recognised by the 2016 Australian Commission on Safety and Quality in Healthcare¹⁵⁶ – to which we strongly lend our support.

154 ACSQHC. Economic evaluation of clinical quality registries: Final report. Sydney: ACSQHC; 2016

155 ACSQHC. Economic evaluation of clinical quality registries.

156 ACSQHC. Prioritised list of clinical domains for clinical quality registry development

A 2016 economic evaluation of clinical quality registries conducted by Monash University and Health Outcomes Australia on behalf of the Australian Commission on Safety and Quality in Health Care demonstrates a strong economic case for establishment of registries. The assessment of five well established clinical registries (prostate cancer, trauma, intensive care, dialysis and transplantation, joint replacement) showed a minimum expected return on investment of 4:1 if full national coverage was achieved.¹⁵⁷

Contributing to the cost-effectiveness of registries is the fact that the benefits they realise include reduced clinical variation with best practice being shared and implemented across the nation; precision medicine approaches; development and testing of novel, more effective treatments; and evaluations of the efficacy and cost-effectiveness of services. The healthcare savings alone for evidence-based care has the potential to be enormous.

The creation of a registry for schizophrenia, for example, would be a significant step in addressing a mental health issue of major economic costs – representing 40% (\$0.59 billion) of the \$1.6 billion in hospital expenditure on mental health, and would have the capacity to impact beyond this by lowering incarceration rates, and decreasing homelessness, suicide, and the burden on individuals and carers.

High-quality information infrastructure

Developing a shared Victorian electronic mental health record is vital to enable accurate information transfer, and improve communication, collaboration, performance monitoring, and data collection. This State-wide mental health record should interface with clinical quality registries for serious mental illnesses.

High-quality information infrastructure is critical to service integration. Integrated information systems, in which up-to-date health records are accessible, shared, and available in real time to all health service components, are essential to maintaining open communication channels between services, governed by suitable communication protocols. These health records should be in an electronic form, as has been implemented in many major health services – such as the Royal Children’s, the Austin, and the Alfred Hospitals – and as is being implemented across key hospitals in the “Parkville Precinct”: the Royal Melbourne Hospital, the Royal Women’s Hospital, and the Peter MacCallum Cancer Centre. Please see “Electronic Patient Records to Save Lives”, the Victorian Minister for Health, 2018.¹⁵⁸

The numerous quality and safety advantages associated with the use of electronic patient records led the Review of Hospital Safety and Quality Assurance in Victoria (2016)¹⁵⁹ to recommend that:

“The department [Department of Health and Human Services] should support Victorian public hospitals to expedite their transition from paperbased to electronic patient record (EPR) systems developed to support clinical decision making and data analytic capability, which have proven benefits for safety and quality of care... The department should adopt a goal of ensuring that, by 2021, all major hospitals have a fully electronic health record that enables interchange of information with other hospitals.”

Progress with this goal is already underway across Victorian mental health services.

Electronic medical records have been shown to lead to streamlined provision of health care, to make such care safer, to assist collaborative efforts between health care providers, and – most importantly – to improve the quality of the patient experience.¹⁶⁰

157 ACSQHC, Economic evaluation of clinical quality registries.

158 <https://www.premier.vic.gov.au/electronic-patient-records-to-save-lives/>

159 Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. Report of the Review of Hospital Safety and Quality Assurance in Victoria 2016 <https://dhhs.vic.gov.au/publications/targeting-zero-review-hospital-safety-and-quality-assurance-victoria>

160 <https://www.thermh.org.au/news/electronic-patient-records-connect-care-parkville>.

The establishment of the Victorian Mental Health Electronic Record System (VMHERS) should involve the creation of agreed common datasets, well-defined, shared referral pathways and protocols. Standard mental health measurements must be agreed to systematically monitor individual-level baselines and outcomes in real time. The systems should be used to aid individual clinical decision-making, and to enable routine data collection so that individual-level as well as aggregated data analysis can be conducted to monitor who is getting what service(s), when, where, with what outcomes, and at what cost. Quality and safety principles need to be embedded in these information systems.

Recommendation 15: A high-quality information infrastructure should be created, including an Electronic Mental Health Record for patients who are served by the public mental health sector, and real-time clinical quality registries. A serious mental illness census should also be undertaken regularly.

6.3. Strengthening the engagement between the private and public mental health sectors

According to a key report from the RANZCP¹⁶¹ psychiatrists are moving from the public to the private sectors.

“Only around a quarter (23–25%) of the psychiatry workforce works exclusively in the public sector. The remainder either work exclusively in the private sector or practise in both. This trend is increasing and concerning. Between 2011 and 2014, the proportion that worked only in the private sector increased significantly from 34% to 45%, while the proportion that worked in both the public and private sectors declined significantly from 43% to 31%. This indicates that a number of psychiatrists who were working in both sectors have ceased working in the public sector.”

The growing disinclination of private psychiatrists to remain partly involved or to engage in the public mental health sector is contributing to major shortages of psychiatrists in that sector. There are specific shortages in two areas of the highest socio-economic disadvantage: Greater Dandenong in the south-east and Brimbank in the west. Rural psychiatry is perennially understaffed by psychiatrists. Aboriginal outreach mental health services are experiencing increasing difficulty in delivering adequate care due to lack of psychiatrist participation. Particular psychiatric specialty areas are seriously short of psychiatrists: inpatient psychiatry, child and adolescent psychiatry, community liaison psychiatry, forensic psychiatry, psychotherapy, and addiction psychiatry. The consequences of the shortage of psychiatrists in public mental health stress the system and participants in a variety of ways, and further increase the movement of psychiatrists to the private sector. The favoured full-time employment model in the public mental health sector provides a high barrier to private psychiatrists wishing to consider contributing to the provision of clinical services in that sector.

Private psychiatrists could help to redress the current staffing crisis in high socio-economic disadvantage areas through appropriate appointments. Solutions for rural psychiatry are more difficult, but creative sessional strategies (including the fly-in-fly-out model) as well as opportunities for telepsychiatry sessions could provide some options. Private psychiatrists specialising in inpatient psychiatry, child and adolescent psychiatry, liaison psychiatry, forensic psychiatry, and addiction psychiatry are all well represented in the private sector and could be attracted to additionally work part time in public settings.¹⁶² Solutions are clearly needed to encourage participation of psychiatrists in Aboriginal outreach mental health services.

161 Victorian Psychiatry Attraction, Recruitment, and Retention Needs Analysis Project Report. Royal Australian and New Zealand College of Psychiatrists, 2017

162 Newton R et al., The challenges facing the public mental health sector: Implications of the Victorian Psychiatrist workforce project. Australasian Psychiatry, in press

There are several other reasons why private psychiatrists should be encouraged to work in both public and private settings. Most psychiatrists start their career in the public sector. The move from public to private coincides with psychiatrists gaining skills and experience, which is then a loss to the public sector. Such skills and experience are important to maintaining a high quality of patient care and to training new psychiatrists.

The private sector specialises in treating serious mood disorders, as shown in a recent audit by Professor Nicholas Keks and colleagues.¹⁶³ As outlined in this document, the public sector primarily treats schizophrenia and related disorders which are often complicated by comorbidity. A return of private psychiatrists to the public sector would significantly augment the skills of the public sector clinicians in managing mood disorders and preventing suicide, including with respect to psychopharmacology. Clinicians in both the public and private sectors have much to learn from each other.

The participation of psychiatrists in both public and private sectors will enable greater cooperation between public and private hospitals and will assist the current common practice of transfer of care from one system to the other as a result of Mental Health Act requirements and the needs of patients. Knowledge of both systems, improved communication, and improved relationships are likely to come from psychiatrists participating in both sectors.

Participation of private psychiatrists in public mental health services will enable greater opportunities for continuing professional education, research, training, teaching, and case conferences which will improve service delivery for patients in both public and private sectors.

We recommend that a committee, convened by the Mental Health Branch be established with representatives from the Department of Health and Human Services, the RANZCP (State Branch and Section on Private Practice Psychiatry), AMA Victoria (Section of Psychiatry), the Directors of Clinical Services, and universities, in order to promote a greater engagement in the public mental health sector of psychiatrists in private practice.

The committee should consider how to enhance the attractiveness of such engagements, including by fostering, and where possible bolstering, the opportunity for private psychiatrists to engage in teaching and research (with honorary adjunct academic appointments if appropriate), to become members of multi-disciplinary teams, and to be involved in treating patients with different types of disorders to those most commonly seen in private practice. The committee should also examine ways to reduce the disincentives associated with such engagements, including how to decrease administrative burdens and to manage medico-legal responsibilities.

Recommendation 16: That energetic steps be taken to foster a greater involvement of private psychiatrists in the public mental health sector by means of detailed conjoint planning by the Department of Health and Human Service, organisations which represent private psychiatrists – especially the Royal Australian and New Zealand College of Psychiatrists and AMA Victoria – and universities.

163 Keks N et al., Characteristics, diagnoses, illness course and risk profiles of inpatients admitted for at least 21 days to an Australian private psychiatric hospital. *Australasian Psychiatry* 2019, Vol 27(1) 25–31

7.

Mental health research

Embedding research into clinical practice will foster a culture of enquiry, excellence, and innovation. Research promotes evidence-based care and needs to occur at multiple levels from basic neuroscience through to health service policy and delivery. The transformational changes that are needed in psychiatry will not occur through incremental shifts in the delivery of care. In re-designing a system, it is necessary to incorporate at its core a philosophy of excellence and innovation that results in a culture of enquiry from which breakthrough improvements and interventions emerge. One breakthrough aim would be to identify the biological aetiology of serious mental illness, and from this to develop precision biological treatments; but many other research goals should also be pursued (please see below).

Major Victorian universities with medical schools should be linked with the new Specialist Mental Health Centres and other existing research centres, creating State-wide nodes of expertise for serious mental illness, with both national and international links. These centres would contain or access cutting-edge technologies, and interface with non-clinical research into these disorders. All other clinical service delivery would be linked to these centres, facilitating information transfer, research engagement and collaboration, education and professional development, and access to novel clinical interventions. The networked model allows clinicians to engage extensively with colleagues and peers, and facilitates education programs, diverse teaching/training opportunities for students, and research and clinical recruitment.

Research areas will encompass broad themes inclusive of neuroscience, genetics, psychopharmacology, biomarker development, clinical trials, digital health including mobile-health approaches, health services research and evaluation, policy and implementation science, health economics, precision medicine, and user experience.

To achieve advances in precision diagnostics, disease-modifying treatments, and specific preventions, we need a whole of system engagement. This will involve data, biosample, and outcome collection across the State; and opportunities for all patients and families to engage with novel treatments, preventions, and recovery-focused intervention trials – akin to those offered in oncology, haematology, and other branches of medicine; and creation of nodes of expertise and research excellence.

Linkage of health datasets with other national and State datasets is an essential tool to determine contributory and precipitating factors to mental disorders and outcomes from interventions. The linked datasets provide an invaluable resource for planning, structuring, and implementing new service-delivery models, but also for creating a registry framework to link with biomarker collection. Together, this is the basis for fine-grained sub-typing of mental disorders that underpins a precision-medicine model. Templates exist already within the Australia-wide cancer registries. Further linking with clinical trial networks will accelerate identification of prognostic and therapeutic-response markers.

The augmented mental health research programs that we are proposing would be able to be conducted within the extensive research facilities currently existing within Victoria – including in research institutes and universities – as well as within the proposed Specialist Mental Health Centres.

Among the foci of these new research programs, we recommend specialised study into women's mental health, adult psychiatry, and inpatient psychiatry. Orygen Youth Health¹⁶⁴ is one existing centre that has done an excellent job specialising in youth mental health research (and care), and we would like to see other areas of mental health emulate that success.

For example, certain mental illnesses are more prevalent in women, women use mental health services more frequently than men, and women would like a broader range of treatment options than are available currently. Women's mental health needs are, in many instances, significantly different from those of men and therefore require different responses.

To date, the insights from evidence have not been translated into mainstream health policy or practice. This has serious implications for the health of our state and the nation, contributing to sub-optimal outcomes of mental health treatment for women. This is one area where specialised research centres could form a crucial part of the overall solution.

Recommendation 17: Victoria should aim to be a world-leading centre for serious mental illness research and discovery, significantly increasing serious mental illness research spending and capacity – from bench to the bedside.

¹⁶⁴ <https://www.orygen.org.au/>

8.

Reshaping governance

Currently, the governance of mental health in Victoria faces numerous problems which reduce capacity “to deliver best mental health outcomes and improve access to, and the navigation of, Victoria’s mental health system.”

For too long Mental Health has been held apart from the broader Health portfolio, offering theoretical “protection” and prestige which has not translated into practical benefits for the field – quite the reverse. We argue that mental health is a part of health, and will benefit from the collaboration, cooperation, and synergies that come from integrating it into the existing governance structures for health.

Currently, core governance functions are fragmented across a range of agencies and roles, with overlapping or sometimes conflicting responsibilities. Key pathways that integrate with other government agencies or sectors are often ambiguous, inefficient, and easily disrupted. There have been many reviews of mental health in Australia over preceding decades – including Medibank’s “The Case for Mental Health Reform in Australia”¹⁶⁵ and the RANZCP’s “Western Australian Mental Health Clinical Governance Review”¹⁶⁶ – and one of the major findings of these reports is the problem of fragmented and poor governance.

A stronger system of governance requires system-wide integration of responsibilities to ensure clear, timely, and well-communicated decision making. Such decisions also need to be better informed by expert clinical advice, and by the kinds of data and information systems we have recommended earlier (see section 6.2.). Moreover, the views and preferences of people with serious mental illnesses (and their families and carers) need to be more fully considered by decision makers.

There is also an over-emphasis on bureaucratic compliance rather than optimisation of quality and safety enhancement, leading to burdensome regulatory requirements that detract from direct clinical care. We need to better harness the expert skills and intrinsic altruism of the mental health workforce. There are many sources of demoralisation for clinicians, many of whom report limited respect for clinical expertise, and frustration over ongoing barriers to quality care. This contributes to increasing staff burn-out, and many experienced clinicians are leaving the public sector to work in private psychiatry instead.

Further, members of our consortium have argued that high performing health systems need clinicians and psychiatrists – not just professional managers – in executive leadership positions.¹⁶⁷ Victoria requires stronger clinical advice in higher positions of executive leadership.

Consumers of mental health services currently often fall into different catchment areas depending on their age, so they are confusingly managed by different governance structures as they grow older.

165 https://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

166 https://www.ranzcp.org/files/resources/submissions/mhcgr_ranzcp-wa.aspx

167 Allison, S., A. Goodall & T. Bastiampillai, ‘Expert leadership – why psychiatrists should lead mental health services’. *Australasian Psychiatry*, 24, 3 (2016), 225-227.

Additionally, specialised mental health services are often inconveniently divided across artificial geographical boundaries which reduce ease of access for patients.

For all these reasons we need to reform the governance of Mental Health Services in Victoria in a root and branch manner.

Overview: schematic representation of governance reforms

Below we describe in some detail the changes we propose for governance. But first, we provide here three schematic Masterplan diagrams illustrating the major changes and the interrelationships between the various components of the enhanced mental health system.

The first diagram depicts reforms to Ministerial portfolios, Mental Health Branch reporting relationships, enhanced clinical input to the Mental Health Branch, an enhanced role for Safer Care Victoria in mental health safety and quality, and the redefined role of the Chief Psychiatrist to focus on regulation – with the creation of a new quality and safety-oriented role of the Chief Mental Health Officer.

Proposed reforms at the Ministerial and Departmental levels

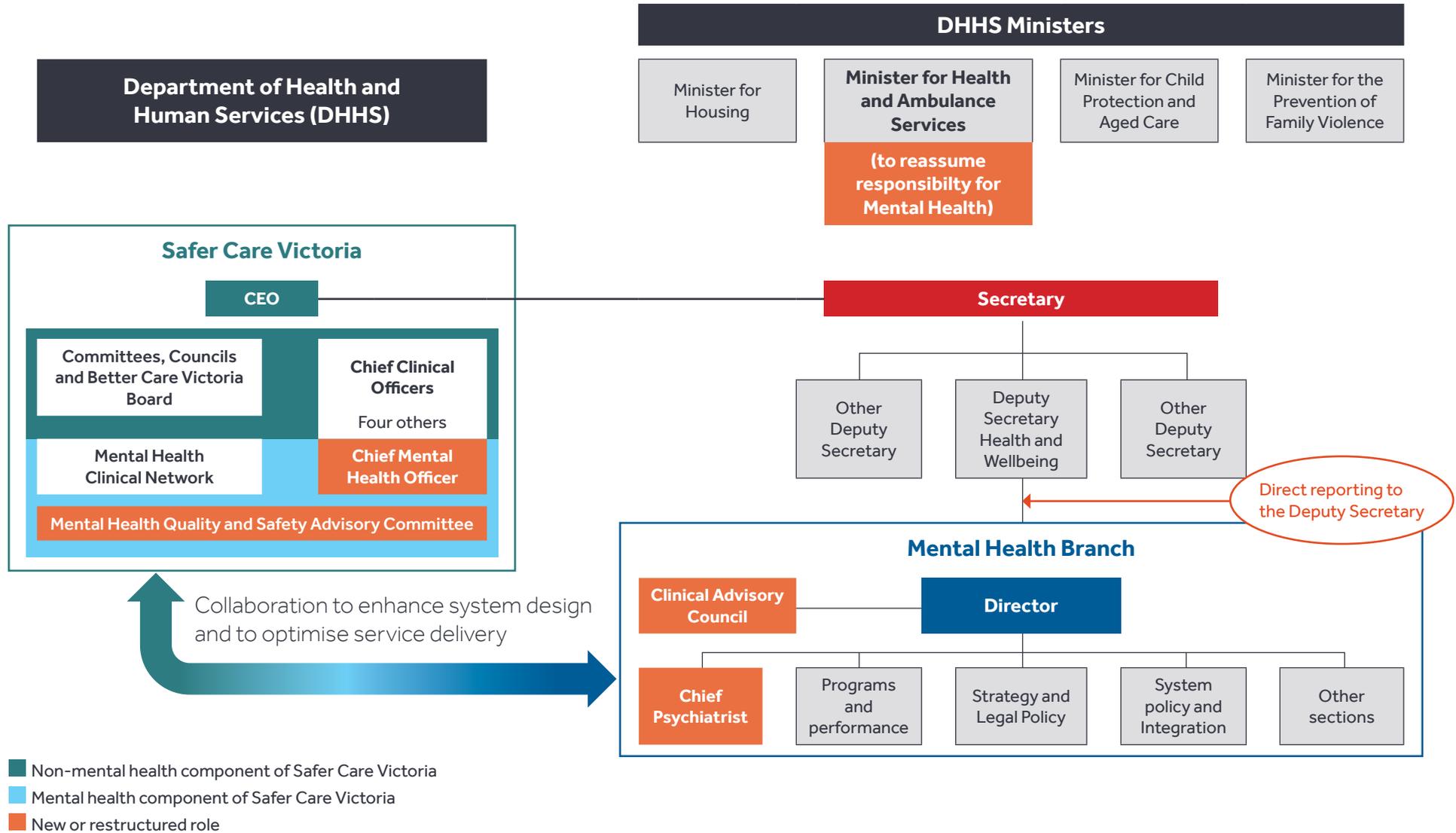
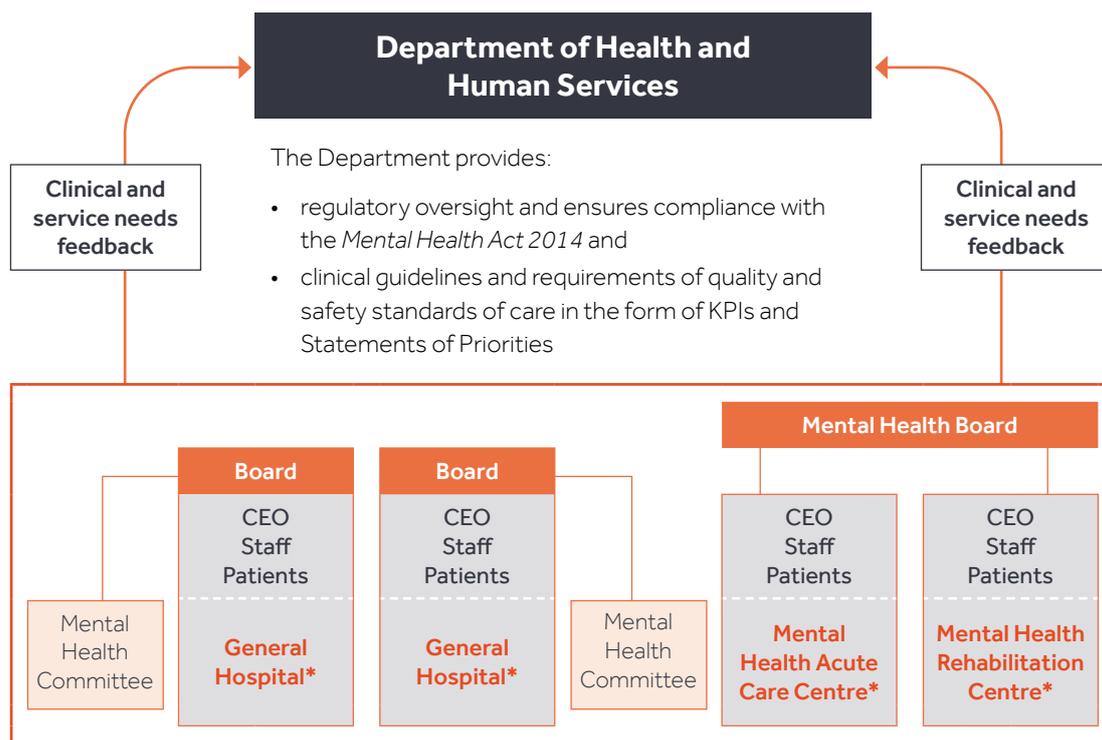


Figure 45. Proposed reforms at the Ministerial and Departmental levels.

The second diagram depicts the relationship between the Department of Health and Human Services and the general hospitals, affiliated community mental health centres, and the new Specialist Mental Health Centres.

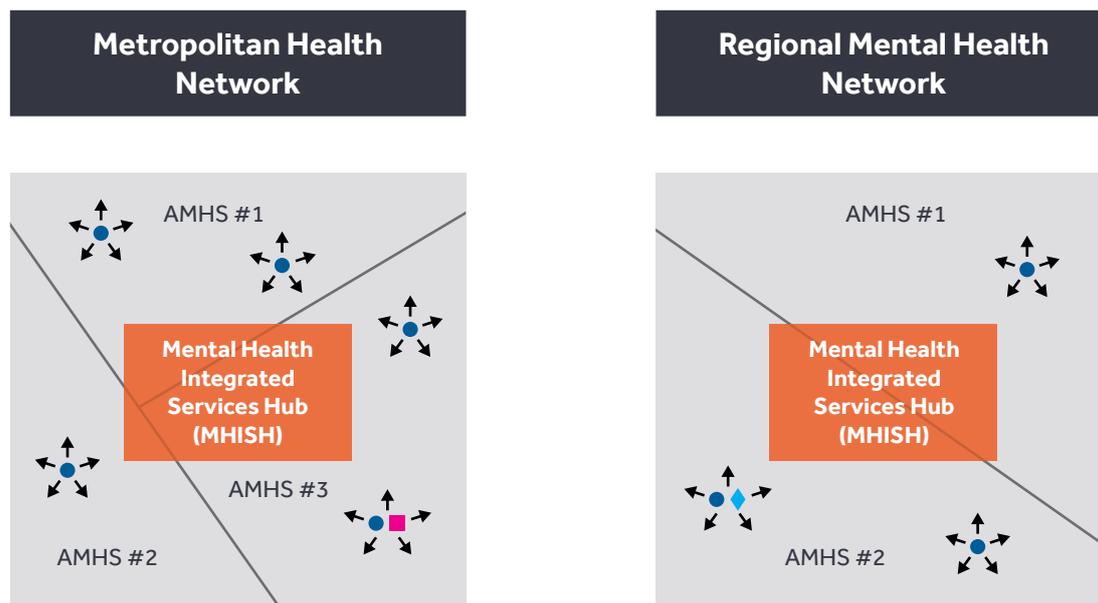


* General Hospitals do, and Specialist Mental Health Centres will provide a wide range of mental health services including inpatient and community mental health care.

Figure 46. The relationship between the Department of Health and Human Services, general hospitals, and Specialist Mental Health Centres in relation to mental health services.

The third diagram depicts the newly created metropolitan and regional mental health networks aligned to PHN boundaries. It also schematically represents the role of the new Mental Health Integrated Services Hubs and their interface with larger catchment area mental health services.

Mental Health Networks, Area Mental Health Services, Mental Health Integrated Services Hubs and Mental Health Boards



Key

- General Hospital
- Mental Health Acute Care Centre
- ◆ Mental Health Rehabilitation Centre
- ↔ Community Mental Health Services

AMHS = Area Mental Health Service

Mental Health Integrated Services Hubs

- Improve the integration of mental health care provision between the public mental health care sector and 1) general practitioners and PHNs, 2) private mental health care providers and 3) relevant services, such as housing and social services
- Ensure co-ordination and continuity of care across health care sectors for patients

Mental Health Boards

Provide governance over:

- Mental Health Acute Care Centres and Mental Health Rehabilitation Centres, and
- Mental Health Integrated Service Hubs

Figure 47. Mental Health Networks, Area Mental Health Services, Mental Health Integrated Services Hubs, and Mental Health Boards.

8.1. Ministerial responsibility

Of Australia's eight States and Territories only Victoria, NSW, and ACT have Ministers for Mental Health – with our first Minister of Mental Health having been appointed in 2006. Although having a dedicated Minister may theoretically prioritise and enhance the focus on mental health within the government, in practice it has led to confusion and an apparent diffusion of responsibility – as evidenced by, for example, a lack of clarity in the minds of many senior clinicians as to where the primary responsibility for certain elements of mental health service delivery lies.

In addition to the currently separate Minister for Mental Health, there are other separations of mental health from general health including the separation of accreditation standards and complaint handling and reporting mechanisms. We argue that these separations should be removed so that there is a more thorough integration of mental health with general health in terms of governance.

Mental health and general health are inseparable; they have many overlaps, interactions, and interdependencies – as highlighted in the Fifth National Mental Health and Suicide Prevention Plan,

“Many people [with serious mental illness] are high users of the hospital system and often have physical illnesses, disabilities, or substance use problems that may be untreated or poorly managed”.¹⁶⁸

Considering this inseparability of mental health and general health, there should be a single point of ministerial responsibility for them.

Another reason for recommending that the Minister for Health should reassume responsibility for mental health is that Ministers for Health have successfully advocated for annual budgetary allocation percentage increases in Acute Health that have exceeded the annual growth rate in allocations to mental health (please see Figure 4 on page 7), especially since 2009. The resumption of responsibilities for mental health by the Minister of Health may well enhance the likelihood of mental health achieving parity of funding increases with acute health in the years ahead.

Recommendation 18: The Minister for Health should reassume responsibility for Mental Health, as part of the portfolio responsibility for nearly all other areas of Health.

8.2. The Mental Health Branch

The Mental Health Branch needs to be elevated in the Department of Health and Human Services organisational hierarchy to report directly to the Deputy Secretary, Health and Wellbeing (see diagrams below). This would give senior staff greater presence and influence, and, in combination with an increase in expert clinical input within the Mental Health Branch, would help to bring more clinical advice to executive leadership levels.

We propose that the Director of the Mental Health Branch should receive clinical advice from a Clinical Advisory Council.

The Clinical Advisory Council should consist of the following members:

- The Chief Psychiatrist
- The Chief Mental Health Officer
- The Chair of the Mental Health Quality and Safety Advisory Committee
- Two senior clinicians from each Mental Health (Area) Network – one Clinical Director and one Allied Health or Nursing Leader
- Two consumers
- Two carers

Recommendation 19: The Mental Health Branch should have greater input of clinical advice to the Branch Director and other senior staff members and have greater interactions with the Directors of Clinical Services in Metropolitan and Regional areas.

168 The Fifth National Mental Health and Suicide Prevention Plan, p. 27 <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf>

Current structure within Department of Health and Human Services



Figure 48. Current structure of governance of mental health. An extract from the organisational chart of Department of Health and Human Services.

Promoting the Mental Health Branch within Department of Health and Human Services

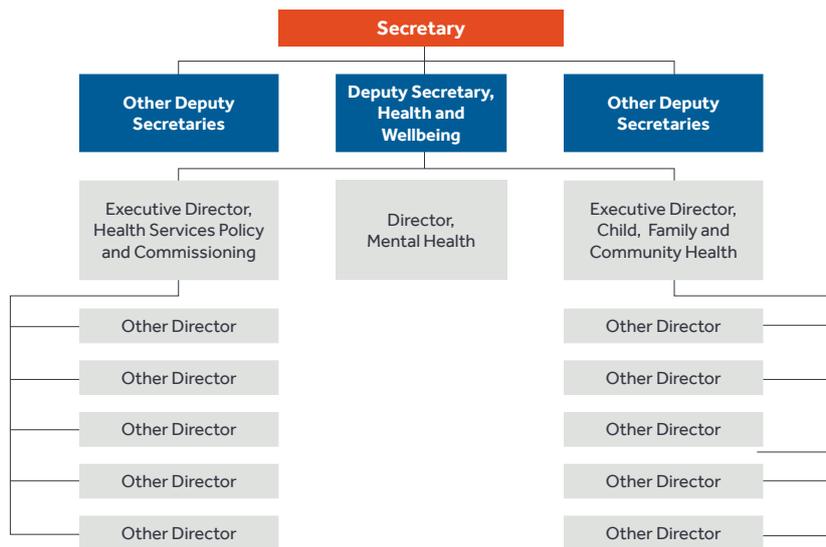


Figure 49. Proposed New Structure of Governance of Mental health, with the promotion of Director of Mental Health.

8.3. Enhancing governance and oversight of quality and safety

Safer Care Victoria (SCV) is the State's healthcare quality and safety improvement agency. It works with patients, families and carers, clinicians, and health services to monitor and improve the quality and safety of care delivered across our public health system.¹⁶⁹ In line with our previous broader arguments, since general-health quality and safety improvement finds its home here, the quality and safety improvement function of mental health should have a comparable home in SCV. The existing Mental Health Clinical Network¹⁷⁰ provides clinical leadership, expertise, and advice to Safer Care Victoria to improve outcomes for people accessing clinical mental health services in Victoria. In partnership with mental health clinicians and people with lived experience, the network facilitates state-wide quality improvement projects. However, because this Network does not have the capacity to set standards and key performance indicators (KPIs) in relation to mental health, we recommend that new structures are established to enhance mental health quality and safety.

Specifically, we propose an overall Mental Health Quality and Safety Advisory Committee, which would sit within Safer Care Victoria and have the role of recommending – to the Secretary of the Department of Health and Human Services – Victoria's performance expectations and targets, to be considered for inclusion in the Statements of Priority by which public health services are held accountable. The membership of this committee should include the Chief Mental Health Officer, the Chief Psychiatrist, expert clinicians, quality and safety experts. There should also be a mechanism for encouraging and receiving advice and feedback from mental health service providers and other stakeholders in order to achieve systemic improvement.

In addition, just as each general hospital health services Board is currently required to include Finance, Audit, Quality and Safety, Primary Care and Population Health, and Community Advisory committees which report to the Board, it is our recommendation that each board should be required to establish a Mental Health Committee. Each Mental Health committee would be responsible for providing advice to the board about the extent to which the mental health service within hospitals were meeting the enhanced State-wide performance expectations and targets. This process would be a central element in enabling each hospital (including Specialist Mental Health Centres) to provide new annual mental health performance reports – which we recommend to be submitted to the Secretary of the Department of Health and Human Services, to the Director the Mental Health Branch, and to the CEO of Safer Care Victoria.

Recommendation 20: A Mental Health Quality and Safety Advisory Committee should be established within Safer Care Victoria.

Recommendation 21: Each general hospital health services board should establish a Mental Health Committee that reports to the hospital board. These committees would have strong mental health service enhancement, monitoring, and reporting roles, with reference to the KPIs established by the new Mental Health Quality and Safety Advisory Committee.

8.4. The Chief Psychiatrist's roles

The Chief Psychiatrist in Victoria currently has two main roles; regulatory on one hand and quality and safety improvement on the other. It is our view that these two functions should be separated due to a potential for a tension between the two functions. The quality and safety function is mainly about improving services by engendering a culture of curiosity and encouraging a range of service

¹⁶⁹ <https://bettersafercare.vic.gov.au/about-us/about-safer-care-victoria>

¹⁷⁰ <https://bettersafercare.vic.gov.au/about-us/about-scv/our-clinical-networks/mental-health-clinical-network>

improvement initiatives. The regulatory function, on the other hand, focuses on the maintenance of high levels of service standards by ensuring regulatory compliance, especially with the legislative expectations contained within the Mental Health Act (2014).

In the context of the proposed changes outlined above, The Chief Psychiatrist would remain in the Mental Health Branch. The incumbent would retain the existing regulatory responsibilities of the Chief Psychiatrist, such as working with the Coroner, dealing with the Mental Health Complaints Commission, accreditation of electroconvulsive therapy (ECT), and monitoring and reporting on restrictive interventions. This should also include important improvements such as working to reduce and streamline the over-burdensome regulatory requirements that are increasing administrative burdens at the expense of time for quality care of patients.

The Chief Psychiatrist's quality and safety function should be taken on by a new role – the Chief Mental Health Officer (CMHO) – which should be located within Safer Care Victoria (SCV).

The CMHO should apply the principles of improvement science to developing a higher quality and safer mental health system. Improvement science as described by Marshall et al. "aims to create practical learning that can make a timely difference to patient care. It is characterised by its large domain of interest, its applied nature, and its commitment to generation of practical learning that can be applied in real-life situations."¹⁷¹ The CMHO would share their learnings with the other four Chief Clinical Officers in Safer Care Victoria, and would have extensive interactions with and receive feedback from clinicians who provide public mental health services, as well as from consumers and carers.

Recommendation 22: Because the current responsibilities of the Chief Psychiatrist involve a duality of roles that can be in tension with each other, involving – on one hand regulatory components and on the other quality and safety enhancement components – these sets of responsibilities should be separated. The reconfigured role of the Chief Psychiatrist should be primarily a regulatory one in relation to the *Mental Health Act 2014*. A new position of Chief Mental Health Officer (CMHO) should be created, whose responsibilities would focus on quality and safety enhancement. That role should be located within Safer Care Victoria (SCV) but would be closely associated with the Mental Health Branch.

8.5. Realigning mental health boundaries

The Victorian Auditor General's Report on "Access to Mental Health Services"¹⁷² highlights another core issue. "Clinical mental health services are provided in geographic catchment areas that were established in the 1990s...

- the catchment areas are not aligned with other health and human service areas, or local government area boundaries, which makes service coordination difficult for consumers and carers, many of whom need support from multiple services
- [there is a] lack of alignment between geographic catchments and age-based service
- [there is a] lack of coordination between catchment areas when patients need to access services across catchment borders
- [there is] misalignment between service levels and types within a catchment and population growth and demographic changes in that area."

The following maps illustrate the lack of alignment between Adult Mental Health services areas and Child and Adolescent Mental Health Service Areas.

171 Martin Marshall, Peter Pronovost, Mary Dixon-Woods, Promotion of improvement as a science, *Lancet* 2013; 381: 419–21, University College London, London, UK. p. 419.

172 *Victorian Auditor-General's Office, Access to Mental Health Services, March 2019: 44.*

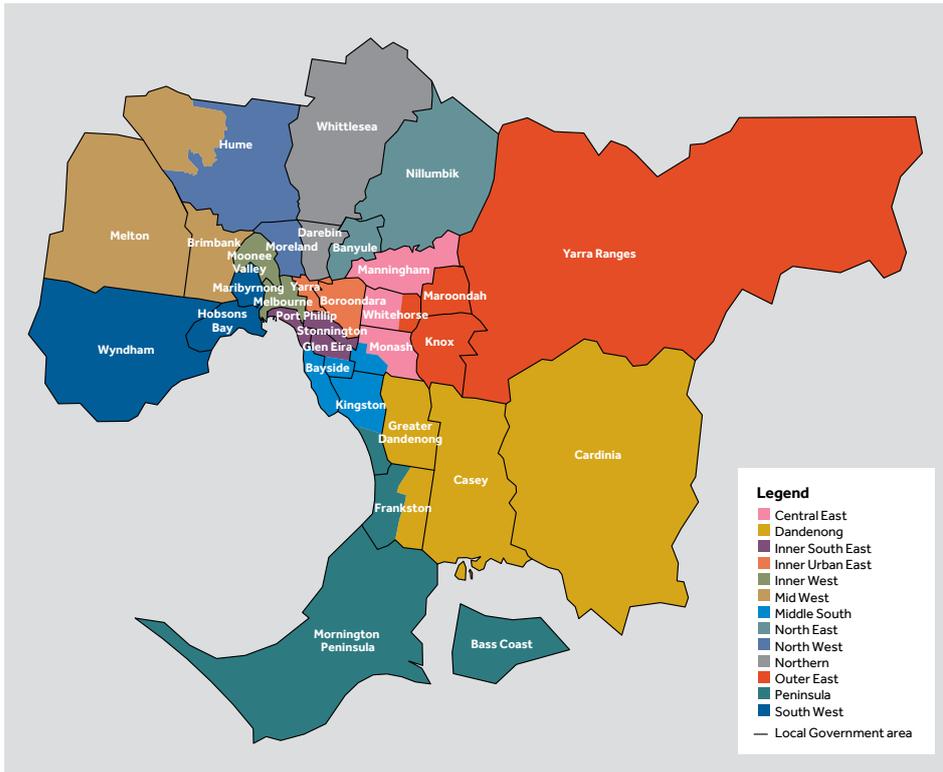


Figure 50. Adult Mental Health Service Area metropolitan Melbourne.¹⁷³

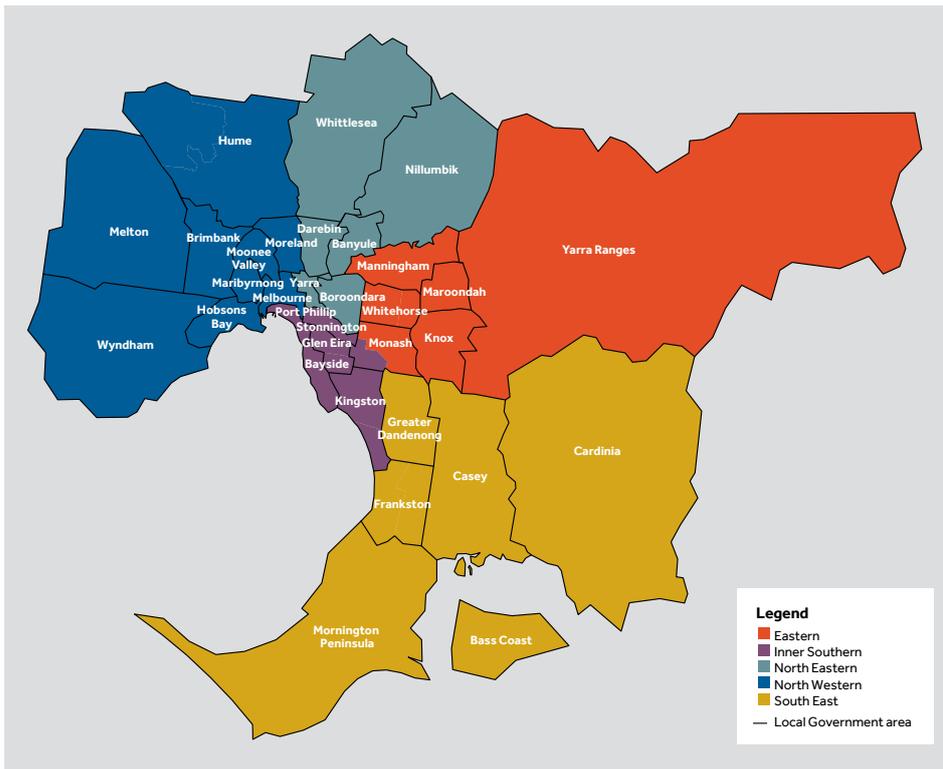


Figure 51. Child and Adolescent Mental Health Service Area metropolitan Melbourne.¹⁷⁴

173 State Government of Victoria, Australia, Department of Health <http://www.health.vic.gov.au/mentalhealthservices/maps/adultmetro.htm>.

174 State Government of Victoria, Australia, Department of Health <http://www.health.vic.gov.au/mentalhealthservices/maps/childmetro.htm>

Six state Mental Health Networks (MHNs) should be established which geographically align very closely with the existing commonwealth Primary Health Networks (PHNs). For purposes of coordinating services and providing specialist mental health services, these six MHNs should be broken down into metropolitan and regional pairings – please see map – so there will be three metropolitan MHNs, and three regional MHNs.

The specific pairs would be North Western and Western Victoria MHNs, Eastern and Murray MHNs, and South Eastern and Gippsland MHNs.

In order to ensure manageable population sizes per catchment area, these broader MHNs should be sub-divided into reconfigured Area Mental Health Services (roughly matching up with clusters of Local Government Areas) aiming for ~500,000 people in each metropolitan catchment and ~300,000 in regional catchment areas. The current catchment areas are too small in Victoria to enable sufficient critical mass to provide all necessary components of an integrated continuum of care and subspecialty services. Increasing the catchment size will also enable integration across the lifespan, aligning child, adult, and older boundaries thereby facilitating smoother transition between these age divisions. Given some anomalies with the current boundaries of PHNs in relation to tertiary hospitals – e.g. the Monash Medical Centre is within the boundary of the Eastern PHN but most of its clinical activities relate to patients living with the South Eastern PHN) the new MHNs should take into account the distribution of tertiary hospitals when determining boundaries to ensure sensible access to services, and appropriate distribution of specialised services. They should incorporate whole-of-life treatment – children, adolescents, adults, and old-age – so that patients are not managed by different governance structures as they grow older. Also, since not every Area will be able to have local specialist treatments (e.g. eating disorder centres), their broader MHN should provide easy transfer to specialist centres in other Areas within the MHN and within paired MHNs.

These recommendations about geographic boundaries and catchment areas for mental health align with the recommendations of the Victorian Auditor-General's Report.¹⁷⁵ This is also in direct alignment with the Fifth National Mental Health and Suicide Prevention Plan which calls for an integration between PHNs and Local Hospital Networks (LHNs).¹⁷⁶

Recommendation 23: Area Mental Health Services (AMHSs) should be reconfigured to better align their catchment areas with other health and human service areas in order to improve service coordination and to enable within-area whole-of-life mental health care. Groups of AMHSs should sit within six new Mental Health Networks (MHNs), which geographically align closely with the existing Commonwealth Primary Health Networks (PHNs). The incorporation of AMHSs into MHNs would facilitate (1) coordination of services between AMHSs, and (2) integration of mental health services with other health and non-medical services – such as general practice, PHNs, housing, social welfare, and legal aid. There should be three sets of metropolitan and regional MHN pairs.

Recommendation 24: New Specialist Mental Health Centres should be established: one or two Mental Health Acute-Care Centres within each metropolitan MHN (also servicing the regionally paired MHN), as well as one or two Mental Health Rehabilitation Centres within each metropolitan-regional MHN pair.

Recommendation 25: A Mental Health Services Board should be established in each MHN metropolitan and regional pair, to oversee the governance of the new Specialised Mental Health Centres in the area (following the principles and practices of current Health Service Boards) and the Mental Health Integration Services Hubs.

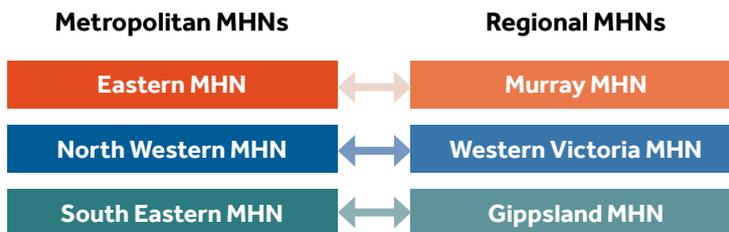
¹⁷⁵ Victorian Auditor-General's Office, Access to Mental Health Services, March 2019: 44, p. 14.

¹⁷⁶ The Fifth National Mental Health and Suicide Prevention Plan, p. 21 <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf>

Adult Mental Health Service Areas – metropolitan and rural Victoria

Mental Health Networks (MHNs)

Boundaries largely based on those of the Primary Healthcare Networks (PHNs), with Metropolitan-Regional Pairings



Each Metropolitan MHN to have one to two **Mental Health Acute Care Centres**.

Each Metropolitan-Regional MHN Pair to have one to two **Mental Health Rehabilitation Centres**.

Each Metropolitan-Regional MHN Pair to have a Health Services Board to oversee the **Mental Health Acute Care Centres** and the **Mental Health Rehabilitation Centres** within their combined boundaries.

Within each MHN, newly aligned **Area Mental Health Service** will provide whole-of-life mental health care and will be closely aligned with Local Government Area clusters and with hospital locations.

Figure 52. Mental health metropolitan – regional pairings.

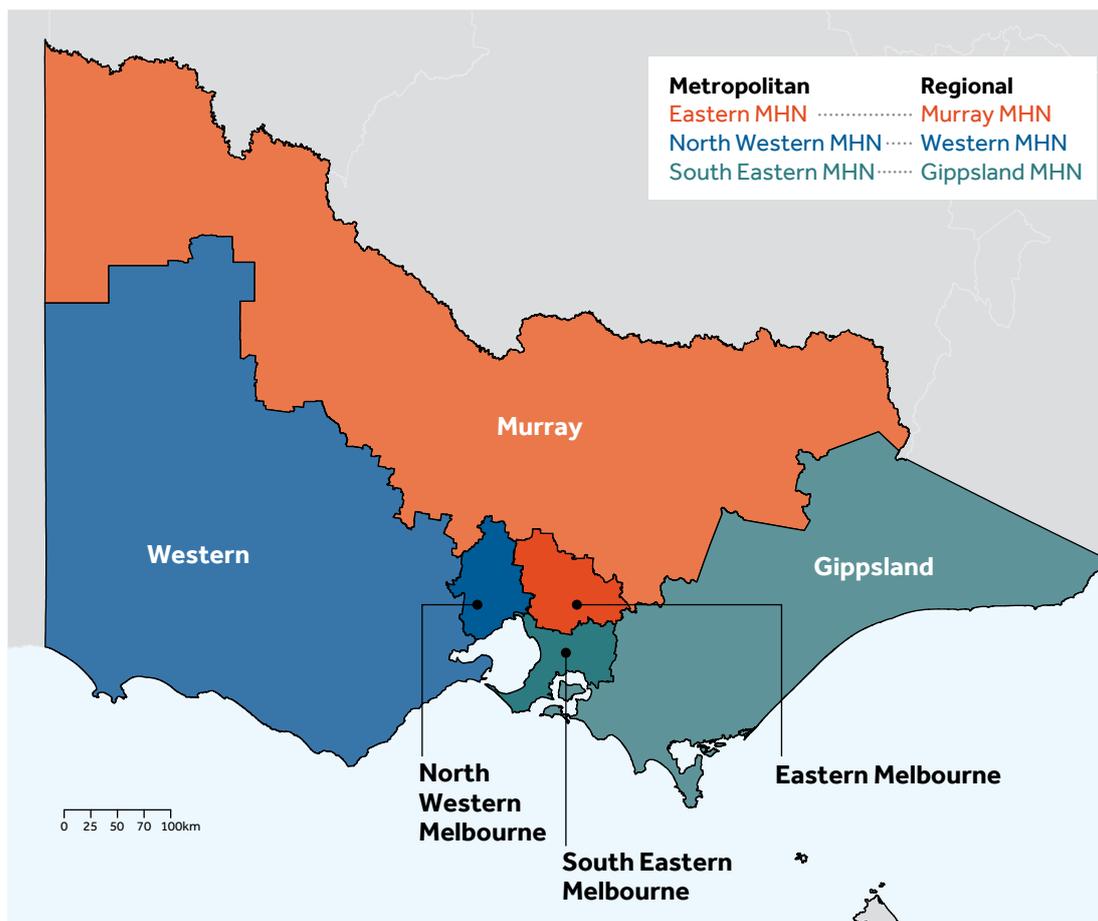


Figure 53. Mental Health Networks (MHNs): geographical boundaries with metropolitan-regional pairings.

Examples for new Specialist Mental Health Centres

Given our recommendation to establish three metropolitan-regional MHN pairs, and one or two Acute-Care Centres plus one or two Rehabilitation Centres per MHN pair, that could range from six to twelve new Specialist Mental Health Centres. This is a substantial investment, so realistically it would require a timeframe of up to 15 years to achieve. However, we recommend that at least two Acute-Care Centres, and three Rehabilitation Centres should be built within five years.

Clearly the details of where and how to construct these centres will need to be decided later, but we would like to put forward some examples to clarify the concept. The initial location for the two Mental Health Acute-Care Centres could be (1) within the Northwest Mental Health MHN, at the Royal Melbourne Hospital (the largest mental health service in Victoria and linked to the University of Melbourne), and (2) co-located with Monash Health (the second largest mental health service in Victoria and linked to Monash University).

Regarding the three Mental Health Rehabilitation Centres, they could be established in the following locations: (1) near the Royal Talbot Rehabilitation Centre (associated with the University of Melbourne and with the Austin Hospital – which has significant expertise in Rehabilitation Medicine¹⁷⁷); (2) in Geelong (Victoria's second largest city), associated with Deakin University – which has a highly productive Centre for Innovation in Mental and Physical Health and Clinical Treatment¹⁷⁸ – and Barwon Health; and (3) near the Frankston Hospital (associated with Monash University's Frankston campus). This last suggestion would align with the Commonwealth Government recently announcing \$32 million in funding to establish a Centre for Rehabilitation, Mental Health, Ageing, and Independent Living at the Frankston Hospital in conjunction with Monash University.¹⁷⁹ It would also be able to take advantage of the major healthcare developments occurring in Frankston as a result of the Victorian Government's allocation of \$562 million in 2018 to redevelop the Frankston Hospital.¹⁸⁰

These suggested locations for the three Mental Health Rehabilitation Centres has several advantages – especially that this would ensure that all metropolitan MHNs would have either an Acute-Care Centre or a Rehabilitation Centre, and that at least one regional MHN (in this example: Western Victoria) would have a Rehabilitation Centre.

We propose that the Rehabilitation Centre in Geelong should have a dual role by establishing there a Centre of Excellence in Regional and Rural Mental Health.

The creation of such a Centre would be important because there are several unique problems facing regional – especially rural – adult mental health services. This includes the fact that in such services there is an amplification of the problems that negatively affect mental health services across the state. This is partly due to the size of rural services, but also due to funding not accounting for the rural locale. As a result, there are hardly any redundancies built into rural mental health services. When there are funding cuts, or even if one staff member leaves (resigning or taking unexpected leave) it has a much larger impact on service delivery, and it take much longer to recruit a replacement.

In terms of geography, rural areas have high transport disadvantage, and there is insufficient investment in telehealth (Department of Health and Human Services does not have a satisfactory telehealth option for rural clinicians to link in). Distances are huge, and populations are more dispersed. It takes longer for travelling clinicians to get to a person and then more time to get to the next person. Such travel times are not counted for as "activity" in any sort of planning, or financial or case-load management. Even if we move to a clinic-based model there are problems. Rural local government areas are over-represented on measures of socioeconomic disadvantage. The rural poor are less likely to own cars or have the means to maintain cars. Even if they do, one appointment can essentially take their working day away, so people cannot attend appointments as often.

177 <http://www.austin.org.au/royal-talbot-rehabilitation-centre#Section2>

178 <https://www.deakin.edu.au/impact>

179 <https://www.monash.edu/news/articles/monash-welcomes-budget-funding-for-key-health-and-environmental-research>

180 https://www.frankston.vic.gov.au/Your_Council/Media_and_Publications/Latest_News/Health_reaches_new_heights_in_Frankston

Maldistribution of resources: many rural mental health services do not have access to Secure Extended Care Unit (SECU) or even Critical Care Unit (CCU) beds. At least one unit has no High Dependency Unit (HDU) beds. Overall, the inpatient bed numbers in rural services are lower than the Victoria average (for example, Goulburn Valley Health has a catchment population of more than 150,000 people and only 20 beds).

A Centre of Excellence in Regional and Rural Mental Health would be a step toward resolving some of these problems. It would have a role in building local capacity both for ongoing training needs and to develop new capacities (e.g. rurally based training in psychiatric nursing, psychology, occupational therapy, social work, and psychiatry). This could also include the study of Telemedicine in relation to mental health, to support and improve the difficult geographical challenges.

Furthermore, firmly linking our metropolitan-regional MHN pairings under one Mental Health Service Board would support regional and rural mental health services to deal with these extra challenges by placing oversight responsibilities with a single Board that would need to deliver outcomes across rural, regional, and metropolitan areas.

8.6. Ensuring the full implementation of the Royal Commission's recommendations

Given the scale of the problems that the Royal Commission into Victoria's Mental Health System is addressing, the clear need for a major system redesign, and the pledge by the Premier to implement all the recommendations of the Royal Commission, there is a compelling case for robust, coordinated, and integrated mechanisms to be established at the highest levels of government to ensure that the Royal Commission's recommendations are effectively and efficiently implemented in a timely manner. To this end, a subcommittee of Cabinet should be established to achieve this priority. It is our understanding that such subcommittees may be chaired by the Premier in order to reinforce a whole-of-government focus on important issues, and this would be our hope were such a subcommittee to be established.

This subcommittee should be shadowed by an Interdepartmental Committee (IDC) – which would be a subcommittee of the Victorian Secretaries Board, would be chaired by the Secretary of the Department of Premier and Cabinet, and be comprised of secretaries of the departments most germane to issues relating to mental health.

In addition, a new agency should be established to support an Independent Monitoring Officer who would monitor the implementation of the proposed reforms and would have statutory powers to request information from government. A similar position was established in relation to family violence, which provided a model for our recommendation in relation to this matter.

Recommendation 26: A cross-portfolio subcommittee of Cabinet should be established to ensure that the policy recommendations from the Royal Commission are effectively introduced. This subcommittee should be shadowed by an Interdepartmental Committee (IDC) of all departmental secretaries germane to mental health. An Independent Monitoring Officer with statutory powers should be appointed to monitor the progress of the implementation of the Royal Commission's recommendations.

9.

Overarching vision

We recognise that the major mental health reforms of the 1980s and 90s have had significant benefits for the sector. However, many of the inadvertent consequences of these reforms have not been addressed, including failure to maintain adequate adult and community care, and to keep up with population growth. This has led to detrimental outcomes for people with serious mental illnesses, their carers and families, and the community as a whole.

A detailed, data-driven analysis of Victoria's current provision of care for adults with serious mental illnesses has firmly demonstrated the significant lack of capacity in acute and non-acute inpatient beds for adults. Although mental health researchers are rightly searching for new and effective methods of preventing mental illnesses, we are not close to the point at which we can rely on prevention to substantially reduce the demands placed on the mental health system by the needs of the seriously mentally ill. We firmly support mental health research continuing and expanding; this is fundamental to improving the system.

In the meantime, Victoria's existing mental health care system cannot wait for scientific breakthroughs: there are major improvements throughout the system that can be made right now – including improvements to existing services across community mental health, inpatient care, emergency departments, drug and alcohol services, and forensic mental health. In parallel with urgently reforming existing services, we need to establish Specialist Mental Health Centres as part of Victoria's longer-term strategy for delivering the best quality mental health care in the decades to come. Specialist care is invaluable across all areas of health care; mental health care is no different. Currently, people with serious mental illnesses are often marginalised when contrasted with those with only general health care needs, and we believe – from an equality and human rights perspective – that this marginalisation should not be allowed to continue. In terms of Victorians receiving care that is known to be of world class standard, we might ask why a Victorian with cancer or with a high risk pregnancy can be admitted to or receive ambulatory care in public hospitals that are of the highest international standing in their specialties – each with very active clinical research programs – but, with the exception of a forensic mental health hospital, there are no specialist mental health hospitals for adults (aged 25–64) in the public sector at all.

Another obstacle to a world class standard of care – one that is particularly salient for adults with serious mental illnesses – is the enormous complexity and fragmentation of mental health services in Victoria. Navigating the wide array of disparate services and bureaucratic requirements would be difficult enough; but the cognitive impairments that often occur alongside serious mental illnesses makes those obstacles all the more problematic. This is not just a challenge for patients – those working within fragmented services often feel frustrated and demoralised by the inefficiencies and flaws in the system. We need to better harness their expert skills and intrinsic altruism. Better integration of services will require a concerted and unified range of reforms to ensure all elements of the system run smoothly together. This will require new information infrastructure, a serious mental illness registry, coordination between public and private mental health provision, improved patient navigation support, and dedicated

Mental Health Integrated Services Hubs to drive all these changes. Good data and data analysis are vital to a well-functioning mental health system: supporting informed and evidence-based governance, research, service integration, and capacity.

Finally, the changes recommended throughout our submission must be underpinned by a more effective governance structure – mental health catchment boundaries need to change, mental health needs to be reintegrated with general health at all levels, and numerous changes are needed in executive leadership positions. Hospitals need clinically informed mental health performance expectations and targets to ensure evidence-based improvements in the system, and to achieve parity of care.

Our overarching vision for a reformed mental health care system is crucial for ensuring the majority of adults with serious mental illnesses do not continue to miss out on the care that they require and deserve. They should receive parity of care with those who only require general health care, across all ages, and across all regions. Moreover, we believe the recommendations we are making would improve the system as a whole: with benefits flowing to Victorians of all ages with mental illnesses who access the public mental health system.

Appendix:

A synoptic overview of the Victorian Mental Health System

This analysis provides a comprehensive overview of mainly Australian Institute of Health and Welfare mental health data, based on the most recent updates. These data are divided into several sections including primary care, community mental health, NGO, residential, inpatient, key performance indicators and expenditure variables. We have highlighted primarily how Victoria compares with the other states inclusive of national averages, in relation to these service delineations. The primary focus is to concentrate on general adult, forensic and youth data. In addition to Australian Institute of Health and Welfare mental health data we have also incorporated OECD and WHO psychiatric bed number data comparing this with Victorian and Australian data. A summarised form of this comprehensive analysis is provided within the main section of the submission. We also provide in this section Victorian suicide data from 2013–17.

Victorian AIHW 2017–18 data: primary care mental health

1. Medicare funding for mental health specific services provided

Victoria receives the highest per capita on mental health Medicare services – \$57 per capita compared to the national average of \$50 per capita.



Figure A1. AIHW Australian Government Medicare expenditure (\$'000) on mental-health-specific services, 2017–18.

2. Population coverage and service contacts

Victorians have the highest population and service coverage of people receiving Medicare-subsidised mental-health-specific services (GP mental health care plans plus mental health clinicians). 11% of the Victorian population received Medicare-subsidised mental-health-specific services compared to the Australian average of 10.2% (<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/medicare-subsidised-mental-health-specific-services>). Victorians also received 536 services per 1000 population 14% higher than the national average of 471 services per 1000 population.



Figure A2. AIHW Medicare-subsidised services, 2017–18

Victorians have the highest Medicare-subsidised mental-health-related services specifically from psychologists/allied health services and psychiatrists in Australia, with 6% of Victorians having seen a psychologist/allied health provider and 1.7% having seen a psychiatrist in 2017–18 (see Figure 2 Appendix). Overall, Victoria has 12% greater population coverage for these specific Medicare-related services compared to the national average.

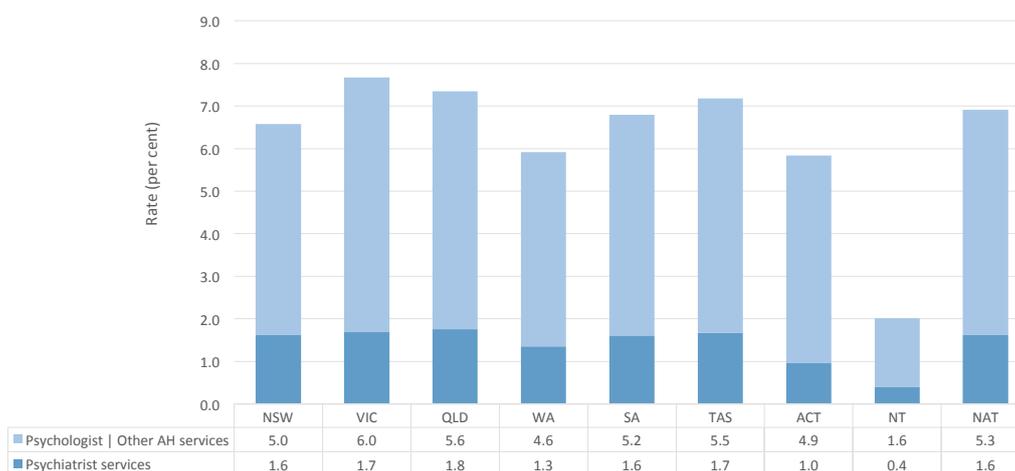


Figure A3. AIHW People receiving Medicare services, 2017–18

The Victorian population coverage has doubled since 2008–9 for people accessing psychology and other allied health providers.

3. Medicare-funded service providers

Victoria has higher than the national average of Medicare-funded mental health clinician providers in all categories, inclusive of psychiatrists, clinical psychologists, other psychologists, and other allied health providers.

4. Mental health prescription medication rates

Victoria's population use of mental-health-related prescriptions is 16.2% of the population – slightly below the Australian average of 16.8% of the population.

Victorian State Government data for overall mental health expenditure (all age groups) compared to Victorian acute health expenditure

Victorian state government spending on mental health has not kept pace with growth in acute health expenditure (see Figure A4). Annual health expenditure has increased annually by 8.1% compared to mental health expenditure having increased by 6.7% annually. This is a relative funding shortfall of 1.4% annually for mental health expenditure compared to acute health expenditure.

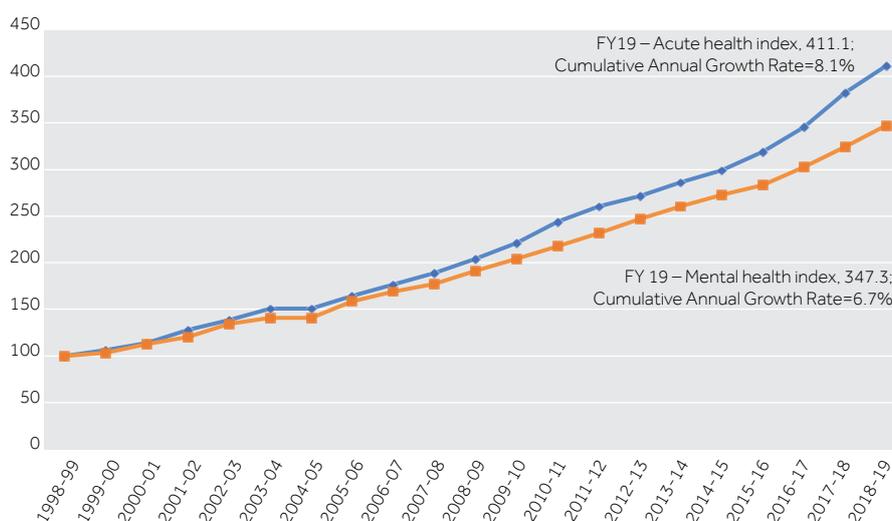


Figure A4. Victorian budget allocations to acute and mental health outputs, from 1998–2019.

Victorian AIHW 2016–17 data: overall mental health expenditure (all age groups)

The Victorian state government spends the lowest per capita on mental health services in Australia, spending \$206 per capita which is 11% less than the national average of \$233 per capita in 2016–17. Victoria was keeping pace with the national per capita mental health expenditure up until 2005–06 but has since diverged negatively compared to Australia.

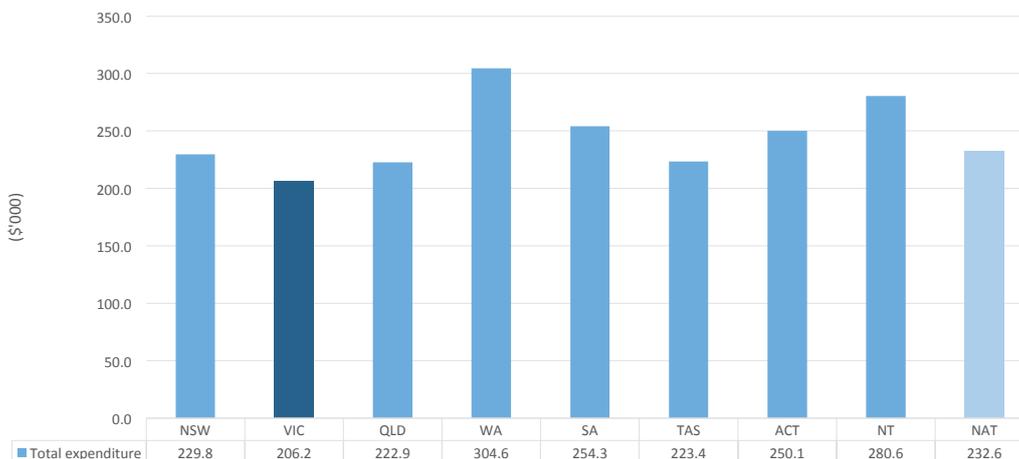


Figure A5. AIHW Expenditure on mental health services, recurrent expenditure (\$'000) on mental health services, 2016–17.

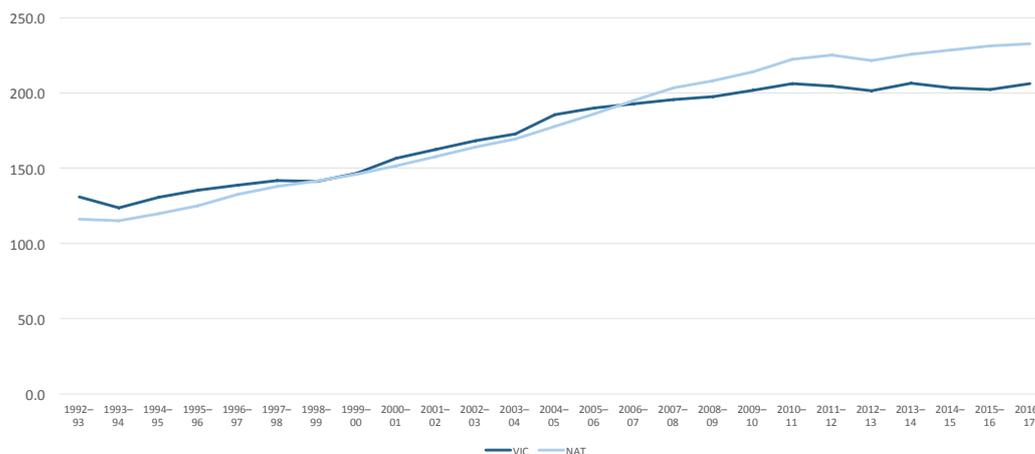


Figure A6. AIHW Expenditure on mental health services, recurrent expenditure per capita (\$) – total expenditure.

The Victorian state government expenditure in 2016–17 can be broken down into four distinct components for all age groups (child, youth, general adult, and older adult) – NGOs, community mental health, residential beds, and specialist psychiatric beds. These components are outlined below:

Victorian expenditure on NGOs and grants (all age groups) is consistent with the national average at \$30 per capita.

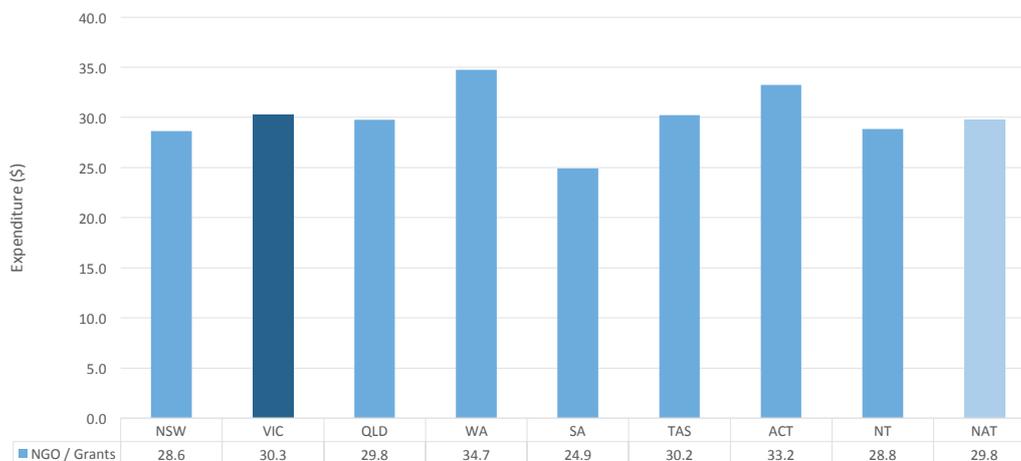


Figure A7. AIHW Recurrent expenditure per capita (\$) – NGO/grants, 2016

Victorian expenditure on community mental health (all age groups) is \$76 per capita, which is 12% lower than the national average of \$86 per capita.

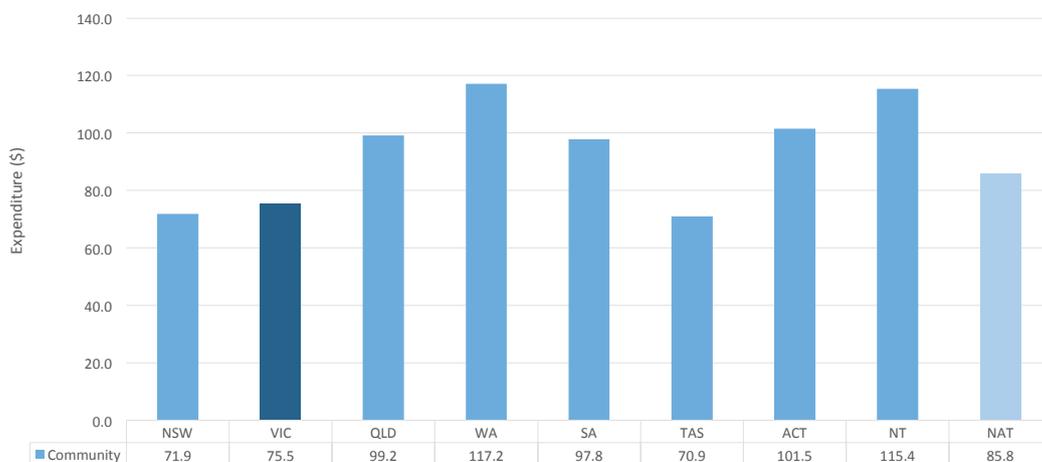


Figure A8. AIHW Recurrent expenditure per capita (\$) – community, 2016–17.

Victorian expenditure on residential beds (all age groups) is \$31 per capita, which is 149% higher than the national average of \$12 per capita.

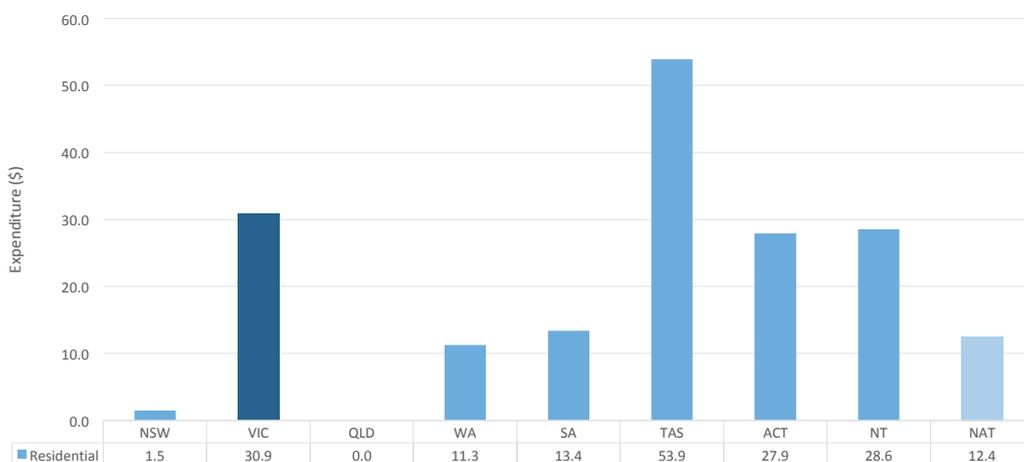


Figure A9. AIHW Recurrent expenditure per capita (\$) – residential, 2016–17.

Victorian expenditure on specialist public sector psychiatric beds (general hospital psychiatry beds and stand-alone psychiatric hospitals) is \$70 per capita, which is 34% below the national average of \$105 per capita.

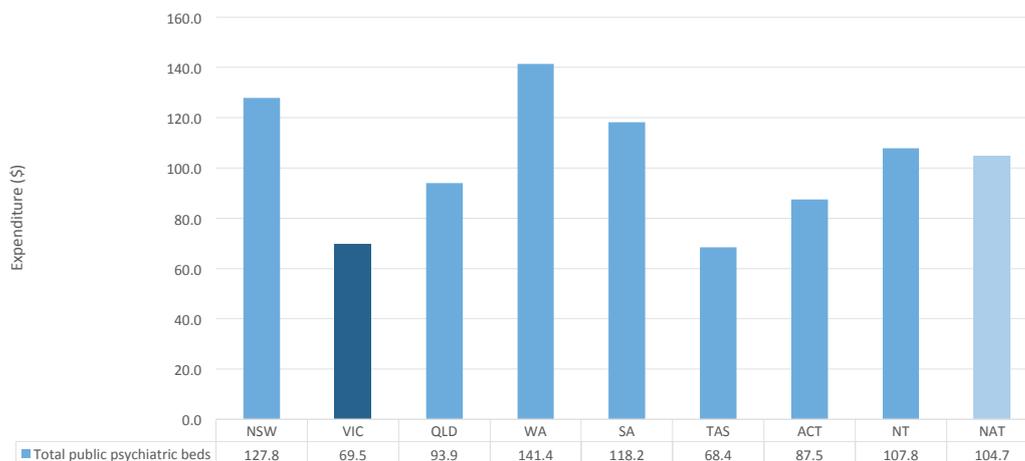


Figure A10. AIHW Recurrent expenditure per capita (\$) – total public psychiatric beds, 2016–17.

The expenditure on public sector psychiatry beds (all age groups) has been consistently and markedly lower than the Australian average, since 1993.

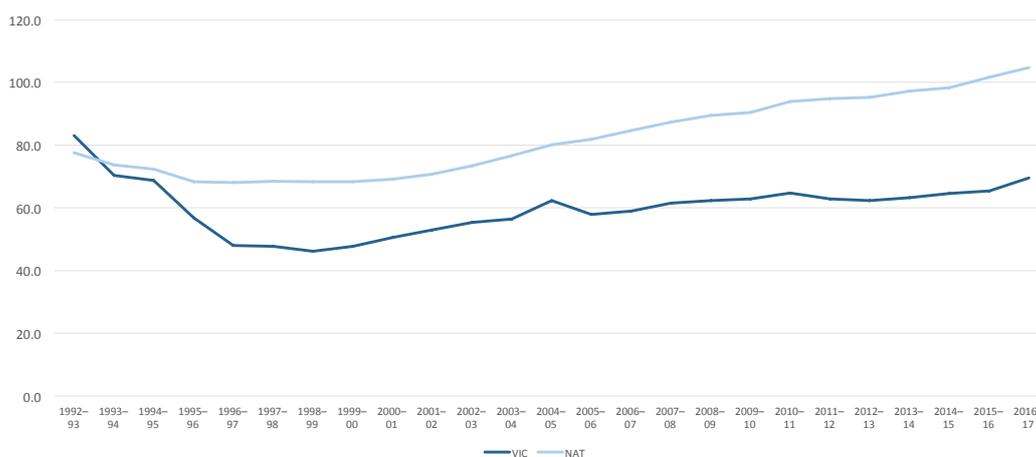


Figure A11. AIHW Expenditure on mental health services, recurrent expenditure per capita (\$) – total public psychiatric beds.

Victorian AIHW 2016–17 data: overall mental health expenditure for all general adult, youth, and forensic services (community, residential, and specialist beds)

Victorian expenditure on the general adult population (community, residential, and specialist beds for ages 18–64) is the least in the nation, spending \$180 per capita, which is 27% less than the Australian average of \$229 per capita.

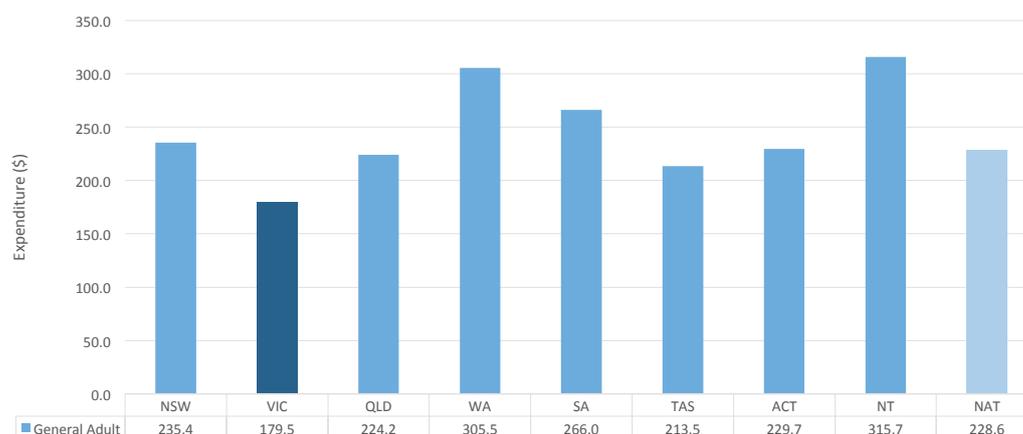


Figure A12. AIHW Recurrent expenditure per capita (\$) on specialised mental health care services – general adult, 2016–17.

Victorian expenditure on youth-specific specialist mental health services (community, residential, and specialist beds) is \$53 per capita, which is 99% higher than the Australian average of \$27 per capita.



Figure A13. AIHW Recurrent expenditure per capita (\$) on specialised mental health care services – youth, 2016–17.

Victorian expenditure on forensic mental health services (community, residential, and specialist beds) is \$12 per capita, which is 39% less than the Australian average of \$16 per capita.

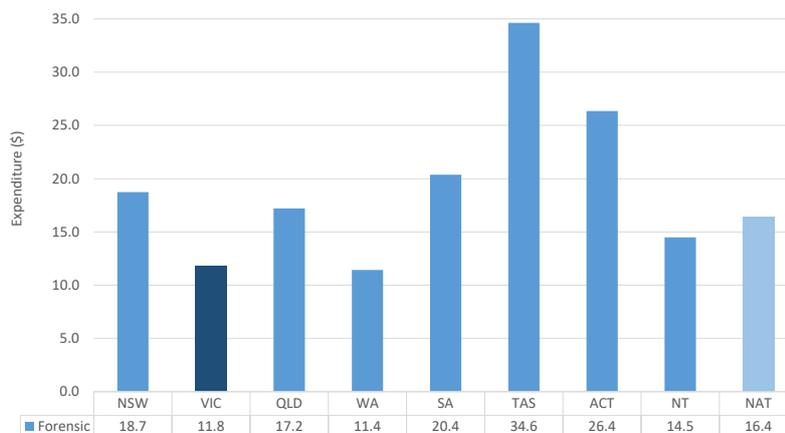


Figure A14. AIHW Recurrent expenditure per capita (\$) on specialised mental health care services – forensic, 2016–17.

Victorian AIHW 2016–17 data: community mental health for adult, youth, and forensic services (State funded)

1. Population coverage and service contacts by community mental health teams

Victoria has the lowest number of adult patient (aged 25–64) population coverage in the nation – with 1.1% of the population seen, compared to the national population coverage of 2%. Victoria also has reduced youth population (aged 15–24) coverage with 1.6% of the population seen, compared to the national average of 2.9%. The community mental health contact data are consistent with the above data: both adult and youth total community mental health contacts are the lowest rates in the nation (41% and 37% lower than the national average respectively).

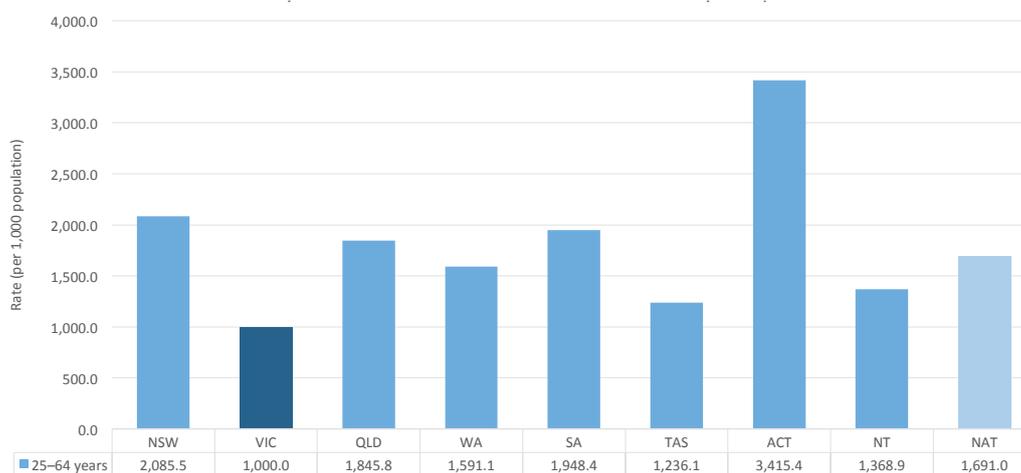


Figure A15. AIHW Community mental health care services contacts z years, 2016–17.

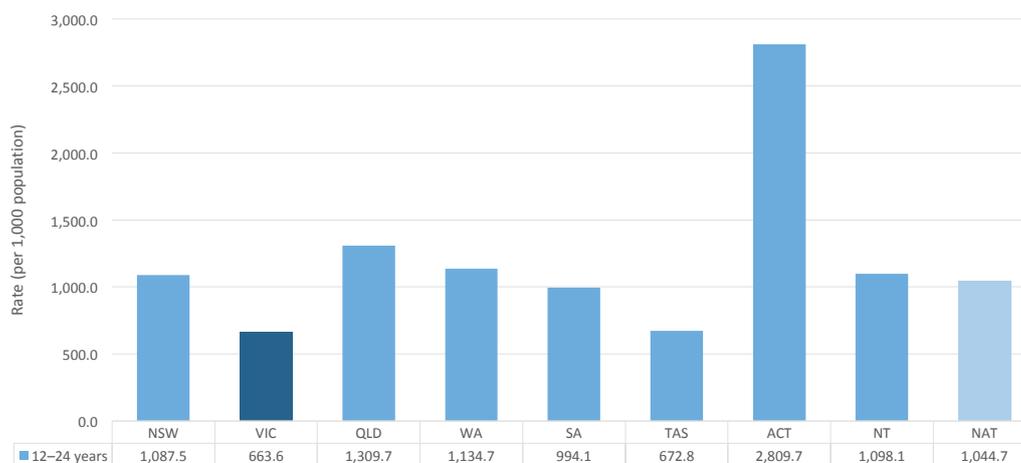


Figure A16. AIHW Community mental health care services contacts 12–24 years, 2016–17.

This pattern of low population coverage by community mental health teams and low numbers of community mental health total contacts is most prominent in metropolitan and inner regional areas of Victoria.

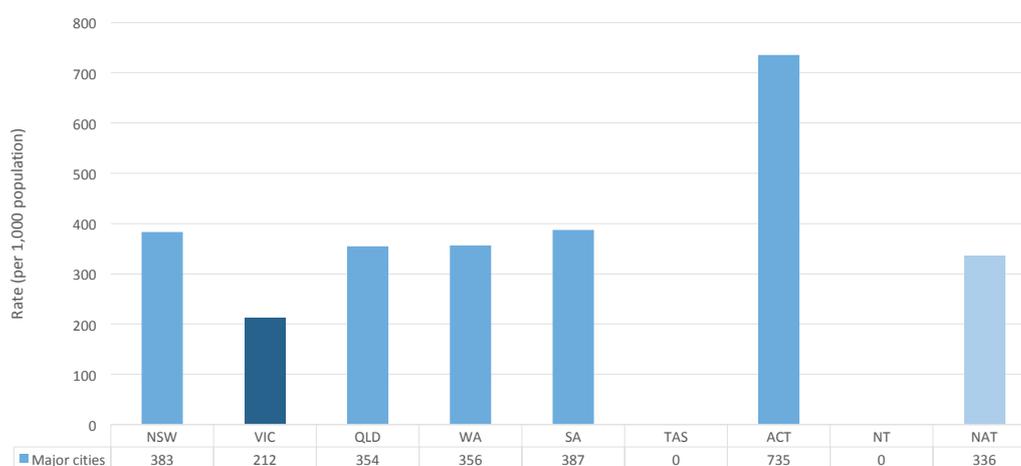


Figure A17. AIHW Community mental health care service contacts major cities, 2016–17.

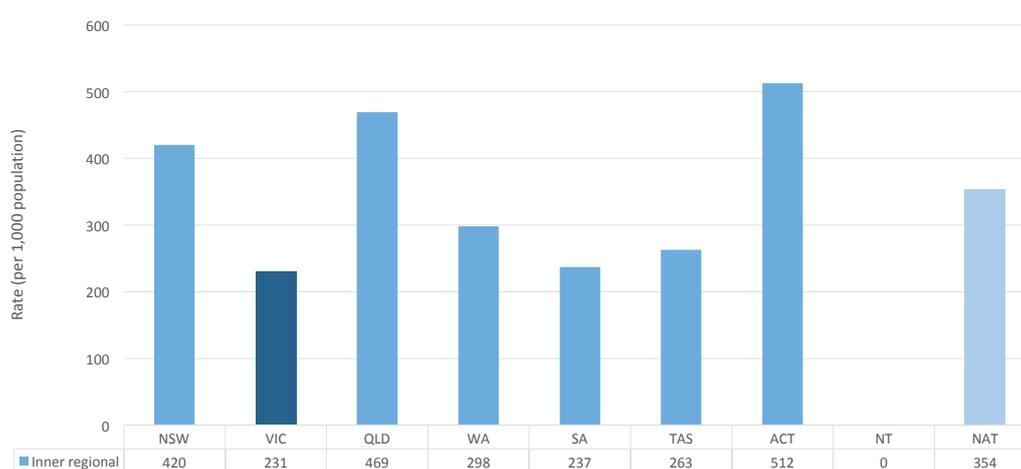


Figure A18. AIHW Community mental health care service contacts inner regional, 2016–17.

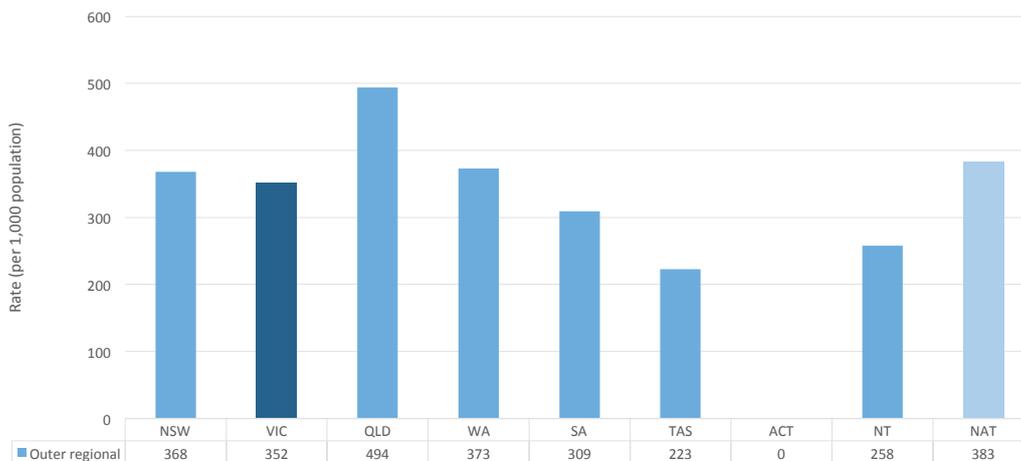


Figure A19. AIHW Community mental health care service contacts outer regional, 2016–17.

This differential in population coverage is present throughout all socioeconomic groups including the most disadvantaged Victorian communities (Socioeconomic Quintiles 1 and 2).

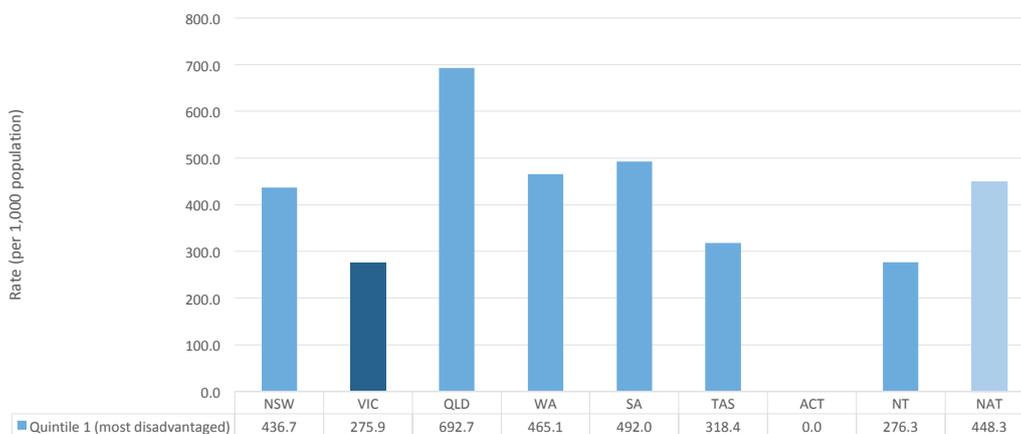


Figure A20. AIHW Community mental health care service contacts Quintile 1 (most disadvantaged), 2016–17

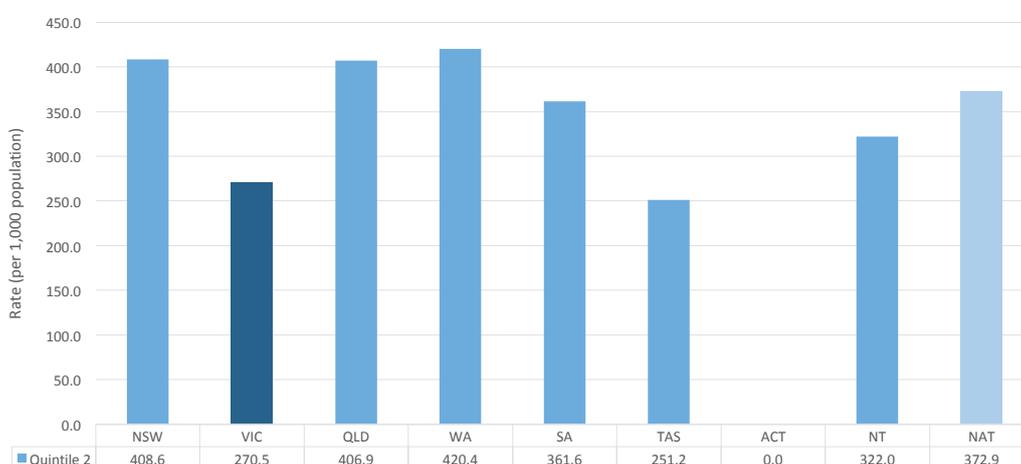


Figure A21. AIHW Community mental health care service contacts Quintile 2, 2016–17

2. Community mental health general adult and youth staffing levels

Victoria is at the national average for general adult (18–64) community mental health staffing levels (50 FTE per 100,000). Victoria is the equal (with Western Australia) highest provider of youth specialist community mental health staff, having 15.6 FTE per 100,000, which is more than double the national average of 7.5 FTE per 100,000. Victoria has 0.9 FTE per 100,000 forensic community mental health staffing levels, which are 47% lower than the national average of 1.9 FTE per 100,000.

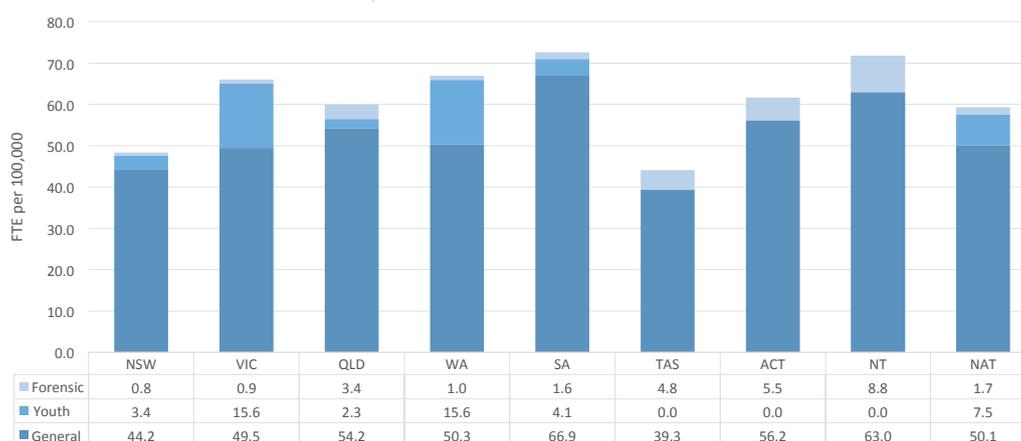


Figure A22. AIHW Full-time-equivalent health care providers by target population, community mental health care services 2016–17.

3. Cost per community treatment day (all age groups)

Victoria's cost per community treatment day (for all age groups) is the highest in Australia at \$459 per community treatment day, 41% higher than the national average of \$325 per treatment day. The AIHW does not break this cost down into child, youth, general adult, and older adult to identify differences within the community mental health sector.

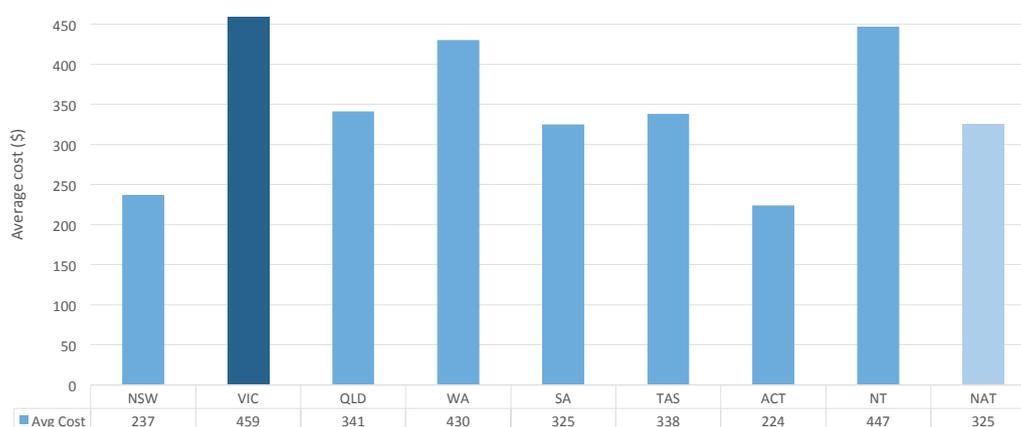


Figure A23. AIHW Average cost per community treatment day (\$), 2016–17.

Victorian AIHW 2016–17 data: supported housing

Victoria has 19.5 supported housing places per 100,000 – 9% less than the national average of 21.3 supported housing places per 100,000.



Figure A24. AIHW Supported housing places per 100,000 population, 2016–17.

Victorian ABS 2013–17 data: suicide

Victoria has the lowest aggregated suicide rate between 2013–2017 in Australia, with an age-standardised rate of 10.1 per 100,000 – 16% lower than the national average of 12.1 per 100,000.

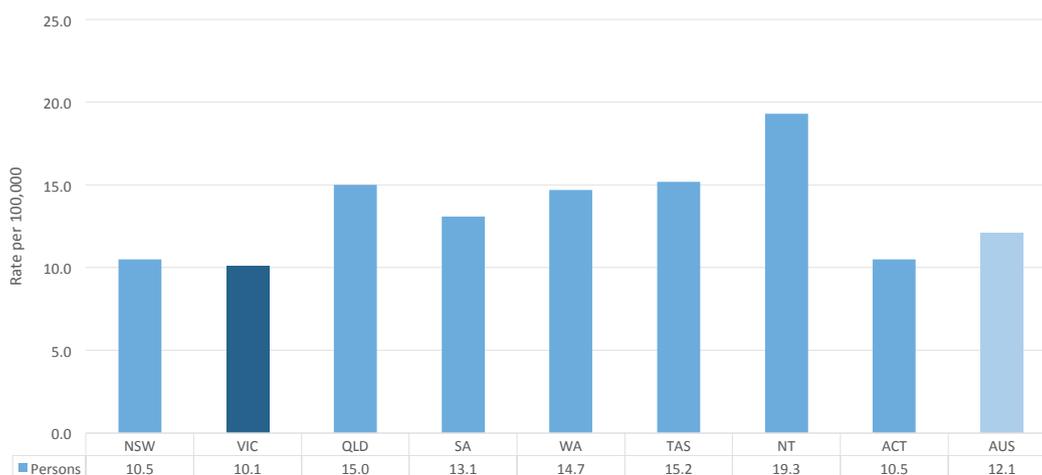


Figure A25. ABS Suicide, standardised death rate, 2013–17: persons.

Victoria has the lowest male aggregated suicide rate in the nation, with an age-standardised rate of 15.3 per 100,000 – 17% lower than the national average of 18.5 per 100,000. Victoria has the equal lowest female aggregated suicide rate in the nation (equal with NSW), with an age-standardised rate of 5.1 per 100,000 – which is 15% lower than the national average of 6 per 100,000.

Victorian AIHW 2017–18 data: emergency department (ED) mental health

1. Victorian emergency department mental health presentations

Victorian emergency department attendances, adjusted for population, are rising every year: mental-health-related presentations to Victorian emergency department in public hospitals have increased by 55%, rising from 58 presentations per 100,000 in 2004–5 to 90 presentations per 100,000 in 2016–17 (see Figure 7).

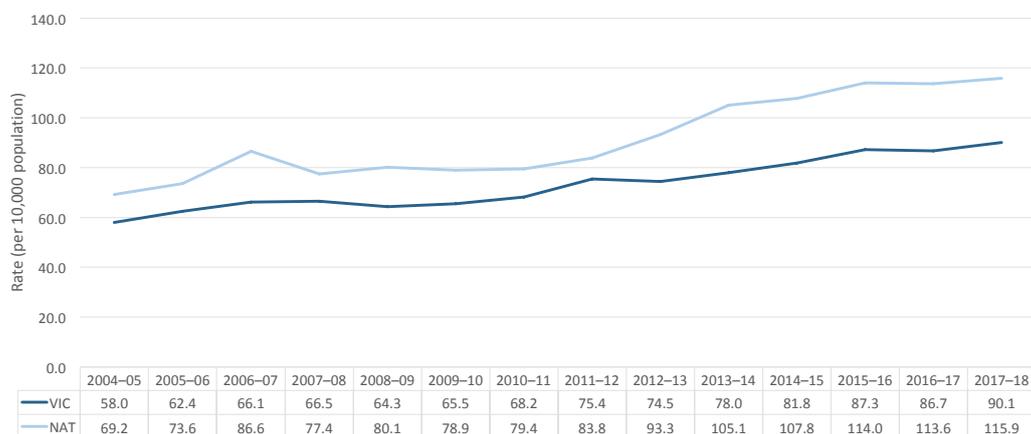


Figure A26. AIHW Mental health related emergency department presentations.

Victoria has the lowest number of emergency department mental-health-related presentations in Australia with 90 mental-health-related presentations per 100,000 – 22% lower than the national average of 116 mental health presentations per 100,000. Victoria has been consistently below the national average for emergency department mental-health-related presentations since 2004–5.

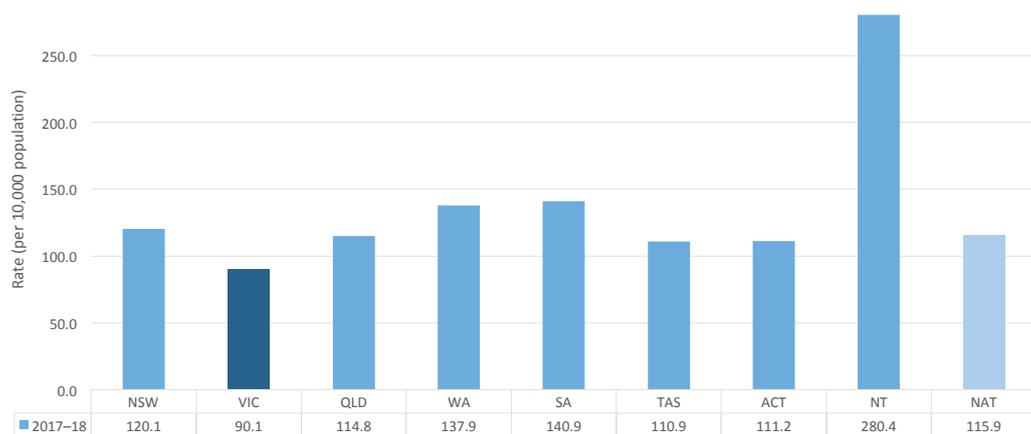


Figure A27. AIHW Mental health related emergency department presentations, 2017–18.

Victoria has a high number of schizophrenia-related emergency department mental health presentations, with 161 per 100,000 – 13% higher than the Australian average of 142 per 100,000. The proportion of schizophrenia-related presentations relative to all emergency department mental health presentations is 17% compared to the national average of 12%.

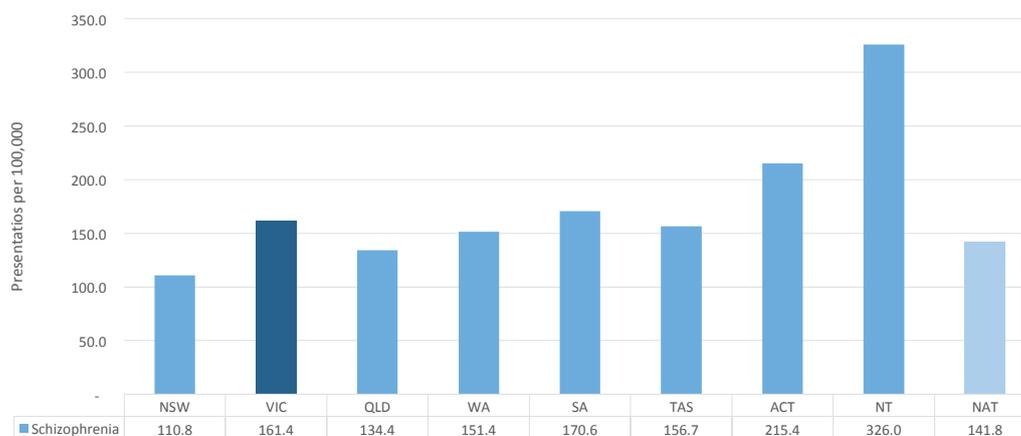


Figure A28. AIHW Mental health-related emergency department schizophrenia presentations per 100,000, 2017–18.

2. Victorian emergency department mental health waiting times

Mental health patients in Victorian EDs wait longer than non-mental-health patients, with the 90th percentile being 13.5 hours – 93% higher than the Australian non-mental-health waiting times of seven hours. Victorian 90th percentile emergency department mental health wait times are also slightly above the Australian average of 12.2 hours.

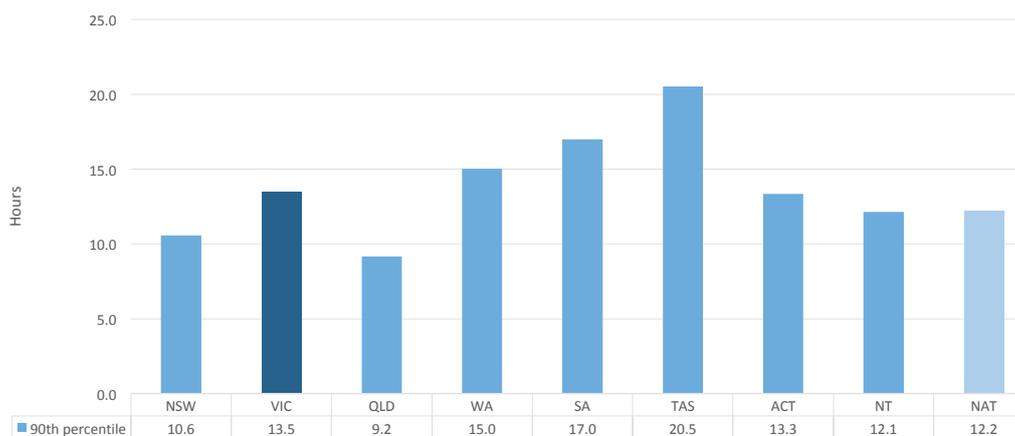


Figure A29. AIHW Mental health related emergency department presentations, 90th percentile length of stay hours, all 2017–18.

The admission stream waiting times for Victorian patients with mental-health-related presentations is high, with the 90th percentile waiting times for the admission stream being 17.6 hours – consistent with the national average of 17.5 hours.

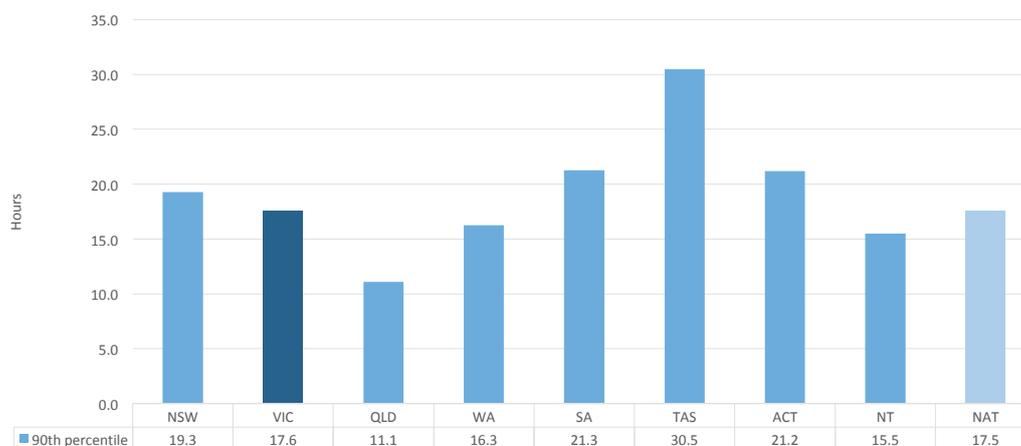


Figure A30. AIHW Mental health related emergency department presentations, 90th percentile length of stay hours, admissions 2017–18.

Across Australia, mental health patients are waiting for extended periods in emergency department while awaiting admission to an acute bed – <https://acem.org.au/News/Oct-2018/A-state-of-crisis> – Data-shows-blow-outs-for-ment. Often mental health patients are stranded in emergency department for over 24 hours across Victoria and Australia.

Australian and Victorian total psychiatry beds compared to international specialist psychiatric bed numbers – OECD and WHO

Australia has 41.7 specialist psychiatric beds per 100,000 – 29.4 within the public sector and 12.3 within the private sector (per 100,000). Across Australia there has been a 4% reduction in public sector beds since 2000–2001: from 30.5 to 29.4 beds per 100,000 in 2016–17. In the same period there has been a 37% increase in private sector bed growth from 9 (2000–2001) to 12.3 (2016–17) beds per 100,000. Overall, since 2000–2001 there has been a slight increase in the combined bed base of public and private sector specialist psychiatric beds in Australia: from 38.4 to 41.7 specialist psychiatric beds per 100,000 in 2016–17, with all of this growth attributable to private sector growth.

Australia's overall specialist psychiatric bed numbers (public plus private) are 41.7 beds per 100,000 – 33% below the OECD median of 62 beds per 100,000. Australia is ranked 23rd out of 36 countries in the OECD in terms of total bed numbers. The WHO specialist psychiatric numbers are 50 beds per 100,000 for European zone countries, and 48 beds per 100,000 for countries categorised as high-income countries. https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/. The WHO dataset reports Australia has having 31 beds per 100,000 as it excludes Australia's private sector bed numbers. Therefore, Australia has 38% fewer public sector beds than the WHO European and high-income country averages when excluding private sector beds (12.3 per 100,000). The above OECD and WHO data do not include residential bed counts and applies to all age groups.

Conclusion: Australia has a significantly lower specialist psychiatric bed base compared to OECD, and to WHO European and high-income comparator countries – the differences ranging between 32–38% lower.

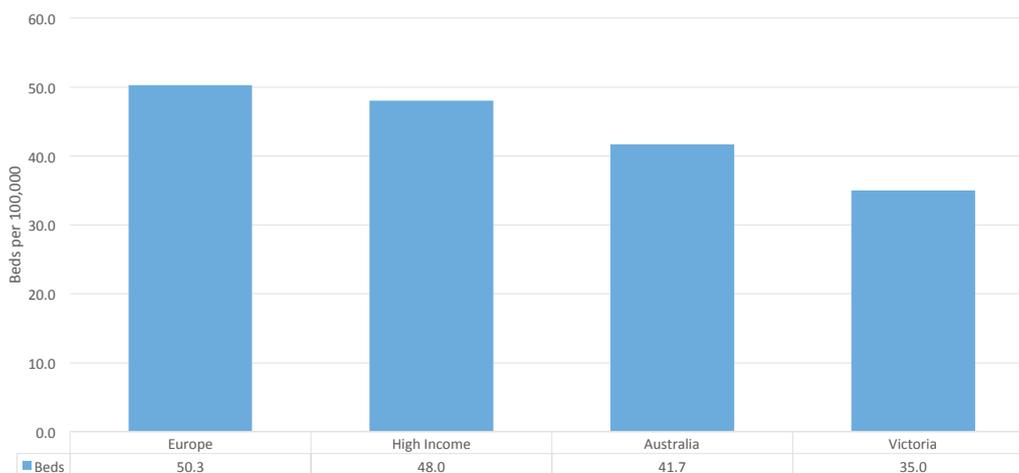


Figure A31. WHO Mental health beds per 100,000.

Victoria had 22 public sector beds per 100,000 in 2016–17, which is 25% below the Australian average of 29.4 public sector beds per 100,000 for all age groups. Victoria has 13 private sector beds (844 private sector beds across Victoria) per 100,000, which is slightly higher than the national average of 12.3 private sector beds per 100,000. Victoria has in total 35 beds per 100,000 (22 public and 13 private sector beds per 100,000), which is 17% below the Australian average of 42 beds per 100,000 and 44% below the OECD median of 62 beds per 100,000. If Victoria were a country this would mean ranking only 29th out of 36 OECD countries in terms of psychiatric bed provision, with only Ireland, Canada, New Zealand, USA, Chile, Italy, Turkey and Mexico ranked lower.

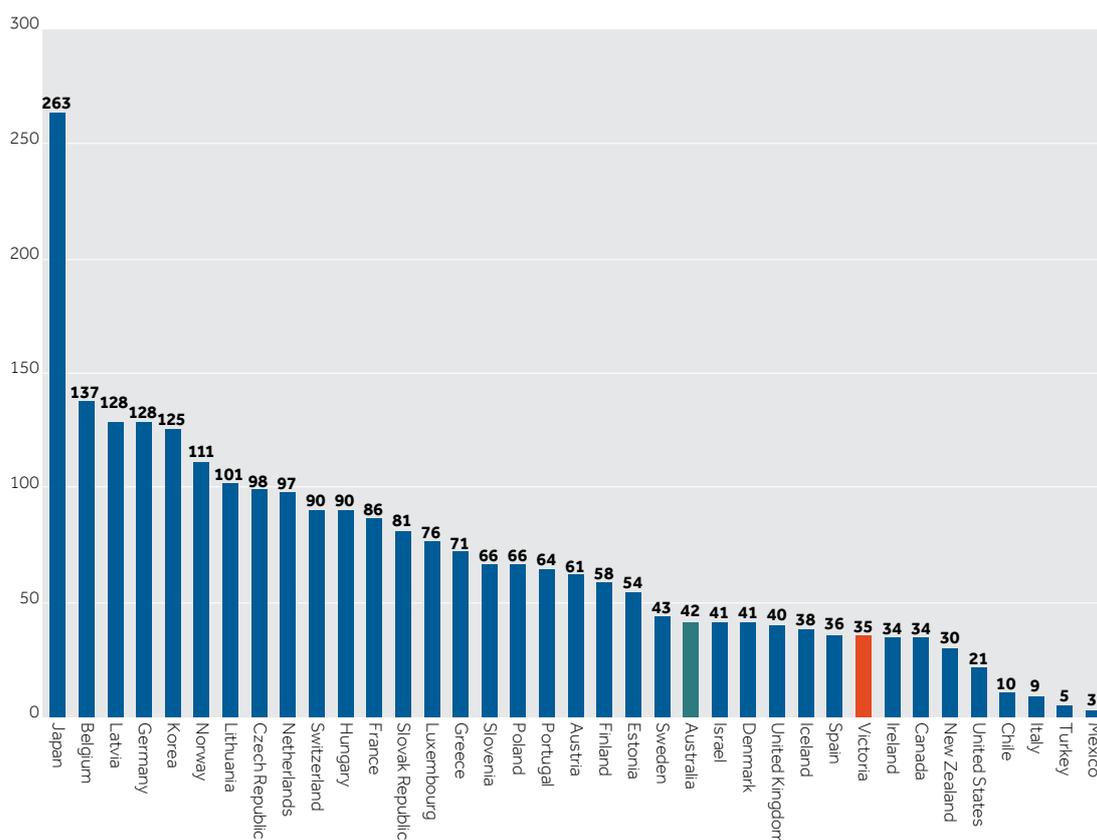


Figure A32. OECD Psychiatric beds per 100,000 population.

Victorian AIHW 2016–17 data: overnight psychiatric admissions (all age groups) – public and private sector

Victoria has 21% fewer overnight mental health separations within all specialist public sector beds: 41 compared to the Australian average of 50 separations per 100,000.

Victoria has 22% more overnight mental health separations within all specialist private sector beds: 21 compared to the Australian average of 18 separations per 100,000.

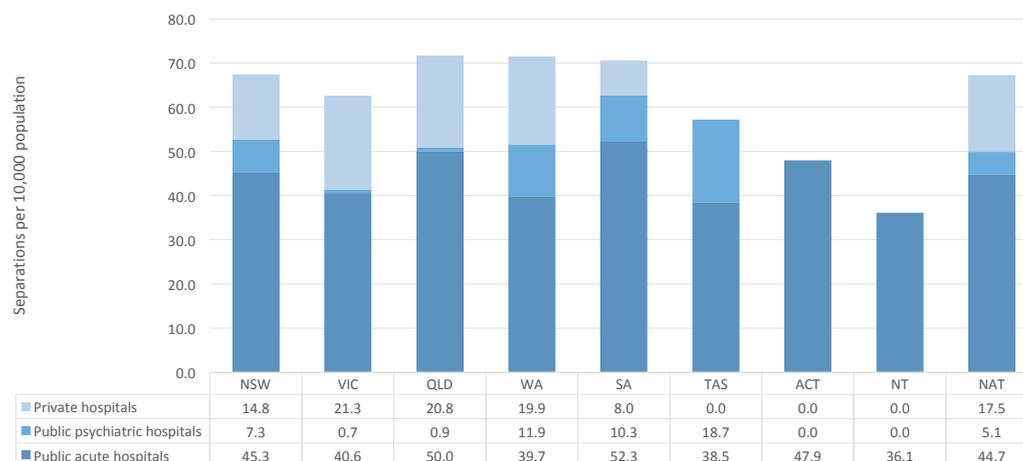


Figure A33. AIHW Overnight admitted mental health separations with specialised care, 2016–17.

Australian and Victorian AIHW 2015–16 My Healthy Communities' data: mental health admissions – diagnostic sub-groups

Within Australian public sector beds, total occupied bed days (OBDs) for mental health patients is at 1044 bed days per 10,000 people. 448 of these bed days are directly related to schizophrenia (43% of total public sector OBDs) and 105 are related to bipolar disorder (10% of total public sector OBDs). Therefore, 53% of total OBDs within public sector beds for mental health patients are for patients with a diagnosis of schizophrenia and bipolar disorder. The proportion of OBDs occupied by patients with schizophrenia and bipolar disorder in Victoria is also approximately 50%. 95% of all total OBDs related to schizophrenia are within the public sector and only 5% are located in the private sector.

Victoria has a much reduced use of public sector bed days in all diagnostic sub-groups – schizophrenia, bipolar disorder, depression, anxiety and stress, and intentional self-harm – when compared to the national average.

Victorian AIHW 2016–17 data: general adult total (acute and non-acute) bed numbers

Victoria has 22.4 general adult acute and non-acute beds per 100,000 – 34% below the national average of 34 beds per 100,000. NSW has the highest number with 41.7 beds per 100,000 and therefore Victoria has 47% fewer total general adult beds when compared directly with NSW.

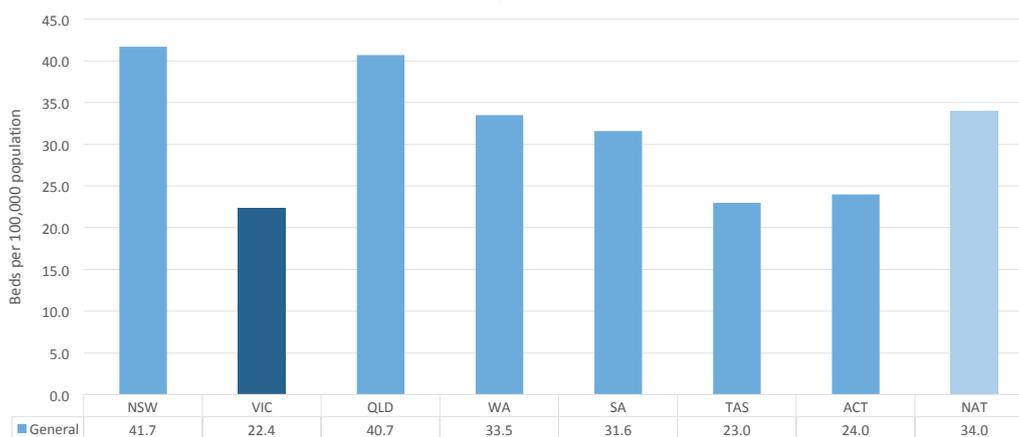


Figure A34. AIHW Public sector specialised mental health hospital beds per 100,000 population – general adult total 2016–17.

Victorian AIHW 2016–17 data: general adult acute bed numbers

Victoria has 19 general adult acute beds per 100,000 – 22% below the national average of 24.5 beds per 100,000.

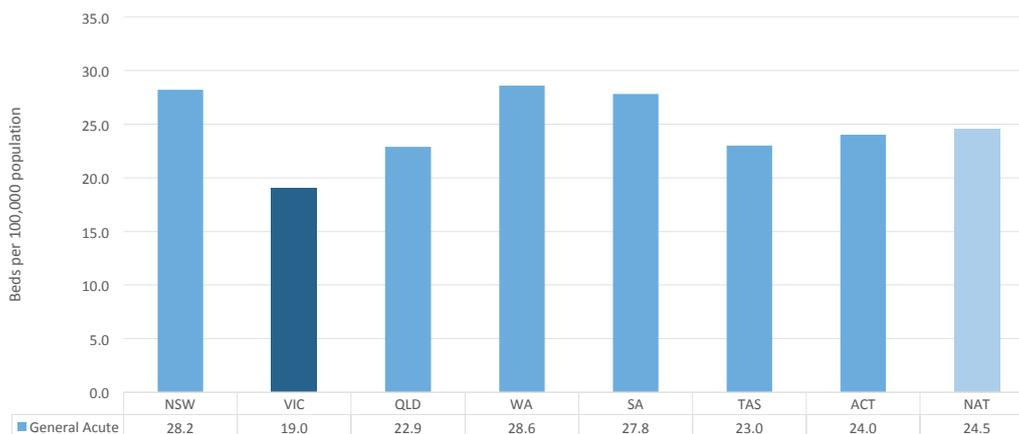


Figure A35. AIHW Public sector specialised mental health hospital beds per 100,000 – general adult acute 2016–17.

Victorian AIHW 2016–17 data: general adult non-acute bed numbers

Victoria has 3.4 general adult non-acute beds per 100,000 – 64% below the national average of 9.5 beds per 100,000.

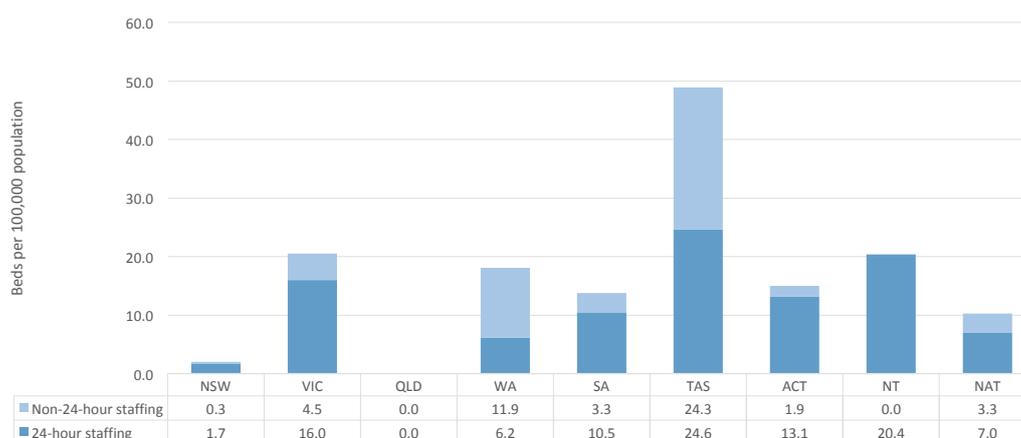


Figure A36. AIHW Public sector specialised mental health hospital beds per 100,000 population – general adult non-acute 2016–17.

Victorian AIHW 2016–17 data: general adult 24-hour and non-24-hour residential beds

Victoria has 16 general adult 24-hour residential beds per 100,000 – 128% more general adult residential beds when compared with the national average of 7 beds per 100,000. The national data do not currently sub-divide these general adult residential beds into short-term sub-acute beds (e.g. Prevention and Recovery Care – PARC beds) or long-term residential beds (e.g. community rehabilitation centres). Victoria has a mix of both short-term PARC (under 1-month length of stay) and community rehabilitation centres (several months length of stay) for the general adult population.

Victoria has 4.5 general adult non-24-hour residential beds per 100,000 – 36% above the national average.

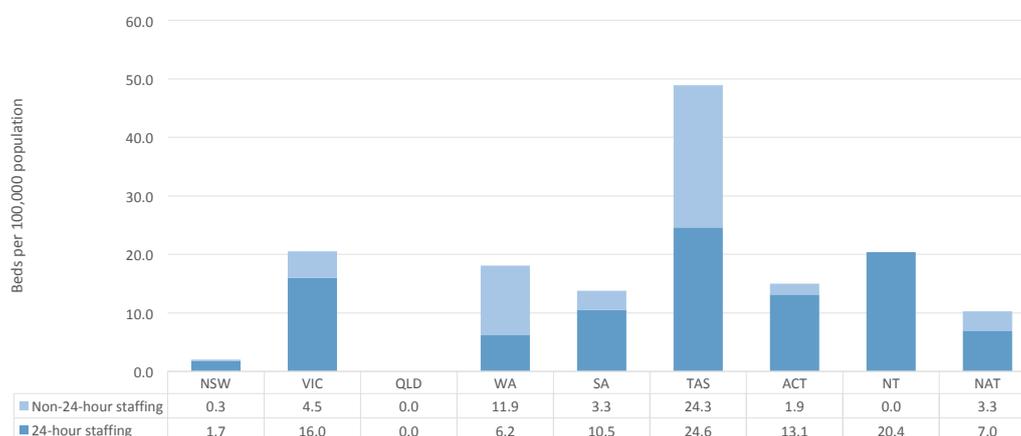


Figure A37. AIHW Mental health service beds per 100,000 population by staffing – general adult 2016–17.

Victorian AIHW 2016–17 data: youth acute beds

Victoria has 2.1 youth acute beds per 100,000 – 24% above the national average of 1.7 beds per 100,000.



Figure A38. AIHW Public sector mental health hospital beds per 100,000 population – youth 2016–17.

Victorian AIHW 2016–17 data: youth 24-hour and non-24-hour residential beds

Victoria has 3.9 youth 24-hour residential beds per 100,000 – 95% higher than the Australian average of 2 beds per 100,000.

Victoria has 13.6 non-24-hour residential beds per 100,000 – 278% above the national average of 3.6 beds per 100,000.

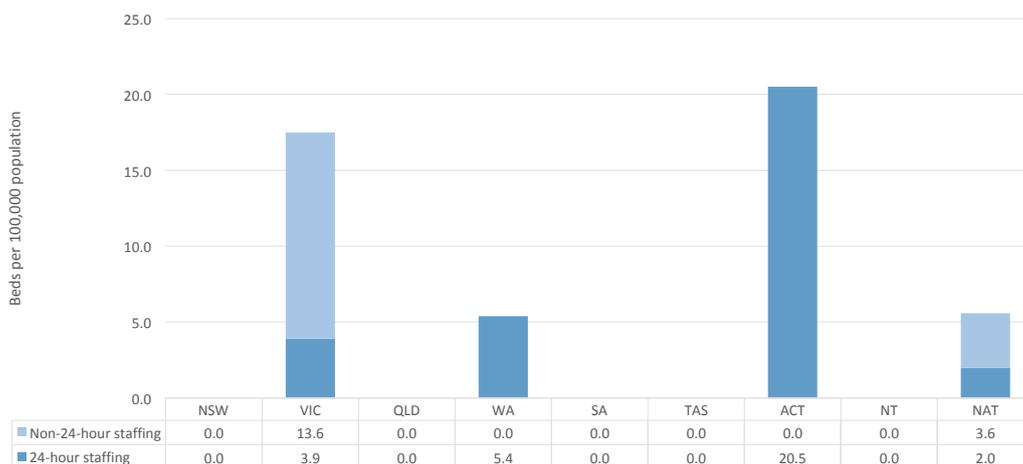


Figure A39. AIHW Residential mental health service beds per 100,000 population by staffing – Youth 2016–17.

Victorian AIHW 2016–17 data: forensic beds

Victoria has 3.1 forensic beds per 100,000 – 14% below the national average of 3.5 beds per 100,000.

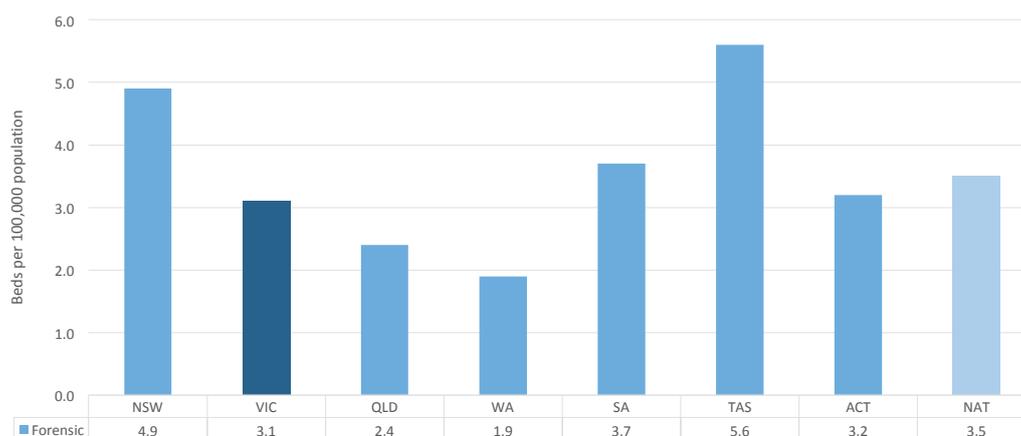
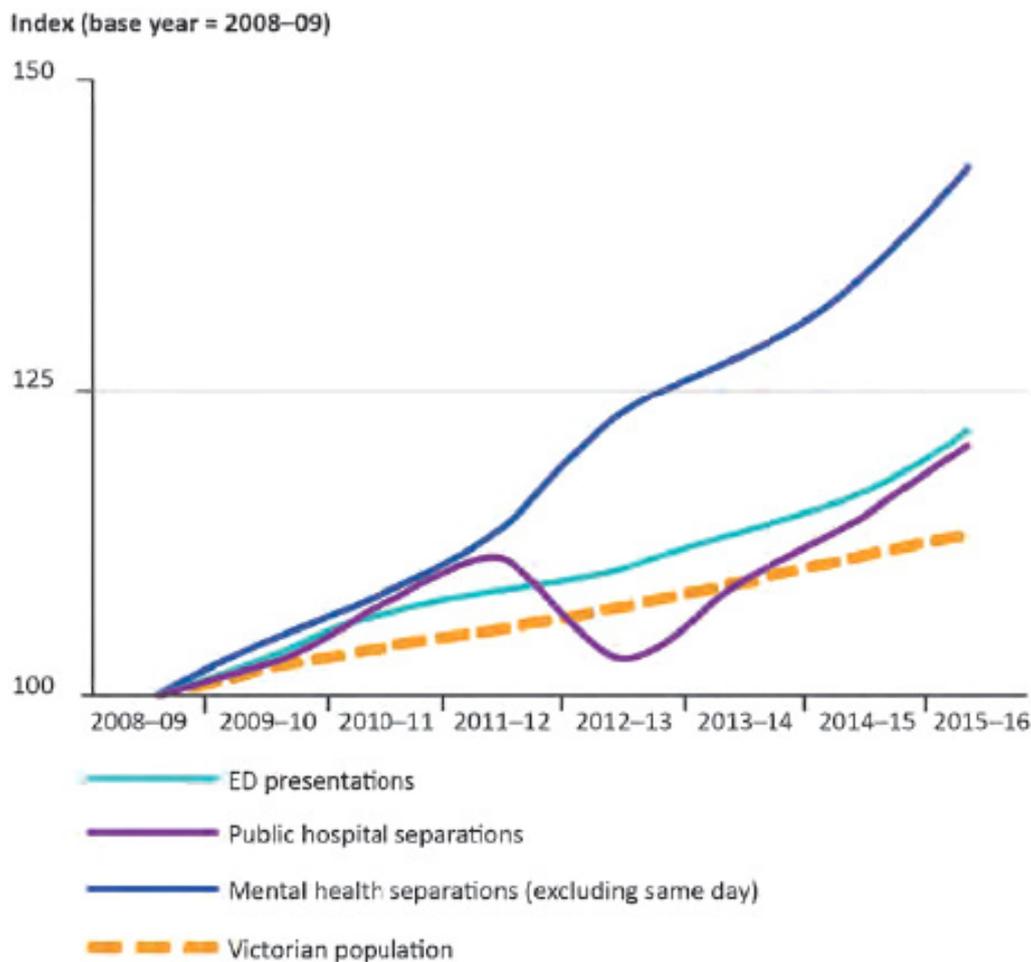


Figure A40. AIHW Public sector specialised mental health hospital beds per 100,000 population – forensic 2016–17.

Victorian AIHW 2016–17 data: general adult acute separations and average length of stay

Victoria's general adult average length of stay is 12.3 days – 7% above the Australian average of 11.5 days.

As a result of the significant increase in emergency department mental health related demand, overnight mental health separations are growing at a rate much faster than both population growth and the growth in health separations (<https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf>)



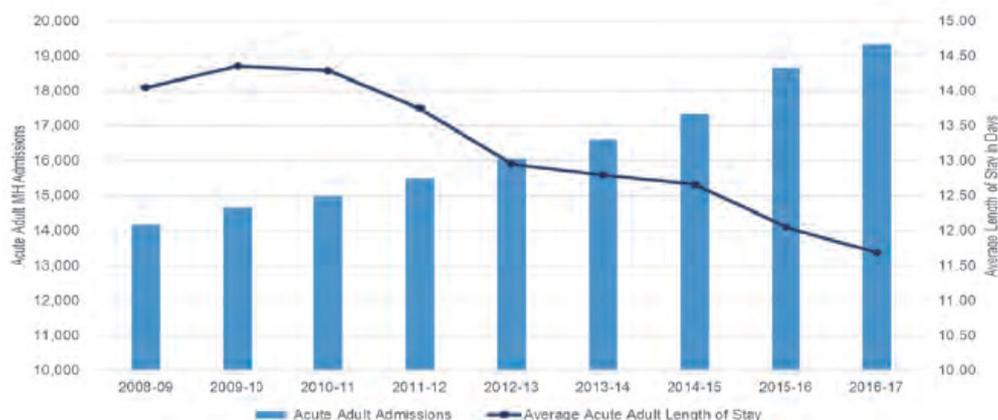
Note: Between 2011–12 and 2012–13 the negative growth in public hospital separations was due to a change in admissions policies (patients accommodated in the ED only were no longer counted as admitted). Once hospitals reconfigured their ED/inpatient interface, growth in separations has consistently increased.

Source: VAGO, based on information from DHHS using internal and Australian Bureau of Statistics data.

Figure A41. Indexed growth in Victorian health service-related events versus population.¹⁸¹

However because the general adult acute bed base per 100,000 has reduced over time, due to both the increased emergency department demand and the increase in Victorian population, there has been a 16% reduction in the general adult average length of stay since 2008/09 from 14 days to 11.7 days in 2016–17. The number of overnight mental health separations has increased significantly from approximately 14,100 separations in 2009/10 to 19,200 in 2016–17 (<https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf>).

¹⁸¹ Figure 3C, *Victorian Auditor-General's Office, Access to Mental Health Services*, March 2019.



Source: Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services, by A.Cockram, S.Solomon, H.Whiteford, 2017.

Figure A42. Acute mental health admissions and average length of stay, 2009 to 2017.¹⁸²

Victorian general adult acute mental health occupancy rates 2018–19

Victorian general adult mental health occupancy rates were 94% between 2018 and 2019 (<https://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=404>) – well above the recommended rates of 85% to prevent emergency department access block.

Victorian AIHW 2016–17 data: re-admissions within 28 days (all wards)

Victorian 28-day readmission rates are at 14.6 days – 2% lower than the national readmission rate of 14.9 days. Australian 28-day readmission rates are high by OECD standards.

Victorian AIHW data: restraint and seclusion

Victoria has the highest use of restraint in the nation with 23.4 per 100,000 – more than double the national average of 10.8 per 100,000 (2016–17). Victoria also has high seclusion rates (2017–18), with 9.1 per 100,000 – 30% above the national average of 6.9 per 100,000.

Victorian AIHW 2016–17 data: general adult costs per acute admitted patient day

Victorian costs per general adult acute admitted patient bed day are \$1007, which is 17% below the national average of \$1206 per bed day.

Conclusion

This detailed analysis has been the basis for our planning recommendations, which are described in full within our submission. This analysis in particular identified significant gaps in general adult acute and non-acute inpatient provision, relative to other components of the Victorian mental health system.

¹⁸² Figure 3F, *Victorian Auditor-General's Office, Access to Mental Health Services*, March 2019.

