Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF RUTH GERALDINE VINE

I, Ruth Geraldine Vine, Associate Professor, of NorthWestern Mental Health (**NorthWestern**), 1 North, Royal Melbourne Hospital, Parkville 3050, in the State of Victoria, say as follows:

1. I am authorised by Melbourne Health to make this statement on its behalf.

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

A. BACKGROUND AND QUALIFICATIONS

(i) Please outline your relevant background including qualifications, experience and provide a copy of your current CV and relevant experience.

3. I have the following qualifications:

   3.1. Bachelor of Medicine & Bachelor of Surgery (MBBS);

   3.2. Diploma of Psychological Medicine;

   3.3. Fellow of the Royal Australian and New Zealand College of Psychiatry;

   3.4. Graduate Diploma of Criminology;

   3.5. Bachelor of Laws; and

   3.6. Graduate of the Australian Institute of Company Directors.

4. I trained as a consultant psychiatrist, and worked initially in that role at the Forensic Psychiatric Services from 1991 to 1999. I was also a Lecturer at the University of Melbourne, Department of Psychological Medicine, and a consultant at the Austin Hospital between 1991 and 1993.

5. I worked at the Department of Human Services (subsequently known as the Department of Health and later the Department of Health and Human Services (**Department**)) over the period from 1999 to 2012. During this period, I took on the roles of Deputy Chief Psychiatrist (1999 to 2004), Director of Mental Health (January 2004 to February 2008) and Chief Psychiatrist (May 2009 to November 2012).

6. I also took 1 year of leave without pay from May 2008 to May 2009, during which I worked part-time as a consultant psychiatrist in the Western Region Community Health Centre, and as a project officer within the Mental Health branch of Department of Health and Aging in the Commonwealth government.

7. I joined Melbourne Health in November 2012, initially as Director of Clinical Services of Inner West Area Mental Health Service. Since July 2013, I have been the Executive Director of NorthWestern but I have been on long service leave beginning from April 2019. The period of my long service leave is up till the end of the calendar year, after which I will cease to be Executive Director of NorthWestern.

8. In summary, I have been involved in clinical, bureaucratic and administrative aspects of the mental health system. Attached to this statement and marked **RV-1** is a copy of my Curriculum Vitae, which sets out further details of my career to date.

(ii) Please describe your current role and your responsibilities in your previous role as Executive Director of NorthWestern.

9. As Executive Director of NorthWestern, I was responsible for NorthWestern's 6 mental health programs:

   9.1. four adult area mental health services (**AMHS**);

   9.2. a youth program (Orygen Youth Health Clinical Program (**Orygen**)); and

   9.3. an aged persons program, which included a number of nursing homes.

10. My role was supported by a Director of Operations and a Director of Clinical Governance, but I had overall responsibility for the financial, operational, safety and quality aspects of NorthWestern. I reported to the Chief Executive of Melbourne Health and attended Melbourne Health's Board meetings, which increased the visibility of NorthWestern to the Board.

11. One of my responsibilities was to ensure that NorthWestern meets its Key Performance Indicators (**KPIs**). The area mental health services' KPIs are generally set by the Department in line with national targets, or by the individual health services for KPIs in relation to areas such as workforce, critical incident and occupational violence data (after taking into account their respective financial and quality expectations). KPIs include targets in relation to seclusion rate per 1,000 bed days, physical restraint, 7 days pre-admission contact, 7 days post-admission contact, readmission into inpatient units within 28 days from initial discharge, length of stay, occupancy rate, post-discharge follow-up, sentinel events and the duration of mental health presentations at Emergency Departments (**EDs**) before admission to an inpatient bed or discharge. The KPIs are largely focussed on processes, with some KPIs easier to meet than others depending on the clinical capacity of a particular health service.

12. One of the main KPIs which does include both quality and process elements is the 4 hour ED target. This contemplates that 85% of all presentations (including mental health presentations) to the ED should be finalised within 4 hours. This is realistically very difficult to attain. The KPI for 24 hour length of stay in the ED is zero. NorthWestern has not been able to reach the 4 hour target (or even an 8 hour target). There are both clinical and systemic reasons why those with mental health presentations may wait a long time in the ED. The person may be intoxicated or under the influence of drugs, and need time to settle before they can be adequately assessed. Obtaining a collateral history from family or other clinical services is an important part of assessment but also takes time. For those who need to be admitted, the most common reason for the delay is finding a suitable bed. Many people with acute mental illnesses need the greater safety and supervision available in an Intensive Care Area (**ICA**). As ICAs are always full, making a bed available requires a decision on who can be moved out of the ICA. Finding any bed is time consuming; finding an ICA bed often takes even longer. Often the ICA bed found is at another service so there is also a delay in getting appropriate transport (usually an ambulance).

13. NorthWestern makes it a priority to ensure that all mental health presentations are resolved (that is, the consumers are either admitted or discharged) within 24 hours, and as a result has very rarely not achieved the KPI target that no person should have to wait in an ED for more than 24 hours. This target has only been achieved at the Royal Melbourne Hospital through the use of a short stay unit.

14. Ideally, the KPIs should be focussed on outcomes and not processes (which may be easier to measure) – for instance, the KPI on pre-admission contact and post-admission contact is quantitative but does not answer the question of whether the contact was good or bad. The "Your Experience of Service" survey exists to understand how people experience mental health services, but that is annual survey and is not a KPI. Attached to this statement and marked **RV-2** is a copy of the summary of NorthWestern's "Your Experience of Service" survey results for 2016, 2017 and 2018.

(iii) NorthWestern

(a) What is NorthWestern and what services does it provide?

15. NorthWestern is a large, age-based and area-based public mental health service that is part of Melbourne Health. NorthWestern comprises 20 – 25% of Melbourne Health's business, whereas the largest component of Melbourne Health is the Royal Melbourne Hospital.

16. NorthWestern provides community, inpatient and rehabilitation clinical services, including compulsory treatment under the *Mental Health Act 2014* (Vic) (**Mental Health Act**). It also provides Consultation-Liaison Psychiatry services at Sunshine, Epping and Royal Melbourne Hospitals and at the Royal Park campus. Consultation-Liaison Psychiatry involves providing assessment and advice regarding the psychiatric management of patients who are in hospital because of physical illness but who also have a mental illness or who have behavioural disturbance. For example, a person may be admitted to the intensive care unit following a drug overdose, depression and anxiety are common in people who have chronic illnesses, and people with head injuries often have delirium and behavioural disturbances which require specific management strategies. These services are provided mainly by consultant psychiatrists and experienced psychiatric nurses.

17. In addition, NorthWestern incorporates a number of research centres and provides medical undergraduate placements, and graduate and post-graduate training for mental health nurses, registrars, psychologists, social workers and occupational therapists.

18. Importantly, NorthWestern is governed by Melbourne Health but also provides inpatient services at the campuses of both Western Health (Sunshine) and Northern Health (Epping and Broadmeadows), and mental health services to the EDs of Sunshine, Epping and Royal Melbourne Hospitals. These are among the three busiest EDs in Victoria. This may be contrasted to other health services (for example, Monash Health) which manage both the mental health services and the hospital facilities for their communities. We also provide community mental health services to communities who access other health services through Western Health and Northern Health.

19. NorthWestern's catchment areas are big and include a number of growth corridors, with a diverse population of over 1.3 million people – this creates major ramifications for access and navigation. Some of the challenges we face are:

    19.1. our catchment areas cover a large geographic area, which impacts on travel time and local accessibility

    19.2. many different languages are spoken across the communities we serve, especially in the northern and western suburbs;

    19.3. our catchment areas include areas with socio-economic disadvantage (for example, Office of Housing accommodation) and where substance use is more prevalent;

19.4. our catchment areas include the Central Business District (**CBD**), where there is a large growth of international students and a large homeless population; and

19.5. there are a number of prisons within our catchment areas, creating a very large prison population. There has been a particular growth in remanded prisoners who may be released precipitously and referred to EDs and community services. – as there are more people remanded in current times, there is a likelihood that these people would be discharged precipitously into EDs.

20. NorthWestern operates 502 beds (some of which are rented from private hospitals) across:

20.1. acute inpatient units (adult, youth and aged);

20.2. Prevention and Recovery Care services (PARC) (a 'step up, step down', short stay supported service – that is, a step up from the community or a step down from an inpatient unit);

20.3. Community Care Units (**CCU**) (a longer-term, clinically supported residential service);

20.4. a Secure Extended Care unit (providing medium to long-term inpatient treatment and rehabilitation service); and

20.5. generic and mental health specific nursing homes.

(b) Where does NorthWestern fit within the mental health system?

21. NorthWestern is part of Victoria's clinical mental health system and is the largest provider of public mental health services in Victoria. It has 4 out of Victoria's 21 adult AMHSs, and interfaces with other AMHSs in both rural and metropolitan regions.

(c) Who receives NorthWestern's services? What are the criteria for people affected by mental illness to access NorthWestern's services? Must NorthWestern's clients come from any particular geographic location?

NorthWestern's consumers

22. NorthWestern provides clinical mental health services to approximately 16,000 people in the community (500,000 occasions of service) and provides approximately 5,000 inpatient admissions per annum. Approximately 50% of the 16,000 community caseload is turned over each year, as demand drives a move away from continuing care to an episodic care model.

23. Our triage service (which provides a clinical triage, including telephone assessment, information provision and referrals) responds to approximately 50,000 calls per annum to process referrals. The triage service is staffed by trained clinicians and it is provided 24 hours, 7 days a week.

24. Due to the great demand for services, it is common for us to direct people to other providers in primary care and the private sector. It should be noted that there is unequal access to primary care or private psychiatrists and psychologists across the State.

Criteria for access

25. NorthWestern's services are targeted towards those who cannot receive care in other settings. In summary, the criteria for people affected by mental illness to access our services are either that:

    25.1. the level of severity or acuity is such that the person cannot receive treatment in the primary care or private sector;

    25.2. the person is in crisis and needs an immediate response; or

    25.3. the person needs to be treated as a compulsory patient under the Mental Health Act.

26. In relation to compulsory treatments, we provide treatment in both inpatient and community settings and in accordance with the rights and protections of the Mental Health Act.

27. The greater the demand for services, the higher we have to raise the threshold for acceptance to our services – this threshold is currently much higher than we would like. This is because the amount of service we can provide is capped by the funding available, creating a form of rationed service. Generally, the people who receive our services have severe mental illnesses (such as schizophrenia, bipolar affective disorder, schizoaffective disorder, a major depressive disorder or a severe personality disorder) or a high risk of self-harm or suicide (assessed by exploring recent adverse life events, recent self-harm or expressed intent and so on). They often have added complexities such as substance use, homelessness, disability and/or other social disadvantage. It is unlikely that our services would accept people with less severe illnesses (for example, mild to moderate anxiety or depression) unless they had added complexities or they presented in crisis at EDs. Many people with such mild to moderate mental illnesses (as listed above) do present to EDs and do receive a service with assessment and intervention provided by NorthWestern and/or ED staff. Those with diagnoses such as eating

disorders may find it difficult to get treatment in the public sector but I believe this is improving at NorthWestern.

28. The only parts of NorthWestern that provide a semi-elective admission process are the specialist areas such as Eating Disorders and Neuropsychiatry.

Geographic requirements

29. In line with other AMHSs, we have defined catchment boundaries and endeavour to provide services primarily to those who live within our boundaries. As we manage 6 mental health programs, there is a degree of fluidity between the component parts of NorthWestern. For example, we try to prioritise transfers within our northern and western corridors to maximise bed availability and utilisation on a day-to-day basis.

30. We admit people aged 18 – 25 to Orygen, even if they are no longer receiving treatment from Orygen in the community. For historical reasons, the areas covered by Orygen (as well as the Aged program) are different and do not exactly overlap with the adult areas covered by NorthWestern's adult AMHSs.

31. We do provide 'out of area' services to people who present through an ED in our catchment areas or upon referral from other services, and we often provide a service (inpatient and community) to consumers residing at the southern end of the Goulburn Valley AMHS catchment. In addition, before additional beds were available at Werribee Mercy Hospital, we were also expected to provide inpatient care to a number of mental health patients in the south west area.

32. The Royal Children's Hospital, and not NorthWestern, provides mental health services to children and adolescents within NorthWestern's catchment areas. It is unusual that child and adolescent mental health is provided by a separate public mental health service. For example, Monash Health, Eastern Health and Austin Health provide their own child and adolescent mental health services (noting that Alfred Health provides community but not inpatient services for child and adolescents).

(d) Does NorthWestern assist people affected by mental illness with all degrees of severity and complexity? If not, what kinds of providers would meet the needs of those people outside of NorthWestern's reach? What other parts of the mental health system are your patients likely to use (or want to use)?

People outside of NorthWestern's reach

33. As discussed in paragraphs 25 to 27 above, NorthWestern does not generally offer a service to those with uncomplicated, mild to moderate illnesses beyond triage and the ED.

34. People with mild to moderate illness access care through the primary care sector or via the private sector (including through the federal government's *Better Access* initiative). Headspace is also an important point of access for young people. People who struggle to access care through these options are those with added problems such as intellectual disability or autism, use of alcohol and other drugs (**AoD**), and some personality disorders.

35. In addition, many people with severe mental illness may only episodically engage with, and tend to drop in and out of, our services – that is, they receive treatment when they met the criteria for compulsory treatment under the Mental Health Act, but then disengage when they no longer meet that criteria and are therefore not compelled to receive treatment.

36. Every part of the system, whether the mental illness is mild, moderate or severe, is constrained.

Other parts of the system for NorthWestern's patients

37. Our patients also use the non-governmental mental health community support services (**MHCSS**), primary care and private services. Access to appropriate supports in the MHCSS has been made more complicated by the National Disability Insurance Scheme (**NDIS**), which may involve more complex assessment and care planning. The NDIS is terrific for some, but it does require the person to actively seek engagement and there can be significant wait times to access services. Greater individual choice through the NDIS may be good for those who are seeking support, but may make it harder for those who are not actively seeking such support (but would benefit from it) to actually get that support.

(e) Briefly, how is NorthWestern funded?

38. Funding to NorthWestern is primarily through the Department. Our main departmental interface is with its Mental Health Branch.

39. New funding is provided to NorthWestern annually, the large bulk of which is block funding and is subject to yearly indexation (usually 1.5 %) against a CPI of at least 3%. The gap between the yearly indexation and the CPI represent the expected 'productivity savings' or efficiencies. This reliance on block funding is in contrast to the acute health sector which has both fixed and activity based funding.

40. Some funding is tagged as 'growth' funding or linked to industrial agreements or particular initiatives (for example, the Fixated Threat Assessment Centre – Clinical Enhancements and the Critical Incident Response Team – Information Sharing

Project). Small amounts of funding are also linked to workforce and training, or to initiatives dating back several years (for example, clinical academic positions).

41. NorthWestern's annual budget is approximately $210 million – this is historically-based, where notional funding allocations had previously been set. The majority of this supports the salary and wages of approximately 1,900 employees.

42. Our annual budget is determined based on using the funding received to achieve activity targets and servicing the community. We are expected to reach a break-even result, taking into account corporate costs and savings and performance initiatives. The quantum of savings required varies from year to year, as is the amount of growth funding received. As an operating unit, NorthWestern contributes to Melbourne Health's overheads. Final budgets are agreed by the Melbourne Health Executive in terms of signing off the Melbourne Health's Statement of Priorities Agreement with the Department.

43. Importantly, the gap between indexed funding and actual cost increases has meant that year on year, except where we had significant and untagged growth funding, NorthWestern has had to find savings with cumulative impact on the amount and quality of our services.

B. RUNNING AN AREA MENTAL HEALTH SERVICE

(i) In your experience, in relation to the needs of people affected by mental illness for clinical treatment:

(a) Is supply keeping up with demand? What gaps have you observed?

44. As compared to other public mental health services, NorthWestern is unusual in that it covers 4 growth areas, including the CBD. Over the past decade, the population has increased substantially such that, on a per capita basis, our funding, bed stock and equivalent full-time positions have declined. We have failed to keep up with demand or to provide services of equal quality.

45. In relation to NorthWestern, the gaps and impacts I have observed include the following:

45.1. A higher threshold for acceptance to services means that some people with moderate to severe illness miss out on treatment or receive only short-term treatment (which increases the risk of relapse).

45.2. There are almost no direct admissions from the community because of lack of bed availability, which has not kept up with population growth.

45.3. Almost all admissions come through the ED with the associated problems of long waits in the ED, increased occupational violence and delayed treatment.

45.4. The pressure for throughput means that people not only arrive when very unwell, but also leave before they are adequately stabilised and before factors that will assist in community stability (for example, accommodation and discharge planning) are finalised.

45.5. When some of our patients leave treatment, they return to homelessness or accommodation which is unlikely to support their recovery.

45.6. Having a greater proportion of new, unknown and unwell patients results in greater risk of occupational and interpersonal violence, and a risk of sexual assault in inpatient units.

45.7. There is reduced capacity for assertive community treatment. This means more people drop out of treatment, fail to engage or become unwell again.

45.8. There are insufficient consultant psychiatrists, registrars and senior nursing/allied health staff. This impacts on our ability to deliver person-centred, recovery-oriented and effective care.

45.9. With each adult community service of NorthWestern having responsibility for up to 300 people with severe illness, there is limited ability to provide adequate engagement and review. As a result, there is perhaps a greater reliance on medication rather than more time-consuming psychosocial interventions.

45.10. Insufficient experienced staff means that the services shift more towards monitoring and assessment rather than therapeutic interventions.

45.11. With the changing view of society towards increased awareness of human rights, the threshold for imposing and retaining compulsory care has become higher.

46. In terms of major advances in how we manage and treat mental illness, the area of psychiatry has not changed much (as compared to, for example, the treatment of cardiovascular disease or cancer). We are becoming more sophisticated in understanding biological and psychological treatments and there have been improvements in areas such as borderline personality disorder, but there has not been any major game changers in terms of recovery options.

(b) If there is unmet need, what needs are the most critical?

47. It is estimated that 3% of Victoria's population have severe mental illnesses, which should be catered for by publicly funded mental health services, but NorthWestern is seeing only about 1.1% of its catchment areas' population. It's likely that the remaining people are either not getting treated or receiving inadequate treatment. An increasing number of people also seem to be homeless or at risk of homelessness, and the numbers of mentally ill people in custody has also increased. This puts pressure on other parts of the service system such as prisons and crisis accommodation services.

48. It is difficult to say which needs are the most critical because the different components of the system work synergistically. Until the deficit in inpatient capacity is addressed, the needs of the community will be hard to fix. I also recognise, however, that addressing the deficits in inpatient capacity cannot be achieved in a short timeframe. For staff to provide recovery-oriented and evidence-based services, we must address the critical gaps in meeting the needs of those with the most severe illness who are at highest risk of harm to self and others, and of functional deterioration with all the negative impact that it has on the person, their family and the community.

49. Critical needs that could be addressed in a shorter time frame include the needs to:

    49.1. provide incentives for experienced staff to remain in the system;

    49.2. improve the amenity of community settings;

    49.3. improve security in current inpatient settings; and

    49.4. increase the workforce to support an increase in service capacity (by, for example, putting in place training and workforce initiatives to attract clinicians of all disciplines and, in particular, medical and nursing staff).

(c) What are the key drivers of unmet need?

50. The two key drivers of unmet need are:

    50.1. lack of capacity in community and bed-based settings in the face of population growth; and

    50.2. inadequate funding to provide a service that meets expected standards of quality and safety.

51. Addressing both of these would enable more people to receive more appropriate and effective treatment.

52. Another driver of unmet need is that the under-funding of inpatient units is cross-subsidised by community teams. This means that community teams are much 'skinnier' than intended and that, for every clinician position that is lost from a community team to fund inpatient units, there is a loss of service availability to approximately 25 patients at any one time.

(d) What kinds of impact does unmet need have on people affected by mental illness?

53. While it is not a direct cause and effect impact, untreated or poorly treated mental illness results in negative social outcomes such as loss of home, work, family or friends, greater risk of substance use, increased likelihood of criminal offending and incarceration, and higher risks of self-harm, suicide and domestic violence.

(ii) Are there enough beds to service demand for acute need? If not, why not?

54. NorthWestern has a total of 203 beds in acute inpatient units, of which 133 beds are for adults, 16 beds are for youths and 54 beds are for aged persons.

55. There are not enough beds to service demand for acute need because bed numbers have not kept up with population growth.

56. Although there have been some improvements in treatment, these have not been of such magnitude that inpatient care is no longer needed. People with serious mental illness sometimes actively seek *not* to engage with services and so present late with the assistance of police and family. Even assertive community care cannot replace the need for inpatient containment, stabilisation and safe treatment.

57. NorthWestern currently has 1.65 beds per 10,000 people for acute need, with a lower ratio in areas of population growth which are catered for by Mid West AMHS and North West AMHS. At a minimum, 3 beds per 10,000 people is required, and this ratio ought to be maintained as the population grows.

(iii) In your experience, are clinical mental health services crisis driven? If so, in what respects and why?

58. Clinical mental health services are now very much crisis driven (as demonstrated by the fact that all our admissions come through the EDs) – this is largely related to all the issues discussed above.

59. Moving some care into the community was and remains a good policy, but this should not be at the expense of losing capacity for ongoing community care for those who need it and sufficient inpatient care (acute and rehabilitation) for those

unable or unsuitable to be managed in the community. Serious mental illness is not well suited to an episodic model of care.

(iv) What treatment is available for people who do not meet the criteria for treatment at the service? What are the barriers to people receiving appropriate treatment, from a systems perspective?

60. As discussed in paragraph 34, treatment for people with mental illness, but who do not meet the criteria for treatment at NorthWestern, is available in the primary and private sectors. The availability and affordability of options in these sectors vary.

61. In the early 2000s, each AMHS was funded to provide a Primary Mental Health Team (**PMHT**) which was intended to provide a primary and secondary consultation service to general practitioners to support them to manage consumers with moderate depression, anxiety and other disorders – these PMHTs have largely been lost. In addition, each major hospital used to have large psychiatry outpatient clinics which served the function of providing short and longer term treatment to people with moderate mental illness (that is, largely non-psychotic but distressing and disabling mental illnesses) – likewise, these have largely been lost in the process of mainstreaming as general hospitals moved to focus on those with psychotic illnesses and outpatient care moved to community care with a less medical focus. The federal government has, however, sought to address some of these deficiencies through added items in the Medicare Benefits Scheme and the *Better Access* scheme.

62. Barriers to people receiving appropriate treatment include the following:

62.1. Every mental health service desires to treat people but is feeling increasingly constrained; there is simply a lack of capacity to provide sufficient community and inpatient services. For NorthWestern, we have not grown in terms of capacity (beyond marginal growth) to provide community and inpatient services but the population has greatly increased.

62.2. There is a Commonwealth and State divide in relation to funding, with the Commonwealth funding largely being a fee for service market based system, and the State funding being a block funded, capped capacity system. These two do not sit easily together, especially when both are under pressure, such that funding is rationed to some extent.

62.3. As very few GPs bulk bill and access to private psychiatrists is generally cost prohibitive, a lack of financial means is a major barrier for

consumers to access care in the private system (especially if they do not have private insurance).

(v) If a person has a chronic mental illness but are not in "crisis" where do they go for immediate support?

63. If a person is not in crisis, they can still get an appointment at a community-based mental health service. If such a person needs immediate support, they can go to an ED or contact triage services. Primary care services are also often the first point of call, as with physical illness, for many who need immediate support.

(vi) Do you have experience of the "missing middle" – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services?

64. We have experience of the full range of people with mental illness (often through the ED), including what might be referred to as the "missing middle" as well as the "missing severe" (that is, people who have severe mental illnesses but are not able to access specialist mental health services). Even those with severe mental illness who do receive a service do not necessarily receive a service that is as assertive, targeted or of the duration that is indicated, or that would be provided in the private sector.

65. Where people have needs which are too complex for the primary care system alone but are not sick enough to obtain access to specialist mental health services, we do not have capacity to treat them and tend to direct them back to primary care providers and private psychiatrists. While we understand they may struggle to attend appointments or successfully engage, the available options are very limited.

66. As noted in paragraph 61 above, the PMHT initiative and psychiatry outpatient clinics of major hospitals previously provided supported to these people, but are largely unavailable now.

67. In my view, it is not just the 'middle' who are missing out because those who have severe mental illnesses are missing out as well. Generally, it may also be said people are getting less from the mental health system (for example, shorter treatment periods, or a treatment plan of only 10 sessions through the *Better Access* initiative), rather than missing out completely.

(vii) How does the complexity of the mental health system (variability between geographic areas, overlaps/duplications between different levels of government, and gaps) impact on people's ability to access services and navigate the system? What tools are in place currently to help people navigate the system? How effective are they?

Complexity of the mental health system

68. The mental health service system is complex and fragmented. In an ideal world, there would be a single layer of government that funds the mental health system, with different providers and different treatment settings. It is complicating to have two systems with different market pressures and different models of distribution and funding.

69. It sometimes seems as if both levels of government are (perhaps inadvertently) making the system more complex and fragmented through 'new initiatives' (for example, suicide prevention initiatives and the Early Psychosis Prevention & Intervention Centre (EPPIC)) rather than system improvement and integration. These new initiatives have separate entry and exit criteria, as well as funding and policy requirements, creating a fragmented system that is hard to manage.

70. While having an area-based mental health service is appropriate in my view for people who need the protection of the Mental Health Act (as there needs to be a mechanism to clearly determine which services are responsible for such people), its rigid application to all is a reflection of a mismatch between system capacity and demand with the resultant loss of goodwill and generosity among mental health services.

Navigating the system

71. Good triage services can help in assisting consumers, carers and private practitioners in 'system navigation'. This is less reassuring or relevant if the triage service itself is so overburdened that there is a long wait to get through.

72. The original intent of case management or care coordination was to assist in navigation but the experience needed for such roles (including the ability to engage consumers) has been diminished. The system is already difficult to navigate, and navigation is made more difficult when the system is under pressure.

73. When a system is under pressure, staff tend to put up barriers and give reasons for *not* accepting a person for care, rather than keeping an open-door policy. Historically, one of the problems we encountered was that the Crisis Assessment and Treatment (**CAT**) and Mobile Support and Treatment (MST) teams set a limit

on their caseloads and then declined to accept new people, with the result that the clinic-based Continuing Care Team (CCT) had to absorb more and more of the demand. This was one of the reasons we moved to integrated teams.

74. So when a system is under pressure, people find it harder to get through to triage, to get to the right place of care and to get that care in a timely way.

(viii) How do your services deliver community-based care?

75. While the community programs across NorthWestern vary, it generally offers multi-disciplinary clinical mental health care. Orygen has a particular model linked to presenting symptoms and is closely integrated with research programs. The Aged program provides an intensive assessment and support program, and a longer term assessment and treatment program. It also provides a support service to nursing homes to assist them in managing elderly people with behaviours of concern.

76. Our adult programs provide the following:

76.1. a rostered function that is more crisis driven and is able to see people in their homes;

76.2. a longer term outreach program that is largely medication supervision and support; and

76.3. clinic-based assessment and treatment.

77. How well each of these adult community-based services function, and the extent to which treatment modalities are appropriately applied, vary. Generally, the scope of these services has narrowed:

77.1. At the point of inception, the rostered function was provided 24 hours a day and had ready access to medical review, but it is now provided for extended hours with reduced hours on weekends. Staffing is also reduced or is less experienced.

77.2. The outreach program was previously focused on treatment and rehabilitation but its focus is now on medication supervision.

77.3. In terms of clinic-based assessment and treatment, some doctors have about 300 people in their caseload – the caseload pressure results in a greater emphasis on assessment and monitoring rather than multimodal treatment interventions. Ideally, clinicians should be able to provide the types of treatment that would be most beneficial. The public system has, however, a reduced capacity to deliver psychological treatments, such as a range of psychotherapies that may require regular lengthy

appointments (including individual, group and family therapy). In addition, while we seek to engage our consumers' families and ensure we take into consideration their physical health and social supports, it is difficult to do so with the caseload pressure. Relevantly, there is a growing awareness of the poor physical health outcomes of mental health consumers, and some mental health services have good initiatives in place in areas such as access to dental care.

78. All of the adult programs also provide some level of family based intervention, and offer peer support. Medical and consultant review is built into our programs, but may be as limited as taking place once every three months.

79. Most recently, NorthWestern ran a refreshed suicide awareness and prevention training in all our community services which was very enthusiastically welcomed. This was a small part of the additional training and capacity building that all staff should regularly access.

(ix) How do CAT/ACIS teams work? What are the resourcing challenges with operating a CAT team? If there are barriers to their effectiveness, what are they?

80. The CAT/Acute Community Intervention Services teams at NorthWestern have moved to a more integrated component of the community service – the rostered function. The original service model of CAT quickly became untenable as services grappled with the competing demands of urgent, face-to-face, home-based *assessment*, and the requirement to provide home-based *treatment*. In the end, both functions could not be performed optimally, and NorthWestern (like many other metropolitan services) has moved away from the CAT model. The more integrated model has advantages of reducing silos between service elements and supporting greater expertise and competence across the staff profile.

81. The issues are, however, the same. Organising an efficient day is difficult because of the following reasons:

81.1. People may not be at home or do not answer calls (especially when the calls are from unknown numbers), but the ability to text people has helped to alleviate this issue.

81.2. The service is not 24 hours a day, 7 days a week.

81.3. Having clinicians out in the community raises safety concerns (especially in areas where there are more homeless people and greater substance use, or isolated areas in semi-rural settings). This means that at least

two clinicians make every call, which is expensive, and that we would not let staff attend some areas without police assistance.

81.4. Traffic congestion and increased geographical spread means that a single visit may take up most of the day.

81.5. Getting medical reviews is problematic.

82. There have been some improvements, such as the implementation of the Police, Ambulance and Clinical Early Response (**PACER**) program. Under the PACER program, one clinician is available to go out to people's homes with a police officer. There are two models under the PACER program – the clinician is either based in the police station or in an ED. The PACER program is a good model, but again is very resource-intensive and variable in realising its intended impact of diverting people from the ED and reducing apprehension by police under section 351 of the Mental Health Act.

83. Another useful model that may help address the CAT function is the Homeless Outreach Psychiatric Service (**HOPS**), which is provided by Melbourne Health (NorthWestern), Alfred Health and St Vincent's Hospital Melbourne. HOPS provides comprehensive mental health assessment, treatment and support to adult clients who are experiencing mental health issues and are homeless or at risk of homelessness. HOPS staff are generally very experienced, and are able to work flexibly in conjunction with other services such as crisis accommodation services, homelessness supports, Royal District Nursing Service, and AoD services.

84. Other service improvements include the Forensic Clinical Specialists, the enhancements associated with the Fixated Threat Assessment Centre and the expanded services for those with mental illness and intellectual disability (not at NorthWestern).

(x) What are the critical things that contribute to the success of NorthWestern?

85. The critical things that contribute to the success of NorthWestern include the following:

85.1. Strong, consistent leadership over a number of years. This has especially been important at the Director of Operations, Director of Clinical Governance, Area Manager and Director of Clinical Services levels. This has supported good collegiate relationships and enabled sometimes difficult decisions and reforms to be implemented.

85.2. The ability to work across NorthWestern's programs and AMHSs to maximise the efficiencies in bed access and flow.

85.3. Critical mass to support large workforce programs, especially across our medical (the specialist international medical graduates program) and nursing programs. For example, in the 2019 academic year, NorthWestern has a record number of 98 nursing training programs (including programs for graduate nurses and postgraduate nurses, as well as an enrolled nurse transition program and a 'return to practise' program). We also arrange for a senior nurse to go to the United Kingdom once or twice a year to actively recruit mental health nurses, which has been very successful at recruiting experienced staff. Even with these initiatives, however, maintaining full recruitment is a major challenge.

85.4. Organisational support from Melbourne Health in areas such as safety, occupational violence, and the interface with EDs.

85.5. Generally strong relationships on the ground with Western Health and Northern Health, where some of our acute services are provided. This has enabled us to better manage our safety and quality agendas.

C. MENTAL HEALTH SYSTEM AND REFORM

(i) In your experience, how does the system we have now compare to what was envisaged in the 1990s?

(a) What has been lost?

86. What we have lost is fidelity to the model set out in the Department's *Framework for service delivery 1994* (**Framework**) in a number of areas. The Framework documents set out the intended components of each part of the community service across the age ranges. While not perfect or fully comprehensive, they were fantastic for their time. The loss of fidelity to the model is in part a result of imposed savings requirements, but it is also related to industrial requirements, safety concerns and workforce constraints. The population growth in outer and inner metropolitan areas, and population decline in some country areas, also made fidelity to the Framework model more difficult.

87. We have also lost the synergy between components – again in part because of savings, but mostly because of demand. As the system came under pressure, component parts put up barriers to access or delay in acceptance – that is, some parts of the services became less flexible and generous. For example, inpatient units are more reluctant to accept patients unless there is a clear rationale or the risk issues are critical. The impact of this includes an increase in caseloads in community settings, and difficulties in consumers accessing beds in a timely way. This impedes our ability to provide person-centred care.

(b) What has been gained?

88. What has been gained – often in response to emerging need – has been stronger and more responsive triage services. The focus of triage services has, however, been on demand management rather than service provision. The EDs have much better services, but this has then meant more and more referrals and admissions go via the EDs.

89. Other important areas where there have been gains include:

89.1. There has been an expansion of, or improvement to, perinatal, dual diagnosis, dual disability, eating disorder and first episode psychosis services.

89.2. We have improved supports to families (for example, through the Families where a Parent has a Mental Illness (FaPMI) program), in schools, and in forensic mental health.

89.3. The development of Spectrum (a service for people with severe Borderline Personality Disorder) was a major advance in the early 2000s and has stood the test of time.

89.4. The recent addition of the Fixated Threat Assessment Centre and related service enhancements has brought back an ability to provide intensive, wrap-around treatment and support to high risk individuals.

89.5. Our mental health services for older people have improved.

(c) What new trends have impacted on community needs since the 1990s?

90. The most important of the trends has been the shift in substance use to a greater proportion of mixed and methamphetamine use, which leads to a rise in drug-induced psychosis and aggressive behaviour by patients towards staff and other patients.

91. Another important trend is the rise in the number of prisoners, especially those on remand who are more likely to be released, which has put a significant and additional impost on our community, ED clinicians and the inpatient units.

92. Other trends include:

92.1. There has perhaps been an increase in levels of aggression in the community by people suffering from mental illness.

92.2. An increased focus on family violence.

92.3. A growing awareness of the needs of people with disability and autism spectrum disorders, which are still under-recognised.

92.4. While attention on, and recognition of, human rights is appropriate, the move to a greater focus on human rights in mental health legislation has made community treatment of some people with severe mental illness more difficult – in particular, if Treatment Orders under the Mental Health Act are shorter or set at a higher threshold, people are at greater risk of dropping out of care and then relapsing. The result appears to be a shift in emphasis from care and treatment to management of risk.

93. In relation to the greater focus on human rights, similar issues arise with recovery-oriented care. The aims of supported decision-making, strengthening agency, and giving hope are excellent and I support these, but there is a conflict at times between these aims, and treatments that will have longer term benefits to the person and the wider community. We also often see this tension when we examine clinical care with hindsight after a critical incident.

(d) How has the system got to where it is now?

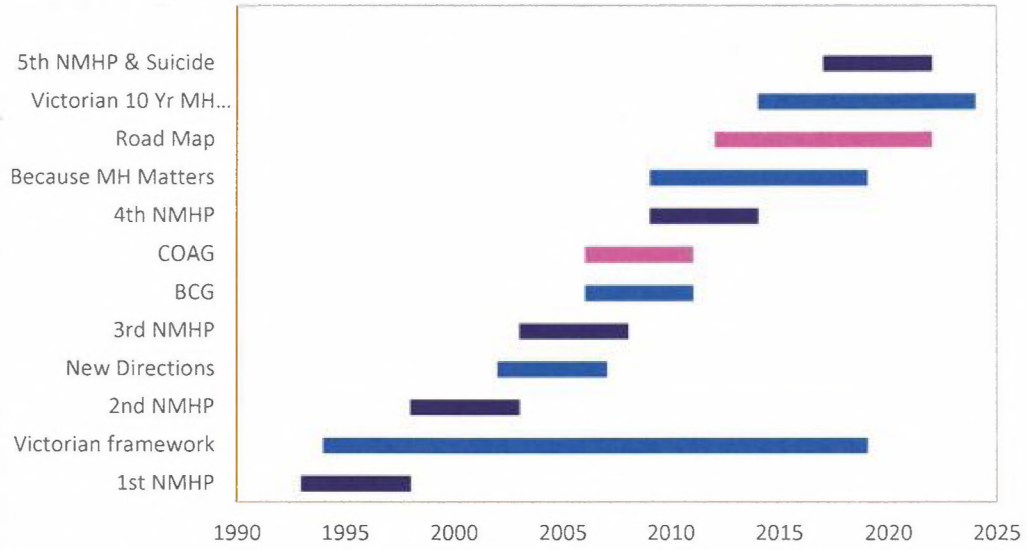
94. The system has not kept up with population growth on a per capita basis (whether in terms of funding, EFT etc).

95. An interesting reflection is how many State and Commonwealth mental health plans we have had since the early 1990s. A summary of such plans is set out below:

Year	State (Victoria) plan	Commonwealth plan
1992		1st National Mental Health Plan (**NHMP**) (1993-1998)
1994	Framework for service delivery	
1998		2nd NHMP (1998 – 2003)
2002	New Directions for Victoria's mental health services: the next five years	
2003		3rd NHMP (2003 – 2008)
2006	Improving mental health outcomes in Victoria: the next wave of reform. Boston Consulting Group (**BCG**) report	
2006		Council of Australian Governments (**COAG**) – National Action Plan for Mental Health
2009		4th NHMP (2009 – 2014)
2009	Because Mental Health Matters (2009 – 2019)	

Year	State (Victoria) plan	Commonwealth plan
2012		Roadmap for National Mental Health Reform (2012 – 2022)
2015	10 year Mental Health Plan (2014 – 2024)	
2017		5th NHMP and Suicide Prevention Plan (2017 – 2022)

96. This summary can be illustrated by the chart below:



(*Black – Australian Health Ministers' Advisory Council (State and Commonwealth); Blue – State government; Pink – Commonwealth government*)

97. It seems that, rather than having a good policy and sticking to it, and building on and growing a solid service system, we have been in a constant state of consultation and distraction. My concern is that this may reflect a lack of clarity about mental illness and state responsibility at government and departmental levels. Mental health used to be deemed to be 'above politics' but it seems to have become increasingly politicised with successive governments wanting to make their mark. This is not good for system development, the clinical workforce and the end users. The government must be bipartisan in relation to mental health as it was in the 1990s and has to be for many years, as the challenges in the system cannot be overcome in a single term of government or by switching between partisan policies.

98. Another issue that is harder to talk about is some loss of respect or regard for the 'expert' in public clinical services. We are highly regulated and overseen and our decisions are often questioned and challenged, most often by people who are not as trained or experienced in the management of mental illness as we are. In addition, while the growth of the lived experience workforce is valuable, their advocacy is more challenging when the intent seems to be to question or even

discredit clinical expertise and input. It seems that, while psychiatrists working in private are in high demand and mostly very respected, psychiatrists and other clinicians working in the public sector receive much more criticism. This may be partly connected to the fact that we are given the task of imposing compulsory treatment and it appears that we bear the brunt of criticism that should really be directed at the system constraints imposed by government. This issue needs more open acknowledgement and recognition.

(ii) Are there ways in which you think the demand for services of the kind NorthWestern provides is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

99. Broadly speaking, unless there is a breakthrough in the prevention or cure of severe mental illnesses, then the nature of such illnesses, how they affect people's lives and the demand for expertise in mental health treatment are unlikely to change significantly. Indeed, demand will keep increasing with population growth.

100. There seems to be little change in the prevalence or incidence of severe mental illnesses such as schizophrenia or bipolar affective disorder. Sadly, presentations that reflect early trauma (arising from the greater levels of family dysfunctions and intergenerational trauma) and longstanding problems following poor early attachment are increasing. These presentations are responsive to treatment but consistency and clarity in providing treatment over the longer term are needed. Public mental health services are not always good at providing such treatment across services, as a lack of clinician continuity and episodic care work against the provision of evidence based models for treatment.

101. The changes to the disability sector and the continuing issues in relation to AoD are also having an impact on increasing demand for services. In my view, there needs to be greater consistency across government on the services required and how they should be provided. I believe parts of the AoD and disability services should come back under the governance of the clinical sector, with strong quality and safety oversight.

102. The most important issue in considering changes in demand for services is that I cannot see the services functioning better without additional bed capacity and greater capacity and amenity in community settings.

(iii) What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental health?

103. As discussed above, there are many challenges facing the mental health system, the dominant ones of which are:

103.1. sufficient amenity and capacity in bed-based and community infrastructure, considering that the government has competing priorities (for example, we have been doing business cases for more beds at Sunshine Hospital for the past 5 years but have still not been successful in attracting funding);

103.2. workforce training; and

103.3. recruitment and retention in all clinical disciplines.

104. It is worth noting that some of the problems and inefficiencies we have are related to industrial constraints. There are good arguments to review staffing models that were put in place in the 1990s such as in CCUs (which was set up with a 24 hour nursing model, but this is no longer required in all CCUs).

105. Other challenges, for which change is imperative, include:

105.1. Sexual safety: Units need to be well designed, have sufficient capacity, and allow appropriate streaming and gender segregation (especially in the intensive care or locked areas). Consumers who require inpatient care should not have their distress of being mentally ill compounded by being in a frightening and unsafe environment.

105.2. Staff safety: Similar to the issue of sexual safety, facilities need to be well-designed and have sufficient capacity. Staff should also be well-trained and experienced, and additional security staff should be present where required.

105.3. Funding: A new funding model is well overdue. We have been discussing some element of activity-based funding since the early 2000s and it has been on the Independent Hospital Pricing Authority's agenda since at least 2012.

105.4. Prison population: The needs of those in custody – across the various age ranges – have been neglected for too long. It is not acceptable in this day and age to have people with severe mental illness detained in the most brutal of environments (where they are deluded, distressed and confused because they will not accept treatment) and be unable to compulsorily treat them within prisons or admit them to a health service where they can be treated because there are no available beds.

106. In addition, a challenge for the community more broadly, but particularly for the mental health system, is how to ensure that people with mental illness access adequate physical and dental care. The current studies in this area reveal appalling findings, with delayed treatment compounded by inadequate treatment.

A database maintained by NorthWestern shows that the average age of a consumer who dies of natural causes is 48 years of age. These deaths mostly arise from preventable causes – a sedentary lifestyle, poor diet, poor dental care, obesity and high levels of tobacco and alcohol use. Often, consumers are presenting too late in their episode of illness for effective medical treatment to be provided.

(iv) What do you think are the critical elements of a well-functioning mental health system?

107. The critical elements of a well-functioning public mental health system include the following:

107.1. sufficient capacity in community and bed-based settings aligned with population growth;

107.2. an engaged and skilled workforce delivering appropriate and effective treatment in a range of settings, especially to people with severe mental illness who need the rights and protections that go with compulsory treatment under the Mental Health Act;

107.3. health services that are well-maintained, clean and safe – people with mental illnesses and those who work with them should have work environments and amenities equal to those with physical illnesses;

107.4. funding to support growth in services in line with population growth is critical; and

107.5. a strong and workable safety net – in this case, mental health legislation that is fit for purpose and can be used to support both individual rights and access to needed treatment. In general, the Mental Health Act is functional and sets an appropriate balance between access to treatment and care, and respect for rights and protections when these are limited. There are, however, issues of administrative burden and excessive oversight through multiple bodies. In addition, the requirement for external review of a clinically indicated treatment (electro convulsive therapy) is excessive in my view and has led to delay and adverse outcomes for people with very severe mental illness.

108. In order to achieve these elements, there needs to be bipartisan support of mental health policy and service development, so that planning and implementation can proceed in an orderly and equitable way.

(v) How has the funding of clinical mental health compared to population growth?

109. As previously discussed, the funding of clinical mental has progressively fallen below that required for acute health on a per capita basis since at least 2006.

110. Attached to this statement and marked **RV-3** is a copy of a journal article I co-authored which considers the impact of funding and service availability on the intended policy and practice directions of mental health legislation in Victoria.

(vi) Why is reform of the mental health system so difficult?

111. Reform of the mental health system is difficult for a number of reasons:

111.1. Mental health is not high on the agenda for community concern (at least for severe mental illness), and there is still stigma about severe mental illness, poor understanding of the links with violence, and other negative social connotations.

111.2. There are multiple and disparate views and advocacy positions. While there are non-mainstream voices in areas such as cancer and cardiovascular disease, the community generally accepts the clinical experts' views which are fairly uniform. In contrast, the mental health sector has seen strong advocates making very disparaging comments about some parts of the service sector and garnering support for particular age groups or particular diagnoses. Hopefully, policy makers and service developers can keep the core expectations of equity and fairness in mind.

111.3. As noted in paragraphs 95 to 97, the State and Commonwealth governments have created many plans. All of the plans except for the early ones have multiple areas of priority, with the consequence that there is a scattered approach to reform to appease multiple special interest groups.

Reform is complicated by how mentally ill people and mental health services are portrayed in the media. This, together with the facts that we do detain and coercively treat people, and mentally ill people do commit serious crimes, makes mental health an area of reform that is difficult to sell. As such, it is much more palatable to talk about the 'soft end' of the system (for example, mental health issues such as mild anxiety and depression) and to use terms like 'prevention and early intervention' (even though the meaning is opaque), rather than talk about 'mental illness'.

(vii) What are the challenges for making a successful business case to government for

(a) reform of mental health?

(b) funding for mental health?

112. A successful business case needs to have a compelling narrative that convinces that it is the solution and will deliver the intended result, rather than another request for more. In my view, this is why the Framework documents were so successful. They had a clear agenda, linked with the NHMP 1st Plan, were consistent with the NHMP *and* had a funding source through the closure of the standalone institutions and industrial reform.

113. We are not in such clear air space now. Regrettably, Victoria has fallen way behind other States. The challenge for both reform of, and improved funding for, mental health is how to convince the government that the proposed business case will make a difference and will have an end point (in the face of the government's competing priorities, such as public transport). The proposed business case must also have a clear agenda, have a cohesive narrative, and be incremental.

114. There are some compelling and costly areas to be considered in making a business case to government:

114.1. there are high numbers of mentally ill people among the homeless, prison populations, and presentations to EDs;

114.2. there is great concern about community safety; and

114.3. there is a fair amount of concern from the general public and the families of mentally ill people that mental health services are failing the mentally ill people.

115. These areas are not all within the remit of mental health services per se, and need to be part of broader social policy.

116. I think it is time to be brave again about the effectiveness of treatment and the importance of incremental but steady investment to pre-empt outright scandal. While there needs to be block funding for some areas (for example, service development, training and clinical research), some funding must be linked to outcomes, including those relating to:

116.1. keeping people out of EDs;

116.2. the severity of mental illness before and after treatment;

116.3. the effectiveness of inpatient care and the type of treatment provided (for example, whether it was evidence-based); and

116.4. social outcomes such as stable housing and community engagement.

117. Activity-based funding is a challenge – there is nowhere in the world that has been very successful at this but some governments have attempted this and the Independent Hospital Pricing Authority has been working on a model for some years. Nevertheless, mental health services need to be incentivised and rewarded where appropriate (for example, for delivering the right treatment and delivering results effectively).

(viii) What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to:

(a) Access to treatment and services;

118. As discussed previously, there needs to be greater capacity in community, bed-based and forensic services. Triage services are important and need to be adequately staffed, but if they have nowhere to which to refer people, and if every referral takes multiple calls, an increase in the capacity of triage services will not improve access.

119. In addition, there is a need to improve the amenity of mental health services to create welcoming environments for access to treatment and services (for example, Headspace centres are generally welcoming and youth-friendly). It is discriminatory to think that people with mental illnesses should have to receive care in run-down or crowded environments.

(b) Navigating the mental health system;

120. Triage services, internet information and improved sharing of clinical information between services will assist with navigating the system. But again, if every service is at or over capacity, they will put up barriers to access even if there are improvements in navigation.

121. In addition, there needs to be good core services that have the flexibility to deal with multiple issues. For example, suicide prevention should be implemented not just in suicide prevention centres but also in EDs and other parts of the health system.

(c) Getting help to people when they first need it?

122. There is no doubt that some people with mental illness are late in presenting themselves to the system, making early intervention difficult.

123. There are three ways by which early help may be given – early in life, early in illness and early in episode. Having expert and accessible mental health services for mothers and infants is important, as is appropriate clinical mental health

support to early childhood services and schools. Mental health services can only assist a person early in the course of an illness if the person seeks help, but it is difficult when the person presents late to health services. As for 'early in episode', we do not intervene as assertively as we should due to the lack of capacity. For example, no beds are available for semi-elective admissions, so that admission is only possible when a person is so acute, of high risk or under the Mental Health Act, and even that is subject to delay and bed-juggling.

124. Getting help to people when they first need it remains largely the province of the primary care sector and community organisations such as lifeline, beyondblue, and Headspace. I think it makes sense for the Royal Australian College of General Practitioners and the Primary Health Networks to work with general practitioners to encourage them to take on this role, but they should be able to expect rapid support and advice from the AMHSs. The State-funded clinical sector should remain focussed on those who cannot receive treatment elsewhere.

(ix) Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

125. This is a wonderful opportunity to have the considered views of highly respected people presented to government and the community. Those views should include that improvement needs to be incremental – as a big part of reversing the decline involves developing new services, improving amenity and re-invigorating a workforce that in places has become de-skilled and dis-engaged. Such improvement will take time.

126. The Royal Commission should not lose sight of the following:

126.1. Mental health services must be delivered by a skilled workforce, even if peer workers may be helpful in some ways. There is a massive difference between the public and private sectors in mental health, as compared to other parts of the health industry. Consumers who go to private psychiatrists will by and large get an individual expert treating each of them. In public psychiatry, however, consumers may see a doctor at the beginning but may not see a doctor thereafter for months; they will see other clinicians or more junior doctors and their case manager may be a social worker, occupational therapist or nurse.

126.2. Funding reform is critical. If the government is to invest in reform of the mental health system, it needs to be buying something better.

126.3. There must be long-term, bipartisan support for improvement to take place. Both the government and the opposition should commit to

undertaking a policy and service platform that cannot be realised in one term of government.

126.4. The Royal Commission needs to be clear about what it can fix – this is a State Royal Commission, and the State is responsible for the 3% of Victoria's population with the most severe mental illnesses. By and large, most of the remaining population with mental illnesses should be able to be managed by the primary care and private sectors. There may, however, be some of these people who may need the help of public mental health services (for example, those who have complex needs requiring multi-sector input such as those with AoD dependence, intellectual disability, or who are homeless).

sign here ▶ 

print name Ruth Geraldine Vine

date 27 June 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RV-1

This is the attachment marked 'RV-1' referred to in the witness statement of Ruth Geraldine Vine dated 27 June 2019.

CURRICULUM VITAE

RUTH GERALDINE VINE
MB BS, FRANZCP, LLB, Dip Crim, DPM
Associate Professor, University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences
Executive Director, NorthWestern Mental Health
DOB: 17/5/57
CITIZENSHIP: Australian

QUALIFICATIONS

1980 MB BS University of Melbourne.
1983 FRACS (Part 1)
1990 Diploma of Psychological Medicine (University of Melbourne)
1990 Fellow of the Royal Australian and New Zealand College of Psychiatry
1994 Graduate Diploma of Criminology (University of Melbourne)
2000 Bachelor of Laws (Latrobe University)
2011 Graduate of the Australian Institute of Company Directors

APPOINTMENTS

July 2013 - 2019 Executive Director, NorthWestern Mental Health, Melbourne Health

November 2012 – July 2013.
Director of Clinical Services, Inner West Area Mental Health Service, Melbourne Health.

May 2009 - November 2012.
Chief Psychiatrist, Department of Human Services. Since August 2009 this was within the Department of Health.

March 2010 - March 2011.
Director, Bushfire Psychosocial Recovery team, Department of Health.

September 2010 - July 2011
A/Director Operations, Mental Health Drugs and Regions, Department of Health.

May 2008 – May 2009.
During a period of leave without pay from the Department, I worked as a consultant psychiatrist in the Western Region Community Health Centre part time and as a project officer with the Mental Health branch of the Department of Health and Aging in the Commonwealth government.

March 2007 – Oct 2007
Acting Executive Director, Mental Health and Drugs division, Department of Human Services.

Jan 2004 – Feb 2008
Director, Mental Health Branch, Department of Human Services.

1999 - 2004 Deputy Chief Psychiatrist, Department of Human Services.
1991 – 1999 Consultant Psychiatrist, Forensic Psychiatric Services.
1991 –1993 Lecturer, University of Melbourne, Department of Psychological Medicine, Austin Hospital.
1990 – 1991 Fellow in Geriatric Psychiatry, Baycrest Centre for Geriatric Care, University of Toronto, Canada.
1986 – 1990 Psychiatry registrar

PUBLICATIONS

- Vine R.G., Judd F.K. Anxiety Disorders and Panic States. **The Disease Index**. 1991/92. 51-55.
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- Vine Ruth, Judd Fiona. 2018. Contextual issues in the implementation of mental health legislation. **International Journal of Law and Psychiatry**

PROFESSIONAL ACTIVITIES

1992 – 1994	Member, Victorian Branch Committee, RANZCP
1992 -	Reviewer for Australian and New Zealand Journal of Psychiatry and Medical Journal of Australia.
1996 - 2002	Member of Committee for Examinations, RANZCP
2005 – 2008	Chair, National Mental Health Workforce Advisory Committee
2005 - 2008	Chair, Mental Health Standing Committee
2005 – 2012	Member, Forensic Leave Panel
2008 – 2009	Member, Mental Health Review Board
2008 – 2009	Board member, Australian Community Support Organisation
2009 -	Surveyor, Australian Council of Healthcare Standards (ACHS)
2010- 2012	Chair Safety and Quality Partnership subcommittee
2011	Member, Reference Committee for review of Guardianship, VLRC
2012 – 2014	Board member, Western Region Health Centre. I was a member of the Board during the amalgamation with Doutta Galla and North Yarra Community Health centres with the formation of CoHealth.
2013 - 2018	Board member, The Haven Foundation
2014 -	Member, Mental Health Tribunal
2015 -	Board member, Victorian Institute of Forensic Mental Health (Forensicare)
2018 -	Member, Victorian Medical Board

During the period of my employment in the Department of Human Services, and the Department of Health, I contributed to a number of Departmental, Inter-Departmental and external committees. Examples include membership of the Disability Legislative Review steering committee, Corrections Health Board, reference group for the Complex Clients project, Inter-departmental liaison committee on women in prison, advisory committees for the Law Reform Commission in regard to People with an Intellectual Disability at Risk, Defences to Homicide, and review of the Guardianship and Administration Act. From 1999 to 2007 I was appointed the Principle Medical Officer under the

Corrections Act. This ended when the responsibility for prisoner health moved to the Department of Justice.

On the National level I was Chair of the Forensic Mental Health reference group, which developed the National Forensic Mental Health Principles, and was on the drafting committee for the Third National Mental Health Plan. I was co-chair of the Co-morbidity taskforce, a subcommittee of the NMHWG during 2004. I was involved in the development of the National Action Plan for Mental Health 2006 – 2011 developed under the COAG. As noted above, I chaired two National committees relating to Mental Health from their inception. I was also involved in the drafting of the revised National Mental Health Policy. During my time working with the Department of Health and Aging, I worked on the development of the 4th National Mental Health Plan and the revision of the National Standards for Mental Health Services. I have been involved in a number of invited service reviews and critical incident inquiries relating to individual and service standards.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RV-2

This is the attachment marked 'RV-2' referred to in the witness statement of Ruth Geraldine Vine dated 27 June 2019.

Summary of NorthWestern Mental Health's Your Experience of Service (YES) Survey Results

	% Usually + Always			
Area	NWMH			
	2016	2017	2018	
Sample	*569*	*684*	*789*	
1. You felt welcome at this service	90%	88%	93%	
2. Staff showed respect for how you were feeling	88%	88%	91%	
3. You felt safe using this service	86%	88%	87%	
4. Your privacy was respected	88%	88%	89%	
5. Staff showed hopefulness for your future	83%	86%	87%	
6. Your individuality and values were respected (such as your culture, faith or gender identity, etc.)	89%	84%	91%	
7. Staff made an effort to see you when you wanted *	85%	74%	85%	
8. You had access to your treating doctor or psychiatrist when you needed *	74%	74%	77%	
9. You believe that you would receive fair treatment if you made a complaint *	77%	73%	78%	
10. Your opinions about the involvement of family or friends in your care were respected *	84%	82%	86%	
11. The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)	88%	85%	84%	
12. You were listened to in all aspects of your care and treatment	82%	83%	86%	
13. Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff)	76%	78%	81%	
14. Staff discussed the effects of your medication and other treatments with you	79%	83%	79%	
15. You had opportunities to discuss your progress with the staff caring for you	83%	84%	85%	
16. There were activities you could do that suited you *	64%	62%	63%	
17. You had opportunities for your family and carers to be involved in your treatment and care if you wanted *	79%	76%	84%	
	% Very Good, & Excellent			
18. Information available to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)	61%	65%	72%	85%
19. Explanation of your rights and responsibilities	58%	63%	62%	84%
20. Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.) *	50%	53%	53%	81%
21. Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)	58%	62%	63%	83%
22. Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.)	60%	62%	66%	83%
23. The effect the service had on your hopefulness for the future	51%	54%	56%	82%
24. The effect the service had on your ability to manage your day to day life	53%	53%	54%	83%
25. The effect the service had on your overall well-being	54%	55%	57%	84%
26. Overall, how would you rate your experience of care with this service in the last 3 months?	62%	64%	64%	88%

Key

80-100%

60-79%

<59%

79%	82%	82%
81%	82%	83%
80%	84%	84%
85%	88%	88%

* Question had an 'NA' option which is included in denominator for 'Usually' percentage

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RV-3

This is the attachment marked 'RV-3' referred to in the witness statement of Ruth Geraldine Vine dated 27 June 2019.

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Contextual issues in the implementation of mental health legislation

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ABSTRACT

Mental Health services in Victoria, Australia have seen major reform over the past 30 years. Rights based mental health legislation and major structural changes supported a reduction in bed based services and the development of a strong community mental health sector from the mid 1990's. Community Treatment Orders were established in the Mental Health Act (1986) and widely used across the State. Reformed legislation in 2014 brought greater emphasis on supported decision making and recovery orientation. Funding for mental health services did not keep pace with significant population growth, with consequent reduction in bed availability and intensity of community based services.

This paper considers the impact of funding and service availability on the intended policy and practice directions of mental health legislation with particular consideration of the impact on the utilisation of Community Treatment Orders.

1. Introduction

Australia is a Federation with responsibility for mental health services shared between the Commonwealth and State governments. There has largely been bi-partisan agreement in regard to mental health policy and plans. Reform of mental health services in Australia, commencing in the early 1990's, was driven by the National Mental Health Strategy which included development of the First National Mental Health Plan, the Statement of Rights and Responsibilities and the National Mental Health Policy in 1992 (Australian Health Ministers, 1992a; Australian Health Ministers, 1992b). The First National Mental Health Plan focussed on the structural move from stand-alone institutions to mainstreamed inpatient and community based mental health services. This was consistent with changes occurring throughout the developed world. Subsequent Plans included greater emphasis on partnership and consumer engagement. Victoria introduced the Charter of Human Rights and Responsibilities in 2006 (Victorian Government, 2006). The Charter included provisions regarding the right to personal integrity and freedom of movement which directly relate to the provision of compulsory care. It also provided for conditions required when rights could be limited, also relevant to treatment under Mental Health legislation. This paper will consider the impact of mental health reform on service delivery in the context of funding constraints and policy and operational issues in other public service areas.

2. Mental health reform in Victoria

Within Australia, Victoria, was in the vanguard of reform of mental health services in the 1980's and 1990's. Closure of the large stand-alone psychiatric facilities was accompanied by the establishment of a range of community and mainstreamed bed based services (Gerrand, 2005; Psychiatric Services Division, 1994). Legislative reform through the *Mental Health Act* (1986) (MHA) introduced external review of involuntary detention through the establishment of the Mental Health Review Board, and the introduction of Community Treatment Orders (CTO) to better support care and treatment in the community (Victorian Government, 1986). By 2003 all mental health inpatient beds other than forensic beds had been moved to general hospital sites, and an age based, area based mental health system was well established. Victorian mental health providers embraced the shift to community based services, including the use of CTO (Light et al., 2012). In 2006 the Victorian government appointed a Minister for Mental Health – one of the first States in Australia to do so. While ostensibly the appointment of a separate Minister for Mental Health may have suggested an increased focus on services for mentally ill people, the separation from Health may have lead to less focus by government on clinical mental health services.

Victoria has continued to be a signatory to National initiatives, the most recent of which is the Fifth National Mental Health Plan

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Table 1
Comparison between MHA 1986 and MHA 2014.

	MHA 1986	MHA 2014
Naming	Involuntary patient	Compulsory patient
External review	MHRB* – Within 8 weeks and annually. Reviews decision by Authorised Psychiatrist	MHT* - Within 28 days and when order due to expire Makes Order and sets duration
Order stages	Recommendation, Treatment order made within 24 h. Duration 12 months unless discharged by Authorised Psychiatrist or MHRB	Assessment Order – 24 h Temporary Treatment Order – 28 days Treatment Order – Inpatient Order max 6 months Community Treatment Order max 12 months
Criteria	Has mental illness; needs immediate treatment; unable or unwilling to consent; risk of harm to self and others; no less restrictive means.	Appears/has a mental illness; needs immediate treatment to prevent serious risk of harm to self/others; no less restrictive means
Capacity	Unable or unwilling to consent to treatment one of 5 criteria	Presumption of Capacity
Decision making	Substituted decision making	Supported decision making strongly encouraged
Mechanisms to assist patient	Right to a second opinion, but could be from within service	Independent Mental Health Advocacy Second Psychiatric Opinion Scheme Mental Health Complaints Commission Nominated persons Advance care direction
Consent to ECT	Authorised psychiatrist consents if patient lacks capacity	MHT must approve if patient lacks capacity and ECT deemed least restrictive
Overarching policy		Explicit reference to Recovery Orientation, tolerance of degree of risk Explicit push to minimise use and duration of Orders

* MHRB – Mental Health Review Board; MHT – Mental Health Tribunal.

(Commonwealth of Australia, 2017). Further reform in policy and associated service directions is evidenced by the enactment of new mental health legislation in 2014, *Mental Health Act 2014* (Vic) (Victorian Government, 2014) with an explicit recovery orientation focus and full compliance with the Charter of Human Rights and Responsibilities. The MHA 2014 places greater emphasis on supported decision making and external oversight, explicitly seeks to reduce the number and duration of compulsory treatment orders, and emphasises that treatment should be provided in the least restrictive way. The differences between the MHA 1986 and MHA 2014 are outlined in Table 1. The major differences in relation to CTO pertain to who can make the order and for what duration, and the criteria for making a Treatment Order.

We have examined a series of patient outcomes under the MHA 2014 compared with the MHA 1986. We found that the introduction of the MHA 2014 has been associated with a reduction in the number and duration of compulsory orders made (Vine et al., in press). We found a 25% reduction in the number of days on a compulsory order in the two years after being discharged from a CTO under the MHA 2014 compared with the same period under the MHA 1986. The index CTO was also shorter under the MHA (2014) compared with the MHA 1986. There was a substantial reduction in the number of orders made in the 2 years following discharge from a CTO under the MHA 2014 compared with those under the MHA 1986. Compared with 1.5 CTO made over 2 years under the MHA 1986, only 1.1 CTO were made under the MHA 2014.

But alongside these apparently positive signs of reduced reliance on compulsory care are a number of areas causing increasing concern. We found that those discharged from a CTO by the Authorised Psychiatrist (AP) under the MHA 1986 were less likely to require treatment as an involuntary patient in the subsequent two years than those discharged by the Mental Health Review Board (MHRB) or whose orders had expired (Vine et al., 2016). We hypothesised that this related to more considered treatment planning and patient engagement. This was no longer so under the MHA 2014. The AP was more likely to place a person who was on a CTO back under an inpatient order. We found that almost 30% of CTO 'ended' by being varied to an inpatient treatment order by the AP. This was a significant change from the findings under the MHA 1986. There are several possible explanations for this finding, including the possibility that people are being placed on a CTO too early in the course of treatment, or that community services are not available in sufficient intensity or accessibility to adequately support persons to remain in the community, or that the overall expectations of the Charter have influenced practitioners to minimise the use of compulsory orders. The data we obtained provided evidence of change, but we could not attribute this change solely to a change in legislation and policy. This highlights the importance of examining the context in which legislative change occurs in order to understand any effects of new mental health legislation.

3. Contextual issues in Victoria

Despite the commitment to improved mental health services, the last decade or more has not seen growth in funding to clinical mental health services in Victoria proportional with population growth. Victoria had the highest per capita expenditure on mental health in 1994/95 and was still ahead of New South Wales in 2008/09 (Australian Institute of Health and Welfare, 2017). By 2015/16 Victoria had the lowest per capita spend on mental health across Australia (AIHW 2017, Table EXP 4). This occurred as a result of significant population growth, without matching growth in funding for mental health.

This relative decline affected both bed based and community services. Victoria made a massive shift from institutional beds to beds located in acute general health services. In 1993/94 only 7.9 beds of a total of 34.2 per 100,000 were located in general hospitals, but by 2008/09, 18.1 of a total 22.9 were mainstreamed acute beds. This shift in bed location was also associated with an actual reduction in the number of beds, especially long stay beds. The acute bed base dropped from 18.1 per 100,000 in 2008/09 to 17.2 in 2015/16 (AIHW 2017, Table FAC 13) compared to the national average of 29.4 These dramatic reforms from a largely stand-alone asylum style institution based service to inpatient services co-located with acute beds were initially associated with the implementation of a range of crisis and continuing care clinic and out-reach community mental health services (Meadows and Singh, 2003). However, the problems in access to services are also evident in community based services. In 2015/16 Victoria had the lowest number of full time equivalent staff with only 121.5 per 100,000 population compared with the national average of 132.9 (AIHW 2017, Table FAC 37). Measurement of community contacts was impacted by industrial action in 2015/16, but even taking this into account there seems to be a reduction in service availability. Service contacts per 1000 population were 332 in Victoria, suggesting less intensive service availability compared with 393 nationally (AIHW 2017, Table CMHC 2).

Table 2
Comparative Mental Health services, (AIHW).

Per capita number/funding/EFT	1994/95	1994/95	2008/09	2008/09	2015/16	2015/16
	Victoria	National average	Victoria	National average	Victoria	National average
Recurrent expenditure per capita*	128.25	113.9	192.98	203.78	197.30	226.52
Acute Public beds in general hospitals per capita**	7.9	12.9	18.1	17.7	17.2	18.0
Total Beds per capita**	34.2	39.6	22.9	30.5	21.9	29.4
FTE equivalent staff per capita***	114.3	102.9	117.7	128.5	118.2	133.3
Proportion of community accessing clinical services****			1.13%	1.6%	1.08%	1.8%
Population (million)*****	3.32	18.07	5.44	21.69	6.24	24.13

* AIHW Mental Health Services in Australia. Table EXP.4.
** AIHW Mental Health Services in Australia. Table FAC 13.
*** AIHW Mental Health Services in Australia. Table FAC 37.
**** AIHW Mental Health Services on Australia Table KPI 8.1; Victoria's mental health services Annual Report 2016/17.
***** Australian Bureau of Statistics.

As shown in Table 2, compared to other States in Australia, Victoria spends less on mental health per capita, has fewer beds and fewer staff across bed based and community services (Australian Institute of Health and Welfare (AIHW), 2017) (Table 2). We aIso have a lower bed day cost. In a recent review of quality and safety assurance in Victoria, the authors singled out mental health services as requiring adequate funding to deliver safe and timely care (Duckett et al., 2016). It should be noted that the Victorian government has substantially increased funding to community mental health services in the 2017/18 and the 2018/19 budgets, but it will take several years of such increases and further investment in bed based services to bring Victoria back to the national average.

These proportional changes in population in the absence of increased capacity in community and bed based services have resulted in increased pressure on state funded health services. The results include increased throughput with a higher threshold for acceptance and shorter length of stay in inpatient units. An example from NorthWestern Mental Health in Melbourne where one of the authors works is that there were 621 admissions to a 25 bed unit in 2011/12, while the same unit had 704 admissions in 2016/17. There were 1092 admissions in 2011/12 to a 50 bed unit, but this increased to 1394 in 2016/17. The increased rate of throughput is reflected in overall increases in acuity, and higher proportion of new, previously unknown patients. While there is not data to indicate whether services have improved, the sense from services is that the increased pressure on throughput has not supported the aims of person-centred care.

These population changes mean that a comparatively lower proportion of the population accesses public mental health care. Victoria's mental health services annual report shows that the proportion of the population accessing state funded mental health services has fallen from 1.13% to 1.08%, (Victorian Government, 2017). This is far lower than conservative estimates of the prevalence of severe mental illness in our community (Harvey et al., 2007). As a consequence of a number of changes in sentencing practices, there has been a substantial increase in the prison population (Sentencing Advisory Council of Victoria, 2016). There are also anecdotal concerns at the rising number of mentally ill persons in prison and homeless crisis services, increased rates of readmission, sexual and physical aggression on inpatient units, and blockages in Emergency Departments (Duckett, 2017; Tomazin, 2017; Dow Aisha, 2018; Sentencing Advisory Council of Victoria, 2016).

It is possible that some of the changes we noted between the MHA 1986 and MHA 2014 are related not to the impact of policy change, but to very different pressures on access and flow. There may have been improvements in treatment such as the introduction of medication with fewer side effects, and improved psychological and family therapies but we also need to acknowledge societal changes such as increased rates of methamphetamine abuse, homelessness and family dysfunction. Pressure on in-patient units in turn puts increased pressure on community services. Shorter length of stay means that patients are likely to be comparatively unwell when discharged.

4. Conclusion

Much has changed since the heady days of the National Mental Health Strategy in 1992, with some commentators noting early in its implementation an increasing distance between what was promised and what was delivered through supposed reforms (Singh and Castle, 2007). It is difficult to determine whether, as intended by those who advocated for mental health legislative change in Victoria, success in achieving the aim of reducing rates and duration of compulsory treatment, represents advancement in care. Unfortunately, as this change occurred at a time of comparatively reduced service availability the good intentions of greater emphasis on recovery oriented services and person centred care may have been confounded by reduced access to appropriate services. From a practitioner's perspective, there is a very real risk that we are no longer able to provide the duration, intensity or accessibility of services that those with severe mental illness and their families should rightly expect. There is a concern that the apparent reduction in use and duration of CTO is not because there is better engagement or better outcomes, but rather because there is reduced access to services. The recognition by government that mental health services have fallen behind acute health services and need greater investment is welcomed. Further research is needed to explore the relationship between policy intentions, impact of legislation and service context, and to link this to patient outcomes.

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