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Submission:
Royal Commission into Victoria's Mental Health System

Eastern Health
July 2019

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It is with great pleasure that I formally present, on behalf of the Eastern Health community, a submission to the ***Royal Commission into Victoria's Mental Health System***.

The Royal Commission into Victoria's Mental Health System provides us with a once in a generation opportunity to accelerate improvements in access to mental health services, service navigation and models of care.

At Eastern Health we are uniquely positioned as a major provider of mental health, alcohol and other drug services to contribute to the future of these services for decades to come.

We understand the importance of addressing each consumer's individual needs throughout their recovery journey and actively work with consumers, carers and families to achieve this.

Fundamental to the success of mental health services is the collaborative nature of working collectively to ensure a recovery-oriented service model.

We are proud that across our Mental Health Program, Turning Point, Spectrum and more broadly our entire health service, our people are absolutely committed to placing our consumers, who are often in a vulnerable state with very complex needs, at the centre of everything we do.

Eastern Health appreciates the opportunity to contribute to the Royal Commission into Victoria's Mental Health System and we encourage the Commission to advocate for fundamental change that will benefit Victorians for decades to come.

Adjunct Professor David Plunkett
Chief Executive, Eastern Health

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

About Eastern Health Mental Health Services

Eastern Health provides comprehensive clinical mental health services across a range of emergency departments, inpatient units (acute and sub-acute), community and residential settings. These services cater to individuals of all ages, their families, significant others and other service providers across the local government areas of Whitehorse, Manningham, Maroondah, Monash (part), Knox and Yarra Ranges in the Eastern Metropolitan region of Melbourne. The services also engage with the community sector to improve the response to consumers with mental illness.

Fundamental to the success of these services is the collaborative nature of working collectively with consumers, carers and key stakeholders to ensure a recovery-oriented service model.

The service profile of the Mental Health Program includes:

1. Child and Youth Mental Health Services (CYMHS): Clients are aged 0-24 years with severe emotional and/or behavioural disturbance and mental illness, inpatient and community services.
2. Psychiatric Consultation and Liaison Service: incorporating a newly established Perinatal Emotional Health Service. These services provide support for managing people with mental illness in hospitals.
3. Adult Mental Health Services: clients aged 25-64 with severe and enduring mental illness, inpatient and community services.
4. Eastern Health has 16 short-term (3 to 6 months) placement beds at Monash Secure Extended Care Unit (SECU).
5. Access Stream: incorporating Telephone Triage, Emergency Department Response and Crisis Assessment and Treatment (CATT) services, Mental Health and Police (MHaP) Response and the Psychiatric Assessment and Planning Unit (PAPU).
6. Aged Persons Mental Health Services: clients aged 65+ with severe and enduring mental illness, inpatient, community and residential aged persons mental health services.

   Services are located at:

   - Community clinics which are based in Ringwood East, Box Hill, Lilydale and Upper Ferntree Gully.
   - Inpatient units which are located at Box Hill Hospital, Maroondah Hospital and the Peter James Centre.
   - Residential facilities (both sub-acute and medium term) are located in Ringwood East, Box Hill, Burwood, Mooroolbark and East Camberwell.

Eastern Health recommendations for consideration by the Royal Commission

Priority areas for change

- Urgent investment in mental health service capacity to meet the demands of children and young people, adults and aged persons. This includes increasing inpatient beds and community services along with the workforce required to support this expansion across settings.
- Expand purpose-built infrastructure for current and increasing demand which is safe and provides a therapeutic environment that achieves optimal care and outcomes for consumers, families and carers.
- Review existing legislation and protocols to eliminate barriers for information sharing between health services and other emergency service providers and the justice system.

Building a sustainable system

- Statewide mental health service planning is required, inclusive of capital and infrastructure planning.
- Statewide mental health workforce planning is required.
- Office of the Chief Psychiatrist to lead consistency of practice across mental health services regarding inpatient safety, response to aggression and a system response to consumers with forensic histories.

Improving understanding of mental health and reducing stigma and discrimination

- Implement Youth Mental Health First Aid training in all schools and other youth agencies.
- Resource Mental Health First Aid for older persons to be delivered to staff working in Community and Residential Aged Care Services, General Practitioners, older persons, carers and families.
- Improve capacity building through primary, secondary and tertiary consultation with agencies in the education, health and welfare sectors.
- Expand the Lived Experience Workforce in health and community settings.
- Provide education and training opportunities for all healthcare providers in mental health; and
- Expand public health campaigns.

Improving prevention, early treatment and support

- Increase service capacity to meet the demands of children and young people, adults and aged persons.
- Increase the capacity of CYMHS to manage first episode psychosis, up to 25 years.
- Increase service capacity to provide inpatient and community care for young people and adults with eating disorders.
- Expand Prevention and Recover Care (PARC) services including Youth, Aged and gender-specific PARCs.
- Expand the Infant Access Program (4 years and under).
- Expand the Perinatal Emotional Health Service to meet demand.
- Establish a mother and baby unit in the eastern metropolitan region.

Developing and expanding suicide prevention strategies, programs, research and services

- Expand services to support early intervention and proactive contact post suicidal ideation or self-harm to reduce the likelihood of subsequent attempts.
- Develop a five-day-a-week step-up, step-down Day Program for young people aged 16 to 25 years to facilitate greater engagement and provide targeted therapeutic treatment with skilled staff that have specialised skills in working with and engaging young people and their families.
- Continue to develop the evidence and research into suicide prevention and share findings across the health sector.

Accessing, navigating and experiencing mental health services

- Establish area-based governance systems to address fragmentation of care and encourage integration and collaboration in mental health care.
- Establish an Emergency Department Access Hub in the east.
- Increase resources for mental health/ alcohol and other drug presentations in emergency departments, as well as telephone triage services.
- A state-wide conversation about access to mental health services when consumers present as "out of area".
- Establish an active post-discharge follow-up service for everyone who attends an Emergency Department with mental health, alcohol or other drug issues to ensure appropriate management and support.
- An initial increase of 25 acute adult inpatient beds in the Central East.
- Develop a sub-acute inpatient service to support transition from acute inpatient units to the community by providing time, clinician intervention and good discharge planning.
- Establish an adult inpatient unit that accommodates high risk and forensic consumers (either within the existing forensic setting or within specific Designated Mental Health Services) to support the safety of all consumers, staff and visitors.
- Expand Consultation and Liaison services in hospitals (24/7) to support management of consumers with co-morbid mental health issues and medical/surgical issues.
- Additional resources and expertise for managing consumers with high complexity issues including forensic histories, co-morbid drug and alcohol issues, family violence, personality disorders and suicide prevention (inpatient and community services).
- Create gender-specific acute inpatient units and gender diverse units.
- Establish central multi-agency healthcare hubs that allow populations of all ages to receive coordinated mental health and support services which are integrated.
- Centralise referral systems that include community providers.
- Significantly expand the Personality Disorder Service at Eastern Health, supported by Spectrum.
- Integration of dual diagnosis and alcohol and other drug services with mental health services.
- Investment in Dual Diagnosis Acute Inpatient Units to address specific treatment needs and reduce exposure of existing units to substance use and behaviours of concern.
- Establish a Rapid Response Service for the 65+ population.
- Relocate South Ward (aged persons acute inpatient unit) to an acute hospital site and substantially expand its capacity for future growth.
- Review the model of care for Aged Persons Mental Health which has a focus on managing mental health along with co-morbid geriatric and physical issues, and supporting people in their homes, including residential aged care, with a multidisciplinary team.
- Provide Consultation and Liaison services in sub-acute services (i.e. rehabilitation and Geriatric, Evaluation and Management).
- Establish a clinical sub-acute service for aged persons with mental illness.

Supporting families and carers

- Establish dedicated funding to support carers.
- Establish bed-based respite services for people with enduring mental illness.
- Ensure that families and carers are adequately and truly represented when reviewing, planning and designing future mental health services.

Developing the mental health workforce

- Progress statewide workforce planning to ensure a sufficient supply of staff and an appropriately skilled workforce relevant to the unique needs of mental health service provision, and ensure that supply meets demand in all healthcare disciplines.
- Collaborate with Universities and other educational institutions to tailor education and training for the mental health workforce.
- Provide tailored University training for case management in mental health to appropriately manage the complexities of consumers with mental illness.
- Continued development of the Lived Experience Workforce, including young people.
- Expand programs which focus on the management of occupational violence and aggression to support staff safety and wellbeing.

Improving social and economic participation for people with mental health illness

- Ensure that the National Disability Insurance Scheme (NDIS) caters for the developmental needs of children and young people, including the provision of psychosocial support.
- Ensure psychosocial supports are available for consumers who need support but are assessed as ineligible or not requiring NDIS, and those who choose not to apply for NDIS.
- Ensure psychosocial supports are available for people aged 65+ where social isolation is a compounding factor to their mental illness.
- Invest in Homeless Models of Clinical and Psychosocial Support across the community.
- Invest in housing models including public housing and supported accommodation.
- Invest in specialist accommodation for consumers with high and complex needs (e.g. mental health and intellectual disability with complex behaviours).
- Incentivise education and training entities to take students with mental ill-health and companies to employ people with mental ill-health.
- Maintain the current focus on family violence prevention and management.

Responses to the Royal Commission's questions

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

With greater understanding comes a reduction in the stigma associated with mental illness.

The community would benefit from:

Consultation and education to primary and secondary agency staff to build their capacity and understanding of mental illness

Research shows that early intervention for mental health difficulties in children and young people reduces the severity and duration of mental illness. As a tertiary service, CYMHS provides significant informal leadership and support to partner agencies across the Eastern Metropolitan Region. This includes provision of once-off primary, secondary and tertiary consultations as well as regular, contracted, secondary consultations to key agencies. In addition CYMHS staff host monthly community education seminars. Consultation to other service providers working with children, young people and their families promotes early intervention and effective delivery of primary and secondary level responses for children and young people experiencing mild to moderate mental health issues. Provision of regular, contracted secondary consultation aims to build the skills, knowledge, confidence and capacity for staff working in education, health and welfare sectors to respond to and support children and young people experiencing mental health issues. Efficient coordination, up-to-date documentation and regular evaluation of consultations is essential to ensure work meets agreed goals.

Currently CYMHS offers contracted secondary consultations to nine different agencies including Worawa Aboriginal College, Youth Support and Advocacy Service in Box Hill, City of Maroondah Youth Services and Inspiro Youth and Family Counselling Service. Tertiary services should be required to provide leadership, support and capacity-building through primary, secondary and tertiary consultation with other agencies including education, health and welfare sectors. This should be done in collaboration with the regional Primary Health Networks (PHNs).

Lived experience workforce

Involvement of the lived experience[1] workforce in health and community sectors will assist in understanding of mental illness and reducing stigma and discrimination.

Mental health first aid

Mental Health First Aid training is the help provided to a person who is developing a mental health problem, experiencing a worsening of a mental health problem or in a mental health crisis. The first aid is given until the appropriate professional help is received or the crisis resolves. This education should be broadly available to staff working in schools, youth agencies, community health agencies, general practice and Community and Residential Aged Care Services; consumers, carers and families. Eastern Health staff are trained to undertake this training and build capacity in the community. As a part of the Community Suicide Prevention Strategy, Eastern Health offers community training for frontline services to recognise mental health issues and suicide risk in people over 65, and to respond accordingly.

Public health campaigns

Many agencies have contributed positively to the awareness of mental illness including Beyond Blue and the RUOK campaign. These need to be continued and expanded to increase understanding of mental illness and reduce stigma.

[1] A lived experience worker is a 'person who is employed in a role that requires them to identify as being, or having been a mental health consumer or carer. https://www.mhcsa.org.au/about

Workforce

Undergraduate training for all healthcare professionals should include education, placements and work experience in mental health, as mental illness is frequently co-occurring with physical illness and needs to be managed holistically.

In summary, tertiary services are well-positioned to provide consultation and education to primary and secondary agency staff to build their capacity to effectively respond to children and young people, adults and older people with mild to moderate mental health difficulties.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Early identification and therefore early treatment and support for people experiencing mental health issues for the first time is important for long-term outcomes. Whilst the identification, treatment and support is ideally provided during the earlier years of life, it is equally important to ensure that measures and services are in place that allow mental health services to adequately support people of all ages and stages of life in the early stages of mental ill-health.

There are services currently available that target early intervention, however these services constantly struggle to meet demand. Stringent triaging of referrals occurs ensuring that only the most serious cases are managed. Many people with severe presentations requiring tier 3 multidisciplinary treatment teams rely on community services designed for milder presentations. Tier 3 services are designed for children and young people who have complex and severe mental health complications and/or are at high risk of harm.

Increasing the capacity of the multidisciplinary tier 3 teams in tertiary services would greatly improve the 0capacity to help those with severe mental health disorders currently underserviced, as well as free up community agencies to more adequately meet the needs of those with mild and moderate presentations.

Adolescent Inpatient Unit

The Adolescent Inpatient Psychiatric Unit (AIPU) serves young people aged 13 to 17 living in the Eastern region and rural areas including Goulburn Valley, North Eastern CAMHS Region, Shepparton, Seymour, Wangaratta, Albury-Wodonga and surrounding shires. Between 2016 and 2018 the number of separations has increased from 448/year to 626/year, while the average length of stay has dropped from 5.7 days to 4.1 days, reflecting an increase in demand. While there are outliers in a young person's length of stay, over the three-year period, only 1.2% of separations were longer than 35 days. Recent patient experience of care data has indicated that 23% of young people admitted to the AIPU identified as LGBITQ+.

A dedicated youth in-patient unit would provide greater access to inpatient care for 18-25 years, minimising delays in acute in-patient care and treatment given the current bed demand within the adult mental health program. It would also provide age-appropriate environments, treatment, education and activities to support positive outcomes for young people. As noted in the 2019 VAGO report, in CYMHS there are no youth specific services such as youth in-patient units, youth PARCs or day programs within the Eastern region.

Children aged 12 years and under

In recognition of the under-representation of children aged 0-12 within mental health services, priority access has been implemented to facilitate greater engagement. Whilst this has been somewhat successful, demand again exceeds resources and many children meeting tertiary criteria are not able to be admitted for assessment and treatment. Those children, who are accepted, typically have highly complex presentations including experiences of significant trauma, family violence, severe attachment difficulties, and parental mental illness. The complexity of such presentations requires flexible, outreach models which are difficult to sustain within current resources and is further compounded by the large Eastern catchment area. Without collaborative engagement with families and the system of care, including Child Protection, Child First,

Maternal Child Health Nurses, schools, to name a few, outcomes are poor leading to family breakdown, school disengagement and poor future prognosis.

Children and young people identifying as Aboriginal

Aboriginal children and their families have prioritised entry to assessment and treatment services. This is supported by routine 'asking the question' and where positive, engagement with the specialist Aboriginal Senior Clinical Social and Emotional Wellbeing clinician to ensure a culturally safe and responsive service is provided. Additionally, CYMHS provides secondary consultation to the national entry girls' only Aboriginal boarding house in Healesville, *Worowa House*.

CYMHS Access

Eastern Health CYMHS provides specialist mental health assessment and interventions for infants, children and young people (0-24 years) and their families residing in the Central and Outer Eastern Region of Melbourne. CYMHS is the lead agency in treating severe and complex mental illness and focuses on early intervention using a developmentally informed framework that is holistic, family based and recovery oriented. The service also supports partner agencies within the region that work to prevent, treat or facilitate recovery from the broader spectrum of mental disorders and promote mental health in children and young people, thus working to improve the lives of young people, strengthen diverse communities and reduce morbidity into the future.

In Australia, mental health presentations occupy the top three causes of the burden of disease for 15 to 24-year-olds. Specifically, suicide and self-harm, anxiety, and depressive disorders are the leading concerns for 15 to 24-year-olds, while anxiety and depressive disorders are the second and third causes of disease burden for 5 to 14-year-olds[2]. CYMHS has insufficient resources to meet current demand. Using data collected over a 12-month period from 1 June 2017 to 30 May 2018, over 10,000 calls were received at Access, the dedicated weekday CYMHS referral and information team. Of the 10,000 calls, 3000 of these were abandoned by the caller in part because of waiting times. The 6700 calls answered reflected concerns about 3235 unique young people. Following a detailed screening assessment, 1207 young people were subsequently accepted into community case management, treatment and support. Given the epidemiology and population of the area (the 0-24 population was approximately 250,000 in the 2016 Australian Bureau of Statistics (ABS) census), it is estimated that approximately 6000 young people need assessment and treatment per calendar year.

Outcome measures show that for those attending CYMHS, symptoms become significantly less severe, and functioning significantly better,[3] evidence of the service's effectiveness. Because of limited resources there is a gap between demand and the service's capacity (the percentage of referrals received that have been able to be accepted over the past five years has varied between 30% and 36%), hence there are opportunities for improvement. Additional resources would improve the ability to meet demand and could make a significant difference to young people at a critical point in their lives.

The 2019 Victorian Auditor-General's Office (VAGO) report into CYMHS noted that there is a gap in the ability to provide services to this vulnerable cohort of consumers and their families. Left untreated, these mental health issues will continue to pose a burden, not only to health services, but to other public services, such as police and ambulance. In addition the impact of mental illness will continue to spiral, impacting future engagement within society, education, employment and, left unaddressed, will eventually impact the nation, for years to come.[4]

Given its limited ability to meet demand, CYMHS accepts only the most severe, complex presentations and those who require treatment beyond the capability of tier 1 and tier 2 services. In 2015, CYMHS implemented a new model of care across Access and the Community teams named Initial Consultations and Treatment in Recovery (ICTiR). CYMHS' implementation of the ICTiR model of care eliminated the waiting list, maximised efficiency whilst providing a framework that maintains collaborative, evidence-based, and therapeutic and recovery-oriented practice. In brief, ICTiR calculates sustainable parameters for new

[2] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
[3] Brann, P., & Coleman, G. (2010). On the meaning of change in a clinician's routine measure of outcome: HoNOSCA. Australian and New Zealand Journal of Psychiatry, 44(12), 1097-1104.
[4] Child and Youth Mental Health Report, Victoria Auditor General, tabled June, 2019.

appointments that allow young people to be accepted for service either immediately (in case of crisis presentations) or within five working days. This is achieved through tracking three measures: staff resources (equivalent full time [EFT]), outcomes and the required average days of assessment and treatment. Changes in EFT automatically lead to changes in the Service's capacity to accept referrals.

ICTiR has assisted the service to focus its limited resources on efficient quality of care for the most complex and severe presentations whilst minimising a reactive, crisis driven approach. Since introducing ICTiR, engagement with young people in the crucial early stages of therapy has increased from 85% to 92%. Failure-to-attend accounts for only 2.9% of case contact time, an exceptional result in a public CYMHS service.

CYMHS assists those consumers it cannot see with sourcing alternative solutions. In 2019, CYMHS implemented a short-term assessment and treatment clinic to assist in bridging this gap. The ICTiR model has proven largely effective with referrals provided with appointments generally within seven days of acceptance. In addition, the absence of a wait list is well received within the community. However, there remains a significant gap in CYMHS resources to meet the needs of significantly unwell consumers aged 0-24, especially considering the limited services available to provide the level of intensive management required. In addition, these issues have a negative impact on staff morale and well-being, particularly the CYMHS Access Team which invests considerable time locating alternative providers for consumers that it cannot service.

CYMHS Community Clinics

CYMHS provides significant community assessment and treatment for young people up to 25 years of age, across a range of sites, within the Eastern Region. Teams utilise a case management model and provide multi-disciplinary, multi-modal treatments including individual therapies, family therapy, parent therapy and group work. There is a significant focus on working collaboratively with partner agencies including schools, health and welfare services.

The Specialist Intensive Mobile Treatment Team provide intensive outreach for young people at significant risk and complexity and are typically within the Child Protection or Youth Justice systems.

The Specialist Child Team works particularly with infants and children under 12 years of age who are highly vulnerable and at risk of requiring Child Protection. The Child Team works closely with Maternal and Child Health Services working with parents and infants with concerns regarding the infants' mental health due to issues such as parental mental health issues, attachment difficulties, or family violence.

The service also provides a three-day a week adolescent day program called Groupworx. This program runs each school term, and is available to 13 to 17-year-olds at risk of school refusal, school isolation, behaviour difficulties, anxiety and depression, or disengaged from, school or work. The program is run in conjunction with Avenues Education. This program accepted 32 young people in 2018 with an average age of 14-15. Most of these young people had either not attended or had disengaged from education, with 10 having not attended school in over six months. Outcomes on education indicated that all but one had re-engaged in school at the conclusion of the program.

CYMHS has a long-standing partnership with Deakin University School of Psychology which provides training for psychology students and includes up to six sessions of brief intervention, typically for children and families with more mild presentations. This work includes group work within local primary schools, one school per term and directed at early intervention for young children presenting with oppositional or conduct issues.

Across all of the community-based teams, there is a strong tendency for adolescents to predominate. Using five-year age blocks, 2.3% of young people were aged between 0 and 4 years at case start, with 7.6% (5-9 years), 27% (10-14 years), 50.7% (15-19 years) and 12% (20-24 years). Comparing the actual case data with an equitable representation of ages indicates that across all elements of the Eastern Health Mental Health Program, young adults are almost equitably represented, adolescents are quite over represented, while primary school aged child are slightly under represented. Infants and pre-schoolers are very much under represented. All age groups are underrepresented in terms of the extent of the community need for treatment of those with severe and complex mental health problems.

The most prevalent diagnoses over the last three years (acknowledging that comorbidities allow for more than one diagnosis per case), were anxiety disorders (25%), mood disorders (20%), personality disorders (8%), eating disorders (7%), adjustment disorders (including PTSD, 7%), psychotic disorders (6%) and pervasive developmental disorders (5%).

As befits the developmental stages of the CYMHS population, and the evidence base on treatment, CYMHS provides treatment through many parties. Just half of all contact time is exclusively with young people. The remaining time is provided with family, referrers or other supporters when the young person is present and when the young person is not present. Of all the additional work provided by CYMHS a significant proportion is directed into clinical reviews, report writing for others and joint clinical work. Focusing on the community teams engaged in the ICTiR model, the average case receives 53 hours of contact time, including all activities attributable to that (e.g. reviews).

CYMHS deliberately targets its limited resources at those experiencing the most severe and complex mental health difficulties. Australian mental health services have a common Outcome Measurement protocol in place. Comparing symptom severity scores with National data on over 58,000 young people entering community treatment within a state-based child and youth mental health service, young people at Eastern Health CYMHS are more severe than those typically seen in ambulatory mental health services at admission. The average intake to community score is a weighted score that reflects the degree of complexity at a point in the continuum of mental health care. The average intake to community score at Eastern Health CYMHS is more severe than 73% of all comparable cases at other CYMHS. Through its recovery treatment approach, Eastern Health CYMHS achieves a reduction of almost one standard deviation in symptom severity. In other words, approximately 71% of cases show significant improvement by case closure.

Eastern Health community service locations enable service delivery close to home, and facilitate close connections with other key stakeholders. However, in its current configuration, infrastructure is insufficient, unsafe and out-dated and there is a lack of medical treatment rooms across the region. It is not unusual to experience late cancellation of appointments, or appointments being held outside of buildings, such as at the local park because mental health workers share spaces with other community services.

Eating Disorders

CYMHS provides priority access to treatment and care for young people with an eating disorder; a decision made because of the increasing incidence of young people presenting to emergency departments with an eating disorder requiring specialist medical stabilisation. The service, developed without additional funding, comprises an integrated paediatric and mental health assessment clinic, Eating Disorders Assessment Clinic (**EDAC**), and provision of evidence-based community mental care. All clinical staff are trained with evidence-based treatments, including family-based treatment for Anorexia Nervosa.

The service has worked in partnership with the Centre for Excellence in Eating Disorders (CEED) to implement multi-family therapy for anorexia nervosa, complementing the suite of clinical interventions. Early recognition and access, either due to lack of recognition by primary health and/or ineffective treatment within Tier 1 and 2 Services [‘tier’ and ‘Tier’ are used in the submission], are ongoing concerns.

Of the 33 young people assessed by EDAC, 13 required immediate hospitalisation for acute medical instability, illustrative of issues with early identification and evidence based early intervention. The Eastern Health paediatric unit expanded its capacity for consumers with eating disorders in 2013 and has high occupancy rates without the benefit of dedicated funding. Funding along the lines of that available to the Royal Children’s Hospital would be desirable. As a consequence, Eastern Health is unable to provide group programs or consistent mental health support across the admission. Young people with a severe eating disorder between the ages of 18 to 25 years are admitted for acute medical stabilisation to a general medical ward. Due to lack of resources, mental health services have been stretched to cover this ward effectively.

Whilst there are funded specialist eating disorders services within Victoria, for the most part they are not accessible to consumers from the eastern region. For example, the BETRS day program located in Kew is inaccessible for clients who are physically or medically impaired, and those who are unable to drive greater

than 40 kilometres for care. The specialist services additionally do not provide case management, nor have any capacity for outreach. As a major mental health condition, eating disorders should be treated and managed within the tertiary mental health service system, a system which provides care within the local community and is in a better position to provide support, coordination and linkages with the broader health system including primary health care.

First Episode Psychosis

There are two Eastern Health Early Psychosis Teams to manage young people presenting with first episode psychosis and mania between the ages of 0-24. The treatment model follows the evidence-based treatment guidelines developed by Orygen Youth Health. The model also incorporates psychosocial support to enable young people continuing with education or employment. The teams provide outreach work to enhance engagement with the young person and family and also deliver consultation and support to the care system to ensure the holistic needs of young people are met. Current resourcing enables a two-year recovery model of care, extended for young people under the age of 18 years and attending secondary school. Thereafter, where acuity remains high, young people are transitioned to the adult mental health service, which is not ideal from a developmental perspective. Where acute inpatient care is required this is provided within the adult mental health inpatient units for young people over the age of 18 years.

Infancy Access Project

The development of this project followed recognition of the under-representation of infants and pre-schoolers under 4 years old within the service. To address these concerns the service embarked on a pilot in 2017 where a senior clinician is co-located with the Maroondah Maternal and Child Health Service to provide conjoint assessment with the Enhanced Maternal and Child Nurse (EMCHN) and mental health clinician in the family home. In particular, referrals are targeted for Aboriginal and Torres Strait Islander families, culturally and linguistically diverse families, refugee families, families with generational trauma/abuse, families with significant mental illness and/or substance abuse, families experiencing violence, or chronic physical impairments, families at risk of/or currently involved with the child protection system. In addition, the service has been contracted to deliver professional development to Maternal and Child Health Nurses regarding mental health.

Pending positive evaluation and resourcing it is hoped to extend the program to the remaining local government areas of Monash, Knox and Manningham.

Older persons GP capacity building project

Nine per cent of people accessing 'Psychological Strategies' mental health supports are aged over 65 in the EMPHN catchment. In 2016, the highest age-specific suicide rate was observed in the male 85+ age group (34.0 per 100,000) with 61 deaths (ABS, 2016). This rate was considerably higher than the age-specific suicide rate observed in all other age groups. Older people are at greater risk due to isolation, loss of identity, emerging physical health issues including mobility issues. There can also be a cognitive decline impacting on an individual's ability to function effectively and independently.

The EMPHN and Aged Persons Mental Health Services GP Capacity building project aims to improve access and understanding of issues and themes related to the delivery of primary care mental health services for older people in the EMPHN catchment. It involves clinical nurse specialists undertaking mental health assessments with GPs in their clinics and the GP having immediate and direct access to a psychiatrist for consultations on medication management. The care and treatment is delivered in the GP practice with engagement of carers and family members. This model of care has mitigated the stigma associated with mental illness as care and treatment is delivered in a GP setting. GPs report a very positive experience and consumers have appreciated the normalising of their mental health treatment with their GP.

Perinatal Emotional Health Service

The Perinatal Emotional Health Service (PEHS) was established in 2018 with specific funding from the Department of Health and Human Services. Eastern Health delivers approximately 5000 babies per annum. It is estimated that one-in-five perinatal women experience depression during pregnancy and across the 12-

month period following the birth of a child,[5] and the Inquiry into Perinatal Services introduced to the Victoria Parliament in 2018 notes that there is a need for greater focus on and integration of perinatal mental health services. This funding will need to be continued and expanded, due to clinical demand from public antenatal services, postnatal services and maternal and child health and primary healthcare. Given service demand and resources, the model of care prioritises women experiencing significant mental illness within the perinatal period. Significantly there are no mother/baby inpatient beds within the Eastern region. This means women requiring inpatient care must travel far from home when they are at their most vulnerable, or be admitted into mental health beds and be separated from their infants/family. This also impacts on discharge planning and connections back to community based local supports.

Youth Engagement and Treatment Team Initiative (YETTI)

In recognition of the importance of effective early intervention the service has developed the YETTI. This service, funded by the Eastern Metropolitan Primary Health Network (EMPHN) is an example of effective partnership between State tertiary and Commonwealth services. The program has established networks and partnerships with primary care in an effort to improve access to early intervention, the YETTI program focuses on young people aged 12-25 years presenting with subclinical forms of serious mental illness, or experiencing symptoms which place them at ultra-high risk of developing such an illness. It operates across the Eastern Metropolitan Region, and through partnership with Austin Health, the areas of Nillumbik and Banyule.

The Program includes consultation, capacity building and support for community providers as well as case management. It has accepted 358 referrals since commencing operations in late 2017. It appears to be meeting an important need in the primary care sector, supporting young people who do not meet the threshold for tertiary mental health services, but who require more intensive follow up than can be afforded by existing providers. This program is illustrative of what can be achieved through the proposed initiative of developing regional mental health governance committees, resulting in a coordinated and shared approach to mental health.

3. What is already working well and what can be done better to prevent suicide?

Suicide Prevention Strategy

The Victorian Suicide Prevention Framework 2016-2025 has set a target to reduce the suicide rate by half over 10 years. Subsequently, Eastern Health was funded to trial a Hospital Outreach Post suicide attempt Engagement (HOPE) Team which commenced in November 2017.

Eastern Health is developing the *Promoting Hope in Life: Zero Suicide Strategy* through research and data-driven decision making, co-designed with people with lived experience of suicide attempts or bereavement by suicide, consultation with local stakeholders in our community, revision of initiatives from other health services nationally and internationally, and implementation of both State (Victorian Suicide Prevention Framework 2016-25) and national (Fifth National Mental Health and Suicide Prevention Plan) frameworks for suicide prevention. Early recommendations for suicide prevention, informed by those with lived experience of suicidal thoughts, suicide attempts, cared for someone who has experienced a suicidal crisis, or were bereaved by suicide include:

- The allocation of resources to enable suicide prevention leadership that includes meaningful participation of people with Lived Experience, their families, and significant persons in the lives of those who have an experience of suicide.
- Understanding, valuing and entrenching the role of the family in the way we provide services and their understanding of legislation including information sharing, supported decision making, duty of care, and confidentiality.
- Ensuring governments understand the scope and extent of suicide and related issues when allocating resource, including the specific needs of target populations e.g. people who identify as LGBTIQ+, Aboriginal Torres Strait Islander, and Culturally and Linguistically Diverse (CALD)

[5] Australian Institute of Health and Welfare. (2012). Perinatal depression: data from the 2010 Australian National Infant Feeding Survey. AIHW: Canberra. https://www.aihw.gov.au/reports/primary-health-care/perinatal-depression-data-from-the-2010-australia/contents/summary (accessed 5/6/2019)

- Facilitation of the release of funding to provide education and training on suicide prevention to families, schools and the broader community.
- Attendance to gaps in resources and navigating the mental health system and other community-based services to enable seamless transition for people at risk of suicide.
- The integration within all frontline services of peer workers who are well trained and educated and integrated with clinicians in the suicide prevention space.
- Modern IT infrastructure that enhances collaboration and information sharing between mental health services and community-based services to facilitate seamless referrals and continuity of care. Examples include Extended Aged Care at Home Packages (EACH), mental health service Neami National and specialist family violence service EDVOS.
- Improved connection and navigation for people with lived experience of suicide attempts and those bereaved by suicide through their care journey 'One person throughout the journey of care'.
- Resourcing of services so that they can provide timely and accessible supports to ensure suicidality is responded to as a mental health emergency at the time when it is needed. 'Instant response' with the right care at the right time.
- Creation of infrastructure to provide dedicated and effective responses to mental health emergencies outside of the current Emergency Departments by designing environments where people and families feel safe and supported, with permanent staffing by peer and clinical mental health staff. This could involve significant expansion of the Psychiatric Assessment and Planning Unit (PAPU) model of care.
- Safe Haven Cafes for addressing suicide prevention and mental health needs outside of a hospital environment. The learnings from medically supervised injecting room (MSIR) services can inform effective suicide prevention. Drop-in centers provide invaluable and accessible community-based support that should be funded and supported by legislation.
- Outpatient group and co-facilitated support programs (e.g. the Alcoholics Anonymous model) for people at risk of suicide.
- Local helplines that provide expertise individualized access to services to support integration into local resources.
- Increased capacity for people to experience more meaningful connection with service providers, having more power and control. Increased staff resourcing to enable a focus on talking, connecting, building a working alliance as a key predictor of mental health outcomes.
- Improved access to psychological therapies provided by psychologists, occupational therapists, and social workers through the GP Mental Health Care Plan for up to 52 sessions per year.
- Generous funding for Suicide Prevention Research Units for all area mental health services
- Identification and focus on the social determinants of health in order to build resilience within our communities and to address risk factors for suicide e.g. homelessness, employment, meaningful activity and social inclusion.
- Establishment of a register for real time monitoring and reporting on rates of suicide deaths to contribute to data driven decision making which engages the public in suicide prevention and health promotion (similar to what is seen in TAC response to address the road toll).

Inpatient services for young people

Young people 18 to 25 years presenting with the need for acute inpatient care are admitted within one of the three adult inpatient units at Eastern Health. This can lead to vulnerable young people being exposed to people with chronic illness and aggression, resulting in the experience of a lack of safety including sexual safety and gender safety, and potentially engendering a sense of hopelessness for their future recovery.

The development of a five-day-a-week step-up, step-down day program for young people with highly complex dual disability presentations occurring between the ages 16 to 25 years would facilitate greater engagement, targeting therapeutic treatment with skilled staff that have specialised skills in working with and engaging young people and their families. These skilled staff also have knowledge related to the developmental tasks that must be achieved in this particular age group. A multi-disciplinary approach incorporating vocational and educational support, potentially through expansion of the existing partnership with Avenues Education, would further facilitate re-engagement to their local communities.

Youth suicide postvention and prevention protocol

The Youth Suicide Postvention and Prevention Project Community Response Plan was developed by a broad range of services across the Eastern Metropolitan Region to ensure that the community is supported following the suicide, or suspected suicide, of a young person within the region. It provides clear and concise information to key community members and agencies to ensure a coordinated and effective response and to minimise the risk of contagion following a suicide incident involving a young person.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

One of the greatest challenges and frequent causes for complaints for mental health service users, carers and other health service providers is the difficulty experienced accessing and navigating the mental health service system, particularly when there are comorbidities requiring other service providers. Whilst services work hard to provide clear referral and care pathways, it is not always achievable due to the often complicated service needs of the person, particularly when alcohol and other drugs are involved.

High level clinical governance

The complexity of the mental health system means that it is difficult for consumers and mental health workers to understand the services available and how to access them. Fragmented and duplicated services and a lack of clinical governance within regions also contribute to the complexity and costs of service provision.

There needs to be a regional mechanism to address fragmentation of care and lack of governance within regions; and to encourage integration and collaboration in mental health care. Tertiary services are well-positioned to lead regional integration. The governance committees would need delegated lines of authorities, terms of reference, performance indicators and reporting requirements. Such robust systems and reporting are supported in both the Adult and Children VAGO recommendations.[6] One example of a regional mental health service alliance is Eastern Mental Health Service Coordination Alliance (EMHSCA). Composed of 30 partner organisations, EMHSCA looks at service gaps and potential improvements. The limitation is that it relies on the voluntary participation and goodwill of the partner organisations.

Adult Community Mental Health Services

Eastern Health provides a comprehensive multi-disciplinary and multi-modality collaborative community care program. Not unlike other sectors of mental health across the State and within the region, community services are under significant pressure with an inability to meet demand due to population growth, increase in mental health burden and limited resources from a workforce, infrastructure and funding perspective.

In January 2017, Adult Community Mental Health Services provided clinical mental health services for 997 consumers in the community as compared to the current 1215 consumers in June 2019. This increase has primarily been in the Case Management teams (both Brief Intervention and Continuing Care) with caseloads having expanded to provide care for more than 200 additional consumers. There is a trend towards a higher acuity and inherent risk in the community cohort of consumers driven by the unrelenting demand on acute adult mental health services. As the length of stay in adult acute inpatient units has decreased, a higher level acuity of mental health consumers was received for treatment in community settings which were not originally designed, nor staffed, for this intent.

The current case management model is no longer sufficient to meet the complex needs of consumers within community settings. This challenge, combined with ongoing population growth and its accompanying mental health disease burden requires a review of the community mental health model of care, with strategic review and planning to cover all resources (funding, infrastructure, staffing skill mix) within the community setting. Adult community mental health services are fragmented and uncoordinated within the region/state. Infrastructure supporting these services is not purpose-built and is out-of-date. There is also

[6] VAGO Access to Mental Health Services report, March 2019 and VAGO Child and Youth Mental Health Report, tabled June, 2019

inadequate funding and insufficient workforce resourcing. These factors result in a service which is scattered and difficult to access and navigate for all stakeholders.

What is needed is coordinated mental healthcare, ease of access, decrease in blockages, increased compliance and improved outcomes (i.e. transportation, travel, time constraints, to name a few.) Including walk-in centres within the model for access to books, informational pamphlets and computers, and early intervention support services, with extended hours; or the ability to reach out in tele-health style, to a mental health worker or crisis support worker, could further address the need for early access and decrease emergency department presentations and waiting times.

These spaces would be designed as gentle spaces to provide for sensory modulation.[7] The type of centre envisioned is not dissimilar to *ConnectedCare Centres* being developed in the United Kingdom. Such an approach supports mental health community services integration into the web of community support, thus increasing awareness and decreasing stigma while empowering the mental health consumer to have an active role in the community as well as their healthcare and thus improving staff, carer and consumer satisfaction and supporting positive outcomes.[8] This cohort requires increased clinical and psychosocial support to successfully transition from inpatient services and optimize recovery.

Adult Mental Health Access Services

Adult Access Services incorporate the Crisis Assessment and Treatment Team (CATT) services, emergency department response, telephone triage, Mental Health and Police (MHaP) response and Psychiatric Assessment and Planning Unit (PAPU). Following the changes implemented on 3 June 2019, the comprehensive suite of Access service functions are now integrated and apportioned to the Outer East and Central East catchments. These changes were part of the broader strategy to build a sustainable workforce creating career pathways for staff, enhance the development of skills for access clinicians and build greater agility to response to service demands at the front end of Eastern Health Mental Health services.

The introduction of telehealth in the emergency department has enabled an improved response time to assessments and the reviewing of consumers on Assessment Orders under the Mental Health Act. In addition, there has been an expansion of the MHaP response to the Central East area and the creation of PAPU, which is a designated Psychiatric Assessment Planning Unit located adjacent to the Maroondah Hospital Emergency Department focused on a short-stay type admission for review and/or management of short term concerns.

Challenges continue with meeting the demand in emergency department referrals for mental health assessments. Over the last 12 months there were 4660 mental health assessments undertaken across the three Eastern Health emergency departments with the most referrals received from Maroondah Emergency Department. In the same period, only 29% of mental health consumers were admitted to an inpatient unit within four hours, impacting the overall ability for Eastern Health to meet its Statement of Priorities target of 81% within four hours. Telephone triage services receive just over 2000 calls each month and the abandoned call rates are approximately 40%. The high rate of abandoned calls in telephone triage is attributed to the delays in answering calls. The current staffing profile for telephone triage does not enable the service to respond to calls within a reasonable timeframe and the demand and resources are mismatched even with the call back functionality of telephone triage. The situation is further exacerbated by difficulties in recruitment to the mental health workforce more generally. There is a requirement to expand the telephone triage staffing resources to match demand with resources by building workforce capacity in the Victorian mental health sector.

There are opportunities for improvement in the delivery of high quality adult access mental health services, and they are set out below for consideration by the Commission:

[7] Williams, B. 2019. *Collaborative and coordinated care: An investigation of the enablers and barriers for adults who experience mental ill-health in eastern Melbourne. pp 36, 43 Deakin University (thesis, publication pending)*

[8] Flatau, P, Conroy, E, Thielking, M, Anne, C, Hall, S, Bauskis, A & Farrugia, M 2013, How integrated are homelessness, mental health and drug and alcohol services in Australia?, AHURI Final Report No. 206, Melbourne, Australia, viewed 7 May 2019, http://search.ebscohost.com/login.aspx?direct=true&db=edsacd&AN=edsacd.293804&authtype=sso&custid=deakin&site=eds-live&scope=site

- ***Emergency Department Access Hubs***

In May 2018 the DHHS provided funding to selected emergency departments (not including Eastern Health) to establish emergency department hubs. These hubs enable people needing urgent mental health treatment to get the specialist care they need, allowing busy emergency departments to treat other patients. It is recommended that emergency department hubs be established at Maroondah and Box Hill Hospitals to support people with mental health, drug and alcohol problems who seek help in emergency departments, when their condition has reached crisis point.

- **Out of area patient presentations**

Consumers may be disadvantaged when presenting to Emergency Departments as 'out of area' patients. Transferring consumers to their usual treating mental health service is challenging, in part due to Health Services prioritising achievement of four-hour access performance targets in their own emergency departments.

- ***Opportunity to create safer mental health services in the emergency department***

Each week between four to five consumers leave the emergency departments prior to being seen by a mental health clinician. This is because wait times for assessment can be long given the limited mental health resources in the emergency department, particularly at peak times between 6:00pm and 11:30pm. In addition, many who present to emergency departments and are discharged do not receive supported mental health services to prevent re-presentation to the emergency department. One option is to establish a post-discharge follow-up service for everyone who attends any of the three emergency departments, similar to the Hospital Admission Risk Program (**HARP**). Mental Health HARP aims to improve people's mental health outcomes and manage the rate in growth and demand for public hospital services by reducing the use of emergency departments and inpatient services where avoidable. Alternative models of care for small cohort of consumers with high visibility and service usage (e.g. substance disorder, personality disorder) should also be established to support highly complex, frequent presenters to the Emergency Department.

- ***Adult Inpatient Service***

The Adult Mental Health Service at Eastern Health provides comprehensive inpatient mental health services for people aged 18-64 (inclusive) who are experiencing serious acute mental health illness. Like many public funded health services, the adult mental health inpatient program is facing challenges related to serviceability, access, care delivery and early discharge, due to increasing pressures in demand, and lack of resources. Eastern Health has 75 adult inpatient beds. In the 12-month period prior to June 2019 approximately 2000 adult consumers with mental illness were admitted to the adult inpatient units.

Aged Persons Mental Health Services

The Aged Persons Mental Health Service is made up of a 30-bed acute inpatient unit (South Ward) and a community mental health team of approximately 23 clinical EFT that services both Central East and Outer East populations. During the period 2017-18 the Aged Persons' Mental Health Service cared for 1035 consumers, with 447 of those being admitted to South Ward.

High quality aged persons mental health services should be holistic with multi-disciplinary teams focusing on the whole person and managing both mental health and other complex geriatric co-morbidities with the aim of supporting people in their homes, including residential aged care.

There are many opportunities for improvement in the delivery of high quality aged persons mental health services, and they are set out below for consideration.

- ***Rapid Response Services tailored for people aged 65+***

There is no specific crisis assessment and treatment services for people aged 65 and over. A crisis response service should be available to support and manage people in their homes, to prevent presentations to Emergency Departments.

- ***Access to acute services for the aged mental health population***

South Ward is currently located on a sub-acute site (Peter James Centre) with limited access to diagnostic support services resulting in frequent transfer of consumers to other Emergency Departments for medical support and for diagnostic services, incurring significant transport costs. Electroconvulsive Treatment (**ECT**) is also currently undertaken in an ECT suite co-located with South Ward. Consumers with medical complications are required to be transported to Box Hill Hospital for ECT. It is recommended that the Aged Persons Mental health inpatient unit be co-located at an acute site with acute services and have access to the full range of diagnostic support services and acute medical specialty intervention and support services. ECT should also be provided at an acute hospital site, with additional staff and resources to deliver this service in line with current best practice. The new facilities would need to be purpose-built to mitigate the major risk areas of falls and aggression.

- ***Access to acute aged-mental health beds***

There are 30 acute aged mental health inpatient beds at the Peter James Centre. Five of the 30 acute beds are in the Intensive Care Area (ICA) that is currently undergoing refurbishment. The ageing population in the Eastern Region will require additional acute aged person's mental health beds. It is anticipated that it will require:

- 25 acute beds for consumers with 'functional' disorders such as depression, anxiety, bi-polar affective disorder, schizophrenia, etc.
- 25 dementia beds in an adjacent but separate unit to maximise the sharing of staffing resources.
- The dementia unit will have five beds to accommodate consumers with delirium and severe behavioural disturbance where a dedicated 'delirium team' offers psychiatric consultation and liaison service across Eastern Health inpatient services to consumers presenting with delirium.

- ***Integrate the workforce through enhancement of an agile workforce that supports learning, career progression for effective and efficient care delivery***

The inpatient unit and community mental health services have separate staffing profiles and work as discrete separate services. The co-location of services provides for good continuity of care with the same medical staff working in South Ward and in the community team. A peer workforce is emerging within South Ward. A geriatric registrar is available on the ward and carries a caseload.

To support high quality aged persons mental health considering the whole person and other geriatric co-morbidities and physical health issues, the workforce needs a combined skill set and multidisciplinary team, with expertise in both mental health and aged care. The teams should work across the care continuum with a focus of supporting people in their homes, including residential aged care. Staffing profiles need to include psychiatry, geriatrics, specialist nursing and allied health (psychology, physiotherapy, occupational therapy, social work, dietetics, speech pathology and diversional therapists).

- ***Connect Consumers with Mental Health issues with community support services as a part of integrated and stepped care, in order to bridge the gap between acute hospital admission and discharge into the community by creating mental health community liaison roles***

One of the major aims of the aged persons mental health service should be to support people in their homes including residential aged care. Currently, consumers who are discharged from South Ward and not requiring ongoing care and treatment by the aged community mental health team are not adequately supported in the community. As the tertiary service in the Eastern region, Eastern Health should provide primary, secondary and tertiary consultation to the community providers, including residential aged care. This may include community development workers roles to link consumers with community supports, following up appointments and general practitioners.

- ***Develop an Innovative model of care for aged persons' mental health***

The aged persons community mental health service currently operates on a traditional model of referrals where the patient has to attend multiple health providers and reports and outcomes are communicated via faxes. The service should ideally work in an integrated model with general

practitioners who can attend appointments with the consumer for joint care planning with direct access to a consultant psychiatrist. Services should be re-configured so that General Practice is the centre of the service. The aged person's community mental health service should see consumers with their general practitioners, or in their residential care service with their general practitioners.

Building partnerships, training and capacity, in particular with general practitioners would more effectively manage the patient's mental health in the community to prevent admissions and Emergency Department presentations which are very traumatic for older consumers and their families.

Homelessness is an increasing issue amongst the aged population. There needs to be a greater focus on support services and advocacy for the homeless and aged population in the catchment.

- ***Enhance the care and treatment of consumers experiencing delirium in sub-acute admissions***

The Aged Persons Mental Health Service (**APMHS**) currently provides a consultation service to the sub-acute services at Peter James Centre and Wantirna Health, but there is no liaison service to support the nursing team to engage effectively with consumers who have delirium or behavioural issues. Consumers with milder symptoms of delirium (a very large cohort) who have been admitted to medical wards could be managed by a consultation and liaison type service that is dedicated to management of consumers with delirium.

- ***Establish a rehabilitation service for Aged Persons Mental Health***

There is no specific rehabilitation service for aged person's mental health in Victoria. A multidisciplinary inpatient rehabilitation service tailored for people with co-morbid physical and mental health issues is required to support recovery with time and clinical intervention with a focus on discharge and community planning. There should be a mix of clinical, psychosocial and other supports that enable gains from the period in the inpatient setting to be strengthened, supplement crisis intervention and enhance access to inpatient services through the prevention of unnecessary inpatient admissions and the provision of an intensively-supported early discharge alternative.

Bed Availability

The percentage of Victorians with mental health issues who have timely and effective access to mental health services is almost half that of other States and Territories within Australia. [9] With 75 acute adult-mental health inpatient beds across Eastern Health providing inpatient treatment to the most acutely unwell consumers, it is difficult to meet demand while supporting an acceptable level of outcome for its consumers. At 1.41 beds per 10,000 people in the 18-64 year-old age group, Eastern Health has the lowest number of acute inpatient beds per capita than any metropolitan health service in Greater Melbourne. The adult acute beds per capita ratio at Eastern Health is well below the metropolitan average and 44% below the health service with the highest ratio of adult acute beds per 10,000 capita. Eastern Health requires a significant increase in acute mental health inpatient beds in order to meet current demand, let alone projected growth over the coming five years.

Box Hill Hospital's adult inpatient unit has run consistently at approximately 98% occupancy over the last 12 months. The unit at Box Hill has seen a significant reduction in length of stay, from an average 11.4 day stay in May, 2018 to an average 9.4 day length of stay in May, 2019. This is well below the State target of 12 days. When length of hospital stay is too short, there is a risk that there is not enough time to establish rapport with a consumer or their family, that the quality of care is not as ideal as clinical staff would like or that it can compromise the ability to undertake comprehensive discharge planning, including basics such as food and accommodation.

When there is insufficient bed capacity in the unit, consumers can be discharged based on an assessment of who is least likely to experience a significant negative outcome (to self or others) in being either discharged, or transitioned into a community service. Re-admissions often occur when the patient deemed to be least at risk needs further care, which they may have had prior to discharge if there had been sufficient bed capacity.

[9] VAGO Report: Access to Mental Health Services, March 2019 https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf (accessed 6/6/2019)

This vicious cycle also plays a role in mental health worker stress levels, desire to work in or remain in mental health and overall general health and wellness of those workers. Some healthcare workers report that it is a constant thought in the back of their minds whether any given discharge, or rejected referral, is the one that may lead to a poor outcome. Consumers are routinely discharged earlier than clinically ideal and are instead treated in the community. Community facilities have limited capability to manage this level of acuity and do not have the appropriate security or safety features.

There is also a need to educate healthcare workers in the community so that they have skills to manage these consumers. Healthcare workers have reported that, at times, the inpatient service is not able to admit people in genuine need of inpatient admission due to capacity or patient safety. As an alternative, consumers are risk assessed and community-based services are organised to support them and their families where required.

Eastern Health is currently in the process of refurbishing an existing ward at Box Hill Hospital for an additional nine adult inpatient beds, co-located with an eight-bed acute drug detoxification unit. There is an urgent need for a purpose-built, 25-bed inpatient unit to support patient safety.

Closing the Gap

Eastern Health Adult Mental Health Program was the 2018 recipient of The Victorian Public Healthcare Award for Improving Indigenous Healthcare. The team, led by the Aboriginal Clinical Engagement Clinician, was acknowledged for improving access to recovery oriented Adult Mental Health Services for the Aboriginal community in the east. Key work was undertaken at Maroondah Prevention and Recovery Care and the Maroondah Adult Inpatient Psychiatric Units where the team worked hard to enhance services and provide a culturally safe environment to improve access and meet the needs of the local Aboriginal community. As a result of the success of the two-year Clinical Engagement Initiative, Eastern Health permanently extended the initiative through ongoing recruitment to the Clinical Engagement role – demonstrating an ongoing commitment to partnering with our Aboriginal Community to maintain improved access to essential mental healthcare.

Collaborative Recovery Model (CRM)

The Collaborative Recovery Model translates a person-centred, recovery vision of mental health to specific principles and practices, which can in turn be used to define related practitioner competencies that are shared across the professional disciplines in mental health. Eastern Health has provided comprehensive training to staff and is currently working to embed the approach into clinical practice. Having a person-centred recovery approach to Mental Health is essential for good long term outcomes. Recovery is a mature approach to consumer management and is a challenging cultural change to the risk management approach embedded in our systems.

Dual Diagnosis

The Department of Health and Human Services estimates that 25% of mental health consumers will have a dual diagnosis; 75% of individuals who experience alcohol issues will have a mental health concern; over 60% of mental health inpatients will have a substance abuse issue, and 90% of people with schizophrenia will experience substance abuse issues.[10] Integrating treatment for both mental health concerns and substance abuse issues will lead to better outcomes than simply treating symptoms. In 2007 the Department of Health (now part of the Department of Health and Human Services Victoria) funded a state-wide initiative "Victorian Dual Diagnosis Initiative" with the goal to positively improve outcomes of dual diagnosis patients.

The Eastern Health Dual Diagnosis service provides the following services to organisations:

- Consultation: Primary, secondary, and tertiary consultations for staff in Community Mental Health Services, Mental Health Community Support Services and Alcohol & Drug Services (adult, youth, and aged).

[10] Department of Health, Substances Abuse and Mental Health Issues. https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/substance-abuse-and-mental-illness-dual-diagnosis?viewAsPdf=true (accessed 17/6/2019)

- Education and training to improve the capabilities of staff in providing integrated assessment, treatment, and recovery.
- Service Development: Building dual diagnosis capacity based on collaboration, development and integrated treatment approaches via the Dual Diagnosis Consumer and Carer Advisory Council and the Linkage network monthly meetings. (The Linkage network includes organisations that represent people with mental health and dual diagnoses, homelessness and families of these people).

In realising that the siloed approach to mental health and alcohol and drug provision was not delivering effective services for consumers with significant mental illness the Eastern Health Dual Diagnosis service was expanded in 2018 to deliver targeted integrated treatment strategies to consumers of clinical mental health services. A brief summary of the early results of this initiative show a positive impact in the following areas:

- Significantly improved engagement by mental health consumers in alcohol and drug interventions.
- Improved engagement by mental health clinicians and medical staff in identification and responding to alcohol and drug issues.
- Improved utilisation of screening tools and improved outcomes for consumers engaging in alcohol and drug interventions and strategies.

Studies are showing a positive impact on integration of the treatment of dual diagnosis with a dual focus on mental health and addiction. However, a multi-disciplinary approach is required with training to ensure that the healthcare provider understands both (a) mental health issues and their treatments and (b) management of addiction and recovery, including acute de-toxification.

Forensic Mental Health

Victoria currently has one forensic mental health facility, Thomas Embling Hospital, which is at capacity and is unable to meet the needs of all incarcerated people with serious mental illness who require urgent mental health treatment. As a result, this group of people are sometimes acutely unwell when leaving custody. At any given time, public health services such as Eastern Health are called upon to care for forensic mental health consumers who may be untreated high risk violent offenders in both inpatient and/or community settings. At any one time, up to 10 forensic consumers are utilising adult inpatient beds (both inpatient and community) at Eastern Health. This equates to approximately 9% of all available mental health beds.

In 2015-16, Eastern Health started noticing increased pressures surrounding management of forensic consumers and began keeping more formal records to track demand. Since that time, this service has received upwards of 100 referrals in relation to prisoners and 83 corrections enquiries, the majority originating in the Ringwood and Lilydale areas of the Eastern Region catchment, and arising from the Ringwood Magistrates Court. Eastern Health has been made aware of an additional 51 Prison mental health consumers whom it may be called upon to provide care for, with insufficient information to appropriately plan for care in a timely and effective fashion.

Typical admitting diagnoses of this cohort includes: comorbid triad of a chronic psychotic illness (schizophrenia or equivalent), personality disorder (antisocial, borderline or mixed) drug dependence (amphetamines, cannabis, opiates, alcohol) in male consumers with co-occurring Acquired Brain Injury, Autism Spectrum Disorder or Intellectual Disability.

Eastern Health has 16 short term (3 to 6 months) placement beds at Monash Secure Extended Care Unit (**SECU**). Currently, the model of care at Monash SECU does not support the provision of care for consumers of this cohort and these referrals are therefore usually not accepted. Eastern Health facilities are not designed to manage this cohort of patient.

Forensic and Correction consumers are extremely resource intensive, both from a clinical and an administrative perspective. There is a great deal of report writing, communications with Courts to vary treatment, etc. In addition, these consumer cohorts are managed, within the corrections system, in a paternalistic, restrictive manner, and thus do not fit with the Collaborative Recovery Model of care. Eastern Health Forensic Clinical Specialists are being called upon to work beyond the scope of practice designed by the Department of Health and Human Services. In addition, considering the breadth and scope of the services required by Eastern Health to provide for this population effectively to date, it would require more

staff resources going forward. Additional resourcing for appropriately trained Forensic Psychiatrist resources will also be required.

Workforce development is also urgently required to ensure that the skill base required to assess, treat and safely manage this consumer group are entrenched into clinical practice.

The National Standards for Quality and Safety in Healthcare (**NSQHS**) Standard 6 requires a health service to ensure that safe and effective handover occurs at every point of service transfer, to ensure information is communicated to allow risk review, needs of patients, carers and families. [1] It is difficult to meet this obligation in dealing with Prison/Corrections organisations. Timely and complete communication is a key concern, with advanced planning a critical consideration to facilitate risk assessment and ensure availability of resources to properly provide for safe and effective care of the forensic consumer, as well as other consumers, staff and visitors. Forensic/Justice and related information from interstate is a challenge that appears nigh on impossible to address. Mental health staff need to be able to access consumers and their information while in prison, prior to presentation to the service, which rarely occurs.

Multidisciplinary care

Consumers admitted to adult inpatient services have severe, enduring mental health issues complicated by poly-pharmacy, physical health issues, intellectual disability and socio-economic issues including homelessness, unemployment, social isolation, drug and alcohol abuse, family violence, stigma and low self-esteem. Managing the complexity of this cohort requires a multidisciplinary approach. Current levels of inpatient funding do not allow for the required staffing profiles and so it needs review. The staffing profile includes, but is not limited to: allied health workers, dietician/nutritionists, dentists and pharmacists. The multidisciplinary approach needs to continue into the community and work collaboratively with other jurisdictions and agencies including justice, domestic violence, employment and housing.

Prevention and Recovery Care (PARC)

Eastern Health has two sub-acute mental health PARC services operating in community settings. PARC services are delivered through a clinical and community partnership model, with both clinical mental health services and Mental Health Community Support Services collaborating to provide an accessible, supportive and therapeutic model of sub-acute care. Changes across the clinical mental health service delivery system at Eastern Health over the past few years have prompted the need for a thorough review of the PARC model of care.

Contributing factors include:

- A sustained increase in the number of ‘step down’ admissions to PARC from Acute Inpatient Services.
- Consumers requiring more complex medication regimes impacting on medication storage and administration practice.
- Increased number of referrals to Maroondah PARC resulting in clinical governance risk issues and the closing of the waitlist to non-Eastern Health consumers in May 2017.
- DHHS has formally acknowledged the significant change in the client group accessing PARC services since its last review in February 2016. In response, additional funding for 6 PARC services in Victoria has commenced for a four-year ‘Clinical In-reach’ Project. Eastern Health was advised in August 2018 of the new ‘Clinical In-reach’ ongoing funding from 2018-19 to enhance the clinical in-reach into PARC.
- Residential Bed Occupancy – Data obtained from Department of Health and Human Services (Extended Treatment Setting Mental Health Quarterly KPI Report) for 2015-16 Quarter 4, 2016-17 Quarter 1 and 2016-17 Quarter 2 indicate that Eastern Health PARC services are averaging at or above the statewide average for bed occupancy for PARC services for each quarter.
- Residential Length of Stay – Analysis of the data also indicates that the average length of stay at Eastern Health PARCs is well below the PARC services State averages for each quarter.
- Health of the Nations Outcomes Scale (HoNOS) – In comparison to other PARCs in the State, clients at Eastern Health PARCs are reported to experience significantly higher symptoms associated with

their mental illness than the State average; indicating that the Eastern Health PARC model is currently treating and supporting a more sub-acute group of consumers.

Whilst DHHS has recently invested in six PARC services across the State to enhance the clinical in-reach and capacity in response to a change in demand, further reforms in the sub-acute adult mental health area are required. It is recommended that short stay sub-acute clinical services be established to address the gap in the current system for consumers exiting an acute inpatient unit. An interdisciplinary clinical service, 24 hours a day, for post-acute care and enhanced discharge to community planning is required to maximise the gains made during the acute care phase and better prepare consumers for community living.

Sub-acute facilities are a large gap in the mental health service. There is a need for sub-acute beds which provide a transition for consumers from acute inpatient settings to the community by providing a safe and supportive clinical environment which allows for more time for recovery, more intensive clinical intervention including stabilisation of medications, psychology and activities of daily living and comprehensive discharge planning. The facilities should not be stand-alone community facilities such as the PARCs, but co-located with other acute facilities with access to medical and emergency response.

Personality disorders

Another challenge being faced in the community setting is the increasing prevalence of Personality Disorder diagnosis within the consumer cohort. At Eastern Health, 28% of adult acute inpatient admissions are for people with a diagnosis of personality disorder, resulting in an increasing profile of consumers with personality disorders referred for case management in the community and residential settings.

From July 2017 through June 2018, there were 549 inpatient admissions at Eastern Health with a primary diagnosis of Borderline Personality Disorder (**BPD**). Eastern Health admits more consumers with a diagnosis of BPD (17%) compared with other mental health services (5% or less for six comparable services). While these inpatient admissions tend to be brief (on average 4.2 days at Eastern Health versus 3.1-10.6 days at other services, and as compared to average 8.9 days for all mental health diagnoses at Eastern Health), frequent readmission suggests that patients' needs are not being adequately addressed in the current community service system.

The substantial expansion of a service to consumers with Borderline Personality Disorder is needed to target consumers with severe personality disorders who experience multiple symptoms and pathologies. Typically, consumers will have a chronically high risk for suicide and high lethality self-harm, with clinical co-morbidities (substances, psychosis, etc.) and their treatment needs are high and complex. They often struggle to engage with treatment.

Direct service needs to be flexible and include both individual and group options, with secondary consultation, education and training (supported by Spectrum). In the current mental health climate, skills are geared more toward generic clinical mental healthcare issues, due to lack of resources and skill deficits.

Seclusion and Restraint

Eastern Health has a strong focus and an ongoing program of improvement work underway to minimise seclusion and restraint, however, high levels of seclusion and restraint continue. During the 12-month period between May 2018 and May 2019, restraints were required in 191 instances involving 75 consumers at Eastern Health. This is 3.1 % of 2445 admissions, with the highest occurring at Box Hill (76) followed by Maroondah IPU2 (65). A multitude of factors contribute to the use of restraint and seclusion, including:

- High volatility of the units given the patient acuity. In the past, the patient mix was a more manageable mixture of acuity, with consumers who were moving along the wellness spectrum; some acute and just entering care with associated high need, a number in the mid-acuity range who experienced periods of wellness with periods of higher need, and those who were pre-discharge and only required supportive-educative care. This complexity results in use of restraints and high costs and quality issues associated with bringing in additional temporary staff to provide closer observation of consumers.
- Lack of experience of inpatient unit workforce with increased graduate nurse requirements to grow the future workforce, medical staff including the most junior trainees and Consultants and significant community growth drawing experienced staff from the inpatient units.

- Facilities which are not purpose built to manage the high acuity of consumers admitted to the units.
- Workforce challenges which mean there is a junior workforce on the adult inpatient units, limited senior support and high casual and agency use.
- Increasing levels of aggression.
- Lack of resources, including staffing, diversional activities and security presence.

Sexual Safety

Eastern Health's inpatient services have had a strong and proactive approach to improving sexual safety on inpatient units. Work has included training, infrastructure (within a limited scope), processes, orientation practices, resource availability and leadership. As a result, Eastern Health has seen a reduction in sexual assault incidents in the adult inpatient units in particular.

Ongoing challenges associated with the patient acuity in the adult inpatient units has led to the exploration of gender specific units at Eastern Health. It is proposed to convert one 25-bed unit into a female (and those identifying as female) unit and another into a male (and those identifying as male) unit, with the remaining unit to retain its mixed gender capacity. This will allow consumer choice. Currently within the Victorian acute mental health system, there is limited resource availability for people who identify as transgender or require specialised response due to a range of diversity needs. It would be beneficial for this population to be able to access specialised inpatient care and support when this is required, in addition to local specialist support within the communities.

Eastern Health would encourage the Commission to consider gender specific acute units, gender diverse units, and higher acuity forensic units (either within the existing forensic settings, or within specific designated Mental Health Services) at it will greatly support the safety of consumers, staff and visitors.

5. What are the needs of family members and carers and what can be done better to support them?

The complex need for support for families and carers of people experiencing mental illness, whilst acknowledged as significant, can often be underestimated and undervalued. Needs of family should be included in all aspects of their loved one's recovery. Families need support, information, respite, to be heard and responded to in times of crisis and to be provided with options of care.

Foot in Both Camps Program

This program is an example of proven supportive mechanisms occurring at Eastern Health. Eastern Health received funding from DHHS to trial the Foot in Both Camps Program. The program is a support group for staff who are carers for a loved one experiencing mental illness. The employment of a peer workforce for carers has proven to be beneficial, particularly when it comes to designing local service improvement that is more tailored to the needs of consumers and the people who care for them. It is critical that these roles continue to grow along with the rest of the workforce, and be engaged at all levels of planning and design, so that a service can be delivered that is truly person-centred.

Post Discharge Peer Support Program

Ten Eastern Health Consumer and Carer Peer Workers have been trained in the internationally recognised Intentional Peer Support Model. This model incorporates the lived experience of mental health illness as a therapeutic tool to engage current consumers and their carers to identify those areas of their life that promote and support recovery following an admission to a psychiatric inpatient unit. The referral process includes participation at multidisciplinary handovers where Consumer and Carer Peer Workers and Clinical Staff collaborate to identify consumers and carers ready for post discharge follow up. Co-design has been a key feature of this new service, where all ten consumer and carer peer workers together with clinical leadership staff, have been engaged in the development of guidelines and processes for referral, documentation and supervision. This program operates across Aged, Adult and Child and Youth mental health services and includes an Aboriginal Peer Worker.

6. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Clinical vacancies continue to be a chronic issue in mental health services statewide. Significant work is underway to improve recruitment processes and ensure that Eastern Health is an attractive employer to support recruitment and retention of staff. It is well-recognised that public and private health services are competing with one another to attract a diminishing number of appropriately qualified and skilled professionals.

Mental health-specific training is under-developed in areas of the current tertiary education system. The cohort of consumers using mental health services come with a whole range of complexities, with more presentations relating to drug and alcohol use, forensic patients, and multiple medical comorbidities.

Clinical staff have undertaken specialist undergraduate and postgraduate education but the rising complexity of mental health presentations and the changing landscape of healthcare (e.g. legislative and governance processes) have created challenges for the mental health workforce. The rate of growth in knowledge requirements challenges the health service to maintain the currency of the knowledge and skills of the workforce.

Adult Community Case Management Model

The current Case Management Model utilised in community clinical services is under pressure as a result of increasing complexities and acuity of mental health consumers. The current workforce is inadequate, from a knowledge, skill mix, resource and funding perspective, to work effectively with this higher risk cohort. Case managers are recruited with a clinical background (nursing or allied health) however there is no specific training for case management for the highly complex consumers managed in the community. Case managers are expected to have a high level of skill in expert areas including personality disorders, drug and alcohol use, forensic backgrounds, family violence and suicide-prevention with a Collaborative Recovery approach. An educational certificate in case management, enforced supervision, career progression opportunities for research and academic linkages with universities, higher remuneration and continuous training structures similar to the medical model for continuing medical education would ensure staff retention, service development and better outcomes for patients.

Occupational Violence and Aggression

Over recent years, the adult inpatient mental health units have been admitting more acutely unwell consumers with a corresponding increase in occupational violence and aggression. This is partly due to the limited bed capacity, as only the most unstable and acutely unwell consumers can access a hospital bed; with others being managed in the Community, also resulting in increased risk to those consumers and staff working in the Community. Other contributing factors to the increasing acuity include:

- Increased alcohol and drug use in the community and admissions related to methamphetamine and other illegal substance use.
- Increasing numbers of consumers with forensic backgrounds with associated risks are being placed on treatment orders from the Courts and/or Prisons and being transferred for admission to the adult inpatient units.
- With limited powers to search an individual's possessions, a variety of weapons are making it into the Units. Hunting knives, blades, fake firearms and pieces of metal are just a few examples.
- Socioeconomic factors including family violence. One-in-six Australian women and one-in-sixteen men will have been impacted by family violence beginning from age 15 onwards.[11] It is the major cause of homelessness amongst women. The Australian Institute of Family Studies lists (amongst others) substance abuse, homelessness, socially disadvantaged, having an indigenous background, mental health issues, including depression in the family, as risk factors for child violence.[12]

[11] Family Domestic and Sexual Violence In Australia, 2018. https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary (accessed 12/6/2019)
[12] Australian Institute of Family Health Studies, March 2015. *Conceptualising the Prevention of Child Sexual Abuse – Final Report* https://aifs.gov.au/publications/conceptualising-prevention-child-sexual-abuse/a4-mapping-risk-factors (accessed 12/6/2019)

The risk of aggression is compounded by the fact that Eastern Health mental health facilities are not purpose-built to manage the complex consumers being admitted. The Department of Health and Human Services lists environmental design as one of the key considerations to address safety and violence in health services. [13] The minimum design standards for acute inpatient units needs urgent review in light of the changing context.

As a result of occupational violence and aggression, staff are experiencing high levels of stress within the workplace. In the most recent Eastern Health *People Matter* survey, 33% of the Mental Health inpatient workforce indicated that they are experiencing extreme levels of stress at work. Staff are frequently injured during the admission process or when caring for a consumer during their stay. At any one time, there are multiple members of the Eastern Health mental health team who are on long-term personal leave directly related to safety and harm in the workplace.

Partnerships with universities

CYMHS enjoys a longstanding partnership with Deakin University School of Psychology which provides a training clinic for psychology students and includes up to six sessions of brief intervention, typically for children and families with mild presentations and early intervention for children with emerging oppositional or conduct disorders.

In addition to education and leadership support, CYMHS provides psychiatric resources to the two local Headspace centres – Knox and Hawthorn, made possible through specific Commonwealth funding.

Educational institutions and tertiary services need to work together to develop an appropriately trained workforce.

State-wide workforce planning

Planning must include mental health specific training in educational institutions and the healthcare setting, to ensure an adequately skilled workforce relevant to the unique needs of mental health services, and ensure that supply meets the growing demand in all healthcare disciplines.

Availability of a quality, purpose-trained workforce is scarce. Many universities who offer post-graduate nursing courses note mental health nursing as a low priority amongst those nurses returning to training. An ageing workforce also means that many nurses who were previously trained in hospital settings which included appropriate exposure to mental health nursing as a part of their training, and remained in the specialty following graduation, are now leaving the workforce. Over time, challenges on any given day in mental health inpatient units increased along with dissatisfaction by the workforce who view mental health as high risk, unrewarding, and an undesirable risk-filled area in which to work. The Victorian Government recently announced an increase in Clinical Nurse Consultant positions available. The number of positions is grossly inadequate to service every inpatient unit and is leaving many highly volatile units without sufficient senior nursing leadership in the clinical setting. Workforce initiatives have been targeted in community mental health settings with minimal growth in senior inpatient nursing positions in the past 10 years.

The increase in the complexities associated with co-morbid presentations, across mental health, is another workforce challenge. All staff, irrespective of discipline, are now required to have complex understanding of physical health, with cardiac and metabolic issues prevalent in this population as a result of the complex medications required to treat this cohort. Life expectancy for consumers with severe and enduring mental illness is shortened, with no correlating increase in dual-funded training models to resource staff effectively to manage the increasing complexity of presentations. The metabolic issues add further risk for this vulnerable population. Strong relationships exist within the health service to support medical in-reach, however, these resources are insufficient to support the volume of consumers presenting with complex co-morbidities. Complex withdrawal from multiple substances is inadequately understood and limited resources exist in the service to provide guidance in a timely manner to support safety for consumers in withdrawal.

[13] Occupational violence and aggression - health facility design. https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/facility-design (accessed 12/6/2019)

The current Nursing Enterprise Agreement stipulates nursing staff levels in acute units, and health services are reluctant to employ above these minimum prescribed levels due to lack of funding provision. There are no provisions for minimum allied health positions within acute units, and when funding is restricted service wide, these have historically been the positions which are relinquished. The availability of allied health resources, particularly out-of-hours, also impacts on timely access to assessments, supports, resources and family interventions.

Working Collaboratively

Whilst there has been significant investment by the Department of Health and Human Services in the development of the Consumer and Carer Lived Experience Workforce in Adult Mental Health, there has not been a comparable investment in the CYMHS services. A recent benchmarking project examining child, youth and family carer participation across CYMHS was undertaken, revealing a considerable variability in resources to support a youth peer and family carer lived experience workforce. As a result of this work, Eastern Health has recently established a voluntary, bi-monthly CYMHS Family Carer Lived Experience Workforce Advisory Team to advise practice. Attendees include representatives from the Royal Children's Hospital, Orygen, Monash Health, Alfred Health and Ballarat Health.

7. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

One of the main objectives of recovery from a mental health perspective is to support individuals to participate in their regular activities of daily living, such as school or work attendance, as well as improving their social interactions.

Whilst reducing stigma through education and awareness is highly beneficial, additional support (i.e. psychosocial support) is often required, but can be difficult to obtain.

Employment

Incentives are needed for education and training entities to take and support students with mental ill-health and for companies to employ people with mental ill-health. Access to employment opportunities will assist in minimising the impact of mental ill-health and support recovery.

Family Violence

Within the community there is an increased focus on family violence prevention. Reducing the impact of family violence will support people to improved socio-economic participation. One in six women will experience violence in some form from the age of 15, and one in 16 men. More than half of those women will experience ongoing family violence. In 2014-15, it is estimated that approximately eight women (and two men) were hospitalised every day as a result of domestic violence.[14] Many of those experiencing mental health issues, socioeconomic issues and/or other pressure are at risk of being victims of violence. There is an opportunity to improve awareness around family violence across communities.

Eastern Health has commenced a program of work to improve identification and management of family violence, funded by the Department of Health and Human Services. The program is overseen by Specialist Family Violence Advisors with the goal of improving early recognition, increasing awareness and education of team members in how to manage suspected and actual family violence as part of everyday clinical care. This includes skills in assessment and management of family violence to meet the needs of victims and perpetrators who are consumers, carers or significant others in our services.

Homelessness/lack of suitable accommodation

Many of Eastern Health's consumers are homeless or lack suitable accommodation options. Eastern Health bridges the gap through brokerage funding, with mental health consumers being discharged to hotels,

[14] 28 February 2018, AIHW, *Family, Domestic and Sexual Violence in Australia.* https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary *(accessed 15/6/2019)*

motels, or other forms of lodging. Eligible clients have the use of designated funding to purchase goods and services in order to achieve positive housing outcomes. Consumers can qualify for up to $5,000 per annum for emergency housing. There are concerns beyond the dollars expended related to lack of accommodation. Lack of lodging and homelessness are issues which impact on compliance, ability to provide consistent services and less than optimal outcomes. However, in spite of these contributing factors, Eastern Health is proud that it is able to follow up with over 90% of its mental health consumers after they have been discharged from hospital.

Over the past few years there have been a number of boarding houses in the Eastern Region that have closed and the options for safe housing in the area have diminished. At the same time more and more consumers are experiencing housing crises and homelessness due to family breakdown, the severe lack of public housing and a reduction in Community Mental Health Supported Housing. Adults are often inappropriately housed in Supported Residential Services as a last resort impacting them and the often elderly co-residents. The Community Model of Care is not flexible enough to meet the needs of itinerant and homeless consumers and often they return to crisis and emergency services, including acute inpatient care; not having their basic human need for safe housing met directly undermines their mental health.

NDIS and children/young people

A number of CYMHS consumers with severe emotional and/or behavioural disturbance have been found eligible for NDIS. Many of these clients have co-morbid disabilities in the areas of physical dysfunction, autism and/or intellect. There is a lack of expertise amongst NDIS service providers to be able to meet the complex psychosocial needs of these children and young people thus, despite having funding packages, they are unable to access appropriate services and their needs remain unmet.

In addition, many children and young people have significant need for psychosocial support to achieve their goals but are found ineligible for NDIS and thus need to rely on alternate funding such as the National Psychosocial Support (NPS) funding. The alternative funding provided to Eastern Health excludes those under 16 years old. NPS funding for the Eastern Metropolitan Region is technically for the entire age range, however there is a lack of staff trained to work with children and adolescents to address their psychosocial needs.

Funding models for psychosocial support, including NDIS, need to acknowledge the unique needs of children and young people experiencing severe emotional and behavioural disturbance. Providers need to have a skilled workforce to work with this vulnerable population to ensure equitable access to psychosocial support and capacity building.

Psychosocial support

Other key drivers are the systematic reduction of specialist community mental health services in the Eastern Region due to funding reforms over the past five years, including the introduction of the NDIS. This has resulted in fewer specialist mental health supports in the community, fewer skilled mental health workers with experience in the community sector and an increasing demand pressure on community clinical mental health services to provide additional support to cover the gap in care.

8. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Increasing capacity

To achieve service improvement, health services need a greater capacity to be able to better serve their populations. This includes increasing inpatient beds and community services along with the workforce required to support consumers' needs.

Policy reform

A review of policies and legislation to improve collaboration of mental health services with other agencies, in particular the justice system, housing and employment.

Purpose built infrastructure

'Future-proofed', purpose-built infrastructure for increasing demand, which is safe and provides a therapeutic environment that achieves optimal care and outcomes for consumers, families and carers.

9. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Adequate planning at the national, State and local level of facilities/infrastructure, systems, legislation, clinical governance, workforce and models of care that can be sustained not only financially, but also physically by the people who are caring for these individuals.

Capital and infrastructure planning

Required to develop purpose-built, safe infrastructure that allows co-location of agencies and expansion of services to meet demand.

Office of the Chief Psychiatrist

The Office must lead consistency of practice across mental health services regarding inpatient safety, response to aggression and a system response to consumers with forensic histories.

Workforce planning

Required to ensure adequate workforce supply to support the increasing demand for mental health services. Training, in conjunction with universities and other educational institutions, needs to be tailored to ensure readiness for working with a complex and vulnerable cohort of consumers, including mental health and other associated issues (complex case management, person-centred care, family violence, drug and alcohol, physical health, BPD to name a few).

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

Eastern Health welcomes the Royal Commission into Victoria's Mental Health System as an opportunity to review and improve the services that we provide to our consumers, their families and carers.

We look forward to hearing further from the Commission, and welcome any feedback or requests for further information in relation to this Submission.

For further information contact:
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Glossary

ABS	Australian Bureau of Statistics
AIPU	Adolescent Inpatient Psychiatric Unit
APMHS	Aged Persons Mental Health Service
BETRS	Body Image & Eating Disorders Treatment & Recovery Service
BPD	Borderline Personality Disorder
CALD	Culturally and Linguistically Diverse
CATT	Crisis Assessment and Treatment Team
CEED	Centre for Excellence in Eating Disorders
CRM	Collaborative Recovery Model
CYMHS	Child Youth Mental Health Services
DHHS	Department of Health and Human Services
EACH	Extended Aged Care at Home
ECT	Electroconvulsive Treatment
EDAC	Eating Disorders Assessment Clinic
EDVOS	Eastern Domestic Violence Service
EFT	Equivalent Full Time
EHPHN	Eastern Metropolitan Primary Health Network
EMCHN	Enhanced Maternal and Child Nurse
EMHSCA	Eastern Mental Health Service Coordination Allianz
GP	General Practitioner
HARP	Hospital Admission Risk Program
HoNOS	Health of Nations outcomes Scale
HOPE	Hospital Outreach Post suicide attempt Engagement
ICA	Intensive Care Area
ICTiR	Initial consultations and Treatment in Recovery
LGBTIQ+	Lesbians, Gay, Bisexual, Transgender, Intersexes, Queer
MHaP	Mental Health and Police
MSIR	Medically Supervised Injecting Room
NDIS	National Disability Scheme
NPS	National Psychosocial Support
NSQHS	National Standards for Quality and Safety and Healthcare

PAPU	Psychiatric Assessment and Planning Unit
PARC	Prevention and Recovery Care
PEHS	Perinatal Emotional Health Service
PHN	Primary Health Network
SECU	Secure Extended Care Unit
TAC	Transport Accident Commission
Tier 1	**Services including** primary care, general practitioners, school-based nurses and community health
Tier 2	**Services including** private psychiatrists, not-for-profit mental health and psychology services (i.e. Headspace)
Tier 3	Tertiary mental health services as provided by Eastern Health
VAGO	Victorian Auditor-General's Office
YETTI	Youth Engagement and Treatment Team Initiative

Eastern Health is accredited by the Australian Council on Healthcare Standards in recognition of the achievement of minimum performance standards in the provision of healthcare services and demonstrated through an independent external peer assessment.

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