Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF JOHN WILLIAM MCLAREN

I, John William McLaren, Community Manager at St Vincent's Area Mental Health, of 46 Nicholson Street, Fitzroy, in the State of Victoria, say as follows:

1 I am authorised by St Vincent's Hospital (Melbourne) Pty Limited (**St Vincent's Melbourne**) to make this statement on its behalf.

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

Please detail your background, qualifications and expertise

3 Between November 1989 – June 2005, I obtained the following qualifications:

(a) professional training to become a Registered Mental Nurse, at Nottingham University, United Kingdom;

(b) professional training to become a Registered General Nurse, at Nottingham University, United Kingdom;

(c) a Diploma in Nursing from Sheffield Hallam University, United Kingdom;

(d) a Postgraduate Diploma in Public Service Management from Nottingham Trent University, United Kingdom; and

(e) a Master in Health Service Studies – Management, Leadership and Research Pathway from Leeds University, United Kingdom.

4 I am also currently a registered nurse with the Australian Health Practitioner Regulation Agency.

Please identify any entities (other than St Vincent's Health Australia) you are associated with or employed by

5 I have worked in mental health services for over 30 years, in Australia and the United Kingdom.

6 Prior to moving to Australia, I worked in various roles within the mental health care sector in the United Kingdom. Between 1989 - 2001, I was employed in the following roles:

(a) Staff Nurse for aged mental health at Mapperley Hospital in Nottingham, United Kingdom;

(b) Staff Nurse for adult acute mental health at Millbrook Mental Health Unit in Mansfield, United Kingdom;

(c) Senior Nurse and Ward Manager for adult acute mental health at the General Psychiatry and Psychotherapy Department of Queens Medical Centre in Nottingham, United Kingdom;

(d) Clinical Nurse Manager and Forensic Specialist at Addiction and Forensic Directorate, Nottingham Forensic Services in Nottingham, United Kingdom; and

(e) Directorate Manager of Nottinghamshire Community Forensic Directorate and Drugs and Alcohol at Nottingham, United Kingdom.

Please describe your role and responsibilities.

7 In 2006, I moved to Australia and was employed by St Vincent's Melbourne as the Acute Inpatient Service Manager at St Vincent's Area Mental Health. In this role, I managed 45 nurses in the acute inpatient service. The acute inpatient service is a 44-bed residential service for clients with acute mental health issues that require hospitalisation to treat and stabilise their mental health. Clients receive support from a multidisciplinary team of specialists including psychiatrists, psychologists, occupational therapists and social workers. The acute inpatient service provides intensive care for clients who may be at risk to themselves or the community due to their psychiatric symptoms, because they have relapsed in their mental health condition or they require clinical assessment and treatment. The service also supports clients with their discharge arrangements to assist them to transition back into the community by seeking to ensure they have adequate support.

8 Since November 2010, I have been the Community Manager at St Vincent's Area Mental Health. I also currently serve as the Manager of the Hospital Outreach Post-suicidal Engagement Initiative (**HOPE**) at St Vincent's Melbourne, an initiative which began at St Vincent's Melbourne on 1 April 2017.

9 As the Community Manager at St Vincent's Area Mental Health, I am responsible for coordinating a number of mental health community programs including the continuing care team (**CCT**) and the primary intervention and care team, the latter which incorporates primary mental health, extended triage services (**Extended Triage**) and HOPE.

CCT

10 CCT is an outreach service for clients who are managing their mental illness and living in the community. CCT clients are generally referred to us from our acute inpatient service, Emergency Department (**ED**), psychiatric triage services (**Psychiatric Triage**), Crisis and Assessment Team (**CAT**) or from primary care providers such as general practitioners (**GP**) and private psychiatrists. Our multidisciplinary team assists clients to manage community-based living through assisting them with their medication, providing treatment (such as psychological therapies, psychoeducation and family work) and supporting them in their recovery goals.

11 The primary aim of the CCT is to stabilise our clients' mental health to prevent relapse and support recovery but we also seek to provide psychosocial support through partnering with other agencies. We work with non-government community mental health organisations such as Wellways Australia Limited (**Wellways**), Mind Australia Limited (**MIND**), Neami Limited and other community-based drug and alcohol services and community health services.

12 Psychiatric Triage is provided by each area mental health service. St Vincent's mental health's Psychiatric Triage is based in the ED. This is a 24-hour, telephone-based service that provides:

(a) information about accessing mental health services, regardless of the query;

(b) information and coordination of emergency assistance for clients and members of the general public who are in crisis and need psychiatric treatment or advice; and

(c) triaging of all external referrals seeking mental health support (such as community case management) and coordination of service response as required.

13 External referrals may be received from GPs, private psychiatrists and psychologists. Triage staff will obtain the necessary information, process the referral and then transfer the client to the appropriate team for follow up.

14 Community mental health services have undergone significant change in the past few years due to the introduction of the National Disability Insurance Scheme (**NDIS**). In the context of changes caused by the introduction of NDIS, St Vincent's Melbourne has partnered with MIND to provide psychosocial interventions for clients not eligible for NDIS or who are having difficulty accessing other supports, either in the community or through NDIS.

Primary Mental Health

15 Primary Mental Health (**PMH**) provides education and support to GPs and primary health care providers within our catchment area to educate on approaches to treating high prevalence mental illnesses such as anxiety and depression. PMH receives referrals for clients with complex conditions who do not require mainstream clinical mental health follow up. Following assessment, PMH will provide the GP or primary health care provider with specialist recommendations regarding mental health treatment options and linkages for the client's long-term support.

Extended Triage

16 Extended Triage is a telephone-based service that supports clients after they have been in contact with our Psychiatric Triage. Following initial assessment and support, some clients will not require mental health follow up. However, a number of clients will require additional support to engage with their usual community-based supports (for example, GP, counsellor, private psychiatrists or other primary health care providers). These clients will be referred to Extended Triage staff, who will:

(a) seek to connect clients with their usual community-based supports;

(b) follow up and engage with clients until clients have made arrangements to see their usual community-based supports, including calling clients on a regular basis to provide direction, ascertain information about service providers and provide emotional safety; and

(c) liaise with and brief the relevant community-based supports about the episode of care each client received at St Vincent's Melbourne.

17 Extended Triage is a separate service from HOPE. Although Extended Triage will support clients that present suicidal ideation, they also support clients with other mental health diagnoses and presentations. All clients that are referred to Extended Triage are assessed as having a low-risk status and do not require intensive follow up.

What is St Vincent's Melbourne and what services does it provide in relation to mental health and wellbeing?

18 St Vincent's Melbourne is a public health service provider and aged care service provider operating across 16 sites in Victoria. It is part of the wider St Vincent's Health Australia Limited group of public and private health services, a significant not-for-profit health and aged care provider in Australia.

19 St Vincent's Melbourne first opened on 6 November 1893, beginning as a small hospital and has since expanded to 16 sites throughout metropolitan suburbs in Victoria. Its

mission is to 'bring God's love to those in need through the healing ministry of Jesus' and its vision is to 'lead transformation in health care' with this purpose in mind.

20 Our mental health services provide services to persons aged 17 years or over, including aged person (via our Aged Persons Mental Health service). These services incorporate acute mental health services including an inpatient service, CAT, Psychiatric Triage and the ED. We also provide continuing care and residential community-based services that offer case management and residential rehabilitation. We do not have child and adolescent mental health services, but we refer our clients to Austin Health who provide this service.

21 Additionally, in partnership with Austin Health, we operate a specialist service for clients who have been diagnosed with eating disorders.

How does St Vincent's Melbourne fit within the mental health system?

22 St Vincent's Melbourne provides clinical acute and sub-acute mental health services to the City of Yarra and City of Booroondara catchment areas in Victoria. As St Vincent's Melbourne is centrally located, we also attract clients who are located outside of our catchment areas. We also admit clients outside of our catchment areas into our bed-based services to preserve their safety and wellbeing, until they are ready to be transferred to their local service. However, our community mental health services only accept clients from within our catchment areas. This permits us to seek to ensure:

(a) continuity of care;

(b) that we are compliant with our obligations under the *Mental Health Act 2014* (Vic);

(c) that our clients are able to access locally-based community resources; and

(d) that we reduce the burden of travel on our clients.

Who does St Vincent's Melbourne serve?

23 St Vincent's Melbourne mainly serves consumers with severe mental health conditions who might be at greater risk, require specialised care or whose mental health condition requires closer monitoring. Our clients tend to be from backgrounds associated with issues such as homelessness, unemployment, isolation, drug and alcohol use, and family or relationship problems.

24 Within our catchment area, we have found that we do not and historically have not had to put clients on waiting lists for our community mental health services. Our service is responsive and resourcing currently ensures we at least meet the minimum requirements to respond to the clinical needs of our catchment area. However,

additional funding would support us to provide extra psychosocial interventions, peer support to consumers and carers and other evidenced based interventions and treatments which our case managers have limited time to provide.

25 Our clients who are from the community may experience a slight delay in comparison to clients who are referred from our hospital. I believe this might be attributed to clients from the community requiring initial assessment by the clinical mental health team as opposed to clients who have been referred by our hospital. The reason for this is to ensure that the service is appropriate for the consumer and that they are willing to engage in case management.

Briefly, how is St Vincent's Melbourne funded?

26 Our mental health services are funded by the Victorian State government (**State**) through the Department of Health and Human Services (**Department**), however we do occasionally receive funding from the Commonwealth government. We also intermittently receive short-term funding from the State for specific projects.

What is the HOPE program, what are its objectives and what services does it provide?

27 HOPE is a clinical-treatment focussed service that specialises in working with clients with suicidal presentation. We particularly focus on providing support within the first seven days of discharge from hospital. Evidence suggests that this period of time is when our clients are at their most vulnerable. Our clients are referred to us from any part of our hospital, although they tend to be triaged through our ED (Psychiatric Triage) or by our CAT. We have a close relationship with our mental health inpatient wards and receive a significant number of direct referrals from there.

28 We receive funding from the State for the HOPE initiative and employ a small team consisting of clinicians, part-time psychiatrists, a family support worker and a psychiatric registrar. The HOPE team has specialist knowledge, training and experience in working with people with suicidal presentations. Currently, the service is open seven days a week but out-of-hours support is provided by the Psychiatric Triage and the CAT.

29 We adopt the 'collaborative assessment and management of suicidality' model of care to inform how we work with our clients. It is a systematic and collaborative approach that specifically addresses the management of suicidality. Our funding permits us to provide support in the form of a three month care package, which involves:

(a) developing a safety plan with the client in the first week, which seeks to provide the client with all the information they might need to seek help if they experience suicidal thoughts at home after being discharged; and

(b) providing intensive support and care using a therapeutic model to target suicidality and provide psychological interventions such as cognitive behavioural therapy, with clinicians working with clients to identify their own goals for recovery and how they can support themselves in the future.

30 Another aspect of our role is to consider whether clients will require continued care and, if necessary, organising continuing care after the three month period has concluded. Where appropriate, clients will be referred to primary care and other community-based clinical support. If a client is still at risk in relation to their suicidality following the three-month support package from HOPE, a referral to the appropriate continuing care team will be made to seek to ensure that the client is able to access long-term support.

31 Attached to this statement and marked (**JM-1**) is a copy of a brochure that we provide to clients describing HOPE's services.

How and when did the HOPE program come into being?

32 In 2016, the Victorian Suicide Prevention Framework 2016-2025 (**VSP Framework**) was introduced to implement strategies to reduce the rate of suicide in Victoria. The VSP Framework consists of a clinical and prevention and early intervention aspect. HOPE is a product of the clinical aspect of the VSP Framework and St Vincent's Melbourne was selected to be one pilot site amongst five others to implement this initiative.

Who does the HOPE program serve? What are the criteria for accessing the program?

33 HOPE serves consumers aged 18 years and over within St Vincent's Melbourne catchment areas. Referrals are accepted from sources including St Vincent's Melbourne ED, CAT, acute inpatient service and other services with a HOPE team.

34 When a client presents to St Vincent's Melbourne, they will be given a full assessment of their needs. We use specific referral criteria to determine whether our service might be appropriate for a client and assess different factors to identify if they are at risk. Attached to this statement and marked (**JM-2**) is a document which outlines these referral criteria. An experienced mental health clinician performs this assessment, taking into account the individual's own needs and goals. This assessment would then be ratified by a Consultant Psychiatrist. Broadly, the assessment would consider:

(a) the person's mental state, previous history and suicide ideation;

(b) whether the person continues to have high level of suicidal intent requiring support;

(c) whether the person has a plan, access and means to engage in a suicidal act;

(d) whether the person is able and willing to be supported by HOPE; and

(e) an assessment of the person's support mechanisms if they are discharged.

35 The methodology that is utilised by a HOPE clinician to perform this assessment involves asking the client a number of questions to determine:

(a) the reason the client has presented for help;

(b) the client's current mental state using a structured questioning process (mental state examination);

(c) the client's past mental health history including whether they presently have any mental health support from public or private sources; and

(d) whether the client may be struggling with alcohol or drug use.

36 If available and with the client's consent, the clinician will seek to obtain information from the client's family members, carers and any other professionals the client may be obtaining support from.

37 The assessment also includes a risk formulation by the clinician, taking into consideration whether the client:

(a) only has suicidal thoughts but does not want to end their life;

(b) has suicidal thoughts and a plan to end their life, but has not followed through with this plan;

(c) has suicidal thoughts and a plan to end their life, including ascertaining the required materials to follow through with this plan;

(d) has suicidal thoughts and a plan to end their life, including having the required materials to follow through with this plan, but has decided not to do so; or

(e) has suicidal thoughts and a plan to end their life, including having the required materials to follow through with this plan, and has attempted to end their life,

(indicating increasingly elevated risks associated with behaviour).

38 This risk formulation will also take into consideration any protective factors that a client may have, such as family support.

39 The above criteria are St Vincent's Melbourne's criteria. Each of the HOPE services will have their own criteria but I believe all HOPE services will have similar criteria.

How does the program work alongside other programs for people with mental illness or in crisis who present to St Vincent's Melbourne, such as the new mental health and AOD hub in the ED and the Safe Haven Café?

40 Currently, St Vincent's Melbourne is implementing its strategy to provide a mental health, Alcohol and other Drugs (**AOD)** and Crisis Hub (**Hub**) in its ED. The Hub will have six short-stay beds and provide community outreach and follow-up for consumers after they have been discharged from the ED.

41 The Hub is for consumers who present to the ED with a mental health and/or AOD related issue (including consumers who are directed to present to Psychiatric Triage by an area mental health service) and who:

(a) require urgent general medical treatment and have a psychiatric comorbidity;

(b) are not registered mental health clients of St Vincent's Melbourne but have presented with high acuity;

(c) present with suicidal ideation or following self-harm; or

(d) present with drug or alcohol dependence with the symptoms of acute intoxication or withdrawal.

42 The Hub aims to provide a responsive and coordinated service – the relevant consumers will be identified through Psychiatric Triage and quickly assisted by a multi-disciplinary team of Hub clinicians (including ED staff, mental health clinicians, AOD clinicians, peer support workers, members of the Assessment, Liaison and Early Referral Team or other psychosocial support staff). This Hub team will work together to assess and respond to the client's needs and to create a collaborative treatment plan.

43 The HOPE team will have an integral role in this new service and will work closely with the Hub team. It is envisaged that the HOPE team will have a daily presence within this Hub to provide timely support to consumers who are appropriate to receive services from HOPE. This may include joint assessment, planning and discharge follow up arrangements.

Are there any limitations of the HOPE program? If so, what are they?

44 One particular difficulty is continuing treatment for our clients after they have been discharged from HOPE. Our funding model only permits us to provide treatment in short-term, three month packages. A significant number of our clients require long-term follow up by a psychologist, psychological intervention or psychiatric treatment which is often difficult for them to access. Under the Medicare program, 10 sessions per year with a psychologist are subsidised, however 10 sessions per year are insufficient to provide our clients with the ongoing mental health care and treatment required.

45 We are also aware that psychologists may charge additional fees in addition to what is subsidised by Medicare. This creates a barrier to treatment for our clients who are often experiencing financial hardship.

46 HOPE is limited by its funding constraints. Of particular concern is the uncertainty as to the availability and continuity of funding for our program because our current funding is expected to end in 2020. As a result of this funding uncertainty, our service is already losing valuable, skilled staff because we are unable to guarantee our staff permanent positions due to the uncertainty as to the continuation of our service. It is particularly difficult to replace skilled staff in mental health services because there are a limited number of qualified and experienced clinicians to meet existing demand. If we continue to lose staff, this will impact the service we provide to our clients because we would need to consider reducing the number of referrals accepted by HOPE.

Is the HOPE program a trial? If so:

how is it being evaluated?

what criteria or circumstances (e.g, funding decisions) will determine whether the program becomes permanent?

should HOPE become a permanent program?

47 The HOPE pilot was allocated funding for a period of up to four years, until 2020.

48 The Department has commissioned the development of an evaluation framework for all 6 of the original HOPE services. I understand that this framework was intended to be implemented by the Department on 1 April 2018. I am aware that the Department is considering updating the evaluation framework and that overall the Department intends the evaluation framework to be finalised by September 2019. We do not know what this updated evaluation framework will look like, as yet.

49 I am aware that in last year's State budget, recurrent funding was allocated to 6 new HOPE services. The total number of HOPE services is currently 12. The original 6 HOPE services, including St Vincent's Melbourne, only have a short-timeframe remaining to receive funding.

50 St Vincent's Melbourne intends to further develop HOPE by establishing closer links with the ED through its proposed Hub. This strategy seeks to provide a more responsive approach to treatment and care, but is subject to whether there will be stable and recurrent funding for the HOPE services to continue. If HOPE does not continue, consumers will be unable to receive the benefit of that additional support and its further integration through the proposed Hub into St Vincent's Melbourne's overall service model.

In your experience, to what extent is the HOPE program at St Vincent's Melbourne meeting its intended objectives? What could be done to further support the program achieving its intent?

51 I believe that the HOPE initiative has been successful in delivering a service for its targeted clients. The HOPE initiative has implemented effective strategies to support clients, seeking to prevent them from relapsing and dying by suicide and supporting their long-term goals and needs. The emphasis has been on supporting clients' psychological and social needs and developing strategies to self-manage in difficult circumstances. I feel the team is embedded into our service model and seeks to achieve the objectives of the VSP Framework.

52 In terms of assisting the HOPE initiative to achieve its intent, although funding was provided for family support, it would be desirable to have further funding to provide not just family support but family therapy as well.

In your experience, to what extent has the HOPE program reduced the risk of participants self-harming, attempting suicide and dying by suicide? If so, in what ways?

53 I believe HOPE is a successful and meaningful program that achieves positive results for our clients. Based on clinical data that we have been recording since April 2017, most consumers have not re-presented to St Vincent's Melbourne HOPE team. If former clients do re-present, they are unlikely to be able to access the HOPE service because the fact that they have re-presented suggest that they need more support than the HOPE team is able to offer. In these circumstances, these consumers will be linked to other support services such as CCT or CAT.

54 Since the introduction of the HOPE initiative, we have received approximately 220 referrals, which has resulted in us assisting over 180 consumers (due to the fact that some clients choose not to engage or may choose to access other services). Of the consumers that we have assisted, we are aware that there have been two suicides by consumers during the program. Whilst every suicide is deeply sad, it is a reality of work in this area of specialist practice that sometimes this will still occur.

55 It should also be noted that staff working in this area of specialist practice must handle a substantial level of clinical risk. I believe that the HOPE team has developed a solid governance structure for its practice, including in how we support our staff. St Vincent's Melbourne has also recognised the need to ensure that specialist supervision is provided to support the HOPE team and as such, the HOPE team receives monthly supervision on the model of care and also monthly team supervision and case review with an independent senior psychologist.

In your experience, are there sufficient services available in Victoria to help people who have attempted suicide, and people at high risk of suicide or self-harm?

56 In my experience, there are many services that provide acute intervention and response in relation to mental health but there appears to be a lack of services when consumers need or are seeking ongoing or extended support and treatment. The availability of services that can provide long-term specialist support and treatment, aside from public mental health services, is even more limited.

57 HOPE has been a successful initiative and has provided improved direction to support people who have attempted suicide and people at high risk of suicide or self-harm. Suicide is an issue that extends beyond health – it is a community-wide and whole-of-government issue that needs a broad and coordinated approach.

What needs to be done in Victoria to better support people who are at high risk of suicide or self-harm?

58 To better support people who are at high risk of suicide or self-harm, there needs to be a more coordinated approach. Currently, there are numerous initiatives that have been implemented, some long-term and others short-term, but they do not operate consistently across Victoria and they do not seem to operate in a cohesive manner. Consideration of high risk groups would enable more focus to be given to vulnerable groups, such as members of the LGBTQI+ community and people who may be living with substances use disorders. Suicide and suicide risk is influenced by factors such as housing, employment, loneliness and relationship breakdown. Current and future strategies need to incorporate, or at least consider, these areas in service planning.

What are the most significant challenges facing the mental health system in supporting people who are at high risk of suicide or self-harm?

Accommodation

59 From an acute inpatient service perspective, discharging clients into the community presents difficulties where the client has limited appropriate accommodation options. For our clients who are experiencing homelessness, there is often little option but to discharge them into temporary crisis accommodation such as boarding houses or motels. In my experience, a lack of stable and permanent accommodation, both supported and independent, is a significant challenge and one that heavily contributes to clients experiencing a relapse of a mental illness.

60 At St Vincent's Melbourne, we have sought to address this issue by partnering with organisations such as Wellways and Launch Housing Limited to assist clients to obtain

stable accommodation. We also support clients with their rental payments to seek to transition them to more stabilised housing.

Stigma and discrimination

61 In addition to the stigma and discrimination surrounding mental health in general, it should be recognised that there is a unique stigma associated with suicide and self-harm.

62 Across mental health services we acknowledge that a number of clients still feel stigmatised about their mental health and this can lead to a delay in accessing treatment and at times prevent them continuing to engage in their treatment. HOPE clients often describe shame about their feelings and actions which can be an initial barrier to working effectively with them to set goals and identifying the appropriate support. I feel promoting positive messages of support for those with mental illness to the public is required to change perceptions about mental illness and suicide. Health promotion is a key strategy that can be employed to seek to address stigma and discrimination, by assisting people to feel more comfortable about accessing and accepting help.

What key changes, including to the mental health system would bring about lasting improvements to Victoria's ability to prevent suicide?

63 In my view, there are many aspects of the mental health system that could be improved to achieve lasting improvements to Victoria's ability to prevent suicide but I believe that these changes are of importance:

(a) providing a stable source of funding for mental health services (for example, by ensuring that funding to support suicidality–targeted services such as HOPE is recurrent); and

(b) ensuring that consumers have access to stable accommodation after they have been discharged from a mental health service.

sign here ►

print name JOHN WILLIAM MCLAREN

date 3 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JM-1

This is the attachment marked 'JM-1' referred to in the witness statement of John William McLaren dated 3 July 2019.

HOPE Program

The HOPE program provides support with the aim of reducing suicide attempts, suicide and psychological distress for clients and their significant others.

Your HOPE appointment:

Your first appointment will be organised by phone with one of the staff on the team. Where possible we will aim to visit you in your home.

At your appointment we will discuss your wellbeing and safety.

If you have any queries about making your appointment please contact us on:

9231 4432 between **9am - 4pm**.

In the event of a psychiatric emergency, please contact:

Psychiatric triage on **1300 55 88 62**.

HOPE (Suicide Prevention) Team

part of **PICT** - Primary Intervention and Care Team

St Vincent's Hospital, Melbourne

Tel: 03 9231 4432 www.svha.org.au

ST VINCENT'S HOSPITAL MELBOURNE

enVision2025

HOPE

ST VINCENT'S HOSPITAL MELBOURNE

A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

HOPE Program: Outreach Support for People Leaving Hospital and At-Risk of Suicide

The three-month period after a person has attempted suicide is a period of increased risk.

Receiving support to address issues contributing to suicidality after your hospital admission can improve wellbeing and reduce the risk of future attempts.

We provide this home based support for people who have recently attended St Vincent's Hospital.

We Provide

- An initial consultation with two mental health clinicians to discuss, identify and plan your support needs
- Short term home and community based intensive support for up to 3 months
- Support to increase resilience and skills to manage social, psychological, economic, and environmental factors that may contribute to suicidality
- Care coordination and community service referral
- Assistance to strengthen connections to carers, family, community and support services
- Inclusion of the people supporting you
- Family Support worker to provide support to involved family or friends.

We Are

We are a team of clinicians trained specially to work in this area.

We See

- People who have presented to St Vincent's Hospital with a suicide attempt or related behaviours
- Are agreeable to being supported
- Are aged 18 years or older and residing in St Vincent's Mental Health catchment (cities of Yarra and Boroondara)
- Are not already engaged with an area mental health service or requiring more frequent or longer term case management

Referral Pathway

Referral to the HOPE program is made by a mental health clinician who works at St Vincent's or at one of the other hospital HOPE teams.

HOPE
Hospital Outreach Post-suicidal Engagement

St Vincent's Hospital, Melbourne

Tel: 03 9231 4432

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ATTACHMENT JM-2

This is the attachment marked 'JM-2' referred to in the witness statement of John William McLaren dated 3 July 2019.

HOPE

Hospital Outreach Post-Suicide Engagement

Mental Health Primary Intervention Care Team

Phone: 9231 4432

Fax: 9231 2372

HOPE Staff

Psychiatrist

Psychiatric Registrar

Manager

Team Leader

Senior Clinician

Senior Clinician

Senior Clinician

Senior Clinician

Clinician

Clinician

Admin Support

Family Support Worker

Roles:

Manager:

Responsible for supervision, annual leave requests, escalating risk issues, meeting with new staff, recruitment,

Team Leader:

Daily clinical oversight and operational matters, meeting facilitator/agenda circulation, staffing and rosters, induction of new staff, coordination of applications e.g. awards, applications

Summary of HOPE

HOPE
(Since 2017) Suicide Prevention with aim of reducing suicide attempts, repeated intentional self-harm and associated psychological distress for clients, their carers and families through coordinated care and assertive outreach support for people who have presented to hospital and are at-risk of suicide

Referral Criteria

HOPE (subcentre 47)
• Consumer lives in St V's catchment • Aged 18+, attended St Vincent's ED or another ED • Referrals accepted from EDMH/CATT/CL/AIS or from other services with a HOPE team eg the Alfred • Client has engaged in a suicide attempt (actual/interrupted/aborted) • Client has suicidal ideation with preparatory behaviours (not suicidal ideation alone) • Client accepting of HOPE

support
BUT we also accept referrals on a case by case basis who have not attended the ED, but who have engaged in high risk suicide behaviours/suicide attempt or are at moderate/high risk of suicide and who live in the St V's catchment area

Please call to discuss these cases 4432

Detailed HOPE Criteria:

The HOPE (Suicide Prevention) Team is part of PICT (Primary Intervention and Care Team) and has now been operating since April 2017 and is funded until June 2020. The team completed training in the CAMS (Collaborative Assessment and Management of Suicidality) model. For further info see 'Managing Suicidal Risk: A Collaborative Approach' by David A. Jobes (2016).

The HOPE team priority group / referral criteria are: to provide support to those people who have engaged in suicidal behaviour according to the Columbia Suicide Severity Rating Scale (see guide below **).

HOPE is a specialist suicide prevention team and we provide:

- Short term community based intensive support (Up to 3 months)
- Assertive outreach (up to 2 x weekly) and telephone support as required over 7 days (1 clinician over the weekend)
- Brief psychological intervention to develop a safety plan and then directly address suicidality using the Collaborative Assessment and Management of Suicidality (CAMS) model
- Care coordination, liaison and community service referral
- Support to increase resilience and capacity to self-manage social, psychological, economic, and environmental factors that can contribute to suicidality
- Family support worker to families and loved ones
- A model that assists in strengthening connections to carers, family, community and support services

Therefore we support those clients who:

- Have presented to any emergency department with
    - With a suicide attempt (actual/interrupted/aborted)
    - Suicidal ideation *with preparatory behaviours* (not suicidal ideation alone)
    - 18 years or older

- Able and willing to be supported by HOPE, with initial phone contact within 24 hours and face to face contact within 72
- Who reside in the St V's catchment area

BUT we also accept referrals on a case by case basis who have not attended the ED, but who have engaged in high risk suicide behaviours/suicide attempt or are at moderate/high risk of suicide and who live in the St V's catchment area

Referrers are encouraged to contact the duty worker to discuss HOPE referrals as cases are not always clear cut and we are aware of more risk factors for each part of the ST V's catchment area which may affect our decision to accept or offer Extended Triage as an alternative

****Key to The Columbia Suicide Severity Rating Scale (Posner, K. et al; 2008):**

Actual attempt: A potentially self-injurious act with at least some wish to die.

Interrupted attempt: When a person is interrupted (by an outside circumstance) from starting the potentially self-injurious act.

Aborted attempt: When the person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behaviour.

Preparatory acts and behaviour: Acts of preparation towards imminently making a suicide attempt (eg, collecting pills, giving away possessions, writing a will).

http://www.health.gov.au/internet/main/publishing.nsf/content/mental-nsps

Processes

HOPE

At Entry

- Review referrals (daily CMI screening reg/ AIS / CAT / other)
- All referrals to have a screening register opened (or diverted) under sub centre 47
- Duty work to contact consumer on day of referral: Interim telephone support to be provided.
- **Any new referrals added to the evaluation spreadsheet located at: G:\Mental - Corrections - DA\MH\Operational\Primary MH Services\HOPE Suicide Prevention\Evaluation\KPMG "HOPE supplementary Data Info
- Referrals to be discussed and allocated at morning handover (exception on weekend and Fri, if the referral clearly meets criteria and there is capacity for assessment over the weekend – in order to meet target of assessment offered within 72 hours of referral)
- Caseload spread sheet to be updated by duty worker: referrals list and caseload allocation.
- If allocation for long term not available, allocation for assessment only can be made.
- Declined offers noted on screening register and referral spreadsheet (take these to clinical review for discussion and closure)
- Allocated clinician to offer assessment time (within 72 hours).

HOPE Assessment Phase

- At Assessment complete PR1, 'Consent to Share Information' (CSI), provide information re 'Rights' and 'Privacy', complete outcome measures (ORS, SCRS, BASIS 32, HONOS)
- After first contact provide PR1 to admin for registration – open CMI episode and MRO episode and ensure all documentation is sent for scanning.
- Document final entry in screening register directing to MRO for further information
- Complete assessment on 'MH eAssessment' (unless the client has been on the AIS – for those clients it is only necessary to complete the St V's risk management form and send to MRO within one week of commencing case)
- Present assessment at clinical review for discussion, confirmation of diagnosis and treatment plans.
- Close screening register
- Keep intake ORS and SCRS within the blue folders

HOPE Treatment Phase:

- All documentation in MRO
- Completion / review of 'My Safety Plan' by end of 2nd session with copy sent to MRO
- CAMS intervention process,
- Regular review of 'My Safety Plan'
- Contact data entered on CMI/PAS
- Ensure medical review and liaison with key stakeholders
- Ensure referral to Family support worker to allow for period of support
- Present at clinical review at for six week review

HOPE Discharge

- Complete HOPE discharge summary (currently letter), therapeutic letter and risk assessment
- Complete outcome measures (ORD, SCRS, BASIS 32, HONOS and Life Skills Profile) in final session
- Complete evaluation form with client in final session (the tailored ones can be found in: G:\Mental - Corrections - DA\MH\Operational\Primary MH Services\HOPE Suicide Prevention\Evaluation\Evaluation Forms HOPE)
- Inform FSW about pending d/c
- Ensure FSW completes evaluation form with their family/loved ones
- Complete intervention evaluation form in d/c clinical review
- Discuss in clinical review and obtain signature from Sally on paperwork
- Send paperwork to/liaise with key stakeholders re d/c and copy to MRO with patient label
- Provide Beck with d/c paperwork (HoNOS/LSP and Basis 32) with note requesting discharge with date specified or put in 'CMI/PAS updates' folder (DO NOT PUT IN FOLDER FOR SCANNING) within 1 day
- Ensure evaluation spreadsheet is up to date
- Put intake and discharge ORS and SRCS in folders for keeping with patient label attached and intake and discharge clearly marked

Clinical Review Presentations

Suggested format for presenting at Clinical Review

New Assessments

Suggested format for presenting at Clinical Review (green to be documented in MRO entry):

1. **Referral source** – ED, CL, AIS, CATT , etc
2. **Antecedents to referral** – e.g. John self-presented to ED with suicidal ideation one day after he was made redundant.
3. **Demographic data** – name, age, marital status, income source, ethnicity, dependents, type and location of accommodation
4. **Presenting Mental Health issues**
5. **Alcohol and Drug issues** – current and historical
6. **Risks** – self/staff/ others
7. **Medications**
    a. **Current** – name, dose, duration and effects
    b. **Past** – name, dose, duration and effects
8. **Social circumstances**
9. **Family History, forensic history, personal and developmental history, medical history** (this following may not need to be detailed, just the *salient* features)
10. **Plan/recommendations**

HOPE 6/52 Review

1. A few sentences re initial referral- reason referred, whom by, stressors at the time and other relevant background info/services involved at time of referral
2. Treatment over the past 6/52
3. Frequency of appt
4. Level of engagement ? Possible barriers to engagement what did person want addressed during the 3/12 when treatment planning discussed.
5. Details on Cams intervention provided- direct and indirect drivers, safety planning, shift in suicidality during involvement, engagement with cams, is CAMS still occurring?
6. Medications commenced/changes if any
7. Other psychosocial intervention provided/referrals made/liaison with other service providers.
8. Involvement of family
9. Proposed discharge planning ? Anticipating need for extension.