

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

## NorthWestern Mental Health A division of Melbourne Health



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## Executive Summary

Melbourne Health welcomes the Royal Commission into Victoria's mental health system, and is pleased to have the opportunity to provide feedback, thoughts and recommendations for change via the formal submission process.

Melbourne Health provides publicly-funded clinical mental health services through NorthWestern Mental Health (NWMH), one of our clinical Divisions. We are the largest mental health service provider in Victoria. Contributions to this submission have been made by a broad cross section of staff working within our mental health services. It is written from the perspective of our specific role within in the Victorian mental health service system.

There is no doubt that Victoria's mental health system is now in a state of crisis. Rising demand and low growth in resourcing have led to an inability of the system to provide services to the population who need them, and inpatient units and emergency departments are under enormous pressure. The report into mental health services by the Victorian Auditor General (March, 2019) provides a clear account of how the system has failed.

This submission begins with our top recommendations to improve mental health services in Victoria. Background information about NWMH is presented to provide some context around the perspective from which this submission is written. A response is then provided across each of the 10 questions asked by the Royal Commission. In response to each question, we have provided some background information, a description of what we believe is currently working well and what issues are faced by our services, and our recommendations for change. Appendix 2 contains data about NWMH demand, access, safety and capacity.

### Top Recommendations

1. **Change funding models:** Implement equitable population based funding models that incorporate complex social factors and take into account available community resources and supports (including private mental health practitioners and GPs). **Considerations:** the level of resourcing should consider and make provision for the level of culturally and linguistically diverse (CALD) population groups, the level of socioeconomic disadvantage, population growth and geography and demography more broadly. The National Mental Health Service Planning Framework and the Jarman Index are good tools to guide this work. (Section 4)
2. **Governance:** Branches within DHHS should establish a closer working relationship for the system management of both mental and non-mental health services. Similarly, health services should ensure organisational structure allows and encourages integration between mental health and non-mental health services.

Such an approach would require 'ring fencing' of mental health funding from acute general services and also separate acute inpatient mental health and community funding streams to ensure that community funding is protected to deliver services in the community. (Section 4)

3. **Increase the number of acute inpatient beds:** Make significant investment in acute inpatient beds to increase access and reduce risk carried in the community. **Considerations:** The target over time should be 3.0 inpatient beds per 10,000 population. New inpatient units should be purpose built and consistent with current best practice in terms of design, fixtures and fittings, and old units should either be renovated to meet the design standards or replaced. Moreover, the Australian Healthcare Facility Guidelines should be updated to include contemporary best practice about gender segregation and the particular needs of vulnerable cohorts of patients. (Section 4)
4. **Support the mental health workforce:** Develop and implement strategies to maximise safety and well-being of workforce (minimise and respond more effectively to occupational violence, effects of vicarious trauma, fatigue and burnout). Improve professional development. Consider workforce incentives such as increased annual leave as for emergency workers, and bonuses for working in the

most difficult areas. **Considerations:** While it is recognised that effecting legislative change is a lengthy process, as a medium to long term goal, relevant legislation should be amended to ensure that mental health clinicians are given equal protection under the law (section 31 *Crimes Act 1958 - amended*) as Paramedics and Emergency Department staff. The Government, via a memorandum of understanding between DHHS and Victoria Police, should make sure Victoria Police respond appropriately and consistently to incidents of OV. This includes investigating all allegations of assault and charging and prosecuting individuals who perpetrate assaults on clinical and non-clinical staff as appropriate. While NWMH has developed a local agreement with Victoria Police in regard to this, clinical staff report that at times they are discouraged by Victoria Police from reporting an alleged assault, or that the response they receive from Victoria Police is inconsistent. NWMH further recommends that the government resource mental health services, both inpatient and community clinics, to implement adequate preventative measures such as additional Closed Circuit Television (CCTV) cameras, Security Officers, Air Locks in Inpatient Units and bolstering of staff base security. (Section 7)

5. **Redevelop the state-wide mental health patient information system:** This would minimise duplication and improve efficiencies in the sharing of information and also support better data collection, reporting, service evaluation and planning. Ideally, the system would be able to interface with the commonly used electronic medical record systems of hospitals. (Section 4 & 5)
6. **Grow the mental health workforce:** Further investment in the full range of disciplines within clinical mental health services, including staff with dual diagnosis (mental illness and alcohol and other drugs), cultural specialists (e.g. Aboriginal and Torres Strait Islander), exercise physiologists, dietitians, family violence specialists and FaPMI workers in order to provide integrated, evidence-based, holistic care. Invest in non-clinical support staff to maximize the efficiency of clinicians. (Section 7 & 8)
7. **Reform and expand program service delivery at community clinics:** Ensure provision of evidence-based care to a larger proportion of the population, and enable holistic service delivery across core practice domains including psychological practice, family and carer support, employment and meaningful activity, physical health interventions, lived experience peer support, treatment for alcohol and other drug misuse/dependence, trauma informed practice and forensic responses. **Considerations:** Investment is also needed to increase capacity to outreach to all consumers and carers as needed, and to provide intensive home-based treatment to a small proportion (10-20%) of consumers. (Section 4, 5 & 8)
8. **Increase community residential services:** Reform and expand community residential services to ensure there is a continuum of rehabilitation options including alcohol and drug (AoD) residential services. (Section 4)
9. **Respond to the increased demand on mental health services from the prison population:** Provide compulsory care for prisoners under the same conditions that apply to consumers in the broader community. This will require amending the Mental Health Act and oversight by the Mental Health Tribunal. Increase growth in forensic clinical specialist positions; provide more appropriate inpatient bed options and more appropriate accommodation services for people exiting prison with serious mental illness. **Considerations:** Young people with forensic problems often take longer to engage in mental health care, and require more flexible and creative approaches. Consideration should be given to an extension of 'problem behaviour services' to consumers younger than 18. NWMH also seeks consideration in regard to the numbers of released adult prisoners placed on Assessment Orders (AO) under the Mental Health Act and sent to an Emergency Departments. Our experience has been that approximately 50% of the AOs are not upheld and it has become clear over time that homelessness and lack of means of support are the predominant drivers for the instigation of the AO rather than acute mental illness. Accordingly, we ask that consideration be given to embedding Department of Housing and Centrelink workers in community mental health clinics. (Section 4)

10. **Extend after hours mental health services:** Increase flexibility in regard to time of care (out of hours) such as extending the hours of operation of community mental health clinics and increase funding to allow for 24 hours/7 days crisis assessment teams. Establish 'age appropriate and specific skill-set' crisis assessment teams for older people that provide timely crisis assessments and intensive support including medication supervision during business hours and out of hours. Increase mental health services in hospital emergency departments during after-hours and weekends to provide consumers with access to specialist mental health care. Necessarily, this should include 24/7 availability of 'stand-up' registrars and consultant psychiatrists. Restore program capacity in community clinical mental health services. (Section 4)
11. **Review service alignment and catchment area size:** Review and improve alignment of mental health service areas with human services areas, police districts and local government boundaries. The 'ideal' size of an Area Mental Health Service should be determined and then appropriately resourced to manage its catchment population. The resourcing should be dynamic in nature and indexed with population growth. **Considerations:** Experience at NWMH suggests that areas need to be of sufficient size to permit some streaming of acute inpatient units, attract sufficient staff and offer opportunities for research and innovation. In our view, this size should be of the order of 750,000 population or more for metro areas.
12. **Increase opportunities for long term management:** Enhance the capacity of services to work with consumers with enduring complex medium to long term mental health needs (i.e. effect a return to continuing care and a reversal of the trend towards episodic care for the consumers / persons living with severe mental illness that has been driven by necessity and resource constraints). The resourcing should be dynamic in nature and be indexed with population growth. **Considerations:** The aim should be to facilitate longer-term engagement to prevent a negative, repeating cycle of relapses with associated poor social and health outcomes. Preventable relapses under these circumstances often lead to relationship breakdowns, loss of employment, loss of housing and the involvement of the criminal justice system. Further, each successive psychotic relapse has a cumulative effect in terms of cognitive decline and risk of developing chronic illness. (Section 4)
13. **Expand early intervention:** Expand the perinatal mental health initiative to allow longer period of treatment and broader referral sources, improve engagement with schools to improve mental health literacy and encourage early intervention. Expand youth mental health services to provide care for all young people who require treatment in the specialist mental health system. This includes extension of youth services to provide services for the full duration of the age-period from 15 to 25 years. Foster programs such as 'HOPE' and 'Engage' for early intervention for suicidal behaviour. (Section 2)
14. **Maximise psychosocial recovery and rehabilitation:** Increase the capacity of clinical mental health services to provide more psychosocial recovery and rehabilitation programs (in reach and outreach), and review governance arrangements to foster closer links between the mental health clinical and community support sectors. (Section 4, 5 & 8)
15. **Fund research and evaluation:** Funding should be allocated to support both biopsychosocial research and program evaluation. This could include the establishment of centres of excellence on a competitive basis. (Section 1, 2, 3 & 5)

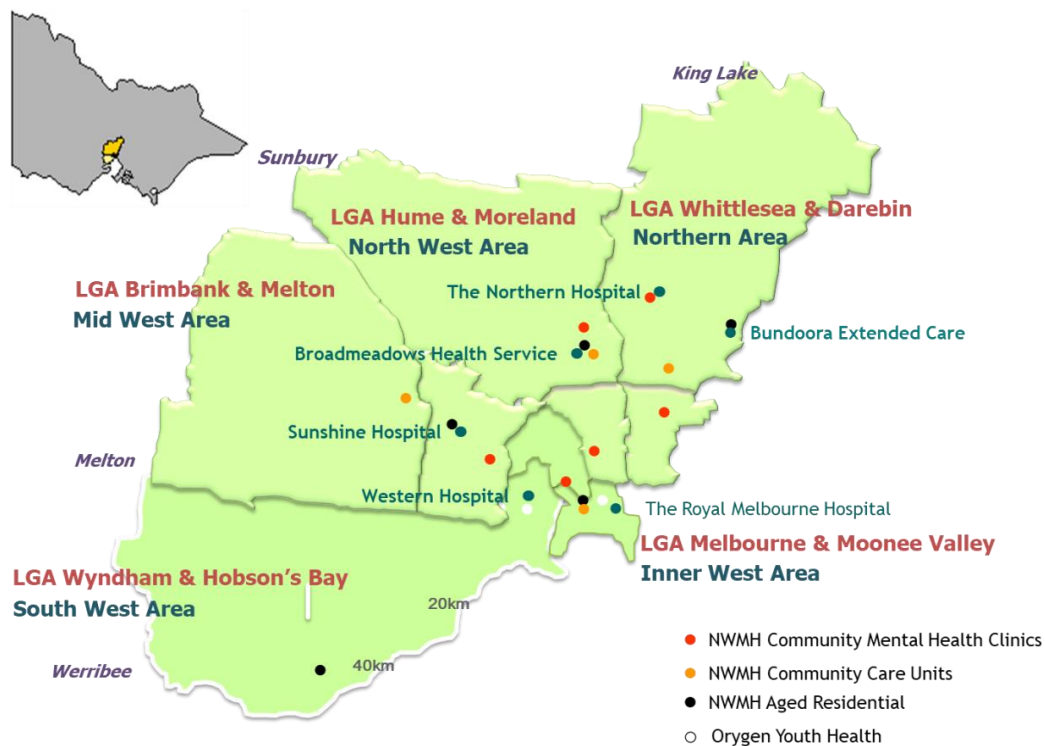
## Background: About NorthWestern Mental Health

NorthWestern Mental Health (NWMH) is a \$210 million per annum, publicly-funded mental health service for people living in northern and western metropolitan Melbourne. A division of Melbourne Health, NWMH is the largest publicly-funded mental health service in Victoria.

### Population

NWMH provides clinical mental health services across a catchment area with a population of over 1.5 million people (see Figure 1 below). The catchments covered by NWMH services include 4 of the largest and fastest growth corridors for metropolitan Melbourne, incorporating the cities of Moreland, Hume, Melton, Brimbank, Moonee Valley, Melbourne, Darebin and Whittlesea (See Appendix 2 – Demand).

FIGURE 1: NWMH catchment, Area Mental Health Services and sites



NWMH delivers a comprehensive range of clinical mental health services for youth, adults and older people who are experiencing or are at risk of developing a serious mental illness. Our services are delivered from a range of locations, including most major hospitals within the north and west of Melbourne, and various community-based mental health clinics based in Coburg, Broadmeadows, Preston, Epping, Sunshine, Melton, Mill Park, Wyndham and Moonee Ponds.

Our services are organised into local Area Mental Health Services and Programs, spanning 32 sites across the north and west of Melbourne. The Area Mental Health Services and Programs managed by NWMH are:

- Inner West Area Mental Health Service (IWAMHS)
- Mid West Area Mental Health Service (MWAMHS)
- North West Area Mental Health Service (NWAMHS)
- Northern Area Mental Health Service (NAMHS)
- Aged Persons Mental Health Program (APMHP)
- Orygen Youth Health Program (OYH)

NWMH manages a range of core and specialist services, some of which have a state-wide or regional focus (see [nwmh.org.au](http://nwmh.org.au) for full range of services). Table 1 below summarises the range of services we provide across age ranges, spanning acute, subacute, specialist, residential, community and inpatient unit services.

**Table 1: NWMH range of services**

Young people (15 to 25 years)	Adults (18 to 65 years)	Older people (65 years +)	Speciality & Regional Services
Specialised youth clinical mental health service	Acute Inpatient Units	Inpatient Units	Triage
Integrated training & communications program	Community teams	Aged Psychiatry Assessment & Treatment Teams	Adult Mental health Rehabilitation Unit
Forensic Youth Mental Health Service	Community Care Units	Behavioural Assessment and Specialist Intervention	Dual Diagnosis (SUMITT)
	Emergency Mental Health	Consultation Service	Eating Disorders Program
	Prevention & Recovery Care	Intensive Community Treatment	Neuropsychiatry Unit
		Residential Services	Private Consulting Suites
			Second Psychiatric Opinion Service
			Victorian Centre for Excellence in Eating Disorders
			Forensic Interface Team

### Bed Stock

NWMH operates a total of 502 beds, 203 of which are acute mental health beds, comprised of 133 adult beds, 16 Youth Acute beds and 54 Aged Person's beds as per Appendix 1.

This bed stock provides NWMH with 1.41 adult beds per 10,000 adult population compared to a State-wide average of 1.8 or compared to another Melbourne metropolitan service (Alfred Psychiatry) 2.6 beds per 10,000 adult population.

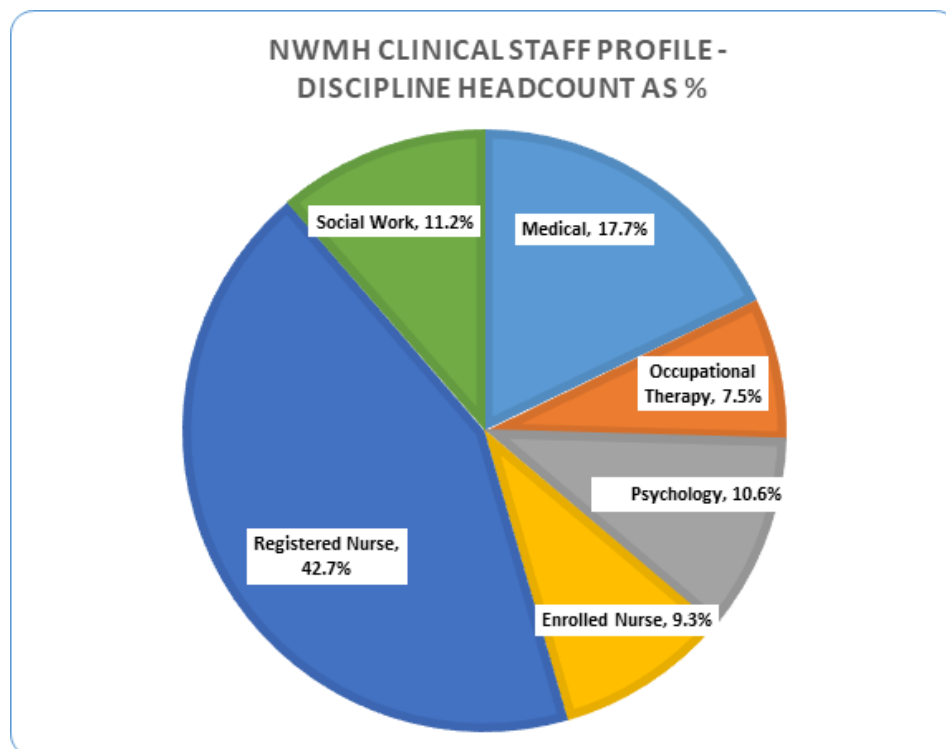
Acute and secure beds are hospital based. It is generally accepted that to be able to efficiently manage unexpected peaks and troughs in demand and acuity, an occupancy rate of 85 percent of hospital beds is best practice. For the last five financial years NWMH acute beds have been operating above the 95 per cent capacity.

NWMH has three Electroconvulsive Therapy (ECT) suites located within the inpatient units and one service provides ECT in the Day Procedure Unit. NWMH is the largest public provider of ECT treatment, and provides approximately 2,900 ECT treatments per annum at Royal Melbourne Hospital, Sunshine Hospital, Broadmeadows Health Service and The Northern Hospital.

### NWMH WORKFORCE

NWMH employs 1344 equivalent full time staff (approximately 1900 people). The total headcount of clinical staff is 1370, and is primarily comprised of the disciplines of medicine, nursing, occupational therapy, clinical psychology and social work (see Figure 2 for breakdown of clinical staff profile). In addition, there is a Lived Experience workforce of approximately 38 staff, comprised of Consumer and Carer Advisors, Consultants and Peer Support Workers (total 22 Consumer and 16 Carer workers). NWMH also employs over 500 staff in administration and support roles. Multidisciplinary teams work in all areas of the service.



**FIGURE 2: NWMH Clinical staff profile 2018, discipline headcount as %****OUR PARTNERS**

NWMH works closely in partnership with a range of external services to ensure that the individual needs of people accessing our services are met (see table below). We also have strong relationships with leading academic institutions across clinical specialities for undergraduate students, staff, post-graduate students and external health professionals.

Primary Care	Community Care	Other
<ul style="list-style-type: none"> <li>• General Practitioners</li> <li>• Primary Health Networks (specifically Eastern Melbourne and North Western Melbourne)</li> <li>• Private psychiatrists</li> </ul>	<ul style="list-style-type: none"> <li>• Community health services</li> <li>• Drug and alcohol services</li> <li>• Mental Health Community Support Services (MHCSS)</li> <li>• Family Violence Services</li> <li>• Aboriginal and Torres Strait Islander Community Controlled Health Services (e.g. VAHS, VACCA)</li> <li>• Refugee Support Services</li> <li>• Community pharmacies</li> </ul>	<ul style="list-style-type: none"> <li>• Acute hospitals and health services</li> <li>• Universities and training institutions</li> <li>• Consumer and carer peak bodies and organisations</li> <li>• Housing Services</li> <li>• Victoria Police</li> <li>• Child Protection Services</li> </ul>

## 1 Improving understanding of mental illness and reducing stigma and discrimination: What we know from our consumers

The past decade has seen significant growth in public discussion and awareness of mental health, but many people with mental illness still experience stigma and discrimination. These experiences can take place in their communities, families, schools, workplaces and, at times, in the organisations from which they seek support. Stigma and misinformation about mental illness can form a barrier to recovery, and contribute to loneliness, distress and increase feelings of hopelessness for consumers and their families. Mental illness can lead to discrimination in areas such as housing, education and employment and can lead to people being more reluctant to seek help and less likely to engage in treatment.

### WHAT IS WORKING WELL?

#### National education campaigns

National organisations such as Beyond Blue, Sane Australia and state organisations such as VIMIAC and Tandem continue to promote mental health literacy and combat stigma.

#### Expansion of the Peer Workforce

The DHHS initiative to fund a small workforce of consumer and carer peer workers (Expanded Post Discharge Initiative) has had a very promising beginning, helping to reduce stigma for consumers newly admitted to inpatient units. This program also supports culture change within health service organisations.

#### Recovery stories

NWMH consumers and carers have been leading a project, Recovery Stories, to promote mental health literacy through video recordings of their stories ([Recovery stories | NorthWestern Mental Health](#)). These stories provide the opportunity to see and learn from people who have a lived experience of mental illness who are living well.

#### Trauma informed training

Trauma informed training encourages staff to understand a person in the context of their life experiences, particularly early traumatic experiences. Applying this lens promotes compassion towards people with a mental illness. Training on offer across services however remains at a foundation level and is optional.

### ISSUES

The following issues are relevant to the Victorian Mental Health System as a whole.

#### Peer Workforce – training and support

The consumer and carer peer workforce is small, and is still developing its professional identity. Role definition, training, support and career structure are all still at an in-progress stage.

#### Skewed image of people with a mental illness

Mental health service reporting and media reporting disproportionally fixates on reporting serious incidents which predominantly include violence and sexual assault, creating a skewed image of people with a mental illness that contributes to stigma and further marginalisation of those with mental illness.

### **Mental health vs mental illness**

Focus on mental health rather than mental illness in a number of DHHS publications and policies adds to public confusion and impairs understanding about the importance of mental illness in health care.

### **Piecemeal approach to trauma informed practice**

Trauma informed approaches are disjointed and services lack specialist expertise and training in this area.

### **Research Gaps**

As long as there is a lack of clarity about causal factors contributing to mental illness, it is likely that there will continue to be some level of fear based discrimination within society.

## **RECOMMENDATIONS**

Below is a list of recommendations provided by consumers currently working in lived experience roles across NWMH.

1. Attempts to increase understanding of mental illness and to decrease stigma and discrimination should not be delivered in a 'one-size-fits-all' method. Specific focus needs to be placed on developing services, campaigns and initiatives that meet the needs of people of Aboriginal and Torres Strait Islander backgrounds, as well as refugees and those who identify as LGBTQI. These initiatives should be co-designed alongside individuals from these communities so they are more likely to meet their particular needs.
2. Increase support for initiatives that decrease the shame and fear associated with speaking openly about suicide. One such initiative is #youcantalk (<https://www.lifeinmindaustralia.com.au/youcantalk/>) which aims to improve understanding of suicide in the community, to increase the confidence of individuals to speak more openly about suicide in their community and to hold supportive conversations with people thinking of suicide.
3. Clearly distinguish between mental health and mental illness in DHHS publications and policies.
4. Increase access to Peer Support Workers, particularly within the school system, community organisations and at a person's first interaction with mental health services. This might be a person with a lived experience of mental illness; a person with a lived experience of caring for someone with a mental illness or a drug and alcohol Peer Support Worker. The ability to connect with someone who may have experienced similar challenges can reduce fear around seeking support and increase a person's ability to navigate the mental health system.
5. Include lived experience perspectives in all mental health-related training, especially training developed and delivered within health services, educational institutions, workplaces and the community. Ideally training would be co-designed and co-facilitated by consumers and carers, in order to best represent the needs of people directly impacted by mental illness.
6. Increase mental health education available for families / carers of those impacted by mental illness to increase their awareness of the challenges that their loved one might be facing and of supports available to them in their caring role.

7. Encourage partnerships with Aboriginal and Torres Strait Islander community-controlled health services and peoples to improve the cultural awareness of mental health staff and to provide an opportunity to learn from traditional approaches to health and healing which incorporate social, emotional, physical and spiritual wellbeing.
8. Increase sharing of lived experience stories on a wide variety of media platforms. These stories should include a full range of mental health challenges and be shared by people from diverse backgrounds that reflect the communities that they are being targeted towards. Individual consumers have stated that they found it particularly empowering to see celebrities or people of power share their experience of mental illness.
9. Strengthen a trauma informed approach to understanding mental illness. This would support a greater awareness of the relationship between mental illness and significant adversity and potentially promote compassion over discrimination.
10. Increase support for translational research and / or centres of excellence in research.

## 2 Prevention and early intervention: What is already working well and what can be done better to prevent mental illness and support people to get early treatment and support

Prevention of mental illness is a multi-faceted undertaking, involving many factors such as childhood environment, connectedness and stable relationships; schooling; employment; and diet and exercise. While mental health services have a role to play in contributing to preventative strategies, much of this work falls under the domain of other sectors. Further developments in genomics may assist in the prevention of some psychiatric disorders, but research into major illnesses like schizophrenia, bipolar affective disorder and depression has found that multiple genetic factors are involved and that specific treatments derived from genomics are unlikely to play a major role in prevention.

Much more progress has been made in the area of early intervention, that is, intervention that takes place early in life, early in the course of an illness, and early in each episode of illness. Significant work has been done specifically in the field of early psychosis (McGorry et al, 2008), but the principles have been found to apply more broadly.

### WHAT IS WORKING WELL?

#### *Early in life & Early in illness*

##### **Perinatal Mental Health Services**

DHHS has funded initiatives in perinatal mental health. NWMH has partnered with Northern Health and Western Health to establish Perinatal Mental Health Services at Sunshine Hospital and The Northern Hospital in 2018.

The perinatal period (the time from conception to the end of the first postnatal year) is associated with a significantly increased risk for onset and relapse of mental illness – higher than at any other time in a woman's life. The Perinatal Mental Health Service is crucial in providing women with access to assessment and treatment with the aim of reducing the impacts of mental illness for the woman, her baby and her family.

The impacts of perinatal mental health can be widespread, affecting the mother and baby, the mother's significant other or partner, other children within the family and the extended family and the risk of mental health problems for the infant later in life. The personal and social costs for individuals and families are substantial, and are supported by health economic analysis. The current program significantly limits the number of women and infants able to access specialist perinatal treatment and care.

##### **Other initiatives**

In the adult areas of NWMH, each service provides some early intervention through programs such as *Every Child, Every Chance*, *CHAMPS* (a program for children whose parents have a mental illness), *Our Time Playgroup* (a playgroup co-facilitated by a mental health clinician, consumer peer worker and an Anglicare worker) and other local initiatives. Each of these programs applies early intervention principles to the known mental health risk factors.

#### *Early in illness & Early in episode*

##### **Orygen Youth Health**

Seventy-five percent of mental illness begins before the age of 25 years and intervention at illness onset has been shown to improve outcomes and limit disability (McGorry et al, 2008). Within NWMH, Orygen Youth Health (OYH) is recognised internationally as a leader for its clinical and research work in early intervention for youth mental health. OYH provides services to the young people aged 15-24, of whom 200,000 live in its catchment area. OYH works to improve mental health literacy in young people and provides them with a range of evidence-based clinical services. Together with its partner organisations, it has championed the development of *headspace* centres to provide a primary care-based, accessible option for young people.

DHHS has funded early psychosis programs across the state based on the Orygen model, and countless similar programs have been established across the world.

#### **Mental Health First Aid**

North West Area Mental Health Service (NWAMHS), one of the NWMH adult services, has delivered and evaluated 16 courses of Mental Health First Aid in the Hume community area to 216 individuals, both residents and workers. Retrospective evaluation revealed an increase in mental health literacy and confidence in intervening with people who have a mental health issue.

#### **Recovery and Wellness Plans**

Recovery and wellness plans developed in partnership with consumers and carers have been introduced by DHHS, and are used across NWMH help to identify early warning signs and to jointly identify recovery goals.

#### **Health Promotion**

##### **Connect for Wellbeing**

NWAMHS has partnered with local community organisations to improve social cohesion, develop social capital and promote protective factors for mental health, '5 Ways to Wellbeing' (a health promotion program based on extensive international research which promotes five simple and effective ways to improve psychological and emotional health – connect, be active, keep learning, be aware, help others) and Connect4Wellbeing (an initiative promoting social connection) are examples of this. Evaluation of their Connect4Wellbeing program showed that 1,112 new connections were made in one suburb alone.

## **ISSUES**

#### **Lack of coordinated, state-wide approach**

State-funded mental health services have concentrated on downstream interventions targeting severe mental illness, and Initiatives in early prevention have been developed mainly at a local level. Greater involvement from DHHS would provide more generalizable and efficient programs.

State-funded youth mental health services are not well integrated with *headspace*, primary care or the school system. Better linkages in these areas would improve opportunities for early intervention.

#### **Demand**

As a result of significant population growth, the demand for OYH's clinical services is much greater than its resources, and it can only provide treatment to 1,000 of the 4,000 young people who are referred each year. This is particularly true of high prevalence disorders such as depression and anxiety. Further, each young person is limited to a two year period of care from OYH, after which they are referred to primary care, private specialists or adult mental health services.

## **RECOMMENDATIONS**

- 11.** Invest in promoting early intervention at the state level through public health campaigns that focus on encouraging social connectedness, reducing stigma and improving mental health literacy.
- 12.** Support the integration of youth mental health care with the primary youth mental health care platforms: *headspace* centres and schools. This will help to identify mental health issues early; improve access to enhanced primary care services for young people with complex or severe mental disorders; and support easier and seamless transition between primary care and OYH as needed.
- 13.** Increase funding for Perinatal Mental Health services to allow more women and infants to receive perinatal mental health care; for the duration of treatment to be clinically indicated and not limited by lack of resources; for development of antenatal high risk clinics; for increased education and training; for supervision/mentorship of midwives; and greater partnership with community services. This would also

improve access to specialist perinatal assessment, diagnosis and treatment for a broad cohort of women within the catchment areas.

- 14.** Increase funding for youth mental health services to provide care for all young people who require treatment in the specialist mental health system for the full duration of the age-period from 15 to 25 years in line with policy and community expectations. This would include removing the two year tenure of care for young people who require an extended episode of care and providing care for young people during subsequent relapses of their illnesses.

### 3 Preventing suicide: What is already working well and what can be done better

Suicide rates are increasing across Australia. Suicidal ideation and behaviour are widespread in our society and are a common reason for presentation to emergency departments and mental health services. The causes of suicide and suicidal behaviour are multi-factorial. Important contributing factors include psychosocial stressors, mental illness, physical illness, substance abuse, access to means and genetic susceptibility. Often the final trigger is a psychosocial stressor such as loss of employment or relationship breakdown. Suicide prevention is a major challenge for mental health services, both in hospital settings and in the community. Prediction of suicide is difficult even for the most skilled clinicians using the best-evidenced tools. Currently, NWMH provides a range of general mental health services which respond to the needs of people experiencing suicidal thoughts and behaviours. These services include a 24 hour centralised mental health triage service, emergency mental health clinicians embedded in Emergency Departments, inpatient services for those at highest risk and community services to provide ongoing care. Interventions targeted more specifically at preventing suicide include the HOPE and ENGAGE initiatives described below.

#### WHAT IS WORKING WELL?

##### **Environmental Checks on Inpatient Units**

Regular environmental Safety Checks and annual ligature audits in NWMH Inpatient Units primarily address the environmental risks and complement the assessment and screening of clinical risk.

##### **Daily Safety Huddles**

Safety huddles occur daily within teams across NWMH (IPU and Community) with the goal of facilitating timely and effective communication, identifying issues and prospectively planning care. They are also used as a regular communication tool to engage staff, improve team cohesiveness and improve patient outcomes.

##### **Training**

Large scale training in suicide recognition and prevention strategies has been rolled out across NWMH in 2017-18 with the aim of improving assessment, risk formulation and safety planning by staff. This training has now been delivered to 530 staff and continues to be offered. Co-designed training for the lived experience workforce has also been developed and a training module for Inpatient Unit (IPU) staff with a focus on meaningful engagement and post-discharge support is currently under development.

##### **Key Initiatives**

The HOPE and ENGAGE Initiatives (MWAMHS and IWAMHS, respectively) are specific suicide prevention programs which provide targeted support to people experiencing suicidal ideation, planning and/or attempts. The ENGAGE initiative operates out of the RMH ED and provides post discharge telephone follow up to people who have presented in the context of suicidal ideation or, an attempt. The HOPE initiative which operates out of MWAMHS (community team), provides 12 weeks of tailored follow-up and includes the use of individualised safety plans, targeted psychological treatment, practical support and linkages and opportunities for family and carer support. A risk formulation approach is adopted to assess and respond to immediate and longer-term risk.

##### **Technology**

Integrated technology-mediated interventions have been used to incorporate service-specific online platforms. Where implemented, such approaches have been shown to be safe, acceptable and well-endorsed by consumers at risk of suicide, especially young people.



## ISSUES

### Premature Discharge

The increase in community demand and registered consumers over the past five years has put extreme pressure on an already challenged system. Premature transfers and discharges from inpatient units are frequently a result of high levels of severely acute incoming patient demand. Despite these significant pressures, NWMH always seeks to do all it can to mitigate the risk of suicide and other adverse outcomes.

### Overall impact of current service system



### Clinical Handover and Managing Transitions of Care

There is considerable variation across Victoria in follow-up arrangements upon discharge from Inpatient Units and crisis teams, initiatives such as HOPE and ENGAGE go some way to address this however, there is still a way to go. The time of transfer between services is a high risk period for consumers; some may drop out of care at this stage, and it can take time to establish trust with a new treating team. Documentation such as transition summaries may be delayed or incomplete as a result of high demand, resulting in gaps in communication to the receiving service (e.g. GP) regarding the needs and risks of a patient.

### Risk Assessment and Documentation

Suicide risk assessments are a critical component of suicide prevention. However, categorical methods for assessing and communicating risk have poor predictive validity, inter-rater reliability, and clinical utility. The risk rating of individuals who suicide is typically low, highlighting the need to revisit the process of risk assessment and formulation. Further research into risk assessment tools is needed, but a more promising approach is to focus on engagement with the consumer. More research is needed in this area.

### Collateral Information from Families, Carers and Friends

Due to time pressure or difficulties in making contact, collection of collateral information from families, carers and others may be missing in the assessment and management of suicide risk. Families and carers may currently not be adequately consulted or supported following discharge for the same reason.

### Interservice Communication

Relationships with GPs and primary care practitioners are variable, resulting in less than optimal communication, coordination and co-operation regarding best care. Internally there is sometimes a lack of communication between treating teams exacerbated by different databases and IT systems.

### **Emergency Department (ED) environments**

EDs are not designed to provide best model of care for people who may be feeling suicidal, the EDs are very high stimulus areas with multiple points of access and egress. ED staff are not trained to assess risk and provide support to this group, and long waiting times can result in a suicidal person being left alone for long periods of time.

### **RECOMMENDATIONS**

15. Ensure that suicide prevention planning starts during the inpatient admission phase, with the period immediately post-discharge resourced as a time of increased clinical focus and follow-up that includes step-down models of care.
16. Increase support for assertive follow-up at points of transition in care (e.g. discharge from emergency departments, inpatient or outpatient care).
17. Prioritise and integrate training for staff in the use of interventions specifically designed to target suicidality as part of clinical practice. This includes programs specifically designed for working with Aboriginal and Torres Strait Islander peoples.
18. Increase training and supervision of staff in best practice approaches to risk assessment and formulation. A whole of service approach to risk should be considered.
19. Foster further research into suicide risk assessment.
20. Develop and resource demonstration projects (and subsequent generalisation and scaling up) of integrated technology-mediated interventions to incorporate service-specific online platforms for suicide prevention.
21. Increase support for initiatives that decrease the shame and fear associated with speaking openly about suicide. One such initiative is #youcantalk (<https://www.lifeinmindaustralia.com.au/youcantalk/>) which aims to improve understanding of suicide in the community, to increase the confidence of individuals to speak more openly about suicide in their community and to hold supportive conversations with people thinking of suicide.
22. Improve communication with families and carers. Caregivers serve an essential role in supporting consumers in the community who are at risk of suicide. There is an opportunity to better support the needs of caregivers through the collection of collateral information, communication of risk, and through providing information to help carers identify, respond to and reduce risk.
23. Develop specific service-integration resources to support linkages between NWMH services and primary care and other services (e.g. GPs, crisis accommodation, vocational services, drug and alcohol). Support efforts to improve communication between NWMH and these services. Such approaches will free-up clinician resources to enable a more dedicated focus on treatment of the underlying mental health problem which has increased the risk of suicide for instance, longer term psychological interventions.
24. Develop and resource a different model of care that works alongside ED departments that is designed specifically for people who may be feeling suicidal (e.g. Safe Haven Café).

## 4 Accessibility and navigating the mental health system: Improving people's access to and experience of mental health treatment and support, and how services link with each other

The mental health system in Victoria is broad and complex. It comprises a large number of mental health service entities, which have distinct service characteristics and incorporate a wide range of healthcare, treatment and support services and activities. Mental health services and programs are funded and delivered by the federal government, state government, local government, non-government organisations and the private sector. While the overarching objectives of many of these programs and services are often quite similar, there is very little in the way of formal links across and between programs, which can impact on consumer experience as they try to access care. The range of different providers, funding sources and criteria for entry render the system fragmented and difficult to navigate. The structure of the system often leaves people unsure of which service can best meet their needs and increases the risk of people 'falling through the gaps' - not receiving the services they need, at the time they need it.

Publicly funded clinical mental health services such as NWMH provide services on a catchment area basis, which requires people to access care in their local area. There is often a significant variation in the availability of primary care providers such as General Practitioners, private practitioners, other primary care services and mental health community support services across the clinical catchment areas, which means that not all services are available to all people within their local area.

### WHAT IS WORKING WELL?

#### Bed call conferences

Twice-daily bed telephone conference calls efficiently manage the constant high demand for beds across the inpatient units. NWMH has very sophisticated bed management systems in place to manage access and flow into acute beds, however it is still confronted with a daily mismatch between service capacity and service demand, which requires active management by senior staff.

#### Specialist positions

NWMH have dedicated positions such as an Aboriginal Liaison Officer in one of our Area Mental Health Services, Specialist Family Violence Advisors and Forensic Clinical Specialists that act as a point of liaison and support for consumers with highly specialised needs to access service.

#### PARCS

Prevention and Recovery Care Services which operate as a partnership between area mental health services and the non-government organisations have provided an effective treatment option for less severely ill consumers who may benefit from pre or post hospital care in a step-up / step-down bed based facility.

*The next section has been divided into two sections: 1) Issues and recommendations for inpatient units and emergency departments, and 2) Issues and recommendations for community services.*

### ISSUES – For Inpatient Units and Emergency Departments

#### Capacity does not meet demand (See Appendix 2, Access – ED presentation)

Access to publicly funded clinical mental health services is generally via a mental health telephone Triage Service or via an Emergency Department (refer section 2 (Access) of appendix 2). The NWMH Triage Service operates 24/7, 365 days per year via **1300Triage** and is staffed by skilled and experienced mental health clinicians. The Orygen Youth Health Youth Access Team (YAT) operates 7 days per week from 09:00-21:00hrs. The NWMH Triage Service and YAT are the first point of contact for all potential consumers of NWMH, and for people seeking assistance on behalf of someone with a known or potential mental illness. The triage system faces huge demand, is currently processing in excess of 70,000 calls per annum, and wait times for an assessment can be up to several hours. In addition to this, triage currently receives around 200 fax referrals per month. Access via one of the three Emergency Departments (Sunshine, Northern and the Royal Melbourne

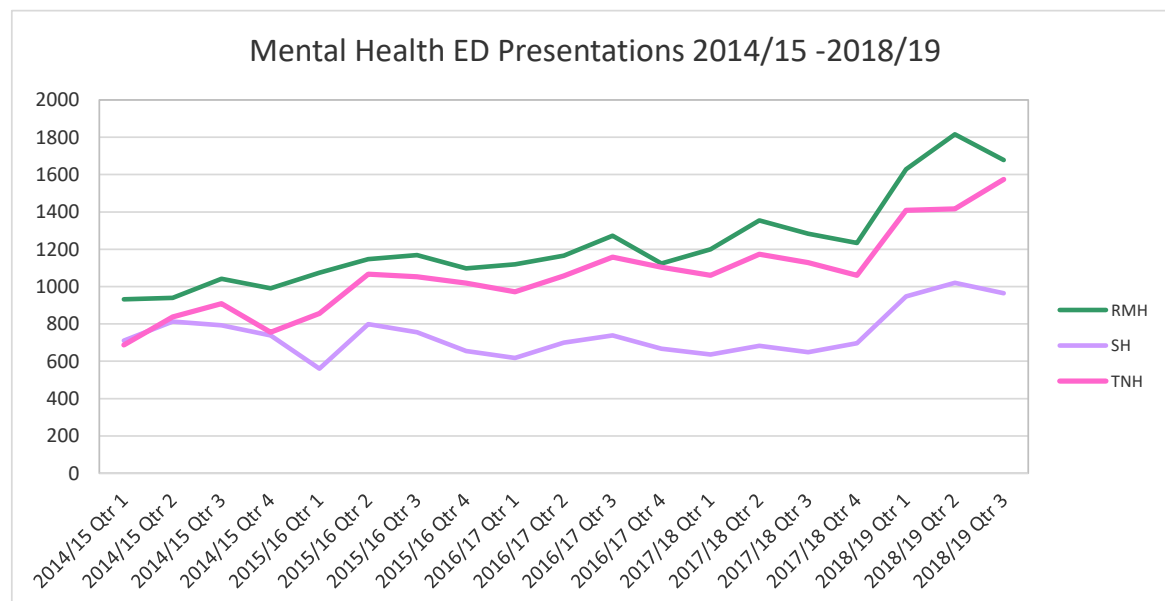
Hospitals) serviced by NWMH occur through: (a) referred by NWMH Triage Service, (b) self-presentation, (c) referral by Community Mental Health teams, (d) apprehended by police and detained under Section 351 of the Mental Health Act, or (e) identified and referred by Police and Clinician Emergency Response services.

NWMH has very sophisticated bed management systems in place to manage access and flow into acute beds, however it is still confronted with a daily mismatch between service capacity and service demand. NWMH is more often than not faced with a negative bed balance, largely due to the demand presenting to the three EDs serviced by NWMH, two of which (The Northern Hospital and Royal Melbourne Hospital) are the busiest EDs in the state. As a consequence of this emergency demand, and consumers often presenting for admission too late in their episode of illness, there are significant limitations on the effectiveness of this process. This means that the EDs become the default entry points for an acute mental health bed and patients are waiting for increasingly longer periods in an ED to access a bed as the mismatch between demand and capacity widens.

### Planning and funding limitations

The Victorian Auditor-General's Office (VAGO) report – *Access to Mental Health Services*, March 2019, describes a mental health system in which is 'under substantial stress' (p 11). Further, 'DHHS has made little progress in closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services'. NWMH was one of the metropolitan services audited by VAGO.

The total numbers of mental health related presentations to the emergency departments (Royal Melbourne Hospital, Sunshine Hospital and The Northern Hospital) have increased by 55.2% over the past 5 years.



- As per the VAGO report average state-wide acute mental health presentations are growing at an annual rate of 2.4%. (p 11)
- Length of stay (LOS) in hospital is trending down from 14.7 days to 11.2 days from 2009 to 2017 –with LOS in 2017-18 at 9.6 days. (p 11)
- Occupancy of acute inpatient beds at NWMH is running in excess of 97%
- Unplanned readmission rates in Victoria are the highest in Australia at 14.7% compared to 13.7% nationally. This is a direct consequence of bed pressure i.e. insufficient bed stock.

These demand pressures have resulted in an increased threshold for access to services so that Area Mental Health Services only see the most unwell. This creates a flow on effect, with the Australian Institute of Health

and Welfare (AIHW) reporting the number of Victorian mental health patients accessing acute services through police, ambulance and self-presentations to EDs increasing from 28,757 in 2004-05 to 54,114 in 2016-17.

### Bed numbers

Throughout Victoria, there is a severe shortage of acute inpatient beds. The state average is 1.8/10,000 population, compared to the OECD average of 5/10,000, and the Australian average of 2.7/10,000 (figures calculated from data in Allison, S. et al, 2017, assuming that 70% of total psychiatric beds are acute). As the Organisation for Economic Cooperation and Development (OECD) has noted, *'...without sufficient high-quality community care, and with low inpatient psychiatric bed numbers, patients with severe mental illness (SMI) risk worsening symptoms, more stays in emergency departments, and more hospital readmissions'* (OECD, 2014). All of these problems are very evident in Victoria. We suggest that a reasonable target is 3.0 acute beds per 10,000. From a NWMH perspective there is a problem both with insufficient numbers of youth and adult acute mental health beds and also with the location and distribution of the existing beds across the state, which is unequal between areas. The tables below the NWMH beds per 10,000 population in 2016-17.

### NWMH Beds per 10,000 population by; service type, corridor (Northern / Western) and, AMHS.

Service Type	Beds	Population (2016)	Beds per 10,000 catchment population	Beds per 100,000 catchment population
Adult	133	943,151	1.41	14.1
Aged	54	227,894	2.37	23.7
Orygen	16	190,605	0.84	8.4

Corridor Adult Bed Types only	Beds	Population (2016)	Beds per 10,000 catchment population	Beds per 100,000 catchment population
Northern	75	482,421	1.55	15.5
Western	58	460,730	1.26	12.6

Area Mental Health Service	Beds	Population (2016)	Beds per 10,000 catchment population	Beds per 100,000 catchment population
Inner West	29	252,952	1.15	11.5
Mid West	29	207,778	1.40	14.0
Northern	50	224,825	2.22	22.2
North West	25	257,595	0.97	9.7

### Intensive Care Area (ICA) Beds

NWMH has insufficient ICA beds (also known as high dependency beds). Currently there are 34 ICA beds out of the total 149 youth and adult acute beds (see Appendix 2, Access). The ICA beds are always full. On average NWMH needs to admit 4-6 consumers into an ICA bed each day which means that 4-6 only marginally less acute consumers have to be transferred out of ICA to a Low Dependency Unit (LDU) bed where treatment and care is still provided however this is provided in an environment that is less supervised and less supported, and in an environment that is less physically robust and which has less ligature safety features compared to ICA. This involves high risk decision making on the part of clinical staff, often under considerable time pressure. These decisions have the potential to contribute to adverse outcomes and NWMH is acutely aware of this when making decisions to transfer a consumer out of an ICA bed. Essentially, clinicians have to consider the relative risks for each patient under consideration for transfer. NWMH clinicians take great care when making

these decisions and give consideration to interventions / strategies which may serve to reduce the risk. These interventions and strategies may include, but not be limited to, provision of 1:1 nursing care for the consumer in a LDU bed, increasing the frequency of visual observations, limiting or curtailing opportunities for authorised leave, changes to medication regime, increased involvement of carer / family / peer worker and /or allocating a LDU bedroom proximal to staff base for ease of observation and support. It is important to understand that there are many clinical reasons why an ICA bed would be preferred over an LDU bed and these include: (a) management of acute suicidality, (b) containment, (c) increased supervision and support, (d) manage particular vulnerabilities – sexual safety / intellectual disability / infirmity / gross disorganisation, (e) predatory behaviours, (f) to facilitate close observation for diagnostic purposes, (g) to reduce stimulation, (h) management of aggression, and (i) prevent absconding.

Access to ICA beds is the 'pressure point' in the acute mental health system at the present time. There is a daily mismatch between capacity and demand. This mismatch is managed partially by having a 'floating threshold' for entry into an ICA bed and partially by admitting a consumer who requires an ICA bed into an LDU bed. The mismatch contributes very significantly to ED Length of Stay and in the case of NWMH, an inability to achieve National Emergency Access Targets (NEAT) performance based measures which are generally considered to be proxy markers for quality of care.

### **Length of Stay (LOS)**

Demand pressures result in a less than optimal LOS. Consumers are admitted to a NWMH bed acutely unwell and are discharged from hospital earlier than they otherwise would be if there were sufficient acute mental health beds. This is evidenced by the differences between the LOS in NWMH facilities compared to the private sector. For example, a young person will have an average LOS of 9.6 days in a NWMH IPU compared to a LOS of 28 days at a youth specific private facility.

There is also a sub-group of consumers whose stay in the IPU is unduly prolonged by lack of appropriate discharge options. This sub-group includes consumers with an intellectual disability (sometimes co-morbid, sometimes not), severe autism, acquired brain injury and some consumers who have severe antisocial behaviours who have effectively '*burned their bridges*' with multiple agencies and who are homeless and '*unplaceable*'. There is generally at least 1 and sometimes 2 long stay consumers in an Inpatient Unit at any given point in time. To quote an average length of stay would be somewhat misleading. A 90 day length of stay is not uncommon and a 15 month stay is not unheard of. Staff always engage with the relevant agencies via a case conference and seek to formulate a discharge plan however, often these cases are complex particularly in relation to securing appropriate housing and support through the NDIS. There can also be delays in having legal guardians appointed which then delays decision making in regard to placement.

### **Maintaining a safe environment**

#### ***Sexual Safety***

Currently the diagnostic mix and the gender mix of consumers in IPU generally, and in ICAs particularly, contribute to a significantly increased risk of sexual and physical assault. There are depressed and withdrawn consumers sharing space with elevated and disinhibited consumers or acutely drug affected consumers and consumers with predatory behaviours. The risk for inappropriate consumer to consumer physical or sexual contact to occur is perhaps not entirely preventable given the current resources and infrastructure. That said, NWMH routinely adopts a number of strategies to mitigate this risk including, but not limited to: (a) cohorting of consumers, (b) more frequent visual observations, (c) 1:1 Nurse 'specialling', (d) allocation of a female consumers bedroom proximal to the staff base, (e) use of the women's own corridor, (f) reinforcement of *SafeWards* principles at Inpatient Unit community meetings, and (g) use of prominent signage in relation to use of CCTV cameras in public areas of the Inpatient Units.

### ***Prisoners and Released Prisoners***

There are major problems with the treatment of consumers with a mental illness who have been released from Victoria's prisons, both during their term of incarceration and at their release. During the term of incarceration, many mentally ill consumers are unable to gain access to the only treatment facility in the forensic system where compulsory treatment is possible, Thomas Embling Hospital. Victoria does not permit compulsory treatment in prisons, so these individuals remain untreated until their release if they decline to consent to treatment.

The following custodial facilities (Dame Phyllis Frost, Ravenhall, Port Phillip Prison and the Metropolitan Assessment Prison) and court facilities (Broadmeadows, Sunshine and Melbourne Magistrates) are located in the NWMH catchment area and result in a disproportionate flow of forensic consumers into the three EDs serviced by NWMH (Sunshine, Northern and Royal Melbourne Hospital). Ravenhall, Port Phillip Prison and Dame Phyllis Frost include units providing treatment to those with mental illness. Consumers with a mental illness released from prisons, especially those who are untreated, bring additional risk and complexity when they are transferred to ED directly from prisons. Many of these individuals are untreated or undertreated and usually have multiple co-existent issues including homelessness, active Intervention Orders and poverty. This is having a profoundly negative impact on NWMH Inpatient Units in terms of the level of acuity, the consumer 'mix', the therapeutic milieu, the impact of predatory behaviours and most noticeably in terms of occupational violence (OV), and destruction of property. Efforts via DHHS and the Office of the Chief Psychiatrist to effect a more rational distribution of released prisoners have to date proved fruitless. NWMH has engaged in correspondence (email and letter) with the Office of the Chief Psychiatrist about this issue. NWMH has also raised this issue very regularly at its performance meetings with the Mental Health Branch. At our behest, the Mental Health Branch convened a forum about this issue and services from around the state, including Forensicare, were invited. NWMH's position then, and now, is that it is proportionately disadvantaged in terms of the number of consumers with a mental illness released from prison by virtue of the number of custodial and court facilities within its catchment area. We proposed (unsuccessfully) that where a person had pre-custodial sentence ties to a particular location s/he should be released from custody back to that area. One of the significant impediments to achieving this is that Ambulance Victoria and Victoria Police will not transport a released person beyond the closest ED or Inpatient Unit and we know from experience that once a person arrives at an ED, for example Sunshine, it is highly impossible to arrange transfer of that person to a mental health bed, at Sale for example. This situation is likely to be compounded by the 2019-2020 budget announcement of an additional 1,200 prison beds into this western suburbs custodial complex.

Assessment Orders are often used to effect a handover of responsibility for the mentally ill consumer released from prison (i.e. from Justice to Mental Health Services), but approximately 50% of the Assessment Orders are not upheld when the individual is assessed by a mental health clinician. This would imply that either the threshold for applying the Assessment Order in prison is too low or, that the Assessment Order is being used as a mechanism of convenience to effect the transfer of responsibility and care.

### ***Environment***

Ageing infrastructure in the adult and aged persons' acute units is a growing problem. Acute units designed some decades ago are no longer fit for purpose and do not reflect the therapeutic environment necessary to support mental health recovery for the consumers who now use our services. Moreover, the infrastructure does not satisfy contemporary design standards in terms of ligature safety. These old and worn units are an unwelcoming experience for consumers, carers and staff.

For example, the ECT Suite at Broadmeadows is at capacity in terms of servicing the list of adult and aged consumers requiring ECT at this campus, and appears old and run-down despite the best efforts of staff.

## RECOMMENDATIONS

### 25. Increase Acute Bed Stock

Acute beds in youth, adult and aged need to be increased to a minimum ratio of 3 per 10,000 target population with a commitment to maintain this ratio. Over time, this will mean that additional provision will need to be made for growth of the youth and aged cohorts. The NWMH catchment area is faced with significant population growth – of mostly young families – in the growth corridors in the north and the west, and there is an ageing population which is living longer and will need an increased number of aged acute beds in the coming years.

### 26. Increase both the number, and the percentage of Intensive Care Area (ICA) beds. Access to ICA beds is the most pressing issue confronting public mental health service providers.

Develop specialised IPU's to assess and treat consumers presenting with drug induced psychosis recognising the high levels of aggression, disinhibition and disturbance exhibited by this cohort, particularly those who are affected by amphetamine based drugs. This recommendation has two parts: (1) development of small ICAs with sufficiently robust infrastructure suitable for the care of this cohort during the acute phase of their illness (i.e. over the first 24-96 hours), and (2) attract and retain suitably skilled and experienced dual diagnosis qualified staff to assess, diagnose, treat and refer this cohort.

### 27. Fund Acute Inpatient Units (IPUs) Adequately

Fund IPU's adequately to meet all of the base operational costs of the unit including staffing, patient meals, medication, interpreters, linen, patient transport etc, including provision for 1:1 nursing as clinically indicated as a means to avoiding restrictive interventions which traumatise or re-traumatise consumers.

NWMH data shows heavy demand for inpatient beds out of hours, with the result that on-call junior and senior medical staff spend long hours recalled to IPU's at nights and weekends. The practical implication of this is that the medical practitioner is 'released from duty' the next working day and essentially the clinical team works one person down. Funding of youth and adult IPU's should include provision for 7 day per week coverage of junior and senior medical staff, and allied health practitioners, particularly social workers, to support discharge planning and the engagement of families and carers.

Funding of youth and adult IPU should include provision for 24/7, 365 days per year coverage of a Security Officer to mitigate the risk of occupational violence and indeed consumer to consumer violence.

### 28. Improve Consumer Safety

DHHS should develop policy in regard to gender separation in IPU's, to provide additional safety and security for female consumers. Ideally, as bed stock increases it will be possible to achieve complete gender separation – however, at the present time, and in the short term, additional funding is needed to do further work in developing 'female only' corridors in IPU's containing bedrooms, lounges and courtyards.

### 29. Reduce the Risk of Inpatient Unit Suicides

Fund the retrofitting of the full suite of anti-ligature hardware into both the Low Dependency Unit (LDU) and ICAs of IPU's. The hardware includes door furniture, hinges, tapware, basins & waste traps, toilet pans, shower fittings, built in bedroom cabinetry & furniture, window coverings and door viewing panels. Bedroom doors and ensuite bathroom doors should be replaced with ligature safe alternative products including 'over-door' alarms linked to staff duress pagers and to a mimic panel in the staff base. The alarms are sensitised to activate if any weight bearing ligature is placed over the top edge of the door. This technology has advanced very significantly in recent years and has been proven to save lives in the IPU setting.

### 30. Provide Adequate Capital Funding to Maintain the Amenity of IPU's and community facilities

IPU's are subject to enormous wear and tear, however very little provision is made for scheduled and corrective maintenance. Consequently, the IPU's look un-cared for, un-welcoming and un-therapeutic and this does not contribute to recovery. Currently, NWMH receives approximately \$450,000 p.a. to maintain all



infrastructure (i.e. community, sub-acute, residential, acute, rehabilitation and sub-specialty services occupying thousands of square meters of property). This funding has effectively reduced down from \$1.1m over the past five financial years. The rationale for this reduction in funding has not been made clear to NWMH and seems inexplicable given that the infrastructure is ageing and therefore costs more to maintain. Services need to receive sufficient capital funding to ensure that there is a schedule for re-painting, replacement of floor coverings, replacement of window coverings, and replacement of bedroom and lounge furniture etc.

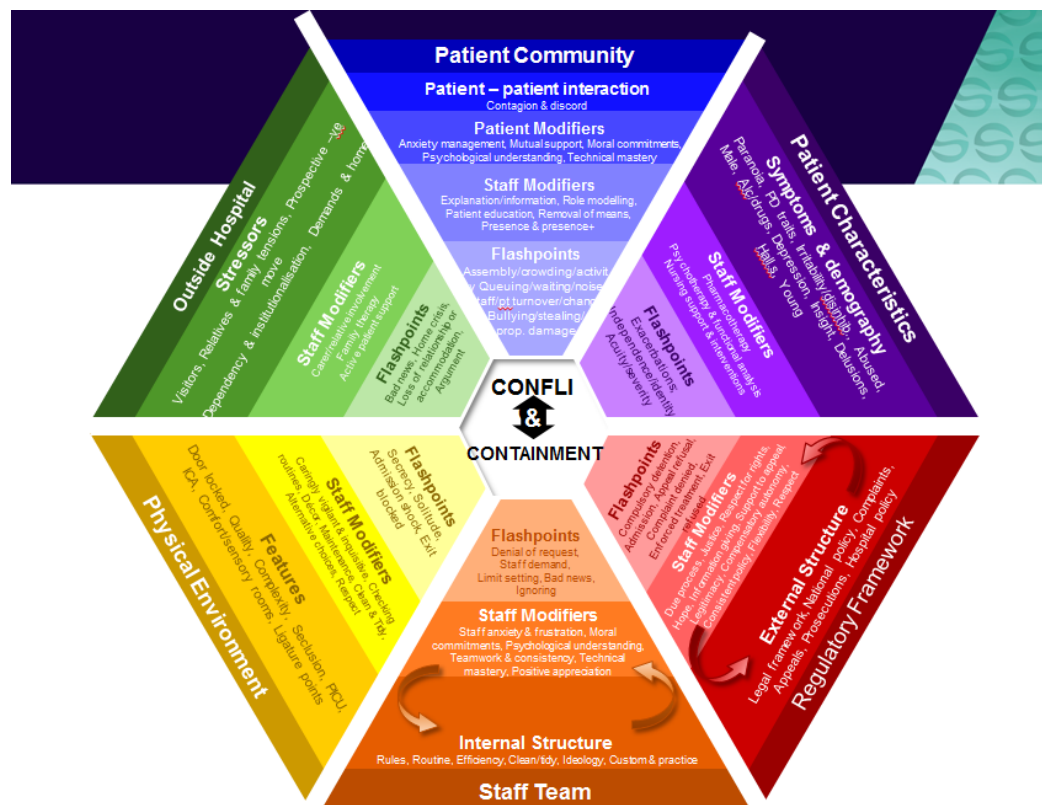
### **31. Support Strategies to Enhance the Therapeutic Nature of IPU's**

The *Safewards* program has been shown to improve quality and safety and to enhance the consumer experience. *Safewards* is a United Kingdom NHS model and associated interventions have been highly effective in reducing conflict and containment, and increasing a sense of safety and mutual support for staff and patients. The model was developed by Professor Len Bowers RMN, PhD.

The full form of the Safewards Model can be found in the image below. Six domains identify the key influences over conflict and containment rates: the consumer community, consumer characteristics, the regulatory framework, the staff team, the physical environment and outside hospital. The outermost ring summarises the key features within those domains that can give rise to conflict and containment events. The next ring indicates the patient modifiers, what consumers can do together that influences the way in which the features of the six domains give or do not give rise to conflict and containment events. The next ring indicates the staff modifiers in a similar fashion. Where arrows exist between this ring and the outermost one, they indicate that staff also have the power to directly modify or alter the features of the domains so as to reduce the risk of conflict or containment events. The innermost ring identifies the flashpoints most closely related to the domains within which they sit, flashpoints being those events or social circumstances that are most likely to trigger a conflict or containment event in the very short term. Conflict and containment are in the centre of the model, linked by a bi-directional arrow representing the fact that while conflict can trigger containment, containment use can itself trigger conflict.

In particular, a number of elements of the *Safewards* program have demonstrated reductions in the use of restrictive interventions. *Safewards* has been successfully implemented by NWMH in all IPU's, however there are further opportunities to sustain and expand this and invest in additional clinical staff and equipment. In particular, IPU's would benefit from more Occupational Therapy input to expand group programs and to have additional capability to provide diversionary activities and sensory modulation interventions. The model has been conceptualised in the model below.

### Safewards Program Model



### 32. Provide mental healthcare to prisoners who need it, and support a more equitable distribution of persons released from prison(s)

Provide compulsory care for mentally ill consumers in custody under the same conditions as apply to consumers in the broader community. This will require amending the Mental Health Act. Care should be overseen by the Mental Health Tribunal. This would reduce both the number of mentally ill consumers in custody who need acute treatment at the time of release from prison, and the level of acuity with which they present.

Develop specific inpatient units for forensic consumers released from prison who require acute inpatient care. These units should be located near to the major prisons. This would alleviate the stress on ordinary acute units from consumers with a serious mental illness released from prison, and who have violent tendencies and who lack pre-existing ties to the ordinary acute units close to their prisons. Alternatively, develop government policy which supports the release of mentally ill consumers released from prison to an area to which they have 'pre-custody' historical and familial ties.

For mentally ill consumers who are experiencing homelessness or who are itinerant, policy should support some equitable load sharing across clinical services. The policy should include the role of Victoria Police and Ambulance Victoria which, at the present time will only convey the released prisoner to the nearest ED and no further. The policy should also examine the use of Assessment Orders as a mechanism to affect a handover of responsibility for the released prisoner from Justice to Mental Health Services.

### ISSUES – for community

NWMH operates a number of multidisciplinary teams that provide community based assessment, treatment and case coordination. This includes short-term treatment for people experiencing an acute episode of mental illness, and longer-term treatment, rehabilitation and support for people with severe mental illness who are

living in community settings (including supported accommodation). Specialist interventions are provided in the domains of Psychological Interventions, Family and Carer Work, Health & Wellbeing, Vocation, Lived Experience and Overcoming Hurdles. Secondary consultation is also provided to people of all ages with high prevalence mental health disorders who are receiving treatment or support from a General Practitioner (GP) or Community Health counsellor.

The criteria for people affected by mental illness to access NWMH's services include the following:

- residence in the catchment area for the particular service;
- diagnosis of a severe mental illness (for example, schizophrenia spectrum disorders, severe mood disorder, severe eating disorder, severe borderline personality disorder) or presents an acute risk of harm to self or others (for example, risk of suicide, disorientation, poor judgement, hallucinations and hostile and aggressive behaviour);
- current symptoms;
- ongoing psychosocial disability;
- history of hospitalisation;
- significant and ongoing risk factors or co-morbid disorders such as substance abuse;
- tendency to relapse;
- impairment of judgement or disorganisation;
- engagement of other health and welfare services significantly; and
- circumstances which present difficulties for GPs, private psychiatrists or disability support services to manage.

#### **Impacts on clinical mental health services in the community**

Lack of investment in services combined with extensive growth in population and service demand has resulted in a very high threshold of risk for acceptance for community treatment, with less than a third of the population who have severe and enduring mental illness being accepted into services. Demand for telephone triage has resulted in long call waiting times and high call-abandonment rates. Access to clinical mental health services is based on acuity, current mental state and identification of immediate risk without much consideration of a consumers' and carers' functional loss and burden of caring. The inflexibility of the current eligibility criteria creates access difficulties.

Once accepted for treatment there has been a re-focus of treatment to acute presentations of mental distress, prominence of pharmacological treatments and less than optimal provision of psychosocial treatment. Brief 'episodic' care and rapid referral out to primary care and private services (for those who can afford it) has become the norm, which does not match the need for ongoing treatment and support required for severe mental health conditions, especially those with a frequently relapsing course. There are long delays in acceptance of referrals and an inability to access services in a timely way.

Consumers needing medium to long term mental health interventions, including those who respond poorly to pharmacological treatment or who have complex needs, have few pathways into the mental health system unless they experience acute relapses. This contributes to deficiencies and discontinuity of care. In addition, increasing demand across all services has resulted in premature discharge from community services, as evidenced by shortened community episodes of care.

Outreach capacity has diminished significantly, and the capacity to provide rehabilitation across a spectrum of bed-based services has evaporated, while ambulatory rehabilitation has moved largely to the mental health community support services. There is an impaired capacity to provide evidence-based psychosocial interventions including psychological, family, occupational and other supports at the recommended frequency, and subsequent lack of implementation of the vision for integrated, evidence-based practice. Community Care Units also identify insufficient access to medical and allied health roles including exercise physiology as a major gap.

There are a range of co-morbidities that receive insufficient attention including drug and/or alcohol dependency, forensic issues, comorbid Autism Spectrum Disorders and intellectual disabilities. A previous

focus on culturally appropriate services has also deteriorated, and there is inadequate investment in culturally safe service delivery for Indigenous people.

From a funding perspective, services have been forced to divert money to acute services that was intended for community settings. To be explicit, funding is effectively redirected to cross subsidise the acute inpatient units, which are unable to meet savings requirements due to the gap between price, need for productivity and the provisions of Enterprise Bargaining Agreements. Whilst there has been some growth funding for specific projects, core funding has lagged far behind population growth. These issues have been well described in the *VAGO report; Access to Mental Health Services* and are not repeated here.

NWMH has raised these issues and, in particular, we argued for over a decade that there was a minimum \$500,000 funding shortfall per Inpatient Unit that was essentially cross subsidised by community programs. This proposition was supported by other senior managers of health services in Victoria and this gap was at least partially recognised approximately 2 years ago.

As with the inpatient units, a lack of long term strategic planning and investment in infrastructure for the growth corridors has resulted in ageing infrastructure for both buildings and information technology within mental health services that are no longer fit for purpose and that impact negatively on wellbeing and hope for consumers and staff.

#### **Recovery and rehabilitation services**

Community Care Units (CCUs) were set up in the period of de-institutionalisation in the early 1990s, with a traditional nursing/medical model of care. They are largely unchanged, and are expensive to run compared to alternative models developed in other states. Ideally there should be a range of residential rehabilitation services, with varying degrees of supervision. There is also a need for respite accommodation to provide relief for carers. Some of these services could be managed by the non-government sector. Consistent models of care need to be developed.

#### **Homelessness and accommodation options**

While not specifically in the field of mental health, the problem of homelessness is a major issue for many of our consumers, and engages considerable staff time. There is a lack of suitable housing options of all kinds, some facilities are substandard and others not safe for either consumers or staff who visit. Metropolitan Melbourne's homeless population has expanded significantly with no additional resourcing to assist the large majority who also have mental health conditions. Consumers who experience homelessness can experience increased difficulties accessing services for a range of reasons, not least of which that they do not have a residential address in a desired catchment area.

#### **Catchment areas**

Service catchments currently do not reflect demographic trends, including population growth, long-term population movement trends and ageing populations.

The service catchment areas are not aligned with other health and human service areas, police districts or local government area boundaries, which makes service navigation and integration with physical health care providers difficult, and transfers of care potentially more complex.

The physical locations of services are not always in close vicinity to where consumers live (service sites do not extend out to geographical regions of growth), which causes inefficiencies in service delivery as staff spend time commuting to locations far from clinics to provide care.

There has been a proposal to abolish catchment areas, but the need for outreach treatment and intensive home-based care, along with the difficulties in funding models for non-area based services, render this premature in our view.

There has been debate about removing the area based system in favour of free choice of service provider for consumers. This has merit in terms of freedom of choice and consumer empowerment, but the problems of

providing assertive outreach and the lack of a viable activity-based funding model mean that it cannot be supported at this time.

The simultaneous erosion of community supports (for example housing, social welfare, alcohol and other drugs and Child Protection and Justice Services) has resulted in further difficulties for consumers. Historical lack of equity in service investment has resulted in variable DHHS investment between the eastern and western metro regions.

#### **Maintaining a safe environment for staff**

There has been an increase in occupational violence in community settings commensurate with the increased incidence of occupational violence we have seen in Acute Inpatient Units. Lack of bed availability results in higher thresholds for admission to hospital, and greater risk carried in the community (clinics and residential). The increase in disengaged consumers on treatment orders has created a small group of individuals who experience severe mental illness and who threaten, intimidate and assault staff, and are extremely difficult to treat in the community. Community clinics are being overcrowded. CCUs and PARCs are being forced to admit increasingly complex individuals who are still acutely unwell which impacts the recovery and rehabilitation prospects of co-residents. The complexity arises for a number of reasons including: (a) homelessness, (b) dual diagnosis, (c) an inability to readily cohabit with others, and (d) oftentimes an element of treatment resistance or refractory illness with breakthrough acute symptoms of psychosis. There has been an increase in forensic orders, use of substances and disenfranchised consumers which has resulted in a significant increase of security events, leading to property damage and staff assaults in community clinics. To cite but one example of the level of occupational violence, we had a situation at a Mental Health Tribunal Hearing in a community clinic at which the consumer responded badly to the hearing outcome. The consumer lashed out physically. Both the doctor presenting the case and the legal practitioner sitting on the Tribunal sustained injuries. The doctor was struck on the head and experienced a loss of consciousness and the legal practitioner sustained a fractured wrist.

Staff exposed to heavy workloads and risk of occupational violence are traumatised and disenfranchised, which can create poor work culture. The heavy workload impairs ability to participate in workforce support programs such as training, reflective practice and professional development. There is a developing pattern of more junior staff managing complex and high risk situations as senior staff enter specialist consultant or managerial roles (often to escape growing work demands, deteriorating work conditions and / or burnout).

#### **Information Technology**

The lack of a dedicated funding stream and strategic planning for digitising mental health services has led to aging information technology infrastructure and inefficient systems, which does not efficiently support the contemporary approach to service delivery for instance mobile care teams. This is a significant risk in terms of transfer of information across services and service settings.

Whilst the DHHS statewide mental health information system, Client Management Interface/ Operational Data Store (CMI/ODS) is a valuable asset, it has significant limitations and does not appear to have a system development life cycle aligned to the service delivery changes. There is functionality that is either not used or no longer meets the services' needs. This issue along with the lack of interoperability with other health service systems creates inefficiencies resulting in local bespoke systems being developed.

The duplication in reporting of mental health activity into the various DHHS datasets creates a burden for both clinical and administrative staff. Staff often triple enter data into local hospital systems, CMI/ODS and bespoke systems to collect the minimum data set. This is highly inefficient and burdensome.

The minimum datasets are designed for hospital based services and do not currently meet the needs of mental health services with regard to informing service planning, monitoring and evaluation.

The issues associated with silos of health information across mental health services and other jurisdictions often mean a lot of time is spent by many health services requesting and reviewing health information for release to support continuity of care.

### **After-hours and weekend access**

There are difficulties in providing seamless care after-hours and on weekends to consumers who may be relapsing and require after hours support. Some issues identified include:

- There is no dedicated after hours support for consumers older than 65 in the NWMH community;
- After-hours crisis and face to face assessments of youth and adult consumers are only available between 17:00hrs and 22:00hrs in the community. After 22:00hrs, consumers are directed to emergency departments and this puts additional pressure on emergency department resources;
- After-hours services are directed towards consumers who are in crisis but a regular after-hours service is not available for consumers who prefer / require more flexible arrangements (e.g. due to work commitments).

### **Access to NDIS**

Consumers with significant psychosocial disability, who should be eligible for supports under funding provided by the National Disability Insurance Scheme (NDIS), are currently experiencing difficulty and long delays in developing a plan and receiving service if at all. Currently the experience at NWMH is that NDIS planners have limited access to non-government community mental health providers to implement NDIS plans. Consumers experience their interactions with the NDIS as very user unfriendly, bureaucratic, time consuming, frustrating and laborious. Regrettably, the experience of clinical staff is similar.

Access to NDIS is creating a burden to consumers, carers and clinicians as there are long waits for access decisions, planning sessions are with assessors who are not familiar with the issues of mental health and the ongoing lack of community mental health service providers who can activate the funds in the plan.

- Consumers are reporting the access process to be complicated with evidence requirements and are experiencing further isolation and poorer outcomes in their plans due to their inability to advocate for their mental health needs.
- Increased burden on mental health workers to provide extensive evidence to demonstrate a consumer's permanence of illness coupled with long NDIS process delays is impacting on consumers accessing ongoing psychosocial rehabilitation, choice and control.
- An emerging issue/pressure for the mental health system is consumers not being able to be discharged from hospital (unnecessary extended admissions) or community mental health services as NDIS plans and community providers resources are not adequate for the consumer.

### **Links with other services**

Given the wide range of potential health and social impacts of mental illness, people accessing mental health services also often require access to a wide range of support from a variety of other services such as alcohol and other drug treatment services, housing, employment, education, family and social support, and the justice and corrections systems. Structures and processes within the broader human service system are currently fragmented and lack integration, resulting in poor coordination of care between services and sectors and negatively impacting consumer outcomes.

Consumers with co-morbidities such as a dual diagnosis, autism or developmental issues or those who have complex health issues, have difficulties accessing all the services they require. Sub-optimal integration with the wider health system, and the lack of knowledge and resources to be able to make the connections often leads to a consumers' total health needs not being met. This is reflected in a very significant reduced life expectancy for people who have a severe and enduring mental illness. In the NWMH catchment area for example, we know that the average age of death for adult consumers who die of natural causes is 48 years of age (note: this does not represent the actual life expectancy of our consumers). Many of these deaths are preventable, and arise from poor diet, sedentary lifestyle, tobacco and other substance use, poor dental care and long term use of antipsychotic medications. Furthermore, people with a severe and enduring illness are oftentimes diagnosed too late in the episode of illness for cancers that could otherwise be treated successfully. We also know that undiagnosed hypertension in this cohort contributes to significant morbidity and mortality.

## Dual Diagnosis

### *Management of people with dual diagnosis of substance use and mental health issues*

Providing appropriate services for people with co-occurring substance use issues in addition to their serious mental health conditions and disorders (i.e. people considered to have a dual diagnosis) is a significant problem. The management of dual diagnosis remains peripheral and an extension of mainstream mental health service delivery, rather than it being 'core business' of clinical mental health services. Despite the development of simplified substance use assessment tools and resources to identify intoxication, withdrawal and risk issues, completion is variable within services. Where these tools are completed, there is a low translation of the assessment into a response or intervention that may minimise harms for the person. There is a lack of a more sophisticated understanding amongst mental health clinicians of alcohol and other drug related issues leading to missed opportunities for risk management and interventions. This all results in increased readmission rates, possible accidental drug overdose and burden on health services. Indeed, dual diagnosis issues frequently contribute to patient deaths and suicides.

The current separation between the mental health and alcohol and other drug sectors has produced a 'silo' mentality: mental health services and alcohol and other drug services rarely communicate well, coordinate and collaborate in management and treatment of shared consumers. Integrated treatment is therefore rarely provided.

There is a paucity of Addiction Psychiatrist expertise within mental health services across Victoria, to provide dual diagnosis specific interventions. A significant number of consultant psychiatrists and registrars are reluctant to initiate opiate replacement therapies stemming from an anxiety about prescribing the drug and a lack of training. Emergency departments have recently been funded to provide AOD input, but are unrelated to Mental Health Services - for instance; there is an Addiction Medicine Department at RMH which sits separately to Mental Health. NAMHS currently has 4 EFT of dual diagnosis clinicians and 1.3 EFT of medical cover with funding for these coming from 5 different sources, some of them time limited.

People with dual diagnosis are not homogenous and have differing needs and challenges. They find it difficult to navigate and engage with two independent service systems that do not communicate well with each other. The service systems also often have competing philosophies; for example the AOD sector does not, for the most part, offer compulsory treatment, and seeks to work with the individual when s/he is ready to address their addiction issues. By contrast the mental health system is treating individuals, with a serious mental illness often involuntarily, whose symptoms, treatment and recovery are often severely impacted by a co-existing dependence on licit or illicit psychoactive substances that impact on judgement, reasoning, mood, perception, impulsivity and problem solving. The co-existing substance dependence issue increases the risk of self-harm and harm to others, and this often leads to the person coming in contact with the acute mental health system. Clearly, the treatment of a mental illness is greatly complicated if the individual is also dependent on alcohol or other drugs and is withdrawing from those substances during an acute admission.

To illustrate the scope of this issue, six years ago, NWMH used saliva drug testing kits (with the consent of consumers) and we tested all admissions to the Intensive Care Area of one of our Acute Inpatient Units over a 3 month period, and 80% of these tests were positive for amphetamine based drugs.

Ideally, Acute Inpatient Units would be sufficiently resourced with appropriately skilled and experienced AOD clinical staff to provide optimal acute care for the person with a dual diagnosis. Also, there should be sufficient capacity in the AOD sector such that consumers with a co-existing substance dependence issue could transition smoothly from the Acute Inpatient Unit to a drug detoxification service when clinically appropriate.

## Forensic Services

### *Interface with forensic mental health services*

The current service system for forensic mental health services in Victoria has a devolved structure, with various components (Forensic Clinical Specialists in clinical mental health services, policing, corrections, Forensicare, Justice Health and the Justice department, amongst others) working under varied service models and governance structures. This limits coordination of care for cohorts of consumers, sharing of information around risk management and mental illness, particularly where it relates to community safety.

A review of sentinel events of homicide and public sector mental health services in Queensland (Queensland Health, 2016) indicated that there is a modest but statistically and clinically significant link between serious mental illness and violence, such that, for example, people with schizophrenia are from three to five times more likely to engage in violence compared to people in the community who do not have such illnesses, and 13 times more likely to commit homicide. The risk is particularly high in those with comorbid substance abuse. In acknowledgement of the increased risk of offending in those with serious mental illness, clinical mental health services in Victoria have access to a small workforce of Forensic Clinical Specialists. These roles are dedicated forensic clinicians within the area mental health services whom provide specialist clinical, training and service development functions, and enhance sector capacity to support, manage and treat clients vulnerable to contact with the justice system. The role includes supporting clinical mental health staff with consumers with a forensic history, development of comprehensive treatment and care plans, consultation / liaison, and referral point for mental health and justice system, education and training, provision of expert advice. There are currently insufficient numbers of staff in forensic clinical specialist positions within NWMH to meet demand.

## RECOMMENDATIONS

### 33. Increase community mental health services

DHHS should address the imbalance between demand for and supply of mental health services (both community and bed-based services) in Victoria, through significant investment in appropriate system-level planning, investment and monitoring, as outlined in the VAGO report (Victorian Auditor-General's Office, 2019). This includes significantly expanding community resourcing for clinics and residential services to ensure provision of service to a larger proportion of the population, and to enable realisation of the holistic service delivery across core practice domains including psychological practice, medical intervention, family and carer support, employment and meaningful activity, physical health interventions, lived experience peer support, treatment for alcohol and other drug misuse/dependence, and forensic responses and trauma informed care. Investment is needed to enable provision of evidence-based interventions, delivered according to the recommended frequency and for appropriate duration according to the consumer's need. Investment is also needed to increase capacity to outreach to all consumers and carers as needed, and to provide intensive home-based treatment to a small proportion (10-20%) of consumers.

### 34. Review service alignment and catchment area size:

Review and improve alignment of service areas with human services areas and local government boundaries. The 'ideal' size of an Area Mental Health Service should be determined and then appropriately resourced to manage its catchment population. Experience at NWMH suggests that areas need to be of sufficient size to permit some streaming of acute inpatient units, attract sufficient staff and offer opportunities for research and innovation. Streaming could be done in many different ways for example by gender, by acuity or by diagnosis and could be conceptualised as sub-specialisation. In achieving this it is possible to see how clinical expertise could be concentrated in a particular unit for the diagnosis and treatment of mood disorders for example or for first episode psychosis. In our view, this size should be of the order of 750,000 or more for metropolitan Melbourne, but regional services will need smaller population sizes due to geographical constraints. By comparison the LGA population and projections across each of the NWMH catchments is as follows:



**Victoria in the Future: Population Age range 0 - 85+ years**

REGION	LGA NAME	Year				
		2016	2021	2026	2031	2036
NORTHERN NORTHERN	Whittlesea (C)	203,397	240,398	278,901	313,959	343,414
	Darebin (C)	153,192	167,184	179,216	191,938	206,274
	Total	356,589	407,582	458,117	505,897	549,689
NORTH WEST NORTH WEST	Hume (C)	200,215	228,651	260,551	293,895	325,999
	Moreland (C)	170,994	187,737	202,175	216,299	231,700
	Total	371,209	416,389	462,727	510,194	557,699
MID WEST MID WEST	Melton (C)	138,181	171,031	215,531	266,008	314,513
	Brimbank (C)	201,429	210,922	218,656	227,544	237,442
	Total	339,610	381,952	434,187	493,552	551,954
INNER WEST INNER WEST	Moonee Valley (C)	121,846	129,889	138,207	146,446	155,764
	Melbourne (C)	135,726	177,010	206,544	229,765	253,116
	Total	257,572	306,899	344,751	376,211	408,880
SOUTH WEST SOUTH WEST SOUTH WEST	Wyndham (C)	220,468	267,356	314,054	361,394	407,509
	Hobsons Bay (C)	93,577	98,582	104,762	109,442	114,665
	Maribyrnong (C)	85,471	101,342	119,044	130,377	142,127
	Total	399,516	467,281	537,860	601,213	664,301

**35. Change funding models**

Implement equitable population based funding models that incorporate complexity factors and take into account available community resources and supports including private mental health practitioners and GPs.

The level of resourcing should consider and make provision for the level of culturally and linguistically diverse (CALD) population, the level of socioeconomic disadvantage, population growth and geography and demography more broadly.

Ensure separate funding streams (and possibly governance structures) for acute and community services to avoid the current situation whereby community funding is subsumed into the acute hospitals.

**36. Increase funding to support after-hours clinical mental health care**

Increase flexibility in regard to time of care (out of hours). Extend the hours of operation of community mental health clinics and increase funding to allow for 24 hours/7 days crisis assessment teams.

Establish 'age appropriate and specific skill-set' crisis assessment teams for older people that provide timely crisis assessments and intensive support, including medication supervision during business hours and out of hours.

Increase mental health services in hospital emergency departments after-hours and on weekends to provide consumers with access to specialist mental health care. Necessarily, this should include 24/7 availability of 'stand-up' registrars and consultant psychiatrists.

**37. Protect community mental health and annual capital growth funding**

Develop a separate funding model which ensures that money intended for community services is protected and not diverted into hospitals. This would protect community clinics, and ensure that high quality buildings are fit for purpose, which consumers, carers and clinicians are able to enjoy inhabiting and attending, and improve information technology infrastructure and contemporary devices support service delivery.

**38. Develop and fund the deliverables of Digitising Victorian Mental Health Services plan**

Enable integration of health information across jurisdictions to increase the sharing of information for consumer care and improve efficiencies by reducing the silos of data.

Invest in health information systems which include prescribing and pathology services.

Provide IT uplift for information technology infrastructure and up to date functional computer hardware to improve work flows and efficiencies for staff.

Invest in reporting tools that enable mental health services the autonomy to report data from the various information systems.

**39. Review the mental health service reporting into the various minimum datasets to DHHS**

Eliminate the duplication across the minimum datasets.

Ensure that the datasets are meaningful for mental health services (e.g. the Australian Standards for Clinical Classification needs to be reviewed to enable the coding of social determinants and mental health interventions that contribute to the consumers care).

**40. Enhance the availability of services to work with consumers with enduring complex medium to long term mental health needs**

Effect a return to continuing care and a reversal of the trend towards episodic care for the seriously mentally ill that has been driven by necessity and resource constraints. The aim should be to facilitate longer-term engagement to prevent a negative, repeating cycle of relapses with associated poor social and health outcomes. Preventable relapses under these circumstances often lead to relationship breakdowns, loss of employment, loss of housing and the involvement of the criminal justice system. Further, each successive psychotic relapse has a cumulative effect in terms of cognitive decline and risk of developing chronic illness.

**41. Reform and expand community residential services** to ensure there is a continuum of rehabilitation options including alcohol and drug (AoD) residential services.

**42. Expand crisis, transitional and permanent public housing** with flexible provision of clinical outreach support.

**43. Generate agreed pathways of care for people with dual diagnosis and/or complex needs**

Routinely measure outcomes which will enable collaborative delivery of care by multiple agencies in response to individual need. Integrate Addiction Medicine into mental health.

**44. Invest in co-delivered services** with a range of community health, housing and social support services to improve consumer access to essential services.

**45. Respond to the increased demand on mental health services from the forensic population**

This could be achieved with growth in forensic clinical specialist roles, more appropriate inpatient bed options and more appropriate accommodation services for people exiting prison with serious mental illness. Embed specialist forensic mental health clinicians within Area Mental Health Services, including access to a dedicated prison liaison coordinator for each Area and legal advisor to assist clinicians and consumers navigate legal system (court support is a good tool for engagement).

Child and Youth services require greater support and resourcing so there is adequate capacity to engage young people with offending histories with appropriate mental health services. In particular, there needs to be a greater ability to provide outreach to these young people who often find it difficult to attend office based appointments in an unfamiliar environment. This also requires an acknowledgement by services that these young people often take longer to engage in mental health care and require more flexible and creative

approaches. Consideration should be given to an extension of 'problem behaviour services' (akin to the Problem Behaviours Clinic currently provided at Forensicare) to under 18s.

Develop a governance structure and memorandum of understanding between forensic clinical specialist services, including the Police, Corrections, Forensicare, Justice Health and the Justice department, to promote information sharing around risk management and mental illness, particularly where it relates to community safety. This should also promote increased communication and flow of information between Youth Justice, Justice Health and Youth Mental Health services to allow for better transition of care for young people going in and out of custody, as well as for those moving between catchment areas

**46. Improve integration of mental health services with other services across the broader health system.**

This includes physical health and other primary care providers, as well as the integration of drug and alcohol support services with community mental health services to improve access for at risk consumers. This might include:

- the establishment of a dual diagnosis withdrawal service attached to all AMHS. Ideally such a service would be gazetted by AMHS and based close to, or preferably integrated into, existing psychiatric inpatient services;
- the development of a mental health gazetted modified residential therapeutic community for people with more complex and severe or treatment-resistant dual diagnosis presentations;
- the establishment of intensive dual diagnosis outreach teams across all AMHS. This is considered essential due to the longitudinal approach and complexities associated with engaging and working collaboratively with dual diagnosis consumers and their families/carers;
- incorporation of a 24/7 response to people experiencing mental health and alcohol and other drug use crises. This would include safely managing intoxication for individuals and collaboratively developing an agreed plan to help people access ongoing care;
- funding all AMHS to have an Addiction Psychiatrist and Registrar;
- funding all clinical teams to have dedicated and trained dual diagnosis clinicians. Factors in the delivery of effective care include a strong therapeutic alliance, therapeutic optimism, and care that reflects the views, needs and priorities on the person and a welcoming 'no wrong door' response when a person presents to services;
- funding Emergency Departments to have a dual diagnosis team led by an Addiction Psychiatrist; and
- employing consumer/carers with dual diagnosis lived experience into clinical teams across all AMHS sites.

**47. Develop and implement a state-wide policy for information exchange between all mental health services.** This should include public and private, to ensure that consumers are receiving the best care, and a continuity of care, by informed clinicians.

**48. Develop the mental health community support service workforce.** This would help to ensure that there is an increase in the number of appropriately skilled workers and services to ensure delivery of services for consumers with NDIS packages.

**49. Increase consumer and primary services providers' knowledge of the mental health system**

This could be achieved by:

- updating the Department of Health and Human Services (DHHS) website to assist consumers and carers on the appropriate services to access based on their current needs;
- adequately resourcing Triage services so that there is sufficient capacity and capability to assist carer's and consumers to navigate the mental health service system; and
- educating carers and consumers on their rights and responsibilities under the MHA 2014.

## 5 Improving mental health outcomes: The drivers behind some communities experiencing poorer mental health outcomes and what needs to be done to address this

Despite a growing local and international evidence base, there continues to be little acknowledgment of the high rates of childhood adversity, including childhood sexual, physical and emotional abuse, experienced by those who receive treatment for a serious mental illness. Moreover, there continues to be a lack of transparency around the adversity and significant psychosocial stressors faced by sections of our community, particularly across the growth corridors. These groups experience higher rates of family violence, poverty, unemployment, homelessness, drug and alcohol use and involvement with the criminal justice system, all of which contribute to poorer mental health outcomes. For example, the Hume region covered by NWAMHS in 2018 had the 3<sup>rd</sup> highest rate of drug offences - 725 Ambulance attendances for drug overdose (Turning Point, 2018), the region has an unemployment rate of 8.8% (compared with the State average of 4.4%), the region had 3,376 recorded incidences of family violence, the 2<sup>nd</sup> highest in Victoria (Vic Pol stats Annual year, 2018), and social connectedness was rated at 51.2%, compared with the State average of 91.9% (Victorian Community Indicators Survey, 2015).

The risk cohorts are many: poor, homeless, refugees, newly arrived migrants, Aboriginal and Torres Strait Islanders, families with dependent children where the parent has a mental illness, children in out of home care, those living in rural and remote locations, those who identify as gender diverse and those with complex physical illnesses/dual disability. Aboriginal and Torres Strait Islander communities are particularly at risk as a result of intergenerational trauma resulting from colonisation and subsequent loss of identity.

*In common with Indigenous peoples in many countries, Aboriginal and Torres Strait Islander peoples are subject to the profound impacts of colonisation, racism, social exclusion and other negative historical and social determinants on their well-being and mental health. Aboriginal and Torres Strait Islander peoples experience significantly higher rates of mental health problems and suicide than other Australians. Impacts are felt in all areas of life: physical health, employment, education, family life, community life and cultural life. (Gayaa Dhuwi [Proud Spirit] Declaration, 27 August, 2015)*

Loss of self-identity and negative self-identity is common across these groups. A greater focus on the social determinants of health would help to address these issues.

A skilled mental health workforce with good awareness of these issues can deliver effective, evidence-based care, but the underlying determinants require a whole of government approach. Clinical research in these areas remains vitally important in finding effective treatments for mental health disorders.

### WHAT IS WORKING WELL?

#### Service Reform and Evidence-based Care

In 2013, NWMH reformed its Adult Community Program and developed a Practice Guide to ensure focus on evidence-based treatments. Practice Domains were identified to facilitate the application of this work, which has now been implemented across all of our adult community services. The domains are: Overcoming Hurdles, Health and Well-being, Family and Carer Work, Lived Experience, Psychological Interventions, and Vocation, Activity and Participation and Medication. Discipline seniors have taken carriage of the domain most relevant to them (e.g. OT leads Vocation, Activity and Participation).

All staff are required to complete basic skills training across each of the domains and identify one area that they would like to specialise in. This is supported by a Learning and Professional Development program and a governance structure that oversees data collection and regular reporting against the practice domains. Implementation of this process has led to an increased ability of staff to articulate evidence-based interventions; has increased staff specialty across the domains; increased staff satisfaction; and, importantly, increased routine provision of recovery-focused and evidence-based care for consumers, families and carers.

This is evidenced by the results of the NWMH Clinical Documentation Audit, ACPR Surveys, People Matters Surveys and Your Experience of Service (YES) survey (*audit and survey results available on request*).

#### **Peer support and lived experience workforce**

The DHHS initiative of Expanded Peer Support has been very welcome. While appropriate supports and training for this discipline group are still not sufficiently developed, peer workers can make a difference by supporting people in understanding their own lived experience of mental illness, supporting harm minimisation in the area of drug and alcohol use (including tobacco) and providing hope for recovery by their own experience. In addition, the employment of peer workers creates the opportunity for people with a lived experience to create and reinforce a positive identity around being a worker and contributing to the wellbeing of others.

#### **Homeless teams (IWAMHS)**

The IWAMHS Homeless outreach team provide a much needed service to the homeless population of urban Melbourne and the opportunity to work in partnership with other support services, such as crisis housing, drug and alcohol services and Aboriginal and Torres Strait Islander community controlled services.

#### **Wadamba Wilam**

Wadamba Wilam 'Renew Shelter' is an intensive support service for Aboriginal people with a history of homelessness who are experiencing mental illness or poor social and emotional wellbeing. This service is a partnership between Neami National, Victorian Aboriginal Health Services, Uniting Care ReGen Alcohol and Other Drug Service and NAMHS.

#### **Specialist positions / portfolios**

Support provided through DHHS-funded specialist positions and portfolios such as Families of Parents with Mental Illness (FaPMI), Every Child Every Chance, Family Violence, Vocation officers, exercise physiologists, driving assessors, physical health nurses, dual diagnosis specialists, Aboriginal and Torres Strait Islander Liaison officers has been effective. Champions and specialists are employed across all of these areas however they are too few and where they do exist additional support is lacking (e.g. supervision and communities of practice).

#### **Specialised Psychology clinics**

NWMH provides targeted evidence-based care through clinical and neuro-psychology interventions, Cognitive Assessment and Advisory Service, ACT-ing recovery (Acceptance and commitment therapy) and Dialectical Behaviour Therapy (DBT) clinics, all of which are demonstrating positive results.

#### **Trauma informed care**

Training and guidelines are available, however uptake of these remains variable. There is also currently a gap in the area of research and evaluation of trauma focussed interventions.

#### **5 ways to wellbeing**

NWAMHS has adopted a population health approach to service planning and has developed a partnership with 24 community agencies and 9 local residents to: establish the social determinants and indicators of good and poor mental health, local population profiles including projected growth, determine the prevalence and incidence of the social determinants of mental health, mental illness and suicidality, and validate the findings and prioritise the identified issues through extensive community focus groups. In collaboration with stakeholders a range of strategies have been developed and implemented to promote mental health protective factors. Strategies include the current public health campaign – 5 Ways to Wellbeing (see [5waystowellbeing.org.au](http://5waystowellbeing.org.au)).

#### **Refugee Access Program**

OYH has been operating a successful Refugee Access Service which has been funded by DHHS for two years as a pilot project improving the access to tertiary mental health services for 0 to 24 year old Iraqi and Syrian Refugees across northwest Melbourne.

### **Research units connected to clinical services and universities**

For many years, DHHS has funded clinical academic positions. In NWMH, the following research units have been established with varying sources of funding: Psychosocial Research Unit, Melbourne Neuropsychiatry Centre, Academic Nursing Research Unit, Academic Unit for Psychiatry in Old Age, Mental Health OT Research Unit, and Orygen the National Centre of Excellence in Youth Mental Health. These have made a substantial contribution to international research and have helped to attract high quality staff to NWMH.

## **ISSUES**

### **Data collection**

The common factors for those with poorer mental health outcomes are often unquantifiable due to a lack of consistent data collection across the State. We know rates of mental illness amongst homeless people are higher than the general population but we do not routinely collect or report data to identify the living situation of those accessing mental health services. We know rates of childhood trauma (including physical, sexual and emotional abuse) amongst those with a mental illness are higher than those without a mental illness but we do not routinely collect or report data on the rate of childhood abuse and trauma experienced by those accessing mental health services. We do not currently have a reliable data source for rates of abuse, victimisation, homelessness, cultural identity or gender diversity. Collecting this information would allow for a better understanding of their prevalence and their relationship to serious mental illness and different symptom profiles, and would allow for the tailoring of services to particular groups.

### **Interface with other government sectors**

#### **Education**

Schools have expressed a need for more mental health support, particularly with issues such as trauma and family violence. There are currently very few connections between schools and mental health services.

#### **Housing**

Around one third of consumers discharged from NWMH inpatient units are currently being discharged to unsafe housing or homelessness (*data available on request*). There is a lack of affordable, safe housing options in the community and a lack of crisis accommodation which is suitable for those with a serious mental illness.

#### **Cultural safety**

Aboriginal and Torres Strait Islanders experience high rates of mental health issues largely as a result of intergenerational trauma, poverty and social marginalisation. People in the Aboriginal and Torres Strait Islander community often fear attending mainstream mental health services due to concerns about, for example, the risk of child protection becoming involved with their children, being unfairly treated, being experimented on or not coming out of hospital alive. These concerns are all predicated on past experiences. Refugee men and women and those on temporary visas are also less likely to seek help due to the potential impact on their Visa status and fears of deportation.

### **Funding has fallen behind demand**

Mental health services have not received the necessary funding to operate beyond crisis mode. Until this is addressed, little can be done to address the broader social issues affecting poorer mental health outcomes. The NWMH Aged Person's Mental Health Program is not funded for safety nurses, nurse practitioners, physical health nurses, grade 1 social workers, residential program social workers, drug and alcohol specialist clinicians, forensic specialists or consumer peer workers. Further, they do not receive any funding for group work in the community. Given that loneliness and boredom is a major contributing factor to depression, anxiety and suicide in the older population, funding these programs should be prioritised.

### **Research and evaluation**

Few resources have flowed into research and program evaluation. Appropriate resourcing of these areas would increase the understanding of causality (e.g. the impact of psychosocial stressors on the brain) and also the ability to evaluate programs and interventions to understand what works. Mental health research is limited and that which exists is not always well integrated into the delivery of mental health care.

## RECOMMENDATIONS

50. Improve data collection and reporting processes across all mental health services to quantify the prevalence of abuse, trauma, homelessness and their relationship to poorer mental health outcomes.
51. Support investment in housing services that provide safe, supported housing for communities most at risk. Services need a range of housing options from crisis and brief services to medium and long term, therapeutic/supported to those with increasing independence (e.g. Housing First Model (which prescribes safe and permanent housing as the first priority for people experiencing homelessness. Once housing is secured, a multidisciplinary team of support workers can address complex needs through services like drug and alcohol counselling or mental health treatment), Common Ground (the Elizabeth St Common Ground provides permanent, affordable, high quality housing to 65 people with complex needs who have been chronically homeless, many for more than 10 years. An additional 66 apartments exist for low income workers and students. The Common Ground model combines the two essential ingredients for ending homelessness: good quality permanent housing and tailored support services), therapeutic communities (time out to recover, supported housing, crisis and refuge type housing, and social and affordable housing)). People need to feel safe before being able to work on underlying issues/trauma. In addition to this, insecure housing can lead to unplanned readmissions and increased burden on family/carers.
52. Connect mental health professionals and GPs with schools so that issues can be identified and addressed earlier and also to assist with strengthening protective factors. The successful Docs in Schools Program funded by DHHS was a good model, but unfortunately funding was discontinued.
53. Support better connection and communication between GPs and Mental Health Services including consideration of co-location of GPs within services.
54. Invest in and support more Aboriginal and Torres Strait Islanders working in mental health. More broadly, this should also include recruiting a more culturally and linguistically diverse workforce that is more reflective of the population groups accessing mental health services.
55. Invest in the development of more culturally safe environments and interventions, including those that encompass social, emotional, physical and spiritual well-being, traditional healing and trauma informed care.
56. Expand the Peer Workforce and ensure appropriate support, training and supervision.
57. Expand training for staff to address trauma, precipitating and perpetuating factors of poor mental health.
58. Support the roll out of evidence-based initiatives such as the 7 NWMH practice domains, including supporting training, specialisation, data collection and reporting (align with activity based funding to ensure all social determinants are addressed/considered in a consistent way across mental health services).
59. Invest in research and evaluation particularly in the areas of trauma, abuse, and psychosocial stressors more broadly, and therapeutic interventions.

## 6 The needs of family members and carers: What we know from our families/carers and what can be done to support them better

Families and carers play a significant role in the lives of people with a mental illness and their voices need to be heard. Families and carers support people with a mental illness, and reduce the risk of hospitalisation, homelessness and suicide, so mental health services need to work with and support the family and carer relationship. Families and carers need to be identified early and engaged often throughout care. Importantly, they need to be provided with the information they seek when they seek it. Good communication is key.

Caring for someone with a serious mental illness can place significant pressure on an individual and/or family unit, mentally, socially and financially and, without appropriate supports, the health of carers and families can also be placed at risk. Families and carers need support services in their own right and can benefit from things like carer peer support, respite and access to carer support funding.

Carers need all staff to be trained in supporting family, carers and children. They need services that are easy to access, connected and easy to navigate. They need services that provide safe, timely, effective, and holistic care.

### WHAT IS WORKING WELL?

#### **Carer Peer Workers and Carer Consultants**

Carer lived experience positions have been successfully established within mental health services, including carer consultants who have input into systems and service design, and peer workers who meet with families and carers 1:1 and facilitate groups. The benefits for organisations include enhancing recovery-oriented approaches, and promoting an organisational culture that treats people with mental illness and their families and carers with greater dignity and respect.

#### **Partnerships with peak bodies**

Partnerships with organisations such as Bouverie and Tandem have helped to raise the profile of working with families and have supported the roll-out of training in the areas of Families as Partners in Care, and Single Session Family Work.

#### **Specialist Positions**

FaPMI (Families of Persons with Mental Illness) specialist positions and Family Violence specialists operate across each of the services. However, there are not currently enough of these specialty positions to meet demand.

#### **Specialist programs**

Let's Talk, CHAMPS (Children of parents with a mental illness) and peer co-facilitated playgroups have been established, and evaluation of these initiatives has been positive. They support communication within families and opportunities to share stories with people who have had similar experiences.

### ISSUES

#### **Issues related to consumer care**

Carers have drawn attention to issues raised elsewhere in this submission, including premature discharge, lack of safe therapeutic environments and reduced opportunities for psychosocial rehabilitation.

#### **Lived Experience workforce**

Among other benefits, carer peer support provides carers with an opportunity to sit and tell their story to someone who understands firsthand and, as clinical staff and management gain appreciation for this workforce, the demands have increased. All of the carer lived experience staff across NWMH are, however, part-time. Consequently, carer workers are not able to keep up with the demands due to their limited EFT. Additionally, there is not enough carer lived experience input into training, program co-design and evaluation.



### **Variation of family service provision across services**

Ad hoc services are offered and provided to families and carers across services. Mental health staff are trained to provide family inclusive practice, but are unable to provide as needed, largely due to demand pressures.

### **RECOMMENDATIONS**

- 60.** Make family-inclusive practice core business and develop KPIs for family and carer contact. Training such as Families as Partners in Care and Single Session Family Therapy, as well as safety and inclusion, trauma informed care, sexual safety, and family inclusive practice should be encouraged for all mental health clinicians regardless of their discipline group.
- 61.** Increase brokerage funding to support families and carers in need and opportunities for respite.
- 62.** Consider increasing the opportunities for services to provide respite for carers for instance by increasing respite capacity within sub-acute services (Prevention and Recovery Care (PARC), Community Care Units (CCU)).
- 63.** Supporting young carers should be prioritised to reduce the likelihood of intergenerational trauma and risk of mental illness.
- 64.** Carer lived experience workers (consultant and peer work positions) should be increased to meet the demand. All families and carers should have the option of meeting with a carer peer worker and should be given a choice about receiving ongoing support. Carer peer support workers can provide emotional support and advice in navigating the mental health system for carers. They can also help effect cultural change within our services.
- 65.** Increase support to particularly vulnerable carers, such as the elderly carers and those caring for behaviourally disturbed consumers.
- 66.** Create more dedicated family rooms, spaces for families and carers and children, on our inpatient units, PARCs, psychogeriatric residential facilities and CCUs.
- 67.** Improve responsiveness of services when families are seeking support, as they are often best placed to know when their loved one is deteriorating. The 'Hear me' program recently initiated by Safer Care Victoria is a good start in this area.

## 7 Attracting, retaining and better supporting the mental health workforce

Significant challenges exist in attracting, retaining and adequately supporting the workforce within mental health services and more generally within the health and human services sector. These challenges exist across Victoria, and will present a significant problem if new funding becomes available to expand services.

NWMH has had a specific focus on workforce attraction and retention, including:

- reviewing and updating materials and resources about NWMH services and career opportunities; service promotion; and advertising placements and strategies;
- targeting those in career transition to expand the pool of potential applicants and employees with whom to promote opportunities;
- improving clarity in role and position outlines to attract appropriately qualified, skilled and experienced staff to specific roles;
- trialling a single point of contact for all enquiries relating to recruitment and opportunities within NWMH;
- restructuring and expanding the NWMH Allied Health Entry Level Program for Occupational Therapy and Social Workers;
- reviewing and refining discipline-specific support mechanisms to ensure appropriate supervision and mentoring of staff;
- providing continued access to professional development and training opportunities;
- prioritising safety initiatives to ensure staff safety and well-being within the workplace;
- fostering a supportive workplace culture and atmosphere; and
- undertaking improvements to physical infrastructure.

NWMH invests heavily in Training and Development through a range of entry to practice programs and ongoing professional development.

### WHAT IS WORKING WELL?

#### **Multidisciplinary mix**

The mental health workforce across Victoria is highly diverse in terms of its roles and functions, and the levels of qualification, skill and experience within it. It is predominantly comprised of mental health nurses, occupational therapists, psychologists, social workers, and specialist medical staff (psychiatrists and psychiatric registrars) and resident medical officers. NWMH employs 1344 equivalent full time staff (approximately 1900 people). The total clinical headcount is 1370. In addition, there are a growing number of lived experience worker roles (both consumer and carer) and other specialist roles. Overall, the mental health workforce is dedicated to providing expert treatment and support for people experiencing mental illness and psychiatric disability. A key strength of the workforce model within NWMH is the multi-disciplinary nature of our clinical teams, which supports consumer and carer access to specialist expertise according to need, and encourages interdisciplinary learning and practice.

Registration requirements with the Australian Health Practitioner Regulation Agency (AHPRA) for the disciplines of medicine, nursing, psychology and occupational therapy supports employment of suitably trained and qualified health practitioners, to practise in a competent and ethical manner and subject to continuous professional development requirements.

#### **Entry level programs**

The NWMH entry level programs in nursing and allied health have been effective in inducting new graduates into the workforce and providing the support and further training needed for them to become competent clinicians. The post-graduate nursing program is successful in advancing the skills and competencies of our nursing workforce in specialist mental health services. The recruitment of nursing and medical staff from overseas has been found to be an effective means of addressing workforce shortages.

### **Supervision and training**

A sound structure of clinical governance and supervision, along with the provision of opportunities for reflective practice, work well to support our staff. Staff also have access to the workshops, courses and programs offered by the Mental Health Training and Development Unit, and more broadly by the Melbourne Health Organisational Development and Learning Unit of People and Culture.

## **ISSUES**

### **Workforce Recruitment and Succession Planning**

There is currently limited availability of suitably skilled and work capable nursing and medical staff within the mental health sector. NWMH has a long history of relying on overseas trained clinicians, particularly within nursing and our junior medical staff positions. For medical positions, this has been the result of a lack of Child and Adolescent (CAP) training positions in our region. These positions are a mandatory part of the Psychiatry training program for local medical graduates, and our capacity to recruit local graduates is directly limited by our inability to provide them with these positions. While our Specialist International Medical Graduate (SIMG) Senior Registrars are highly valued, it takes a considerable amount of work to recruit and on-board them and there are often delays through AHPRA and Immigration which leave gaps in our medical cover. These SIMGs have come to be an integral part of our workforce and we support them through the exam and College assessment process.

Our nursing workforce is ageing; there is a wide acknowledgement that there will be significant impacts on the workforce with the imminent retirement of older nurses. There are major stresses in the workplace due to the high demand on inpatient beds in particular, leading to reduced length of stay and high acuity. These factors have caused a critical shortage of nurses in mental health. There is a projected national undersupply of 18,500 by 2030 (Health Workforce Australia, 2014).

### **Lived Experience workforce**

This is a relatively new and quickly growing workforce with a limited number of senior roles. Because of this, lived experience workers currently have inadequate access to supervision, support and training that can be provided from a lived experience perspective. This can lead to workers being in their roles for many months before receiving the levels of support and training that are necessary for them to succeed. Limited career progression opportunities within this workforce impairs the capacity to support and maintain itself.

### **Impact of the 'generic' nature of work in clinical mental health services**

Many roles within clinical mental health are generic in nature, making it difficult to retain staff with specific areas of clinical expertise and experience, particularly those with an interest in developing and utilising skills in discipline-specific interventions. These generic 'case management' or 'key clinician' roles lead to a lack of differentiation and under-utilisation of the specialist skills and knowledge possessed by allied health staff and have resulted in career dissatisfaction.

Too few opportunities exist for senior clinicians to take up advanced clinical positions meeting their skills and interests to stay involved in direct clinical care. Instead, senior staff often move into operational, managerial or project management and advisory roles in order to advance to higher levels of remuneration and authority, resulting in a lack of senior clinical expertise in the direct service provision. Similarly, there are too few incentives and efforts to build opportunities for senior clinicians to work across the public and private sector which leads to a loss of seniors to the private system.

### **Workplace safety**

Within the general mental health workforce, there is increasing concern regarding workload and safety issues, including occupational violence, especially in the provision of after-hours cover to our wards and the Emergency Departments.

Occupational Violence (OV) is a serious and significant issue for NWMH. In 2016-17, NWMH identified OV as the most significant issue confronting the organisation and in particular the health, safety and wellbeing of our staff. At the end of 2016, NWMH formed an OV Steering Committee comprised of clinical staff, managers,

OH&S specialists, representatives from People and Culture and representatives from the AMNF and HACSU. Collectively, a number of strategies to improve safety in IPU were identified and implemented, including the following:

- implementation of a campaign to increase reporting of OV incidents;
- development of a protocol for the reporting of OV incidents to Victoria Police;
- introduction of CCTV cameras;
- introduction of a drug detector dog program;
- purchase of sand filled 'Norix' brand furniture;
- installation of 'custody suite doors' between the ICA and the staff base in IPU;
- introduction of saliva drug detection kits;
- introduction of a Security Officer at Broadmeadows Health Centre on a PM shift, 7 days per week. this service is supplemented by the Security Officers at Broadmeadows Health Service;
- introduction of hand-held metal detectors used by nursing staff to screen for weapons or contraband (we seek to do this with the consumer's consent wherever possible);
- introduction of rubberised toothbrushes to prevent the making of 'shivs';
- introduction of specialised 'custodial style' paper cutlery for use with consumers known to use cutlery as weapons;
- introduction of a Nurse Practitioner Candidate to Northern IPU to model de-escalation techniques, be a champion for the Safe Wards program, provide teaching, training and education and run simulations for the use of least restrictive interventions; and
- redevelopment of the Management of Clinical Aggression training syllabus.

Collectively, these initiatives cost in the order of \$1.8m. The rollout of CCTV cameras was partially funded by a DHHS grant. Staff experience the full range of OV, from racial, sexist or homophobic insults, to spitting and scratching, through to very serious physical assaults that can be career-changing or career-ending in nature. Instances of OV over the past two years within NWMH include: a female nurse had her skull fractured following a punching assault, a male staff member experienced a dislocated knee and a broken front tooth after being chased into the office and assaulted, a male doctor received multiple punches to the head and lost consciousness, and a female lawyer experienced a fractured wrist following an assault at a Mental Health Tribunal hearing. Four weeks ago a doctor was seriously assaulted at a different Mental Health Tribunal hearing – he was punched in the head multiple times and the consumer then bit him, removing a piece of his earlobe. He was admitted to hospital and required a surgical repair. Two weeks ago, a nurse was punched multiple times in the face at ██████████ Hospital IPU, his nose was fractured and he was hospitalised and requires further surgery. It is very difficult to measure cause and effect in terms of the impact of these initiatives, particularly because these interventions have been in place for a relatively short time, however we know that our staff feel more supported in the workplace. It would be fair to say that the number of incidents is trending up – perhaps as a consequence of increased reporting, but perhaps also related to increased activity in our Acute Inpatient Units. While the number of incidents is trending up, the impact of the incidents is less as measured by lost time injuries and the number of WorkCover claims lodged. We think that our efforts to encourage staff to report all OV incidents is gaining traction and that the investment in these initiatives is impacting positively in terms of reducing both the frequency and the seriousness of injuries experienced by our staff.

*Please note: NWMH can provide to the Royal Commission on request visual imagery of OV incidents. The imagery can be presented in such a way as to protect the privacy of clinical staff and consumers via pixelation. As a further protection, NWMH would request that the imagery be viewed in camera.*

The table below represents OV Riskman incident reports submitted over a 90 day period (2<sup>nd</sup> quarter 2019). It is understood that: (a) OV incidents are under-reported, and (b) data is 'hard to find' because staff record these incidents under a range of categories (i.e. OH&S, OV, Absconded Patient or Seclusion). To use seclusion as an example, a staff member may report that a consumer has been secluded and incidentally report that s/he was kicked during the process of secluding a patient. It is difficult to benchmark NWMH against other publicly funded mental health services because: (a) reporting rates are highly variable across Victoria, (b) the demography in each catchment area is very different – even within NWMH, and (c) the forensic load is mal-distributed across services, with a disproportionate load going to MWAMHS and IWAMHS by virtue of their proximity to the custodial centres in the west of Melbourne which, in combination, will shortly hold 3,500

prisoners. We are aware however that many other publicly funded mental health services have sought to implement many of the OV initiatives adopted by NWMH.

#### NWMH OV Incidents (March – May, 2019)

Primary Category	Total number of incidents	Inpatient	Residential	Community	CCU/PARC
Bullying/harassment	18	5	9	4	4
Causing disruption	26	20	3	3	
Discrimination	1	1			
Inappropriate manner/conduct	65	48	5	9	
Inappropriate manner/physical	44	40	2		
Inappropriate manner/relationships	5	4		1	
Spitting	3	2	1		
Stalking	5	2	2	1	
Threatening Behaviour	78	50	5	21	3
Physical assault	68	46	18	2	1
Sexual assault	12	10	2		
Verbal assault	27	12	3	10	3
<b>TOTAL</b>	<b>352</b>	<b>240</b>	<b>50</b>	<b>51</b>	<b>11</b>

Occupational violence is a daily event, which has significant impact on morale, recruitment and staff retention. Understandably, it impacts on the capacity of staff to engage therapeutically with consumers when they feel that their personal safety is under threat. Illicit drug use, and in particular the use of Ice or other amphetamine-based drugs in the community contributes very significantly to OV in IPU. As an example of the prevalence of the use of Ice, NWMH used saliva drug testing kits (with the consent of consumers) to test every person admitted to an ICA bed in one IPU over a 3 month period, 80% of these tested positive to amphetamines. Clinical services have routinely used urine drug screening (UDS) for decades, however the relatively recent availability of saliva drug testing kits has meant that results are available instantly (compared to a minimum of 3 days for UDS), and the collection process is more dignified and less intrusive for consumers.

Staff exposed to extreme workloads and the risk of occupational violence are traumatised and disenfranchised, which contributes to a poor work culture. The lack of available time creates an inability to participate in workforce support programs, such as training. There is a developing pattern of more junior staff managing the most complex high risk situations as senior staff enter specialist consultant or managerial roles (often to escape growing work demands, deteriorating work conditions and burnout). The recent 'Doctors in Training EBA' has attempted to address these issues, in addition to improving leave entitlements/cover and other issues that could assist with doctor welfare, however the funding to support the implementation of many of these entitlements doesn't appear to be available. Investment is required to support all disciplines in this area.

#### Undergraduate training

There are currently limitations in undergraduate training, particularly in relation to the integration of the knowledge, skills and expertise required of new graduates entering the mental health workforce into undergraduate training – often relating to lack of exposure and development of 'enterprise' skills.

### RECOMMENDATIONS

In order to attract, retain and better support a skilled and sustainable mental health workforce, the following are recommended for consideration:

68. Increase the number of dedicated graduate positions for Allied Health, with pathways to more senior clinical roles – including provision of appropriate support and training.

69. Support the growth of the Lived Experience workforce including supporting the provision of appropriate levels of training, support and supervision.
70. Broaden workforce planning and development to ensure alignment of the mental health workforce with other service system reforms (e.g. changes in the service system and workforce models as a result of the NDIS). This includes appropriate planning and investment in non-clinical supports such as quality, improvement, planning and health information management.
71. Review workforce related funding models, with a specific emphasis on better coordination and allocation of resources to minimise 'piecemeal' funding for specific (often limited tenure and part-time) roles – with a view to ensuring a stable, agile workforce with appropriate skills, expertise and experience are able to respond flexibly where and when demand requires.
72. Further develop the Transition to Mental Health Practice Program in order to attract experienced staff from other sectors.
73. Review roles/workforce models to ensure that best use is made of skills/expertise (for example, discipline-specific roles to focus on delivery of targeted and evidence-based interventions depending on individual need, review of skills required support/coordination roles (better matching workforce to requirements of role), and increased involvement of senior, experienced staff in the direct provision of clinical care whilst creating flexible arrangements to enable part-time and public-private synergies).
74. Ensure that there are opportunities for professional growth within each discipline, including options regarding both Operational and Clinical Leadership job opportunities/progression.
75. Develop a robust professional development program to support implementation of psychosocial interventions, including apprentice support models, where senior staff take an active role by buddying junior staff for direct service provision for complex cases. This might include consideration of range of learning and skill development opportunities (i.e. face to face training, online training, group and individual supervision) for staff to develop specific therapy skills in endorsed evidence based interventions.
76. Review technology to support the mental health workforce, and to support new modes of service provision (e.g. opportunities around telehealth, technology to maximise safety, access, new ways of engaging).
77. Allow specific time allocation for clinicians to provide publicly-funded psychological therapy to fill the gaps for people who cannot afford private practice (or require more than the rebated 10 sessions per year).
78. Improve state-wide coordination of mental health workforce learning and development to ensure easier access to expertise, knowledge and resources, and facilitate translation of evidence into practice (both for the mental health workforce and workforces across related sectors) – include more targeted learning and development in priority/emerging areas of trauma, family violence, forensic issues, dual diagnosis, safety and inclusion/responding to diversity.
79. Further invest in the full range of disciplines and specialty groups within clinical mental health services, to include staff with dual diagnosis capabilities (especially in relation to alcohol and other drugs), cultural specialists, forensic specialists, family violence specialists, exercise physiologists, and dietitians, in order to provide integrated, evidence-based, holistic care.
80. Further invest in specialist services such as Consultation Liaison Psychiatry, Neuropsychiatry, neuropsychology and Eating Disorders.
81. Develop and implement strategies to maximise safety and well-being of workforce (minimise and respond more effectively to occupational violence, effects of vicarious trauma, fatigue and burnout). We

recommend that relevant legislation is amended to ensure that mental health clinicians are given equal protection under the law as is currently afforded to Paramedics and Emergency Department staff under section 31 of the *Crimes Act 1958* (amended). In addition, it is recommended that the Government develop a binding memorandum of understanding between Victoria Police and the Department of Health and Human Services (as the funder of mental health services) to ensure that Victoria Police responds appropriately and consistently to incidents of OV and investigate, charge and prosecute individuals who perpetrate assaults on clinical and non-clinical staff working in publicly funded mental health services – as appropriate. NWMH developed a protocol (appended) with Victoria Police with regard to the reporting of OV incidents, however our staff receive a highly variable response from Police when seeking to report these matters. [REDACTED].

Certainly, the Mental Health Tribunal presents a high risk environment for clinical and administrative staff, as well as Tribunal members. Consider employing security staff in community clinics to reduce likelihood of violence. This would need to be funded by government.

82. Review workforce 'pathways' and traditional education/training models – development at undergraduate/post-graduate levels to ensure work-ready graduates, with an appropriate range of knowledge, skills and competencies.

## 8 Improving social and economic participation for people living with mental illness: Opportunities and what needs to be done to realise them

Social connection and participation is integral to good mental health. It is what gives purpose and meaning to people's lives. The neurobiological evidence also increasingly supports that this is how human beings are wired. Mental health clinicians, conversely, often hear stories of disconnection and shame. Underpinning this is a feeling by people with mental illness that they are not good enough, which a biomedical model of health can unwittingly reinforce. This negative self-identity is intensified by a focus on violent depictions of people with a mental illness in the media, a lack of employment opportunities and a lack of activities which would help to reinforce a positive self-identity.

Results from the Victorian sample of the National Survey of High Impact Psychosis (SHIP) (Morgan et al, 2011) provided strong evidence of social dysfunction as a significant clinical problem for people with a psychotic disorder, yet still not enough is being done to address these needs. Results in the area of social and personal functioning indicated that 87% of people in the study had noticeable difficulties in occupation, relationships or self-care within 12 months of the National Survey of High Impact Psychosis (SHIP) interview. However, for the majority, medication was the only form of regular treatment being provided by services.

One of the consequences of the mental health reforms of the 1990s was the separation of psychiatric rehabilitation and recovery services (PDRSS) from clinical services. This has led to discontinuities and problems with engagement. The impact of the NDIS, which operates on principles and eligibility derived mainly from physical disability, has compounded this problem.

### WHAT IS WORKING WELL?

#### **Psychosocial interventions – Activity and Participation Practice Domain**

In NWMH, the Activity and Participation practice domain helps to maintain a focus across all staff groups on opportunities for employment and education, group programs and social skills training.

Social enterprise employment opportunities have been found to work well, creating opportunities for people with serious mental illness to work, and forming a stepping stone to engagement in mainstream employment.

Community activities that have been developed specifically for people with a mental illness, such as drop-in centres and group activities that promote connection with others (men's groups, women's groups, dance groups, art therapy and daily living skills groups).

#### **Lived Experience Workforce**

Peer work models have been implemented for people with mental illness. These positions not only provide connections for consumers of the service, but also provide opportunities for peer workers to gain work experience and to develop confidence working within teams.

#### **Vocational Consultants**

Vocational Consultants and Occupational Therapists at NWMH work closely together to enable access and availability to employment, studying and volunteering opportunities for consumers with mental illness.

There are 6 vocational consultants working across NWMH. Vocational consultants work closely with teams and services to explore the range of employment and vocational opportunities including education and retraining, volunteering and work experience as well as pathways into paid employment. The vocational consultants also explore opportunities and pathways to employment via social firms innovation hubs.



## ISSUES

### **Restructure and down-sizing of Mental Health Community Support Services (PDRSS, MHCSS)**

These services previously provided opportunities for social connection, drop-in centres, social skills programs, group programs to improve daily living skills, and safe housing with a strong rehabilitation focus. The closure and restructure of many of these services has left a significant hole in the lives of people with a serious mental illness. Lack of activities is one of the most common themes qualitatively in the YES survey results and quantitatively one of the lowest rating items in the experience of service questions.

### **NDIS is failing people with a mental illness**

Related to the closure of the MHCSS services is the failure of the NDIS system to reach people with a serious mental illness. The application process is laborious and difficult for consumers and carers to navigate. Meeting the necessary requirements to ensure a successful NDIS application is in fact beyond the capacity of many, and the application process goes against a recovery focus as it requires individuals to highlight their deficiencies and illness, and to hold a belief that these problems will be life-long. Further, when consumers are not successful in getting a NDIS package, they find that the previous services are no longer available. The consequence of this is that a consumer's recovery is delayed or impeded, and this may result in the consumer remaining in the care of the publicly funded mental health system longer than s/he needs to. Because our services work on a 'one out – one in' model to maintain acceptable caseloads, this means that another consumer is effectively denied access to the publicly funded mental health service.

### **Working within a bio-medical model / reduced capacity to offer psychosocial interventions**

*"Psychosocial interventions that address social inclusion, community participation and meaningful occupation for consumers who are clearly telling us that they are lonely, want a job, want a life partner, that they have no friends are not being delivered consistently or effectively."* (OT Discipline Advisor)

Mental health services continue to work predominantly within a bio-medical model of care. There is less than optimal availability of evidence based psychosocial interventions.

## RECOMMENDATIONS

- 83.** Invest in more psychosocial treatment / intervention opportunities within mental health services, including rehabilitation and recovery programs, vocational consultants, Drive Safe assessors and exercise physiologists. Increasing resources across these discipline groups would also support the opportunity for specialised practice development across each discipline, increased group programs and psychosocial research and evaluation.
- 84.** Create opportunities for mental health staff to provide more outreach support so that they can focus on rehabilitation in the community - for instance, taking people out of their homes, assisting with connections to community programs, GPs, education and employment.
- 85.** Reinvest in community support services, including group activities such as social groups, drop in centres, and support groups for people with a mental illness. Ensure that these are accessible to people in all areas.
- 86.** Support and invest in social enterprise employment opportunities for people with chronic or severe mental health issues so that they can participate meaningfully in the workforce. Programs that can build on the many and diverse skills of people with a serious mental illness should be supported and rewarded.
- 87.** Connect employment and training support services with mental health services. Consider co-location of employment / vocation services and mental health services.

## 9 Priorities for change: areas and ideas for reform to improve Victoria's mental health system

Victoria's mental health services have been overwhelmed in the last 20 years, resulting in the current perception of crisis which has led to this Royal Commission. DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they pay to deliver mental health services; and in addressing historical inequities in funding allocations that do not align to current populations and demographics (VAGO report, pg.8). The funding problem has occurred partly due to government not increasing funding comparable to increase of non-mental health services, and partly due to the unanticipated effects of mainstreaming. Following mainstreaming of mental health services with acute general hospitals, there have been some positive outcomes with improved access to physical health clinicians and reduced stigma associated with mental health illness. Mental health services and non-mental health (physical health) services within the general hospital, however, remain very separate and the potential benefits of more close working relations have not yet been realised.

The separate branches within DHHS and their different approaches to system management have contributed to the lack of interaction between non-mental health and mental health services, and to the slower rate of growth funding in mental health compared to non-mental, physical health. The separate governance of mental health and physical health within health services has also contributed to the limited interaction and integration. This has become more problematic with the growth in acute mental health presentations to the Emergency Department. This siloed approach is not addressing the significantly lower life expectancy of mental health patients due to under-treatment and delayed diagnosis of physical illnesses. It is well recognised that mental health services are very different to acute physical health services and specific needs of mental health services must be protected and nurtured however, a closer working relationship with non-mental health services and mental health services would assist in realising the potential of mainstreaming, and improve the outcomes of the increasing number of patients with physical illness and mental health issues, as well as outcomes of patients with mental illness.

There is a severe shortage of both acute inpatient and rehabilitation beds. Victoria has led the way in reducing the need for beds through better community treatment services, but the long-standing funding shortage has resulted in a depletion of community services in order to sustain inpatient units, with the result that neither is able to adequately manage the demand. Activity-based funding is a potential way of keeping funding aligned better with demand, though has its own risks due to the lack of clear association between diagnosis and cost of treatment.

Another important area is to review the question of catchment areas or free choice, and the alignment of mental health services with local government and emergency service boundaries. There are arguments in favour of each proposition but in this era of consumer empowerment, free choice might be preferred. However, this would need a viable form of activity-based funding which has not yet been established, and would lead to a disconnect for some consumers between regular care and assertive outreach. On balance therefore, NWMH believes that catchment areas of sufficient size to allow streaming of some services such as inpatient units, is preferable.

Finally, there is an opportunity for funding innovation, such as establishing centres of excellence in service innovation and delivery. These could be modelled on a competitive process, such as that used by the National Health and Medical Research Council to develop research excellence.

Below, we repeat our top recommendations for reform, in no particular order.

### Top Recommendations

1. **Change funding models:** Implement equitable population based funding models that incorporate complex social factors and take into account available community resources and supports (including private mental health practitioners and GPs). **Considerations:** the level of resourcing should consider

and make provision for the level of culturally and linguistically diverse (CALD) population groups, the level of socioeconomic disadvantage, population growth and geography and demography more broadly. The National Mental Health Service Planning Framework and the Jarman Index are good tools to guide this work. (Section 4)

2. **Governance:** Branches within DHHS should establish a closer working relationship for the system management of both mental and non-mental health services. Similarly, health services should ensure organisational structure allows and encourages integration between mental health and non-mental health services.

Such an approach would require 'ring fencing' of mental health funding from acute general services and also separate acute inpatient mental health and community funding streams to ensure that community funding is protected to deliver services in the community. (Section 4)

3. **Increase the number of acute inpatient beds:** Make significant investment in acute inpatient beds to increase access and reduce risk carried in the community. **Considerations:** The target over time should be 3.0 inpatient beds per 10,000 population. New inpatient units should be purpose built and consistent with current best practice in terms of design, fixtures and fittings, and old units should either be renovated to meet the design standards or replaced. Moreover, the Australian Healthcare Facility Guidelines should be updated to include contemporary best practice about gender segregation and the particular needs of vulnerable cohorts of patients. (Section 4)
4. **Support the mental health workforce:** Develop and implement strategies to maximise safety and well-being of workforce (minimise and respond more effectively to occupational violence, effects of vicarious trauma, fatigue and burnout). Improve professional development. Consider workforce incentives such as increased annual leave as for emergency workers, and bonuses for working in the most difficult areas. **Considerations:** While it is recognised that effecting legislative change is a lengthy process, as a medium to long term goal, relevant legislation should be amended to ensure that mental health clinicians are given equal protection under the law (section 31 *Crimes Act 1958* - amended) as Paramedics and Emergency Department staff. The Government, via a memorandum of understanding between DHHS and Victoria Police, should make sure Victoria Police respond appropriately and consistently to incidents of OV. This includes investigating all allegations of assault and charging and prosecuting individuals who perpetrate assaults on clinical and non-clinical staff as appropriate. [REDACTED] NWMH has developed a local agreement with Victoria Police in regard to this, [REDACTED]. NWMH further recommends that the government resource mental health services, both inpatient and community clinics, to implement adequate preventative measures such as additional CCTV cameras, Security Officers, Air Locks in Inpatient Units and bolstering of staff base security. (Section 7)
5. **Redevelop the state-wide mental health patient information system:** This would minimise duplication and improve efficiencies in the sharing of information and also support better data collection, reporting, service evaluation and planning. Ideally, the system would be able to interface with the commonly used electronic medical record systems of hospitals. (Section 4 & 5)
6. **Grow the mental health workforce:** Further investment in the full range of disciplines within clinical mental health services, including staff with dual diagnosis (mental illness and alcohol and other drugs), cultural specialists (e.g. Aboriginal and Torres Strait Islander), exercise physiologists, dietitians, family violence specialists and FaPMI workers in order to provide integrated, evidence-based, holistic care. Invest in non-clinical support staff to maximize the efficiency of clinicians. (Section 7 & 8)
7. **Reform and expand program service delivery at community clinics:** Ensure provision of evidence-based care to a larger proportion of the population, and enable holistic service delivery across core practice domains including psychological practice, family and carer support, employment and meaningful activity, physical health interventions, lived experience peer support, treatment for

alcohol and other drug misuse/dependence, trauma informed practice and forensic responses.

**Considerations:** Investment is also needed to increase capacity to outreach to all consumers and carers as needed, and to provide intensive home-based treatment to a small proportion (10-20%) of consumers. (Section 4, 5 & 8)

8. **Increase community residential services:** Reform and expand community residential services to ensure there is a continuum of rehabilitation options including alcohol and drug (AoD) residential services. (Section 4)
9. **Respond to the increased demand on mental health services from the prison population:** Provide compulsory care for prisoners under the same conditions that apply to consumers in the broader community. This will require amending the Mental Health Act and oversight by the Mental Health Tribunal. Increase growth in forensic clinical specialist positions; provide more appropriate inpatient bed options and more appropriate accommodation services for people exiting prison with serious mental illness. **Considerations:** Young people with forensic problems often take longer to engage in mental health care, and require more flexible and creative approaches. Consideration should be given to an extension of 'problem behaviour services' to consumers younger than 18. NWMH also seeks consideration in regard to the numbers of released adult prisoners placed on Assessment Orders (AO) under the Mental Health Act and sent to an Emergency Departments. Our experience has been that approximately 50% of the AOs are not upheld and it has become clear over time that homelessness and lack of means of support are the predominant drivers for the instigation of the AO rather than acute mental illness. Accordingly, we ask that consideration be given to embedding Department of Housing and Centrelink workers in community mental health clinics. (Section 4)
10. **Extend after hours mental health services:** Increase flexibility in regard to time of care (out of hours) such as extending the hours of operation of community mental health clinics and increase funding to allow for 24 hours/7 days crisis assessment teams. Establish 'age appropriate and specific skill-set' crisis assessment teams for older people that provide timely crisis assessments and intensive support including medication supervision during business hours and out of hours. Increase mental health services in hospital emergency departments during after-hours and weekends to provide consumers with access to specialist mental health care. Necessarily, this should include 24/7 availability of 'stand-up' registrars and consultant psychiatrists. Restore program capacity in community clinical mental health services. (Section 4)
11. **Review service alignment and catchment area size:** Review and improve alignment of mental health service areas with human services areas, police districts and local government boundaries. The 'ideal' size of an Area Mental Health Service should be determined and then appropriately resourced to manage its catchment population. The resourcing should be dynamic in nature and indexed with population growth. **Considerations:** Experience at NWMH suggests that areas need to be of sufficient size to permit some streaming of acute inpatient units, attract sufficient staff and offer opportunities for research and innovation. In our view, this size should be of the order of 750,000 population or more for metro areas.
12. **Increase opportunities for long term management:** Enhance the capacity of services to work with consumers with enduring complex medium to long term mental health needs (i.e. effect a return to continuing care and a reversal of the trend towards episodic care for the consumers / persons living with severe mental illness that has been driven by necessity and resource constraints). The resourcing should be dynamic in nature and be indexed with population growth. **Considerations:** The aim should be to facilitate longer-term engagement to prevent a negative, repeating cycle of relapses with associated poor social and health outcomes. Preventable relapses under these circumstances often lead to relationship breakdowns, loss of employment, loss of housing and the involvement of the criminal justice system. Further, each successive psychotic relapse has a cumulative effect in terms of cognitive decline and risk of developing chronic illness. (Section 4)

- 13. Expand early intervention:** Expand the perinatal mental health initiative to allow longer period of treatment and broader referral sources, improve engagement with schools to improve mental health literacy and encourage early intervention. Expand youth mental health services to provide care for all young people who require treatment in the specialist mental health system. This includes extension of youth services to provide services for the full duration of the age-period from 15 to 25 years. Foster programs such as 'HOPE' and 'Engage' for early intervention for suicidal behaviour. (Section 2)
- 14. Maximise psychosocial recovery and rehabilitation:** Increase the capacity of clinical mental health services to provide more psychosocial recovery and rehabilitation programs (in reach and outreach), and review governance arrangements to foster closer links between the mental health clinical and community support sectors. (Section 4, 5 & 8)
- 15. Fund research and evaluation:** Funding should be allocated to support both biopsychosocial research and program evaluation. This could include the establishment of centres of excellence on a competitive basis. (Section 1, 2, 3 & 5)

*(For full list of recommendations see Summary table of issues and recommendations pg. 73).*

## 10 Preparing for change: what can be done now and what will support improvements to last?

Most of the recommended reforms needed will require time to work through and to secure funding.

### **Start planning:**

Work could commence now at a DHHS level to:

- establish a practical vision and plan for mental health services, with specific targets, such as providing services to the 3% of the population identified as having a need, and providing 3.0 acute inpatient beds per 10,000 population;
- develop a transparent, population-based funding model, this includes the cost of maintaining infrastructure;
- ensure that services are of a sufficient size to enable streaming of different groups of consumers within inpatient units; and
- establish a firewall between hospital and community funding streams.

Such measures will support lasting improvements. The vision needs to be practical and focussed on treatment and prevention/early intervention of mental illness, rather than nebulous concepts of improving mental health generally.

Planning can begin for significantly increasing the workforce by reviewing workforce related funding models, ensuring that best use is made of skills/expertise; for example, discipline-specific roles to focus on delivery of targeted and evidence-based interventions.

Planning can begin for increasing and uplifting the existing infrastructure, this should include increasing the number of sub-acute facilities (PARC, CCU and SECU - women's only, adult and youth specific), increasing the number and size of community clinics so that they can comfortably house the number of staff required to provide treatment and support and, increasing the number of acute beds (LDU and ICA). Particular attention should be given to growth corridors and areas with greater socio-economic disadvantage.

Development of clinical and service key performance indicators could begin as a joint work by DHHS and the sector, as suggested by the VAGO report. Work could also commence on developing a shared IT platform to replace the obsolete CMI/ODS system; ideally such a platform would have the capacity to communicate with Electronic Medical Record systems. This would minimise duplication and improve efficiencies in the sharing of information and also support better reporting, service evaluation and planning.

### **Call for legislative changes:**

Relevant legislation must be amended to ensure;

- mental health clinicians are given equal protection under the law as is currently afforded to Paramedics and Emergency Department staff;
- providing equivalency of care for mentally ill persons in prison as applies in the general community including access to compulsory treatment where appropriate as a means to alleviating suffering; and
- information sharing between mental health and justice systems.

### **Fund research and evaluation:**

Funding should be allocated for specific research and program evaluation targeted at identified gaps or deficiencies in service provision. This could include planning for the establishment of centres of excellence.

**Acknowledge the efforts of mental health service staff**

Finally, Melbourne health and NWMH acknowledge the passion and dedication of staff working across Victoria's mental health system who, despite everything, continue to come to work each day committed to improving the lives of people with a mental illness.

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## Glossary

<b>AMHS</b>	Area Mental Health Service
<b>APMH</b>	Aged Persons Mental Health
<b>CCTV</b>	Closed Circuit Television
<b>ECT</b>	Electro-Convulsive Therapy
<b>ED</b>	Emergency Department
<b>EMH</b>	Emergency Mental Health
<b>ICA</b>	Intensive Care Areas
<b>IPU</b>	Inpatient Unit
<b>IWAMHS</b>	Inner West Area Mental Health Service
<b>LOS</b>	Length of Stay
<b>MWAMHS</b>	Mid West Area Mental Health Service
<b>NAMHS</b>	Northern Area Mental Health Service
<b>NWAMHS</b>	North West Area Mental Health Service
<b>NWMH</b>	NorthWestern Mental Health
<b>OH&amp;S</b>	Occupational Health and Safety
<b>OV</b>	Occupational Violence
<b>OYH</b>	Orygen Youth Health
<b>YES</b>	Your Experience of Service

## Appendix 1

Table 1. NWMH Breakdown of beds

NWMH BEDS	Beds
Adult Acute Inpatient Units	133
Broadmeadows IPU - 20 LD + 5 ICA	25
Northern Hospital IPU 1 - 20 LD + 5 ICA	25
Northern Hospital IPU 2 - 20 LD + 5 ICA	25
Royal Melbourne Hospital John Cade IPU - 21 LD + 8 ICA	29
Sunshine Hospital IPU - 21 LD + 8 ICA	29
Adult Prevention and Recovery Care Services (PARCS)	40
Inner West-PARC	10
Mid West-PARC	10
Northern-PARC	10
North West-PARC	40
Adult Specialist	16
Eating Disorders IPU	8
Neuropsychiatry IPU	8
Youth Acute	16
Orygen IPU	16
Adult Secure Extended Care	26
Adult Mental Health Rehabilitation Unit (AMHRU)	26
Adult Residential Rehabilitation Units	80
Inner West-Community Care Unit (CCU)	20
Mid West-Community Care Unit (CCU)	20
Northern-Community Care Unit (CCU)	20
North West-Community Care Unit (CCU)	20
Aged Hostel	32
McLellan House	32
Aged Acute Inpatient	54
APMH-Bundoora Extended Care	15
APMH-Broadmeadows Health Service	19
APMH-Sunshine Hospital	20
Residential Aged Care Facilities	105
Merv Irvine	30
Boyne Russell House	30
Cyril Jewell House	45
NWMH TOTAL	502

Adult, Youth & Aged Acute Mental Health Beds. NorthWestern Mental Health.		
Adult Acute Inpatient Units	Bed Type	Total
John Cade Unit. Royal Melbourne Hospital	21 LD + 8 ICA	29
Northern Psychiatry Unit 1. The Northern Hospital	20 LD + 5 ICA	25
Northern Psychiatry Unit 2. The Northern Hospital	20 LD + 5 ICA	25
Sunshine Adult Psychiatry Unit. Sunshine Hospital	21 LD + 8 ICA	29
Broadmeadows Inpatient Psychiatry Unit. Broadmeadows Health Centre	20 LD + 5 ICA	25
<b>Sub Total Adult Acute</b>		<b>133</b>
Youth Acute Inpatient Unit		
Orygen Inpatient Unit. Western Hospital Campus	16 LD	16
<b>Sub Total Youth Acute</b>		<b>16</b>
Aged Acute Inpatient Units		
Sunshine Aged Acute Inpatient Unit. Sunshine Hospital Campus	20	20
Broadmeadows Aged Acute Inpatient Unit. Broadmeadows Health Centre	19	19
Kath Atkinson Wing Aged Acute Inpatient Unit. Bundoora Extended Care Centre	15	15
<b>Sub Total Aged Acute</b>		<b>54</b>
<b>Total</b>		<b>203</b>

## Appendix 2 – NorthWestern Mental Health Service Data

The purpose of this appendix is to provide an overview of select NorthWestern Mental Health (NWMH) service activity that provides insight to:

1. Demand
2. Access
3. Safety
4. Capacity

Further information is available on request via Melbourne Health.

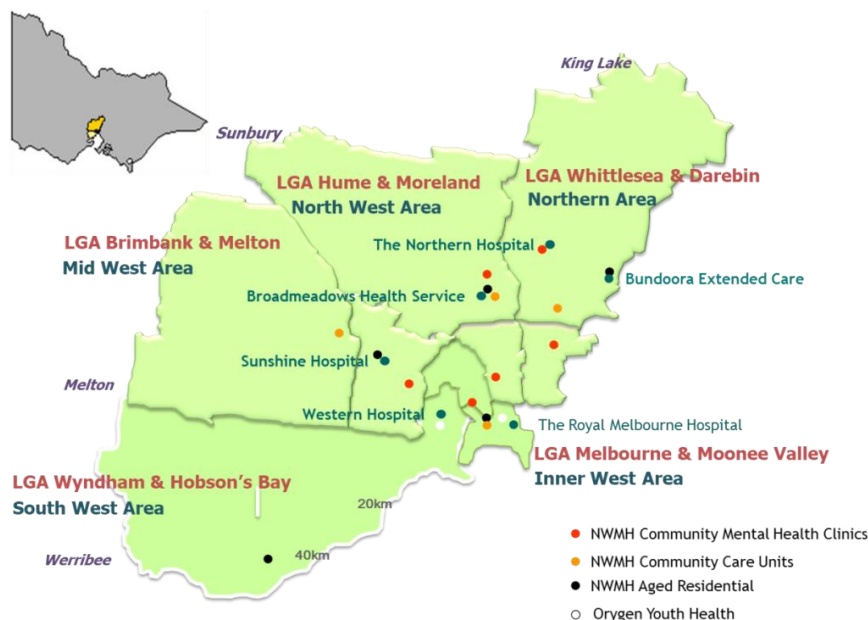
### 1. Demand

NMWH has four of the fastest and largest growth corridors in its catchment areas identified by Futures Victoria 2016 as the Top 5 Growth Areas 2011 -2031

These local government areas are:

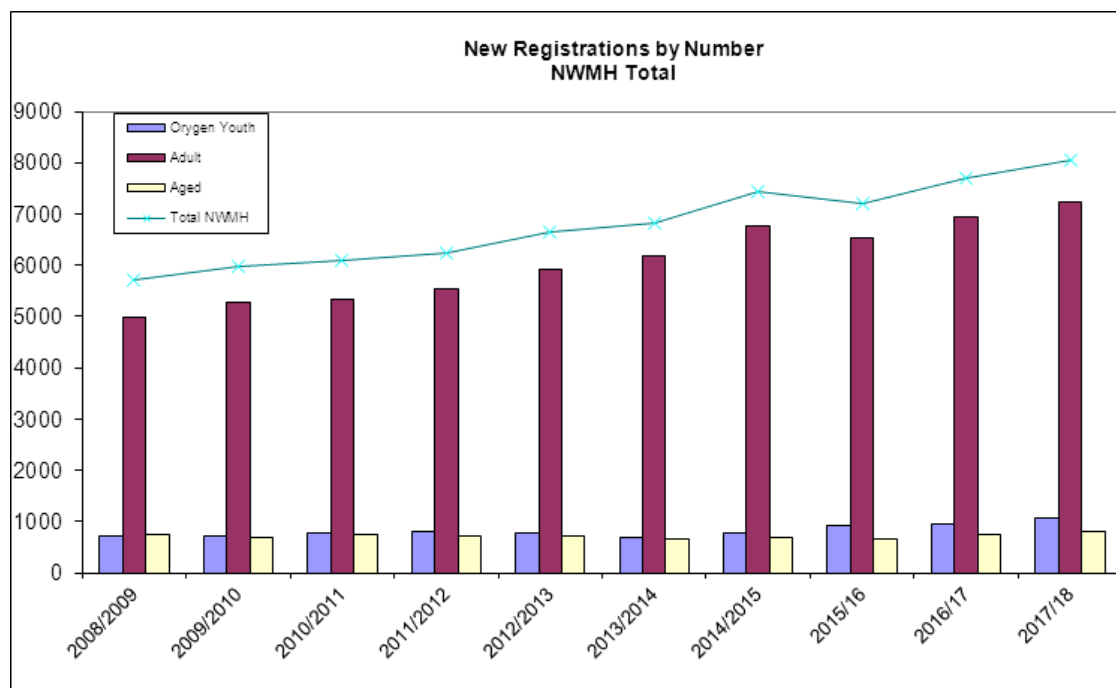


These growth areas are increasing the demand to access mental health services. The physical location of NWMH services is currently located mid to south of the catchment areas. This creates inefficiencies in service delivery and access to services. The following diagram provides the location of NWMH services.



### Newly Registered Clients

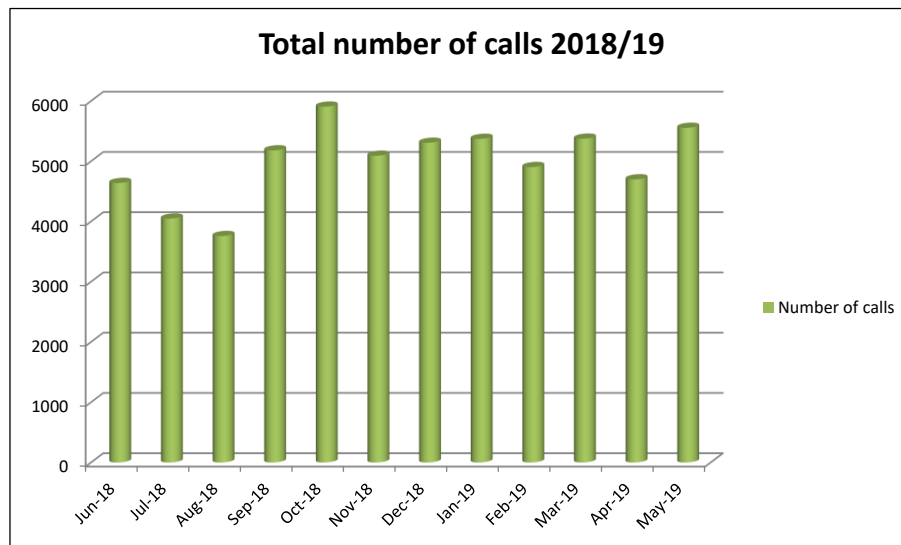
The number of newly registered clients accessing NWMH is increasing each year. Over the past 10 years there has been a 40% increase in the total number of new clients registered, accessing NWMH services. This correlates with the population growth.



## 2. Access

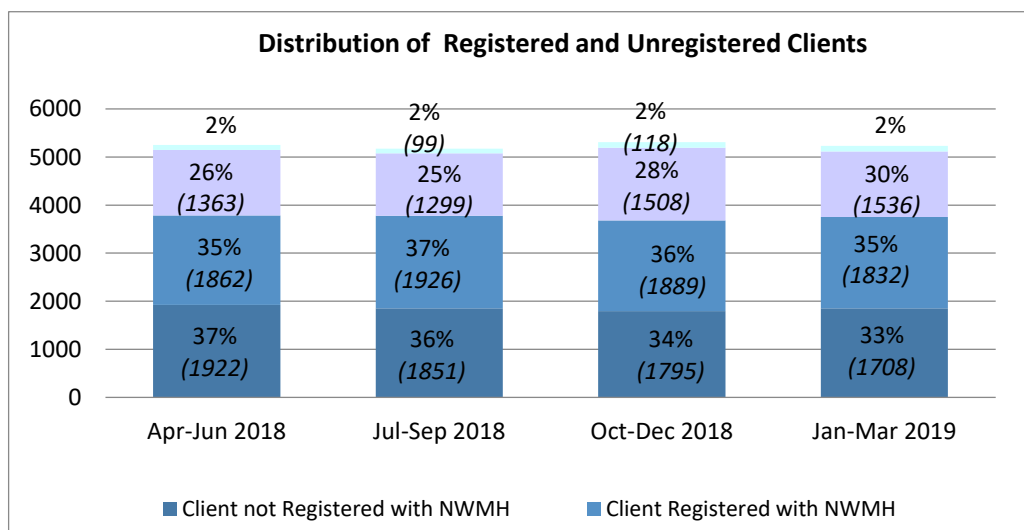
### Triage Services

Access to publicly funded clinical mental health services is generally via a Triage Service. The NWMH Triage Service and the Orygen Youth Health Youth Access Team (YAT) are the first point of contact for all potential consumers of NWMH, and for people seeking assistance on behalf of someone with a known or potential mental illness. The triage system faces huge demand, is currently processing in excess of 56,000 calls per annum, and wait times can be up to several hours. The following graph demonstrates the number of calls NWMH Triage service has received over a 12 month period.

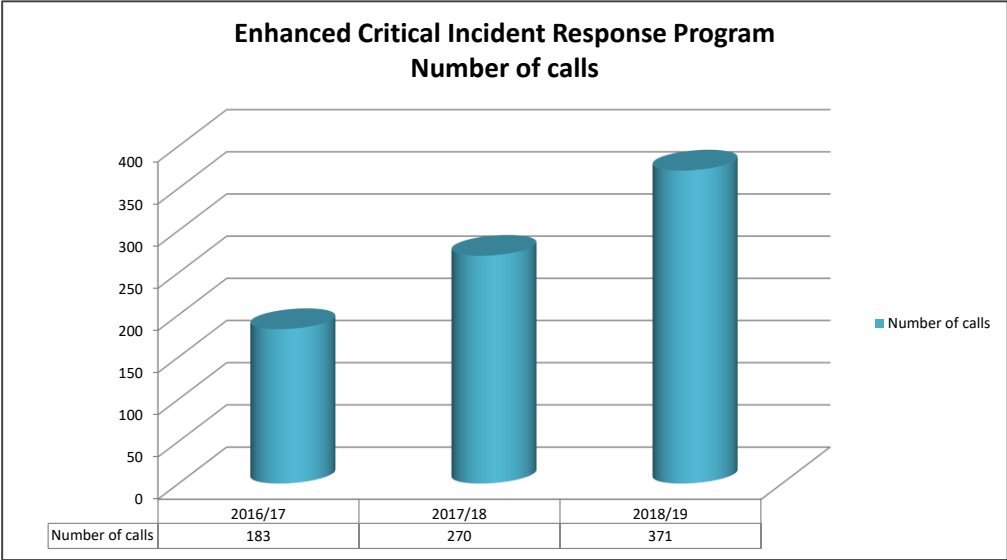


NB: This graph excludes Orygen Youth Health Youth Access Team telephone calls.

During April 2018 – March 2019, 20,968 screening register events occurred over the 12 month period. The graph provides a distribution of the Registered and Unregistered clients using the service during this time, along with other users of the service. The number of calls has increased over the year which aligns with the population growth.



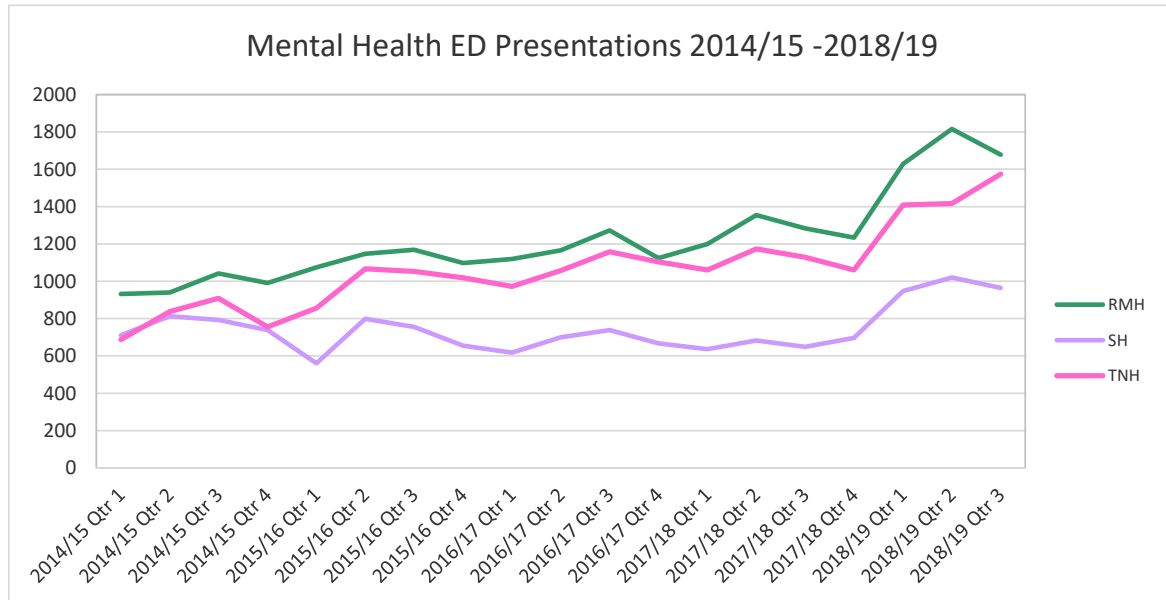
NWMH Triage provides an Enhanced Critical Incident Response Program to the Victoria Police. This is a statewide support service where the number of telephone calls for this program has grown by over 100% for the past 3 years.



### Emergency Department Presentations

NWMH provides specialist mental health services from three Emergency Departments. These services are located at The Royal Melbourne Hospital, Northern Hospital and Sunshine Hospital.

The total numbers of mental health related presentations to the emergency departments have increased by 55.2% over the past 5 years.

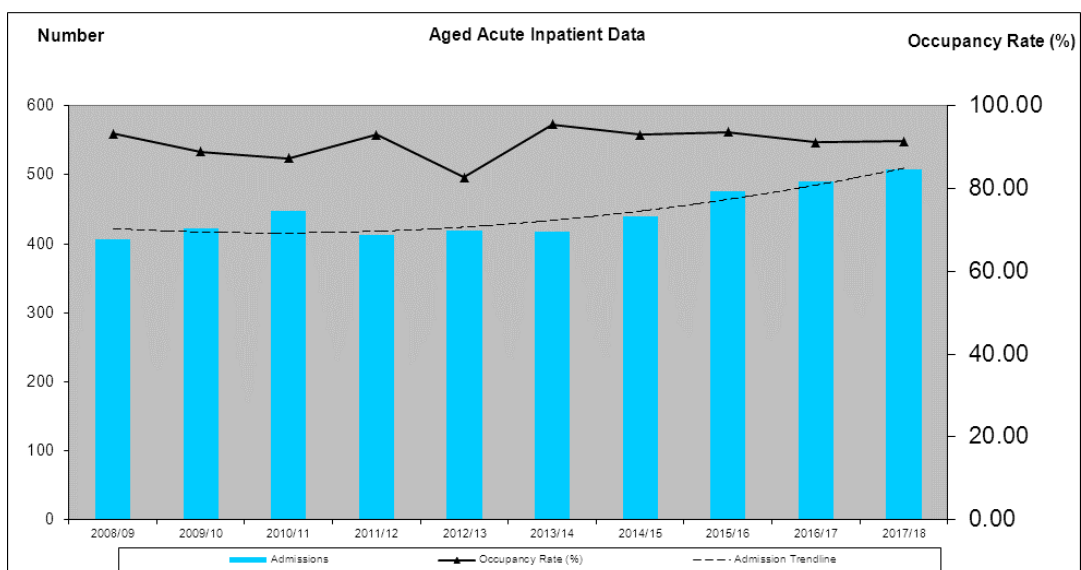
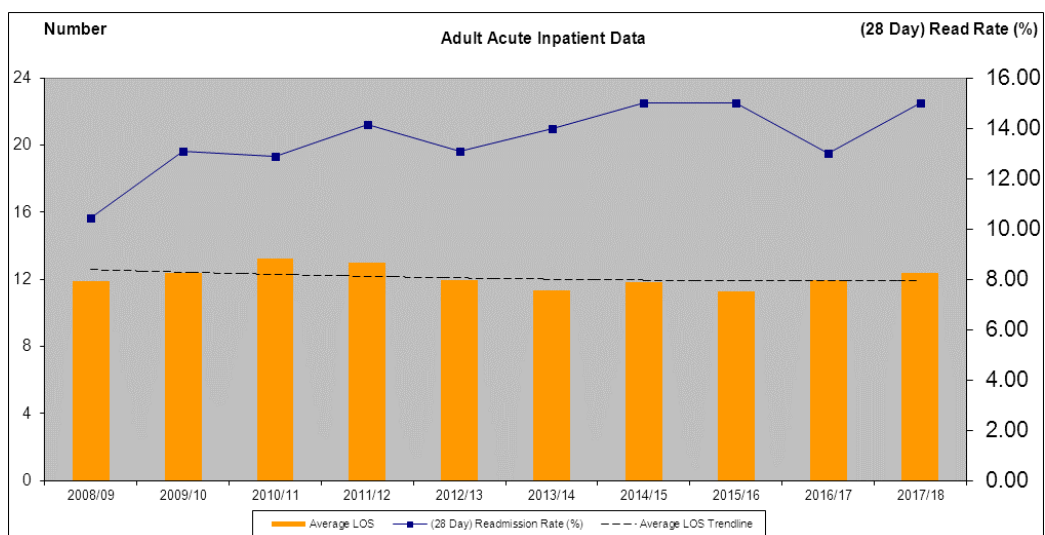
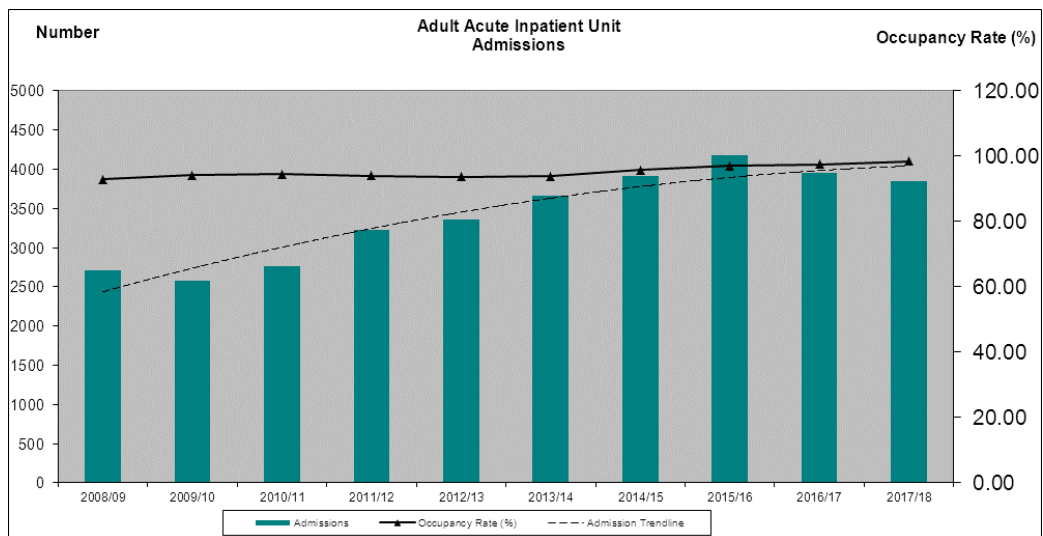


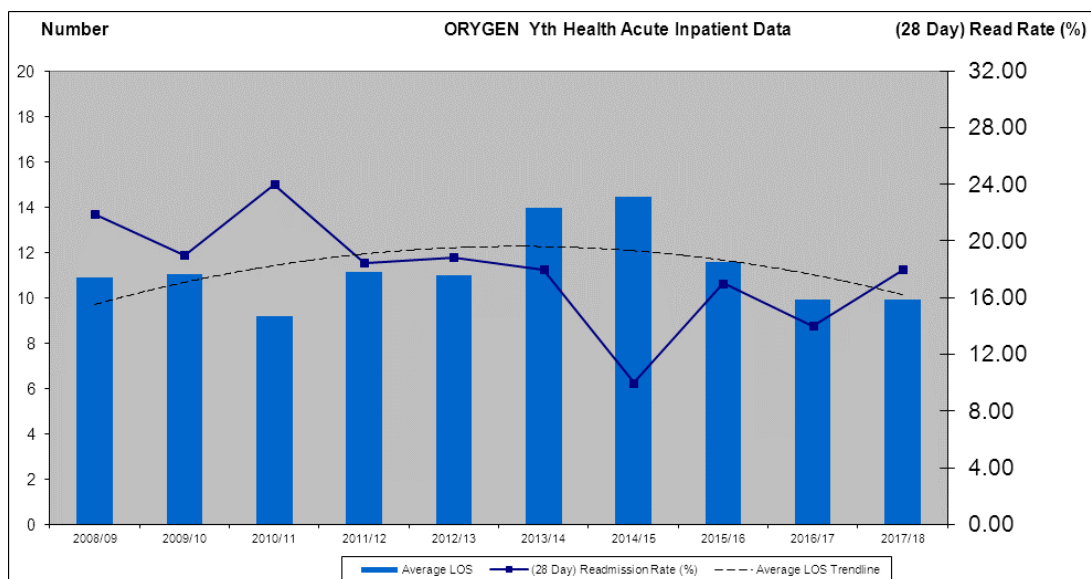
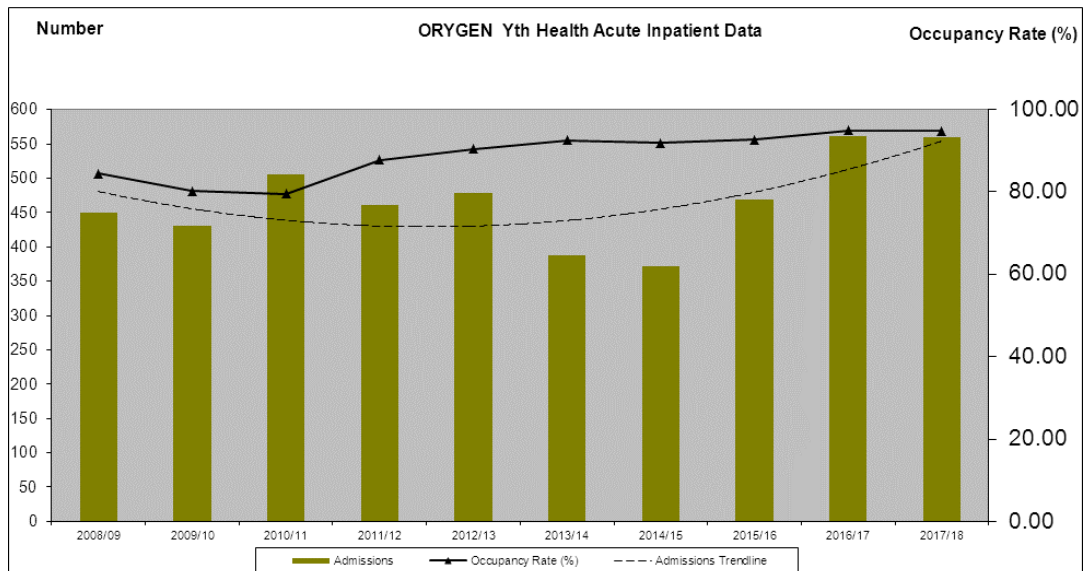
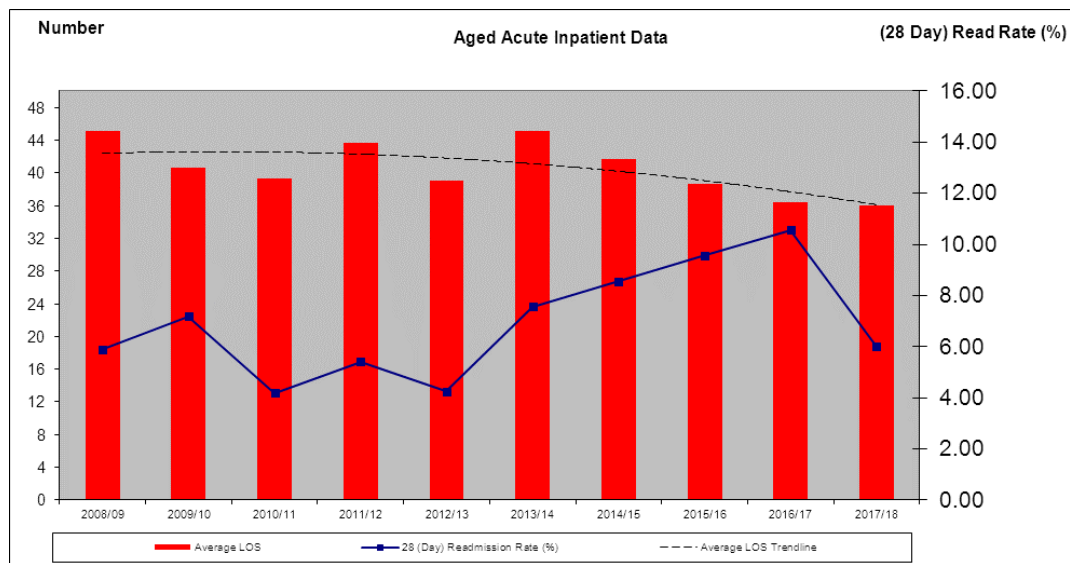
### Bed Based Services

NWMH operates a total of 502 beds, 203 of which are acute mental health beds, comprised of 133 adult beds, 16 Youth Acute beds and 54 Aged Person's beds. Acute and secure beds are hospital based. It is generally accepted that to be able to efficiently manage unexpected peaks and troughs in demand and acuity, an occupancy rate of 80-85 percent of hospital beds best practice. For the last five financial years NWMH acute beds have been operating above the 95 per cent capacity. The remaining 299 beds are a mixture of residential and prevention and recovery bed based services.

In 2017/18 financial year, 4,584 Mental Health admissions across our adult, youth, aged and specialist services were provided. The following graphs presents the consistent occupancy rate across Adult, Aged and Youth bed based services over the past 10 years. The increasing number of admissions correlates with a reduction in the length of stay to enable support access to beds.





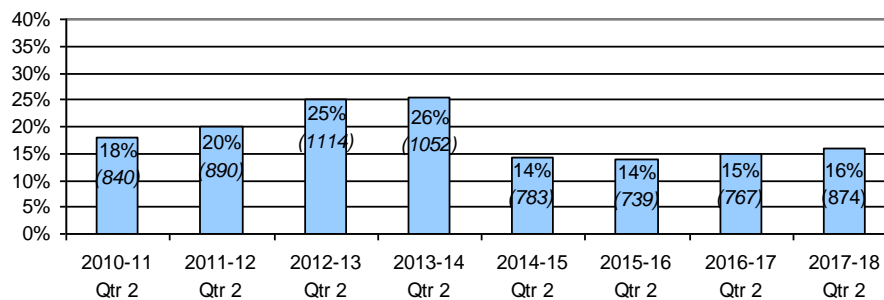


### Community Services Activity Data

NWMH provides a range of community and hospital outpatients services. Throughout 2017-18 the following were provided by community and hospital based outpatient care settings:

- 586,682 mental health service contacts were provided;
- over 23,941 total patients were seen; and
- 16% of the patients were on a Community Treatment Order under the *Mental Health Act 2014*.

**Percentage of Clients on a CTO  
NWMH**



### Clinical Interventions

A variety of clinical interventions are provided by NWMH to the consumers receiving care across the services.

An example is the provision of Psychological Interventions.

It is the expectation across NWMH for all consumers in an ongoing episode of care that every consumer will receive a comprehensive assessment and will be considered for the provision of fundamental and/or specialist psychological interventions based on:

- a) the nature of their presenting difficulties and diagnosis;
- b) their particular stage of recovery;
- c) the consumer's preference; and
- d) the available staff resources.

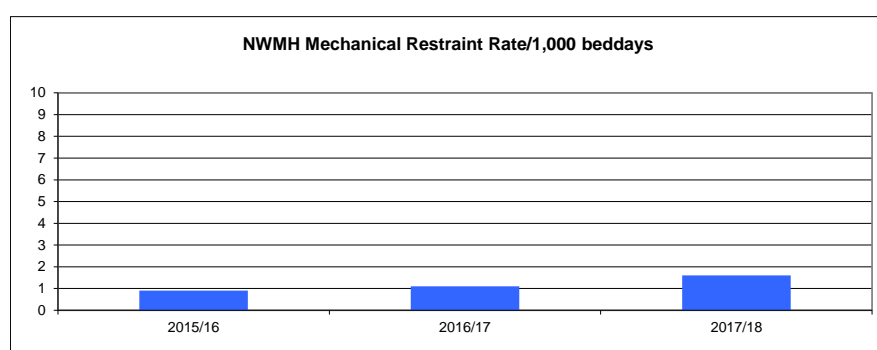
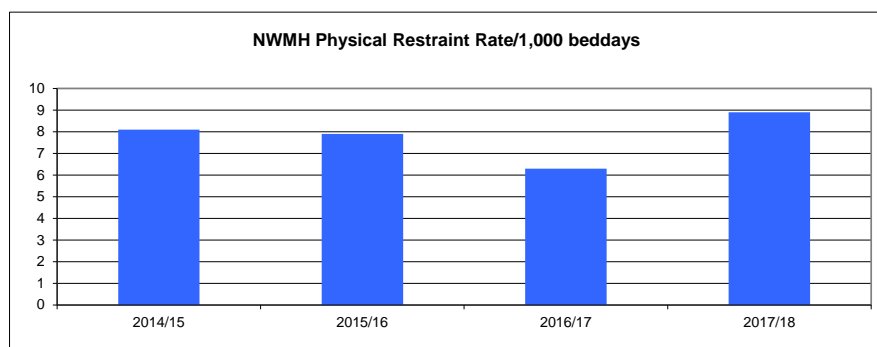
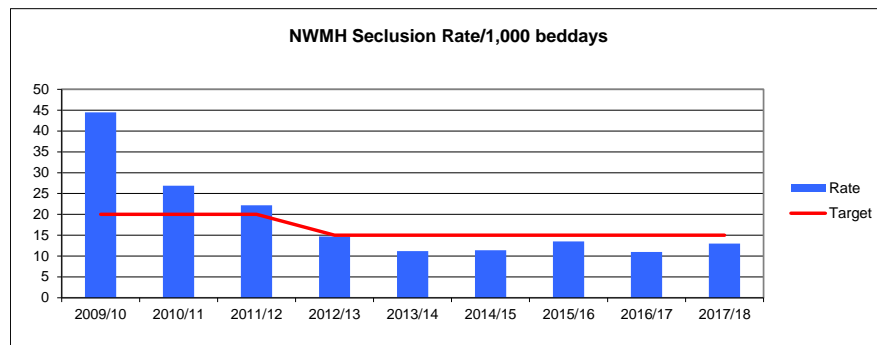
In 2017, 80% (697 of 873 consumers reviewed) were provided fundamental psychological interventions. This was incorporated into the care plans which included areas such as problem solving skills, goal setting, personalised psychoeducation, behavioural activation, coping strategy enhancement, and relaxation.

AMHS	NO	YES	Total
APMHP	32 (27%)	88 (73%)	120
IWAMHS	31 (22%)	113 (78%)	144
MWAMHS	26 (17%)	124 (83%)	150
NWAMHS	28 (17%)	133 (83%)	161
NAMHS	46 (28%)	121 (72%)	167
OYH	13 (10%)	118 (90%)	131
<b>NWMH Total</b>	<b>176 (20%)</b>	<b>697 (80%)</b>	<b>873</b>

### 3. Safety

#### Restrictive Interventions

Restrictive interventions involve the use of bodily or mechanical restraint and seclusion (confinement of a person to a room or an enclosed space). These may only be used if needed to prevent serious harm to the person or another person. This is used only after all reasonable and less restrictive options have been tried or considered. Our rate of physical restraint during 2017/18 was 8.9 episodes per 1,000 bed days and mechanical restraint was rarely used at a rate of 1.6 episodes per 1,000 bed days.



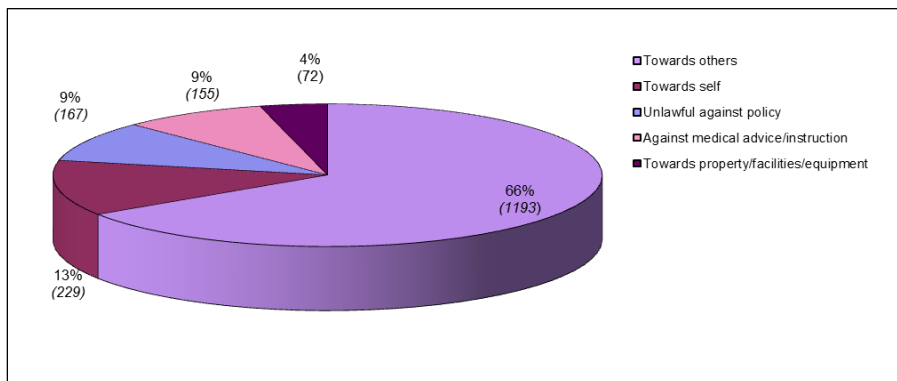
#### Occupational Violence

Occupational violence is increasing across mental health services. In the 2017-2018 financial year, 50% of the total incidents that were reported via RiskMan for NWMH were related to **behaviour/conduct/abuse** (1816 incidents of all incidents reported).

Of these **behaviour/conduct/abuse** incidents they were:

- 66% (n=1193) towards others incidents;
- 13% (n=229) was towards self;

- 9% (n=167) unlawful against policy and (n=155) against medical advice; and
- 7% (n=72) property/facilities/equipment.



## 4. Capacity

The following tables demonstrate how access to both adult bed based and community services per 10,000 populations for the age range 15-64 is reduced overtime with the population growth. Along with this is the reduction in EFT numbers across the services per 10,000 populations across the adult age ranges.

The population data was based on the projections the Victorian Government, Department of Environment, Land, Water and Planning published, in Victoria in the Future 2014.

### 30<sup>th</sup> June 2016 - projected population

	Inner West	Mid West	North West	Northern
<b>Community</b>				
EFT - 1 June 2014	51.75	46.61	76.68	81.71
EFT - per 10,000	3.41	1.82	3.37	3.38
Contacts per 10,000	4,150	2,357	3,582	2,212
Contact hours per 10,000	1,900	1,083	1,440	856
<b>Acute</b>				
EFT - 1 June 2014 - IPU	48.26	47.83	40.67	81.29
Beds per 10,000	2.0	1.3	1.3	2.2
<b>Residential</b>				
EFT - 1 June 2014 - CCU	19.19	24.29	17.92	26.42
Beds per 10,000	1.8	1.2	1.3	1.3
TOTAL EFT per 10,000 15-64yrs	11.21	8.88	8.35	11.39

### 30<sup>th</sup> June 2021 - projected population

	Inner West	Mid West	North West	Northern
<b>Community</b>				
EFT - 1 June 2014	51.75	46.61	76.68	81.71
EFT - Per 10,000	3.00	1.70	3.05	3.03
Contacts per 10,000	3,657	2,200	3,241	1,985
Contact hours per 10,000	1,674	1,010	1,303	767
<b>Acute</b>				
EFT - 1 June 2014 - IPU	48.26	47.83	40.67	81.29
Beds per 10,000	1.8	1.2	1.2	2.0
<b>Residential</b>				
EFT - 1 June 2014 - CCU	19.19	24.29	17.92	26.42
Beds per 10,000	1.6	1.1	1.2	1.2
TOTAL EFT per 10,000 15-64yrs	9.88	8.29	7.56	10.27

### 30<sup>th</sup> June 2026 – projected population

	Inner West	Mid West	North West	Northern
<b>Community</b>				

#### Please note the following when looking at this data:

- 1) Oxygen beds have been distributed across IW, MW and NW
- 2) Acute bed numbers are for acute inpatient units. Speciality units and AMHRU have been excluded
- 3) Residential bed numbers include CCU and PARC
- 4) Population data is based on Estimated Resident Population (ERP) and is for age range 15-64
- 5) Oxygen community EFT has not been distributed across the adult services
- 6) Northern AMHS community team has been funded an extra 6.2 EFT for youth services
- 7) IW EFT data excludes Eating Disorder and Neuropsychiatry cost centre EFT
- 8) Community data based on 2013/14 contact data

#### Data sources:

NWMH Workforce Profile Report 2015

- 1) Population data – Victoria in the Future 2014, Department of Environment, Land, Water and Planning
- 2) Patient data – CMI, NWMH Reporting Tool June 2013/14

#### Calculations:

EFT per 10,000 = Total EFT / Total Population X 10,000

Contacts per 10,000 = Total Contacts / Total Population X 10,000

Contact hrs per 10,000 = Total Contacts hrs / Total Population X 10,000

Beds per 10,000 = Total Beds / Total Population X 10,000

EFT - 1 June 2014	51.75	46.61	76.68	81.71
EFT - per 10,000	2.79	1.54	2.84	2.75
Contacts per 10,000	3,400	1,984	3,018	1,801
Contact hours per 10,000	1,557	911	1,214	631
<b>Acute</b>				
EFT - 1 June 2014 - IPU	48.26	47.83	40.67	81.29
Beds per 10,000	1.7	1.1	1.1	1.8
<b>Residential</b>				
EFT - 1 June 2014 - CCU	19.19	24.29	17.92	26.42
Beds per 10,000	1.5	1.0	1.1	1.1
TOTAL EFT per 10,000 15-64yrs	9.19	7.47	7.04	9.39

Further analysis of the number of the beds available to the 2016 population data across NWMH was undertaken in 2018.

The beds per 10,000 continue to be lower than the recommended 3.0 inpatient beds per 10,000 population for Adult, Aged and Youth Services.

Service Type	Beds	Population (2016)	Beds per 10,000 catchment population	Beds per 100,000 catchment population
Adult	133	943,151	1.41	14.1
Aged	54	227,894	2.37	23.7
Orygen	16	190,605	0.84	8.4

Corridor Adult Bed Types only	Beds	Population (2016)	Beds per 10,000 catchment population	Beds per 100,000 catchment population
Northern	75	482,421	1.55	15.5
Western	58	460,730	1.26	12.6

Area Mental Health Service	Beds	Population (2016)	Beds per 10,000 catchment population	Beds per 100,000 catchment population
Inner West	29	252,952	1.15	11.5
Mid West	29	207,778	1.40	14.0
Northern	50	224,825	2.22	22.2
North West	25	257,595	0.97	9.7

**References**

Victoria in Future 2016; <https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future-2016>

Department of Health and Human Services, Mental Health Quarterly Key Performance Indicator report

**Data sources**

CMI/ ODS patient administration system  
Riskman – NWMH Annual Incident Analysis  
Victorian Emergency Minimum Dataset



<p>Summary table of key issues and recommendations</p> <p><b>KEY ISSUES</b></p>	<p><b>SUMMARY OF RECOMMENDATIONS</b></p>
<b>Stigma and discrimination</b>	
<p>Peer Workforce – training and support</p> <p>Skewed image of people with a mental illness</p> <p>Mental health vs mental illness</p> <p>Piecemeal approach to trauma informed practice</p> <p>Research Gaps</p>	<ol style="list-style-type: none"> <li>1. Attempts to increase understanding of mental illness and to decrease stigma and discrimination should not be delivered in a ‘one-size-fits-all’ method.</li> <li>2. Increase support for initiatives that decrease the shame and fear associated with speaking openly about suicide.</li> <li>3. Clearly distinguish between mental health and mental illness DHHS publications and policies.</li> <li>4. Increase access to Peer Support Workers.</li> <li>5. Include lived experience perspectives in all mental health-related training.</li> <li>6. Increase mental health education available for families / carers.</li> <li>7. Encourage partnerships with Aboriginal and Torres Strait Islander community-controlled health services and peoples.</li> <li>8. Increase sharing of lived experience stories on a wide variety of media platforms.</li> <li>9. Strengthen a trauma informed approach to understanding mental illness.</li> <li>10. Increase support for translational research and / or centres of excellence in research.</li> </ol>
<b>Early intervention</b>	
<p>Lack of coordinated, state-wide approach</p> <p>Demand</p>	<ol style="list-style-type: none"> <li>11. Invest in promoting early intervention at the state level through public health campaigns that focus on encouraging social connectedness, reducing stigma and improving mental health literacy.</li> <li>12. Support the integration of youth mental health care with the primary youth mental health care platforms: <i>headspace</i> centres and schools.</li> <li>13. Increase funding for Perinatal Mental Health services.</li> <li>14. Increase funding for youth mental health services to provide care for all young people who require treatment in the specialist mental health system for the full duration of the age-period from 15 to 25 years in line with policy and community expectations. This would include removing the two year tenure of care for young people who require an extended episode of care and providing care for young people during subsequent relapses of their illnesses.</li> </ol>
<b>Suicide Prevention</b>	
<p>Premature Discharge</p> <p>Clinical Handover and Managing Transitions of Care</p>	<ol style="list-style-type: none"> <li>15. Ensure that suicide prevention planning starts during the inpatient admission phase.</li> <li>16. Increase support for assertive follow-up at points of transition in care.</li> </ol>

<p>Risk Assessment and Documentation</p> <p>Collateral Information from Families, Carers and Friends</p> <p>Interservice Communication</p> <p>ED environments</p>	<p>17. Prioritise and integrate training for staff in the use of interventions specifically designed to target suicidality as part of clinical practice.</p> <p>18. Increase training and supervision of staff in best practice approaches to risk assessment and formulation.</p> <p>19. Foster further research into suicide risk assessment.</p> <p>20. Develop and resource demonstration projects (and subsequent generalisation and scaling up) of integrated technology-mediated interventions to incorporate service-specific online platforms for suicide prevention.</p> <p>21. Increase support for initiatives that decrease the shame and fear associated with speaking openly about suicide.</p> <p>22. Improve communication with families and carers.</p> <p>23. Develop specific service-integration resources to support linkages between NWMH services and primary care and other services (e.g., GPs, crisis accommodation, vocational services, drug and alcohol).</p> <p>24. Develop and resource a different model of care that works alongside ED departments that is designed specifically for people who may be feeling suicidal (e.g. Safe Haven Café).</p>
<b>Accessibility - Acute</b>	
<p>Capacity does not meet demand</p> <p>Planning and funding limitations</p> <p>Bed numbers</p> <p>Intensive Care Area (ICA) Beds</p> <p>Length of Stay (LOS)</p> <p>Maintaining a safe environment</p> <p><i>Sexual Safety</i></p> <p><i>Prisoners and Released Prisoners</i></p> <p><i>Environment – unfit for purpose</i></p>	<p>25. Increase Acute Bed Stock</p> <p>26. Increase both the number, and the percentage of Intensive Care Area (ICA) beds.</p> <p>27. Fund Acute Inpatient Units (IPUs) Adequately</p> <p>28. Improve Consumer Safety</p> <p>29. Reduce the Risk of Inpatient Unit Suicides</p> <p>30. Provide Adequate Capital Funding to Maintain the Amenity of IPUs and community facilities</p> <p>31. Support Strategies to Enhance the Therapeutic Nature of IPUs</p> <p>32. Provide mental healthcare to prisoners who need it, and support a more equitable distribution of persons released from prison(s)</p>
<b>Accessibility - Community</b>	
<p>Impacts on clinical mental health services in the community</p> <p>Homelessness and accommodation options</p> <p>Catchment areas</p>	<p>33. Increase community mental health services.</p> <p>34. Review service alignment and catchment area size.</p> <p>35. Change funding models.</p> <p>36. Increase funding to support after-hours clinical mental health care.</p> <p>37. Protect community mental health and annual capital growth funding.</p>

<p>Maintaining a safe environment for staff</p> <p>Information Technology</p> <p>After-hours and weekend access</p> <p>Access to NDIS</p> <p>Links with other services</p> <p>Dual Diagnosis</p> <p>Forensic Services</p>	<p>38. Develop and fund the deliverables of Digitising Victorian Mental Health Services plan.</p> <p>39. Review the mental health service reporting into the various minimum datasets to DHHS.</p> <p>40. Enhance the availability of services to work with consumers with enduring complex medium to long term mental health needs.</p> <p>41. Reform and expand community residential services to ensure there is a continuum of rehabilitation options including alcohol and drug (AoD) residential services.</p> <p>42. Expand crisis, transitional and permanent public housing with flexible provision of clinical outreach support.</p> <p>43. Generate agreed pathways of care for people with dual diagnosis and/or complex needs</p> <p>44. Invest in co-delivered services.</p> <p>45. Respond to the increased demand on mental health services from the forensic population.</p> <p>46. Improve integration of mental health services with other services across the broader health system.</p> <p>47. Develop and implement a state-wide policy for information exchange between all mental health services.</p> <p>48. Develop the mental health community support service workforce.</p> <p>49. Increase consumer and primary services providers' knowledge of the mental health system.</p>
<b>At risk groups</b>	
<p>Data collection</p> <p>Interface with other government sectors</p> <p><i>Education</i></p> <p><i>Housing</i></p> <p><i>Cultural safety</i></p> <p>Funding has fallen behind demand</p> <p>Research and evaluation</p>	<p>50. Improve data collection and reporting processes across all mental health services to quantify the prevalence of abuse, trauma, homelessness and their relationship to poorer mental health outcomes.</p> <p>51. Support investment in housing services that provide safe, supported housing for communities most at risk.</p> <p>52. Connect mental health professionals and GPs with schools.</p> <p>53. Support better connection and communication between GPs and Mental Health.</p> <p>54. Invest in and support more Aboriginal and Torres Strait Islanders working in mental health.</p> <p>55. Invest in the development of more culturally safe environments and interventions including those that encompass social, emotional, physical and spiritual well-being, traditional healing and trauma informed care.</p> <p>56. Expand the Peer Workforce and ensure appropriate support, training and supervision.</p> <p>57. Expand training for staff to address trauma, precipitating and perpetuating factors of poor mental health.</p> <p>58. Support the roll out of evidence-based initiatives such as the 7 NWMH practice domains.</p> <p>59. Invest in research and evaluation particularly in the areas of trauma, abuse psychosocial stressors more broadly and therapeutic interventions.</p>
<b>Families and carers</b>	
<p>Issues related to consumer care</p>	<p>60. Make family-inclusive practice core business and develop KPI's for family and carer contact.</p> <p>61. Increase brokerage funding to support families and carers in need and opportunities for respite.</p>

<p>(premature discharge, lack of safe therapeutic environments and reduced opportunities for psychosocial rehabilitation)</p> <p>Size of Lived Experience workforce (Carer)</p> <p>Variation of family service provision across services</p>	<p>62. Consider increasing the opportunities for services to provide respite for.</p> <p>63. Supporting young carers should be prioritised to reduce the likelihood of intergenerational trauma and risk of mental illness.</p> <p>64. Carer lived experience workers (consultant and peer work positions) should be increased to meet the demand.</p> <p>65. Increase support to particularly vulnerable carers, such as the elderly carers and those caring for behaviourally disturbed consumers.</p> <p>66. Create more dedicated family rooms, spaces for families and carers and children, on our inpatient units, PARCs, psychogeriatric residential facilities and CCUs.</p> <p>67. Improve responsiveness of services when families are seeking support.</p>
<b>Workforce</b>	
<p>Workforce and Succession Planning</p> <p>Lived Experience workforce – lack of training and support</p> <p>Impact of the ‘generic’ nature of work in clinical mental health services</p> <p>Workplace safety</p> <p>Undergraduate training</p>	<p>68. Increase the number of dedicated graduate positions for Allied Health, with pathways to more senior clinical roles – including provision of appropriate support and training.</p> <p>69. Support the growth of the Lived Experience workforce including supporting the provision of appropriate levels of training, support and supervision.</p> <p>70. Broaden workforce planning and development to ensure alignment of the mental health workforce with other service system reforms.</p> <p>71. Review workforce related funding models.</p> <p>72. Work to attract experienced staff from other sectors to fill our growing workforce needs could be enhanced by developing the Transition to Mental Health Practice Program further.</p> <p>73. Review roles/workforce models to ensure that best use is made of skills/expertise.</p> <p>74. Ensure there are opportunities for professional growth within each discipline, including options regarding both Operational and Clinical Leadership job opportunities/progression.</p> <p>75. Develop a robust professional development program to support implementation of psychosocial interventions.</p> <p>76. Review technology to support the mental health workforce, and to support new modes of service provision (e.g. opportunities around telehealth, technology to maximise safety, access, new ways of engaging).</p> <p>77. Allow specific time allocation for clinicians to provide publicly-funded psychological therapy.</p> <p>78. Improve state-wide coordination of mental health workforce learning and development.</p> <p>79. Further invest in the full range of disciplines and specialty groups within clinical mental health services, to include staff with dual diagnosis capabilities (especially in relation to alcohol and other drugs), cultural specialists, forensic specialists, family violence specialists, exercise physiologists, and dietitians, in order to provide integrated, evidence-based, holistic care.</p> <p>80. Further invest in specialist services such as Consultation Liaison Psychiatry, Neuropsychiatry, neuropsychology and Eating Disorders.</p>

	<b>81.</b> Develop and implement strategies to maximise safety and well-being of workforce. <b>82.</b> Review workforce 'pathways' and traditional education/training.
<b>Activity and social participation</b>	
<p>Closure and restructure of Mental Health Community Support Services (PDRSS, MHCSS)</p> <p>NDIS is failing people with a mental illness</p> <p>Working within a bio-medical model / reduced capacity to offer psychosocial interventions</p>	<b>83.</b> Invest in more psychosocial treatment / intervention opportunities within mental health services. <b>84.</b> Create opportunities for mental health staff to provide more outreach support. <b>85.</b> Reinvest in community support services including group activities such as social groups, drop in centres, and support groups for people with a mental illness. <b>86.</b> Support and invest in social enterprise employment opportunities. <b>87.</b> Connect employment and training support services with mental health services.