

# New Directions for Victoria's Mental Health Services

## The Next Five Years

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# Introduction

I am very pleased to present New Directions for Victoria's Mental Health Services which outlines the Victorian Government's priorities for the development of mental health services provided to consumers and their carers, over the next five years.

Although Victoria continues to lead the way in the provision of a comprehensive community oriented public mental health system, within Australia and internationally, demand for treatment and support by people with mental illness continues to grow. Currently one in five people experience a mental health problem with depression predicted to rise from the fourth to the second most common cause of global disease over the next twenty years. Growing service demand by consumers with more serious forms of mental illness, combined with increasingly complex consumer presentations, clearly indicate the need for a new stage in reform of the specialist mental health system.

The directions outlined in this paper for the next five years will position mental health services to better respond to existing and future demand for care, by building on the strengths of the current system, developing an appropriate mix and level of services and implementing new and innovative approaches to consumer needs. The new directions include a range of initiatives that will expand the *capacity of services* to respond to growing demand, starting with the opening of 30 additional inpatient beds in 2002–03; create *new service options and alternatives to inpatient care* to improve consumer outcomes; provide the *practice based evidence* needed to inform future service responses; reduce the *incidence and impact* of mental illness and the need for high-intervention services through early intervention and relapse prevention strategies; build a *stronger workforce*; and further *strengthen consumer and carer involvement*.

Central to realising the Government's vision for mental health care are a number of innovative initiatives that have been developed, including:

- New sub-acute services, with 30 beds opening in 2002–03, which will provide much needed transitional 'step-down' services between acute inpatient and community based services for people recovering from acute illnesses who need additional support to successfully manage in the community.
- Specific responses tailored to the needs of young people, which will focus on responding to earlier phases of illness to reduce the incidence and impact of mental health problems.
- New service models that will provide an integrated care response to the needs of the growing group of people with both mental illness and a substance abuse problem.
- Re-engaging the workforce through a comprehensive strategy that will attract and retain skilled people in all mental health disciplines.

These and other new mental health service initiatives flagged in this paper will be underpinned by long term planning and structural improvement to better manage demand for services and improve the quality of care.

This document has been informed by extensive consultations undertaken with mental health consumers, carers, service providers and key stakeholders, and I look forward to working with all of these groups to further develop and implement the new directions.



**Hon John Thwaites MP, Minister for Health**

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# The Need for New Directions

This section outlines the main reasons for undertaking a new stage of mental health reform in Victoria, including the relevant policy and historical context and progress with reform to date.

## Victorian Government Policy

Policies and plans for the future of mental health services have been shaped by *Growing Victoria Together*, Victoria's whole-of-government social policy framework. Key elements of *Growing Victoria Together* include:

- Reducing inequality and disadvantage
- Developing cohesive, caring and safe communities
- Improving access to high quality health, community and education services
- Protecting rights and respecting diversity
- Supporting community participation and partnerships between Government and community stakeholders.

*Growing Victoria Together* also reflects the Government's commitment to sound financial management of public services. One of the Government's key strategies is to support initiatives that will reduce the need for costly, high-intervention services (such as inpatient and residential care). Prevention and early intervention are seen as vital for all age groups to reduce the incidence and harmful consequences of health and social problems.

*Growing Victoria Together* includes strategies for responding to increased demand for health and other social services, including the service needs of an ageing population and the increased complexity of young people's needs.

There is also an emphasis on improving access to local health services—particularly in rural and regional areas—and on strengthening relationships between and within local services to help build a 'sense of common purpose' and improve coordination of care for individuals.

## Service Development in Related Human Service Programs

A critical aspect of mental health planning is the need for effective linkages and coordination with services that have similar or overlapping consumer<sup>1</sup> groups. While much has been achieved over the past few years in improving the linkages between different human service programs, there is still much to do in this area. As a starting point, plans for the future development of mental health services should take into account other service developments that will affect mental health consumers, and other people in the community who may need assistance with mental health problems.

Relevant service development initiatives that are occurring within the Department of Human Services ('the Department') include:

- Primary Care Partnerships
- The Working Together Strategy
- 'Responding to People with High and Complex Needs' Project
- Hospital Demand Management Strategy
- Homelessness Strategy
- DisAbility State Plan
- Acquired Brain Injury Service Plan
- Supported Residential Services (SRS) Demand Management Strategy.

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1. A consumer is defined as a person making use of mental health services.

## National Mental Health Strategy and Plans

Following the adoption of a National Mental Health Strategy in 1992, all state and territory health ministers endorsed the *First National Mental Health Plan* for the five years from 1992–93 to 1997–98. The *First Plan* focused on moving mental health care away from stand-alone psychiatric institutions to a community-based system of care. Other key themes included consumer rights; support for carers<sup>2</sup> of people with mental illness; and measurement of service performance and consumer outcomes.

A *Second National Mental Health Plan* was developed for the years 1997–98 to 2002–03. The *Second Plan* maintains the commitment to the principles enunciated in the *First Plan*, while calling for a broader ‘population focus’ for mental health and special efforts to tackle high prevalence disorders such as depression. Depression and anxiety disorders have been identified as a leading cause of disability in the community and can be expected to increase in prevalence over the next twenty years.<sup>3</sup>

The *Second Plan* asserts that the ‘burden’ associated with mental health problems should be addressed through greater attention to mental health promotion, illness prevention, early intervention and relapse prevention. The *Second Plan* argues that, although they are targeted to the estimated three percent of the population with serious mental illness, mental health services should be seen as one component of a broad system of services that affect mental health outcomes. The need for stronger links between mental health services and other health and social services is a key theme of the *Second Plan*. It also emphasises the need to improve the quality and effectiveness of mental health care, in both specialist and primary care settings.

A mid-term review of the *Second Plan*, completed in November 2001, identified areas requiring particular attention. These included service responses to people with co-existing substance abuse and mental illness, mental health coordination with other health and support services, workforce shortages, and the need for more research into models of primary mental health care. The review also indicated universal support for a third national mental health plan.

The Victorian Government supports the National Mental Health Strategy and is committed to working with the Commonwealth Government to improve responses to people with mental health problems in the community.

## Mental Health Reform to Date

Modernisation of Victoria’s mental health services began in the mid 1980s with the closure of some large psychiatric institutions and the redirection of mental health resources to community services.

A second stage of mental health reform in Victoria paralleled the *First National Mental Health Plan*. More than any other State, Victoria met the challenges of the *First Plan*, introducing a systematic approach to the closure of psychiatric institutions and replacing these facilities with mental health services in the community as an integrated part of the general health system.

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2. A carer is defined as a person whose life is affected by his or her close relationship with a consumer, or who has a chosen and contracted caring role.

3. World Health Organisation (1996), *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020*.

The main elements of the second stage reforms, which were implemented in the mid to late 1990s, were:

- Decommissioning of all remaining psychiatric institutions.
- Replacing these services with a system of ‘mainstreamed’ inpatient mental health services (co-located with general hospitals or general aged care services) and community-based assessment, treatment and support services.
- Grouping of services into area mental health services (AMHS) across Victoria, each of which provides a range of services—covering both inpatient and community clinical treatment, and disability support—to a defined geographic catchment.
- Prioritising services for people with ‘serious mental illness’ and/or significant psychiatric disability.

The 1990s reforms established the structure of the current service system, as described in Appendices One and Two.

Since 1999, the Victorian Government has implemented a number of major new service initiatives in response to the further reforms outlined in the *Second National Health Plan*, as described under ‘Recent Mental Health Initiatives’ (page 11). In particular, the establishment of Primary Mental Health and Early Intervention teams and Victoria’s participation as an active partner in *beyondblue: The National Depression Initiative* has strengthened the capacity of the State’s mental health services to respond to high prevalence mental health problems.

## The Need for a New Stage of Service Development

There is widespread agreement that Victoria has laid the foundations of a comprehensive public mental health service system. The mental health system is now well established, and contains most of the elements needed to effectively treat and support people with mental illness. However, while previous service reforms have led to considerable gains in mental health care, further improvements are required to better meet the needs of people with severe and ongoing mental health problems, and those with more complex needs.

A new stage in the continuum of reform is needed to enable Victoria’s mental health system to:

- 1 Manage the growing demand for mental health services.
- 2 Respond to increasingly complex consumer needs—particularly the needs associated with increasing drug use amongst young people with mental illness.
- 3 Develop improved responses to consumer and carer needs, including developing new models of care - particularly for people with high needs.
- 4 Establish and maintain an appropriate balance between inpatient and community-based services.
- 5 Address workforce challenges, including education, training, recruitment and retention.
- 6 Ensure the future sustainability of services.

This stage of service development will be underpinned by evidence-based practice, informed by research and evaluation.

These key areas are driving the new stage of reform and are discussed over the page.

## 1) Growing Service Demand

Demand for public mental health services in Victoria has grown strongly since 1997–98. Numbers of registered clients have risen from 40,394 in 1997–98 to 53,443 in 2000–01. Community-based clinical contacts increased by 36 percent over that same period.

Factors contributing to increased demand for mental health services include:

- Increased numbers of people with a serious mental illness due to population growth.
- Increased prevalence of mental health problems, especially depression and related disorders.
- Improved community recognition of mental illness and treatments for these conditions.
- Increased numbers of people with age-related psychiatric disorders due to the aging population.
- The growing complexity of consumer needs.
- Increased rates of mental illness triggered or exacerbated by substance abuse.

In response to growing demand for mental health services, the Department is expanding existing services and has commenced the development of a demand management strategy. This strategy will address service system pressure points through service improvement and diversion initiatives. It will also focus on the further development of need reduction strategies, including strategies relating to prevention and early intervention. Enabling services to provide more timely and effective interventions through better demand management will result in improved outcomes for consumers.

## 2) Increased Complexity of Consumer Needs

Public providers of adult mental health services estimate that over 50 percent of new consumers present with problematic substance use, as well as mental illness. This change in the consumer profile has a major impact on clinical caseloads, as these consumers commonly require more integrated, intensive and ongoing treatment.

In addition to people with both mental illness and substance abuse (a ‘dual diagnosis’), service providers are increasingly seeing consumers who have multiple and complex social and health problems, including histories of abuse, intellectual disability, criminal behaviour, homelessness and general welfare issues.

An increase in the number of consumers—particularly teenagers and young adults—who have severe and complex social, behavioural and emotional problems has been noted by other health service providers, and by education, welfare, justice and police and emergency services. These problems tend to be difficult to treat and manage in traditional service settings, which often leads to poor clinical and social outcomes for consumers.

Other factors contributing to the changing nature of mental health presentations include:

- Growth in the number of older consumers, who tend to have more complicated presentations.
- The need to support people with higher-level mental health needs in the community, as a result of the closure of large psychiatric institutions and reduced lengths-of-stay in inpatient facilities.

### 3) Need for Improved Responses to Consumer and Carer Needs

As noted on page 4, the service reforms of the 1980s and 1990s involved a shift in the focus of care to the community and the provision of local mental health services consistent with other health services. As a result of these reforms, there is now a growing group of consumers who have experienced 'mainstreamed' mental health care. While they receive mental health treatment and psychiatric disability support, the social, physical, accommodation and general welfare needs of consumers may only be partially met.

The availability of more psychiatric disability support services (PDSS)<sup>4</sup> and more options for intensive community-based care, supported accommodation and extended residential care would enable the mental health system to meet a broader range of consumer needs, ease carer burden and support a sustainable mental health system. At present there is a high level of demand for these service types. The demand for PDSS home-based outreach support is of particular note, as these services assist people with serious mental illness to obtain and maintain public housing tenancy<sup>5</sup>. The need for supported housing for people with mental illness has been exacerbated by the decline in low cost private accommodation, especially in pension-only supported residential services<sup>6</sup>.

Additional community-based mental health services (including improved continuing care case management and expansion of inpatient capacity) are also considered necessary to ease pressure on acute inpatient beds and manage service demand. The total number of acute inpatient beds has increased since 1997–98 (refer to Table 1), but these increases have not kept pace with the average 6.4 percent growth in the number of registered clients over the past four years. Based on the latest comparative data (1998), the availability of general acute inpatient beds in Victoria was below the national average of 24.4 beds per 100,000 adults by 2.6 beds.

**Table 1: Acute Inpatient Bed Increases from June 1998 to June 2002**

Month/Year	Number of Beds
June 1998	917
June 1999	903
June 2000	940
June 2001	949
June 2002	949

Although Victoria's acute inpatient beds are being used more efficiently, there are 'bed blockages' due to a lack of suitable options for moving patients from inpatient beds to the community. In 2000–01, eight percent of patients stayed more than 35 days in adult acute inpatient services.

### 4) Need for a Balance of Care

The continuing success of the service reforms depends on having both sufficient inpatient services to stabilise people who are acutely unwell and access to a range of community-based services aimed at reducing relapse and readmission amongst people with mental illness.

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4. Psychiatric Disability Support Services provide practical assistance to enable consumers to live in the community. Services include day rehabilitation programs, home-based outreach, respite and residential programs.
  5. *The Second National Survey of Mental Health and Well Being (1999)* identified a lack of supported accommodation services and high levels of homelessness for people with psychotic disorders.
  6. Supported residential services are private businesses that provide accommodation and care on a fee for service basis. A number of these services cater specifically for low income people with complex needs.

The effectiveness and efficiency of the whole mental health system requires the right ‘balance’ between inpatient and community-based services. When community-based services are not available or under pressure, the mental health system is less likely to be responsive at earlier phases of the consumer’s illness, thus diminishing the capacity to maintain people in the community and placing pressure on resource-intensive inpatient services.

The efficient use of inpatient services, and the ability of services to discharge people at an appropriate time, depends on having supports in the community and the effective use of community-based resources. For example, provision of additional community services and programs and extended care places, including some secure beds, would free up a number of adult acute beds and provide consumers with better options.

An additional element in the ‘balance’ of mental health care is the need to provide an appropriate level of resources to mental health prevention and early intervention. In the longer term, these activities can be expected to ease pressure on both inpatient and community-based mental health services.

## **5) Workforce Challenges**

A major factor in determining the ongoing sustainability of mental health services will be the effectiveness of strategies to address workforce issues.

The current workforce in Victorian public mental health and PDSS services comprises approximately 4000 clinical staff (including psychiatrists, other medical staff, nurses and allied health professionals) and 700 non-clinical staff (including consumer or carer consultants). The majority of clinical staff are nurses.

The reforms of the mid to late 1990s were not supported by a comprehensive workforce development plan. A particular issue was the devolution of workforce education funding and responsibility to the new area mental health services. These changes limited the capacity of the workforce to keep pace with service developments and resulted in variable levels of in-service education and training.

Concurrently, there were changes to the undergraduate curriculum for psychiatric nursing which was, until the mid 1990s, a direct entry course. The curriculum was changed in line with mainstreaming and integration to include a base level of psychiatric training within a general nursing course. To specialise in psychiatric nursing it is now necessary to undertake post graduate studies.

Public mental health services face serious difficulties in recruiting and retaining skilled staff. There are shortages of psychiatrists, and nurses in mental health—especially in inpatient and aged care services—and a lack of other mental health allied health professionals. These shortages are particularly evident in rural areas.

As well as problems in attracting skilled staff to the public system, it is difficult to retain them, especially psychiatrists, once they have completed an initial training period.

## **6) Service Sustainability and Infrastructure**

Members of the mental health sector have suggested that the area mental health service (AMHS) model may not be sustainable in all locations, and that resource pressures are already leading to movement away from the originally prescribed structures (as described in Appendix One). These

issues have led to a number of Health Services integrating area mental health services under their responsibility, to enable more flexible use of available resources and provide improved workforce support and services.

Approaches to resource allocation have resulted in variable access to mental health services across the State. This is a particular issue for bed-based services—such as secure extended care, PDSS residential rehabilitation and acute inpatient services—where equitable resource distribution based on changing needs is constrained by the availability of costly capital infrastructure and the capacity to replace and expand this infrastructure. This issue has been exacerbated by the reductions in inpatient beds during the reforms of the 1990s which occurred without sufficient provision for other types of bed based services and the associated capital and support infrastructure, to maintain an appropriate balance of care across the system.

Improved access to beds relies on an appropriate mix in the types of bed and non bed-based services available for people within a defined geographic area and the efficient management of those services. The Department has commenced a project which will identify the range of bed-based services needed in different areas of the State and inform future planning decisions regarding these services.

The *Review of Adult Acute Inpatient Mental Health Services* found significant differences between areas in respect to access to beds, cost of services and work practices. Similarly, the recent *Review of Statewide and Specialist Mental Health Services* identified variability in specialist models and access to specialist services, as well as lack of clarity about the role of some services in the broader mental health service system.

Table 2 summarises key recommendations contained in the above Reviews and related Departmental responses. In some instances responses have already been implemented. Other responses will form part of more comprehensive strategies currently being developed. Further details can be found in the *Directions for the Next Five Years* (page 15) and *Making it Happen: Leadership, Support and Structural Change* (page 41) chapters.

**Table 2: Adult Acute Inpatient and Statewide and Specialist Reviews**

Major Recommendations	Responses
Clarify role and function of services	<ul style="list-style-type: none"> <li>Examination of the role and function of services referred to on page 42</li> </ul>
Further analyse and develop funding models	<ul style="list-style-type: none"> <li>Current review of the resource allocation formula referred to on page 41</li> <li>Assessment of output and casemix approaches referred to on page 41</li> </ul>
Assess inpatient cost differences between agencies	<ul style="list-style-type: none"> <li>Current study of cost drivers for inpatient services</li> </ul>
Improve agency accountability for expenditure	<ul style="list-style-type: none"> <li>Development of key performance indicators linking activity to funding levels referred to on page 41</li> </ul>
Increase the focus on quality improvement	<ul style="list-style-type: none"> <li>Development of practice protocols and guidelines referred to on page 44</li> <li>Extension of clinical outcome measurement to all mental health services referred to on page 42</li> </ul>
Improve workforce training, education and professional development	<ul style="list-style-type: none"> <li>Development of a comprehensive workforce plan referred to on page 34</li> </ul>

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## Recent Mental Health Initiatives

Since 1999, the Victorian Government has responded to a number of important mental health issues. The 2000–01 and 2001–02 State Budgets included significant new recurrent funding for Victorian mental health services. The 2000–01 Budget provided an additional \$9.8 million for new initiatives and to enable services to keep up with growth in demand. The 2001–02 Budget provided a further \$7.5 million for mental health services.

Amongst its major achievements, the Government has:

- Established **Primary Mental Health and Early Intervention teams** in all Area Mental Health Service (AMHS) catchments. The teams will assist local primary care providers to recognise and treat mental health problems—particularly high prevalence disorders such as depression—by providing education, training, secondary consultation and short-term shared care. This initiative also includes a specific service to prevent mental health crises and improve early intervention for young people.
- Established the **statewide dual diagnosis program** to assist consumers who have both mental illness and drug use problems. The program provides training and consultation to mental health staff, and also has a direct service component.
- Established a **Victorian centre of excellence in eating disorders**. The centre will develop and promote best practice in the treatment of eating disorders. In addition, new eating disorder services have been established in Geelong and Bendigo.
- Collaborated with the Commonwealth Government in the creation and funding of *beyondblue: The National Depression Initiative*. *Beyondblue* aims to improve community awareness of depression and associated disorders, and to promote effective treatment and care for people with these conditions. Under the aegis of *beyondblue*, a **centre of excellence in depression and related disorders** has been established in Melbourne.
- **Improved acute inpatient bed availability** through increasing bed occupancy rates.
- **Expanded clinical and disability support** to homeless people with complex needs.
- **Improved employment conditions for psychiatric nurses**. The creation of 116 additional senior nurse positions, and more training places for specialist graduate nurses has given nurses greater access to clinical support, education and supervision.
- **Increased the number of direct care staff** in mental health services.
- Supported **MindMatters**, a school-based mental health promotion program funded by the Commonwealth Government.
- Supported **VicHealth's comprehensive mental health promotion plan** for the period 1999–2002. The plan aims to increase community understanding of mental health issues and to identify models of best practice in mental health promotion. The plan's main themes are 'social connectedness', 'valuing diversity', 'working against discrimination', and 'economic participation'.
- Coordinated the **Suicide Prevention Strategy** and implemented a number of suicide prevention initiatives, including gay and lesbian support services for young people and research projects to inform future service development.

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# Principles

The following principles will guide the development of Victorian mental health services for the next five years:

## Priority to Those in Greatest Need

People who are most severely affected by mental illness will continue to receive priority for public mental health services, and the needs of this group will be specifically researched and evaluated. As discussed on page 42, the Department will—where necessary—clarify the targeting of particular service types.

## Care in the Community Whenever Possible

Mental health care will continue to be provided in the community whenever possible. This requires a range of services to support consumers moving from inpatient facilities to the community, and crisis and relapse prevention services. At the same time, consumers should have access to inpatient services when this level of care is the most appropriate.

Mental health legislation states that mental health care should be provided in the least restrictive setting that enables the effective provision of care and using the least intrusive intervention consistent with the safety and protection of consumers, their families and friends, and the wider community.

## Consumer and Carer Participation

The Government is strongly committed to consumer and carer participation in the development and review of mental health services, and the involvement of consumers and carers as active partners in individual treatment and care planning.

## Service Quality and Responsiveness

Improving the quality and effectiveness of all health and social services is a key goal of the Government. Services should meet accepted standards of good practice, be within reasonable reach of where people live, and available when people need them. The availability of a suitably skilled workforce is a major prerequisite in achieving these improvements.

Services should also be responsive to consumer's individual needs. Victoria's *Growing Victoria Together* policy identifies several groups that may require special strategies to help them access health and welfare services. These include women, indigenous communities, people from culturally and linguistically diverse backgrounds, and people in rural areas. The diversity of Victoria's population means that flexibility and innovation are important in responding to community needs, especially in rural areas.

## Continuity of Care

The Government believes that services should offer 'continuity of care' for consumers. This requires the different parts of the mental health system to work effectively together and to develop strong relationships with primary care, education, disability, housing, welfare, aged care, and other services.

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## Directions for the Next Five Years

This section describes the Government's priorities for the development of public mental health services over the next five years. It outlines strategies and priority actions that will help the service system meet current and future demand for mental health care.

These directions have been shaped by a range of consultations, service reviews, and recent data on the mental health needs of the Victorian community. In particular, the Department has been informed by a series of focus groups conducted between October 2001 and February 2002. The focus groups brought together consumers, carers, clinicians, service providers and others with experience and understanding of mental health issues. During 2001 specific consultation processes were also undertaken regarding services in rural Victoria and services for children and adolescents.

A prominent feature of these consultations was the extent of common ground in people's views on the way forward for mental health.

The consultations and reviews provided many valuable ideas and suggestions for improving the service system. Six key directions have been identified on the basis of this feedback and other information on the need for change in the mental health service system. These are:

- Expanding service capacity
- Creating new service options
- Extending prevention and early intervention
- Building a strong and skilled workforce
- Strengthening consumer participation
- Improving carer participation and support.

### The 2002–03 State Budget

The recently announced 2002–03 State Budget provides additional recurrent funding of \$61 million over four years for growth in key mental health service types and for new initiatives designed to address gaps in the service system. These initiatives represent the first phase of implementing the Government's new mental health directions.

The \$15 million in new funding in 2002–03 includes:

- \$4 million to re-open approximately 30 **acute inpatient psychiatric beds** to deal with current demand and expected demand growth in 2002–03.
- \$6.32 million to expand **adult and aged clinical community services** and **psychiatric disability support services**.
- \$2.76 million to **pilot 'sub-acute' services** in Melbourne and a regional centre. A total of 30 short-stay sub-acute places will be involved in the pilot projects.
- \$1.16 million to provide **clinical and support services linked to 50 Office of Housing properties** that have been prioritised for people with mental illness, and to assist the implementation of the Rooming House Plus Project.
- \$0.36 million for two pilot programs providing **innovative dual diagnosis services to young people** who have both mental illness and a drug abuse problem.
- \$0.4 million for a **rural workforce initiative** to enhance professional supervision and secondary consultation for clinical staff in rural mental health services.

## Priority Action Areas

New recurrent funding for mental health in 2002–03 will be used to implement the priority actions identified for each of the six key directions. Each action is associated with a range of specific initiatives, some of which will be implemented immediately (that is, in 2002–03).

Specific initiatives identified as future priorities will be developed and implemented progressively over the next five years as funding becomes available. These developments will be informed by an ongoing program of research and evaluation that will identify the most effective approaches to service development from a clinical, cost and demand management perspective.

In addition, further initiatives will flow from the planning and structural improvement work discussed in the remainder of this section and the next section (see *Making it Happen: Leadership, Support and Structural Change* page 41).

## Expanding Service Capacity

One of the most important considerations in the mental health area is the need for service growth to keep pace with increasing demand for mental health treatment and care.

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### Action 1: Strengthen the capacity and quality of acute inpatient services

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Efficient and effective use of acute inpatient beds is highly dependent on improving the availability and responsiveness of non-acute services (including sub-acute, extended care, intensive supported accommodation services, and PDSS) and strengthening assessment processes in all parts of the service system. Greater availability of community-based options will allow for substantially improved access to acute inpatient beds, with a relatively modest growth in bed volume.

#### Immediate Response

The Government recognises there is a need to increase the capacity of acute inpatient services and is taking action in 2002–03 to open approximately 30 acute beds, including some that have been closed in previous years, to ease pressures on inpatient services. This will occur within existing capital infrastructure and mainly in metropolitan areas, although there will be some provision for extra beds in regional centres where there is high demand on inpatient services.

#### Future Priorities

A range of responses to demand for acute inpatient services will be considered, including the improvement of consumer access to the different types of bed-based services available in inpatient and community settings. These responses will also include the development of services that provide pathways out of inpatient beds and, where appropriate, alternatives to inpatient admissions.

Priority will be given to the following strategies:

- Planned development of capital infrastructure to enable further increases in acute inpatient beds in adult, aged and Child and Adolescent Mental Health Service (CAMHS) services.
- Development of new sub-acute and intensive treatment and support models.
- Strengthening of in-home acute treatment by Crisis Assessment and Treatment Services (CATS).
- Ensuring that Community Care Units (CCUs) are used in the most effective way.
- Identification of options for improved local inpatient care arrangements in rural areas.

Key issues identified in the *Review of Acute Inpatient Mental Health Services (2000)* referred to on page 9 will be addressed through:

- Further development of clinical and service guidelines
- Staff training
- Improved bed management
- Possible expansion of secure extended care beds (to assist in preventing people who need this level of care from being placed in acute psychiatric inpatient services for extended periods).

The need for further increases in inpatient bed numbers will depend on the impact of demand management strategies and the following measures to provide better access to inpatient services:

- Improved distribution of inpatient services across the State.
- Improved availability of a range of bed-based services.
- Improved collaboration between inpatient services in different areas.
- More flexibility in the application of catchment boundaries.
- Better coordination of CATS and bed-based services.
- Improved discharge planning and continuing care case management.

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## Action 2: Strengthen services for young people aged 16 to 25 years

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The need for improved service responses for young people (aged approximately 16–25 years) emerged as a prominent theme in recent mental health consultations. This age range represents a peak period for the onset of psychiatric symptoms. Unresolved mental health problems in these years can seriously damage young people's psychosocial development and future life opportunities.

Existing mental health services are usually focussed on 'children and adolescents' or 'adults'. However, there is growing awareness that young people have special needs and that more effort is required to make all health services acceptable and accessible to them. The high incidence of substance use in this group presents particular difficulties.

In particular, there is a need to coordinate services for young people, both within the mental health system and with other health and support services. Significant benefits can be derived from implementing integrated approaches to meeting the special needs of young people, including the development of comprehensive responses to the growing complexity of problems evident in this age group.

Benefits of coordinated early intervention programs for young people include:

- Minimising the disabling effects of serious mental illness.
- Reducing poor clinical and social outcomes such as self-harm, criminality and homelessness.
- Improving capacity for community participation, education and future employment.

### Immediate Response

The 2002–03 State Budget provides funding to trial the expansion of existing dual diagnosis programs for young people with co-existing mental illness and substance abuse in metropolitan and rural Victoria. This initiative responds to growing evidence that standard treatments for substance abuse are ineffective when substance use is combined with or triggers psychosis. The Substance Use Mental Illness Treatment Team (SUMITT) evaluation in 2000 found that integrated mental health/drug treatment approaches have positive outcomes, and are particularly effective for young people.

### Future Priorities

Future priorities for the development of services for young people are:

- Extension of early treatment programs for first episode psychosis.
- Further development of specific models of PDSS to meet the needs of young people which focus on recreational and outdoor activities as part of rehabilitation and respite programs.
- Strengthening the capacity of CAMHS to provide assessment and treatment on an assertive outreach basis.
- New measures, such as joint case management prior to handover, to improve the transition from CAMHS to adult mental health services.
- Strengthening the relationship between CAMHS and other services, such as education, to enhance the capacity of these services and achieve better outcomes for young people.
- Further development of suicide prevention initiatives aimed at improving access to mental health services for young people, particularly those in rural and remote communities.
- In collaboration with other Departmental programs, support for the development and evaluation of integrated youth health centres that bring together a range of health, mental health and drug and alcohol services.

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### **Action 3: Provide additional services for older people with mental illness**

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Further strengthening of aged persons mental health services (APMH) is required to meet demand from the growing number of older people with mental illness. The ageing of the population will continue to lead to an increased prevalence of age-related psychiatric disorders in:

- People who develop disorders such as depression for the first time in later life.
- People who develop psychiatric symptoms and behavioural disturbance associated with organic brain disorders such as dementia.
- People with longstanding mental illness that is complicated by conditions of ageing.

In addition to responding to growing demand, there is evidence that current service models require further development if they are to be responsive to the particular needs of older people. For example, more specialised psychosocial rehabilitation approaches are required if older people with mental illness are to overcome social isolation and associated health problems.

#### **Immediate Response**

In 2002–03, additional resources will be used to provide approximately 15 extra clinical staff for APMH teams across the State, which will assess and treat older people in their own homes and in mainstream residential aged care. Recent evaluations suggest that APMH teams are effective in improving clinical outcomes for older people with mental illness. They also contribute to reducing the need for acute inpatient services and APMH residential services.

#### **Future Priorities**

Future priorities for the development of services for older people are:

- Further development of APMH teams, to support mainstream aged community and residential services caring for older people with a mental illness.
- Strengthening links between aged acute inpatient services and APMH and other residential services.
- Improving consumer pathways from acute to APMH and other residential care services, including the development of transitional 'step-down' services.
- Expanding psychosocial activity programs targeted at older people as part of the delivery of PDSS.

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### **Action 4: Strengthen service responsiveness to parents with dependent children**

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Parents with mental illness with responsibility for dependant children have been identified as a group in need of specific forms of support and assistance. Family focused care practices are required to support these parents, and also to meet the needs of their children, particularly when a parent with a mental illness has primary or sole parenting responsibility.

Currently there are a number of programs and services in Victoria that focus on the needs of parents with a mental illness and their dependent children. These include:

- Peer support groups and camps for children who have a parent with a mental illness.
- Paying Attention to Self (PATS), a specific program for adolescents who have a parent with mental illness, conducted by the Centre for Adolescent Health.
- The *Hard Words* video, a training aid targeting children, parents and health, welfare and education professionals. *Hard Words* aims to raise awareness of the issues facing children who have a parent with a mental illness.

A number of relevant support services and programs to assist women with mental illness who have parenting responsibilities are being developed in the context of the Government's *Women's Health and Wellbeing Strategy*<sup>7</sup>.

### **Immediate Response**

As part of the expansion of psychiatric disability support services to be funded in 2002–03, additional staff will be employed in two specialist pilot projects that will provide practical home-based support and links with community services for women with a mental illness who have dependant children. This initiative complements two other initiatives being undertaken to improve the health and well-being of women and children. These initiatives include:

- Detection of antenatal and postnatal depression by primary care services, including maternal and child health services and general practitioners<sup>8</sup>.
- Building partnerships between mental health, sexual assault and domestic violence services.

### **Future Priorities**

Further development of services and programs for women with mental illness will occur in the context of the *Women's Health and Wellbeing Strategy*.

Within the mental health program, priority will be given to the development of specific program guidelines and in-service training in case management and care practices focusing on the needs of parents and dependant children.

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## **Action 5: Expand Aboriginal specific services**

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The Mental Health Branch has worked closely with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to develop a strategic plan to improve service responsiveness to the social, emotional and cultural needs of Aboriginal people.

### **Immediate Response**

Evaluation of the strategic plan will occur during 2002–03. The outcomes of the evaluation will inform the development of initiatives that build on existing mental health services for Aboriginal communities.

### **Future Priorities**

Future priorities for the development of Aboriginal specific services are:

- Establishment of ongoing arrangements for mental health Koori liaison positions in all rural area mental health services.
- Further development of partnerships between Aboriginal health and mental health services, particularly the links between Primary Mental Health and Early Intervention teams and Aboriginal health services.

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7. The Government's *Women's Health and Wellbeing Strategy* will outline key strategic directions for improving the health and wellbeing of Victorian women, particularly those who are most disadvantaged. The Strategy will aim to improve women's mental and emotional health through gender specific initiatives targeted at the most disadvantaged groups, for example, women with mental illness, women at risk of depression and young lesbian women.

8. *Beyondblue* funding.

- Further development of home-based outreach models for Aboriginal people. This follows the successful development of a home-based outreach support program within the Victorian Aboriginal Health Service in 2001.
- Support to indigenous services to develop effective links with mainstream health services in relation to suicide prevention in indigenous communities and provide training for mental health staff on indigenous issues.

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### **Action 6: Further develop services for people from culturally and linguistically diverse communities**

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Since 1996, the Victorian Trans-cultural Psychiatry Unit (VTPU) has been funded to assist area mental health services to improve access and service responsiveness to culturally and linguistically diverse (CALD) communities. The Unit provides education and training, community development, research and consultancy services.

Other recent initiatives that assist mental health services to improve services to people from CALD communities include:

- Provision of ethnic mental health consultants and support for employment of bilingual case managers in services.
- Funding for projects on specific aspects of service delivery to CALD communities, including the CAMHS cultural competence project.
- Funding to the Victorian Foundation for Survivors of Torture for counselling services.
- Funding to organisations that advocate for people from CALD communities, including Action on Disabilities in Ethnic Communities (ADEC) and the Ethnic Council of Victoria.

### **Immediate Response**

- Continued participation in the national program of multicultural mental health and suicide prevention.
- An evaluation of specialist trans-cultural services commencing in 2002–03. This process will examine how mental health services can be supported to develop practices, service models and referral pathways that respond to the needs of CALD communities.

### **Future Priorities**

Future priorities for the further development of trans-cultural services are:

- Improving linkages between the VTPU and the Ethnic Mental Health Consultant program and enhancing the ability of these programs to provide integrated support and advice to clinical and PDSS services.
- Implementing a strategy for the provision of language services to PDSS services.
- Supporting the expansion of the bilingual case manager program within specialist mental health services.
- Strengthening trans-cultural secondary consultation services, which assist clinicians in specialist mental health services.
- Providing education and training on trans-cultural issues and primary mental health to general practitioners and mental health staff.

## Creating New Service Options

Recent consultations and reviews of mental health services have identified areas where the service system requires development in order to better meet consumers' needs. Additional funding in 2002–03 will be used to develop and implement some new service models in the mental health service system.

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### Action 1: Develop new sub-acute (step-down) models of mental health care

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Acute psychiatric inpatient units are integrated with general hospitals and are designed to provide intensive short-term treatment for acute episodes of mental illness. Admission to an acute inpatient facility may be a difficult experience for both consumers and carers.

Consumers, carers and service providers have consistently identified the need for improved treatment and support options as possible alternatives to admission and following discharge from inpatient services. At the same time, service providers report that the limited range of intensive treatment and support options in the community can reduce their ability to discharge some consumers from inpatient units. This is an issue for inpatient services across all age groups and is of particular concern for adult and older persons inpatient services.

### Immediate Response

In 2002–03, new sub-acute service models will be developed and piloted in Melbourne and in a major rural centre. The pilots will offer 30 new sub-acute places, including bed-based services and, if needed, in-home support. The initiative will aim to reduce the need for inpatient services by providing:

- Post-acute treatment and support for consumers recovering from an acute phase of illness, but not yet ready to return to their usual accommodation.
- Short-term flexible funding packages for consumers requiring support on returning home.
- Treatment and support to people experiencing a mental health crisis that, if unmanaged, may lead to an inpatient admission.

The sub-acute facilities will provide clinical, therapeutic and support services. They will be staffed by clinical and support staff, who will be assisted by the local CATS.

### Future Priorities

Subject to evaluation and evidence that the new sub-acute services reduce demand for acute inpatient services, sub-acute service models, including suitable models for older people, will be progressively developed and extended to other areas over the next five years. Specific models of sub-acute care for rural areas will also be developed.

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### Action 2: Develop intensive accommodation support services for people with high needs

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Focus group participants highlighted the need for more supported accommodation for people with ongoing mental illness and associated disabilities. The perceived value of these services is consistent with overseas studies showing that people with mental illness experience lower rates of relapse and admission to inpatient facilities when they have stable housing combined with support services.

People with mental illness may need intensive support in order to maintain their tenancy in community accommodation, including supported residential services and public housing. New support and accommodation service models are needed, particularly for people with high-level health and social needs.

People with mental illness who are homeless, or at risk of homelessness, are one of the groups to benefit from increased funds to social housing and homelessness services through recent State budgets. Initiatives that have specifically targeted homeless people with mental illness include:

- Significant expansion of the Community Connection Program, an assertive outreach program that aims to increase access to mainstream services for people with disabilities who are homeless or living in insecure/marginal accommodation.
- Additional clinical positions and an expansion of disability support services for people who are isolated and/or homeless.
- New APMH positions to provide mental health support to older people who are at risk of homelessness.

### **Immediate Response**

New funding provided in the 2002–03 State Budget will be used to employ approximately 50 additional staff in mobile support and treatment services (MSTS) and psychiatric disability support services in metropolitan and rural areas. These new positions will provide intensive outreach services to consumers with co-existing mental illness and substance abuse and to those who are homeless or at risk of homelessness. Initiatives made possible by these new resources include:

- Provision of clinical treatment and disability support to tenants of 50 public housing properties that have been newly prioritised for people with mental illness.
- Piloting of integrated service approaches, by introducing clinical treatment to existing residential rehabilitation services to enable more consumers with high needs to receive these services.
- Participation in the Department's Rooming House Plus Project, which will support approximately 30 people with a mental illness.

### **Future Priorities**

Supported accommodation services for people with mental illness will continue to be a high priority. Expansion of these services will be considered in the context of the demand management strategy being developed in 2002–03. In addition, staff training and improved targeting of mental health services will assist area mental health services in responding to people who need support to obtain or maintain accommodation in the community. This training will also be made available to non-mental health workers, such as housing service providers, where there is an expectation of intervention.

The Department will also develop, pilot and evaluate new service models for people with mental illness requiring intensive in-home support in rural and metropolitan settings.

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### **Action 3: Provide improved service information and effective triage and intake assessment, especially for people in crisis**

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Although information about mental health services is available in the telephone directory and on the Internet, the general public needs better information about how to access these services. The public needs to be able to find out easily what services are available and how they operate, and how to make links between the various components of the system.

There is also a need for more consistency between mental health services in what happens when people try to make initial contact with the service. Currently services vary as to whether triage and intake assessment<sup>9</sup> are available on a 24-hour basis, provided by phone or face-to-face, how these functions are staffed and by whom, and where they are undertaken.

Another issue is that emergency departments have become the 'first port of call' for many people seeking help for mental health problems, especially in times of crisis. Whilst this is an outcome of the mainstreaming of mental health services with general hospitals it can present difficulties—particularly in busy emergency departments—as the physical environment may not be well suited to responding to people with mental health problems. However, newly developed emergency departments provide safe and private facilities for assessment and urgent treatment of people with acute mental illness.

Emergency departments have access to CATS or psychiatric nurse clinical consultants who are able to assess and arrange treatment and support for people with mental illness presenting to emergency departments. In addition, some psychiatric consultation and liaison<sup>10</sup> support is funded within the majority of metropolitan general hospitals.

However, the demand for CATS to assess people in emergency departments is increasing, especially outside business hours, which means they are less available for assessing and treating people with acute mental illness in the community. Similarly, APMH teams need to maintain their community focus and have a limited capacity to assist emergency departments with older people. Enabling CATS and APMH teams to be more responsive to the community will reduce the demand on emergency departments.

There is also a need in some major metropolitan hospitals for mental health clinical input into emergency department triage, to facilitate the prompt admission of people presenting with acute mental illness to inpatient services and divert people with less serious presentations to community-based mental health or primary health services.

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9. Mental health triage and intake assessment are two facets of the initial service response to a person presenting with a mental health problem. Mental health triage aims to determine whether the person has a serious mental health problem and if so, the nature and urgency of the required response. If indicated, triage is followed by an intake assessment to determine what type of intervention is needed and which service should respond.

10. Consultation liaison psychiatry is the diagnosis, treatment and prevention of psychiatric morbidity among physically ill patients who are patients of an acute general hospital. This activity includes the provision of psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and their clients/patients.

## Immediate Responses

In 2002–03 the Department will:

- Review publicly available information about mental health services and examine the feasibility of a statewide 24-hour seven-day telephone service to provide information, preliminary assessment, and referral to mental health and/or other necessary services.
- Develop and pilot standardised triage and intake assessment for area mental health services.
- Fund specific projects under the Hospital Admission Risk Program that aim to reduce unnecessary use of metropolitan emergency departments and inpatient services. Four of these projects will reduce the use of emergency departments by people with a mental illness through:
  - More effective linking of consumers with mental illness and/or substance abuse further complicated by homelessness, social isolation, or other medical problems, into appropriate community and hospital services to reduce their emergency department attendances (Royal Melbourne Hospital).
  - The provision of assessment, crisis and early intervention, referral, and follow-up to young people with complex needs who present, or are at risk of presenting, to the emergency department with a suicide attempt or deliberate self harm (Northern Hospital).
  - The creation of a Drug and Alcohol Liaison clinical position to provide support and training to emergency department staff, extension of psychiatric services to the emergency department and augmented overnight psychiatric triage (Frankston and Rosebud Hospitals).
  - Early identification, comprehensive assessment and care planning which crosses emergency, inpatient and community care, and the provision of practical support to people with complex needs, to reduce multiple emergency department attendances (St Vincent's Hospital).

## Future Priorities

Future priorities for the improvement of service information and the development of effective triage and intake assessment processes are:

- Development of better and more accessible public information about mental health services.
- Provision of additional mental health support, including consultation and liaison psychiatry and mental health triage clinicians, to emergency departments that experience high numbers of complex mental health presentations. Importantly, this increased capacity would enable an improved response to the presentations of older people, as well as young people and adults.

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#### Action 4: Implement new approaches to rural issues

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A number of innovative approaches have been developed to improve services to small rural communities. These include the use of videoconferencing for consultation and supervision, and the development of local collaborative arrangements with primary health and other community services. Table 3 identifies rural initiatives implemented between 1999 and 2002.

**Table 3: Rural Initiatives Implemented between 1999 and 2002**

<p><b>New Services and Activities</b></p> <p>Establishment of:</p> <ul style="list-style-type: none"><li>• Primary Mental Health and Early Intervention teams in each rural area mental health service, to support general practitioners and other primary health services.</li><li>• Senior psychiatric nursing positions and Graduate Year Nursing positions in each rural area mental health service, to support local workforce development.</li><li>• Specialist dual diagnosis positions in each rural area mental health service.</li><li>• Associate Professor of Psychiatry positions in Mildura and Gippsland.</li><li>• The Bendigo Centre for Rural Mental Health.</li><li>• The Professor of Mental Health Nursing position in Bendigo.</li><li>• Five Mental Health Court Liaison positions located at the Magistrates Courts in Bendigo, Ballarat, Geelong, Shepparton, and Albury.</li><li>• Three Koori Mental Health Liaison positions located in Shepparton, Gippsland and Bendigo.</li><li>• Eating disorder services in Geelong and Bendigo.</li></ul>
<p><b>Areas of service expansion</b></p> <p>Expansion of:</p> <ul style="list-style-type: none"><li>• Psychiatric disability intensive outreach support to homeless people with a mental illness in Grampians Department of Human Services Region.</li><li>• The Mental Health Homelessness Program in Barwon South Western Department of Human Services Region.</li><li>• Services to older people at risk of homelessness with a mental illness and complex needs in Grampians and Loddon Mallee Department of Human Services Regions.</li><li>• Home-based outreach support.</li><li>• Planned respite support.</li></ul>

However, further effort is necessary to improve rural communities' access to a range of mental health services. Service planning for these areas must take into account issues such as the difficulties of recruiting and retaining trained staff, inadequate numbers of trained staff, managing small numbers of staff in small rural sites, particularly in CAMHS and APMHS, the lack of a career path—particularly for sole practitioners—the distances involved in outreach casework, and transport difficulties for consumers and carers.

Participants in rural consultations highlighted the need to adapt current mental health service components and delivery models to the rural environment, recognising that services need to be a certain size and have sufficient activity to remain clinically and financially viable. They identified a range of possible approaches to meeting the needs of rural communities and ensuring ongoing service viability in rural areas.

### **Immediate Response**

A rural mental health strategy, drawing on the results of the rural consultations conducted in late 2001 and early 2002, will be developed during 2002–03. The purpose of the strategy will be to identify new and improved models of funding and service provision for rural environments. As part of developing the strategy, research will be conducted to identify optimal service structures/profiles for mental health services in regional centres (with populations over 20,000), districts (5,000 – 20,000 people), towns (1,000 – 5000 people), and small communities (under 1000 people).

### **Future Priorities**

Over the next five years, the Department will develop and trial models of funding and service provision designed for rural environments, and will evaluate new approaches for both clinical and cost-effectiveness.

The new approaches will include metropolitan/rural partnership projects to enhance clinical service delivery in rural areas. Key areas for partnership between metropolitan and rural services will include clinical supervision and consultation for staff in rural areas, arrangements for clinical leadership (particularly in CAMHS and APMH), access to CAMHS inpatient services, joint training arrangements, and staff rotations. The rural workforce initiative, described on page 34, is one example of how service partnerships can be used to enhance rural service providers' access to specialist expertise, training and professional development.

Other approaches to rural service development to be considered include:

- Development of flexible funding models, so that agencies can tailor services to consumer needs, rather than have funding tied to beds or particular service types.
- Development of flexible models for pre and post-inpatient care in rural areas. For example, intensive home-based outreach support with associated brokerage funding has been implemented in Bendigo and Mildura, and may be suitable for other areas.
- Refinement of current resource allocation methods, including a review of the 'rurality' weighting factor used in the current formula (see page 41).
- Development of integrated approaches to consumers' social, cultural, employment and health needs.
- Further technological and other solutions (for example, staff rotations) for providing greater rural access to specialist services, information and clinical supervision.
- Improved access to consultation and liaison psychiatry services through the further development of partnerships with general hospitals and metropolitan mental health services, particularly in areas where there is limited or no access to private psychiatrists.

- Partnerships and shared care arrangements between clinical mental health services and PDSS and with local private psychiatrists (where they exist), local health and community services (including drug and alcohol services and general practitioners) and metropolitan mental health services.
- Targeted training programs for rural mental health professionals.
- Incentives for mental health professionals to train and work in rural services, including the development of career structures and improved support for sole practitioners. This will be considered in collaboration with the Commonwealth Government, and in the context of developing a mental health workforce plan (see page 34).
- Strengthening local access to specialist and statewide services for all age groups.
- Continuing to develop legislative and administrative arrangements to enable consumers living along the Victorian/New South Wales border to access mental services in the other state, on the basis of clinical need.

## Extending Prevention and Early Intervention

The further development of the mental health service system must take into account the mental health needs of the wider community. A key component in managing the growing demand for services is the implementation of effective early intervention and prevention strategies based on available evidence together with a research program that will strengthen this evidence base.

The following actions will be pursued to improve prevention and early intervention for mental health problems, in both the general community and amongst consumers of mental health services.

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### Action 1: Implement mental health prevention and early intervention programs for specific disorders

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Research in Australia and overseas confirms that the incidence and impact of many forms of mental illness can be reduced by programs targeting people at risk of the disorders and/or those showing early symptoms.

Much progress has been made in understanding the nature of mental illness and interventions that work. For example, conduct disorder in childhood has strong continuity with personality problems and substance abuse in adolescence and adulthood. Similarly, severe anxiety disorders and depression in adults usually first appear in childhood and adolescence. Needs reduction strategies relevant to these disorders should include targeted prevention and early intervention programs in education, primary health and welfare settings.

Over the next five years, the Department will support a number of specific mental illness prevention and early intervention programs—some of which will use funding made available by Victoria through *beyondblue*: The National Depression Initiative. Due to the importance and effectiveness of interventions at an early stage of life, these programs will focus particularly on children and young people.

However, there will also be more focus on the early detection and treatment of mental illness in older people. Depression in this age group can present special problems for diagnosis and treatment, because it is often masked or compounded by physical complaints or degenerative brain disorders and, if untreated, can be severely disabling.

### Immediate Response

In 2002–03, the Department will:

- Extend APMH services providing early intervention for older people with psychiatric and behavioural disturbances, as mentioned on page 19.
- Continue to participate in a five-year national program aimed at preventing depression in year 8 to 10 students, the high-risk years for onset of depression in teenagers.<sup>11</sup>
- Continue to support the Compass Project, which is designed to promote early help for young people with major depression and bipolar disorder.<sup>12</sup>

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<sup>11</sup> *Beyondblue* funding.

<sup>12</sup> *Beyondblue* funding. This project has also received funding from an ANZ Charitable Trust Grant.

## Future Priorities

Future priorities for prevention and early intervention activities are:

- Piloting and evaluation of programs for school-aged children who have a conduct disorder. These children are at risk of developing mental health and social problems, including offending behaviour, depression and substance abuse.
- Development of PDSS and early psychosis programs for young people, as mentioned on page 18.
- Supporting improved primary health responses to people with high prevalence depression and anxiety disorders at all stages of life.

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## Action 2: Strengthen partnerships with other services working with people with mental health problems

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Many services in the community are well placed to identify individuals who are at risk of or showing early signs of mental health problems, and to intervene before problems become entrenched. These services include early childhood services, schools, primary health providers, child protection agencies, aged care facilities and the justice system.

A good example of a collaborative partnership between mental health, child protection services and community agencies is the Stargate program. This program provides early intervention for children and young people in 'out of home care'. It is an initiative of the Royal Children's Hospital CAMHS service, the Department's child protection services and out of home care agencies in the Western Metropolitan Region.

The need for stronger partnerships and linkages between mental health services and other community services was mentioned frequently in the Department's mental health consultations. Members of the mental health sector are aware that providers of other health and social services often struggle to manage the mental health problems of their consumers. Mental health providers want to be able to do more to assist other services—particularly primary care providers—to identify mental health problems and treat people who have less complex mental health needs.

In addition, general acute care services frequently need consultation and liaison support from a specialist psychiatrist to assist them in treating people with a serious mental health problem who are admitted to inpatient services with a physical illness or injury. Greater integration and consultation between emergency, acute medical, surgical and mental health staff is likely to improve outcomes for consumers with complex presentations and result in a more efficient use of resources. At present, consultation and liaison services are not available in all hospitals.

## Immediate Response

Responses in 2002–03 will include:

- Piloting of a brief assessment instrument, for use in primary care settings, to identify the need for psychological treatment.<sup>13</sup>
- Evaluation of the recently established Primary Mental Health and Early Intervention teams.
- Provision of training for Primary Mental Health and Early Intervention teams in responding to groups at risk of depression or psychosis.
- Research on pathways to mental health care (especially in relation to depression) in rural areas.<sup>14</sup>

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<sup>13</sup> *Beyondblue* funding.

<sup>14</sup> *Beyondblue* funding.

- Continued leadership of the whole-of-government and national suicide prevention response.
- Continue development of relationships between mental health services, community health services, and general practitioners to improve outcomes for consumers.

### **Future Priorities**

Relationships between specialist mental health services and primary health services will be progressively strengthened and consolidated. This work will build on a new agreement on roles and responsibilities for primary mental health treatment. The agreement describes the complementary domains of three service sectors—specialist mental health services (particularly the new Primary Mental Health and Early Intervention teams), community health services and general practitioners—in the provision of mental health treatment in primary care settings in Victoria. The agreement, which will be finalised in 2002, has been prepared as part of the Commonwealth and State Government Bilateral Agreement for the Primary Health and Community Care Sector.

The Department will place a high priority on:

- Building the capacity of child and adolescent mental health services to provide advice and consultation to schools and primary care practitioners.
- Expansion of consultation and liaison psychiatry to hospital emergency departments and inpatient services.
- Evaluation of collaborative partnerships, such as the Stargate program, and strengthening of support to such initiatives.

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### **Action 3: Increase the focus on relapse prevention and recovery within the mental health system**

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Many consumers and carers consulted in the focus groups raised issues about what they saw as a 'crisis' approach to mental health treatment that often focuses on management of acute episodes of mental illness, rather than on the consumer's ongoing need for treatment and emotional and practical support.

It is important that consumers receive treatment and support from services before they are in crisis. Minimising crisis episodes improves clinical and social outcomes for consumers. In addition, consumers need services that go beyond symptom management and deal with their general health care needs and employment, accommodation, and psychological issues.

A stronger focus on relapse prevention and recovery will assist in reducing the need for more intensive services.

### **Immediate Response**

In 2002–03, training will be developed for mental health professionals which will focus on improved approaches to the broad range of consumer needs, including improved case management practice and new approaches to relapse prevention and interventions that foster recovery and rehabilitation. The training programs will draw on the growing body of evidence about effective ways of treating mental illness and minimising its impact on consumers and carers.

## **Future Priorities**

Many of the strategies and initiatives described elsewhere in this document will support early intervention and relapse prevention for people with mental illness. For example, improved access to community-based services, in particular access to continuing care, case management and supported accommodation services, is essential to preventing crisis and relapse in people with mental illness. As described on page 44, the Department will improve coordination between different types of mental health services, and between mental health and other community services.

## Building a Strong and Skilled Workforce

The availability of a suitably skilled workforce is a major challenge facing mental health services and a prerequisite to achieving the directions articulated in this document.

The current and projected undersupply of practitioners in public mental health is greatest for psychiatrists, nurses and allied health staff, particularly in rural areas.

Since 1999, there has been an increase in the number of direct care staff employed in Victorian mental health services, with services reporting an overall increase of more than 230 staff between 1999–2000 and 2000–2001. In addition, a commitment was made through the Psychiatric Services Enterprise Bargaining Agreement in 2000–01 to fund a wide range of nursing initiatives, including 116 education, training and supervisory positions and an additional 130 nurse positions over a three-year period.

These initiatives included a significant increase in nurse training and development positions at Grade 4, 5 and 6 or 7 level, representing the first formal recognition of the need for training and development positions in mental health since mainstreaming occurred in the 1990s. Staff in these positions will support improvements in clinical practice and skill development and will assist nurses working in an increasing complex environment.

Funding has also been provided for the development of the specialist one-year graduate mental health nurse program to support recruitment and skill development. A senior mental health nurse advisor position has been created in the Mental Health Branch to provide strategic direction and a coordinated approach to psychiatric nursing education, training, recruitment and retention.

A specific localised mental health nurse recruitment and retention campaign has been developed, following on from the specialist nurse recruitment and retention campaign.

Re-entry and refresher programs for psychiatric nursing have commenced. Some provision has also been made for study leave to support mental health nurses wanting to upgrade their qualifications. Specialist scholarships for post graduate study in mental health have also been made available in 2002.

Funding has been allocated to address training needs in the PDSS sector, with particular attention to further education and national competency standards. This has resulted in increased training and professional development opportunities for PDSS workers, the accreditation of PDSS specific training, training and information resources, and backfill funding for staff attending relevant accredited training.

These new developments support the maintenance and development of a quality workforce and work towards achievement of improved outcomes for consumers and carers.

Furthermore, academic positions are funded to foster recruitment and retention and to improve career structures for psychiatrists, nurses and allied health staff. These positions also support the engagement of new entrants in a range of service development activities.

Notwithstanding the progress made to date, further action is needed to attract new, suitably skilled recruits from all disciplines, retain and train psychiatrists, nurses and allied health staff in the public mental health sector, and encourage and support staff to continue working in the public mental health sector.

Similarly, further action is needed to address the significant turnover of staff in the PDSS workforce. While PDSS are often successful in attracting new graduates, with over 80 percent of workers holding a post secondary qualification, they are often unable to provide the necessary incentives to retain these staff. This limits the capacity of PDSS to provide continuity of care, and results in shortages of appropriately skilled workers.

Additional training is needed to improve understanding of mental health legislation, clinical case management, the use of psychosocial interventions, and other core components of service delivery. The need for such training has been accentuated by inadequacies in pre-employment education and training, increased numbers of consumers with complex mental health presentations, and the expansion of community-based services that demand specific skills. These issues suggest that a statewide program is required to provide consistent and high-quality training.

Particular issues are evident regarding the undergraduate nurse curriculum. There is general agreement that the course content and structure of the curriculum does not have sufficient psychiatric nursing content to support and prepare new nurse graduates entering the mental health workforce.

Consequently, student nurses either do not choose mental health nursing as a career or leave soon after entering the mental health field, due to a lack of preparation from clinical and theoretical perspectives.

Steps are being taken to address the undergraduate nurse curriculum. The Nurses Board has recently released a discussion paper which considers a number of these issues.

All stakeholders—including service providers, consumers and carers, unions, professional bodies, universities and training organisations—agree on the need to move beyond current approaches to workforce planning, and to develop a more proactive and coordinated approach to mental health workforce issues in rural and metropolitan settings.

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### **Action 1: Develop and implement a comprehensive mental health workforce plan**

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The Department will lead the development of a comprehensive mental health workforce plan, and will progressively implement this plan over the next five years.

#### **Immediate Response**

In recognition of the particular difficulties faced by rural services in recruiting psychiatrists, especially in CAMHS and APMH services, the 2002–03 State Budget provides an additional \$400,000 in recurrent funding to allow medical and allied health staff in the eight rural Area Mental Health Services greater access to expert clinical advice and supervision. Metropolitan services and possibly private psychiatrists will now be able to provide much of this support through teleconferencing and other media. Additional funding for PDSS training has also been provided in 2002–2003.

Development of the workforce plan for clinical services will occur during 2002–03 in consultation with key stakeholders and will be based on an analysis of:

- The changing demands of work in public mental health services, and the skills required for this work.
- Optimal staffing configurations for major service types.

- Pre and post-employment training requirements.
- Factors contributing to high staff turnover.
- Current and future staffing requirements.

Given the primary responsibility of the Commonwealth for workforce issues, it will be important for the two levels of government, Commonwealth and State, to coordinate their strategies for developing the mental health workforce. Matters for joint Commonwealth-State attention include increasing the number of psychiatrists and trainee psychiatrists in the public sector and HECS funded tertiary training places for nursing, and the distribution of psychiatrists. The State will actively pursue resolution of these issues with the Commonwealth to develop both a short-term response and plan for future years.

The workforce plan will position the Department to have a greater say in current processes, which are occurring at both the state and national level, aimed at overcoming problems in the training and availability of health professionals generally and particularly in areas of significant shortages of supply, such as mental health nursing and public sector psychiatrists.

As part of the workforce plan, a specific mental health nursing strategy will be developed. This will include strategies for encouraging participation in undergraduate courses and improving preceptorship (including supportive role modelling and setting and observation of practice standards), mentoring and support, and clinical placements for undergraduate nurses in metropolitan and rural Victoria.

### **Future Priorities**

As part of developing the mental health workforce plan, the Department will evaluate a range of possible initiatives for responding to workforce issues and will implement initiatives considered to have merit. Table 4 lists some of the possible initiatives to be considered and implemented over the next five years.

In addition, priority will be given to resolving specific PDSS workforce issues. This will include consideration of minimum qualifications and competencies in the context of developing a quality framework for PDSS, and further training.

Full consideration will be given to the different requirements of rural services in developing specific workforce initiatives across all disciplines.

**Table 4: Possible Mental Health Workforce Initiatives**

Desired Outcome	Possible Initiatives
<p><b>More people attracted to train and work mental health</b></p>	<p>Campaign to raise awareness and improve the image of mental health careers in the general community and amongst nurses, social workers, doctors, psychologists, occupational therapists and other allied health workers.</p> <p>Ongoing program of recruitment and retention.</p> <p>Incentives (such as scholarships) for students to undertake undergraduate and post-graduate mental health nursing and allied health courses.</p> <p>Development of student support programs.</p> <p>Encouragement for undergraduates from relevant disciplines to undertake clinical placements in mental health services, with improved support during placements.</p> <p>Consideration of traineeships and part-time employment opportunities.</p>
<p><b>New entrants better prepared for work in public mental health services</b></p>	<p>Evaluation of the effectiveness of existing education and training programs in preparing nursing staff to work in specialist mental health services and examine a range of options for the future.</p> <p>Improvement in the mental health content in nursing courses.</p> <p>Additional training and skill development for entry level staff from all disciplines.</p> <p>Establishment of entry level supported allied health positions.</p> <p>Additional trainee positions to attract new recruits.</p> <p>Induction program for all new employees.</p> <p>Mentoring and supervision programs for new graduates moving into mental health.</p> <p>Orientation programs for overseas psychiatrists new to Victoria.</p>
<p><b>Availability and skills of existing workforce better matched to service needs</b></p>	<p>Commissioning of statewide in-service training to develop core competencies and support implementation of new initiatives.</p> <p>Refresher courses to assist nurses to return to the mental health workforce.</p> <p>Negotiation with the Commonwealth regarding incentives to attract psychiatrists, nurses and allied health staff to rural services.</p> <p>Up-skilling of the existing workforce, including scholarships and other support such as increased study leave.</p> <p>Further development, in conjunction with the Commonwealth, of shared care arrangements with private psychiatrists.</p>
<p><b>Skilled and experienced workers stay longer in the public mental health system</b></p>	<p>Encouragement for psychiatrists to enter and stay in public mental health services.</p> <p>Improve career paths and opportunities for allied health and nursing staff to develop and use specialised skills.</p> <p>Consideration of expansion of practice in the mental health workforce.</p>

## Strengthening Consumer Participation

One of the most important changes witnessed by the mental health sector in recent years is the emergence of a vital consumer movement. While Victoria has a strong track record in encouraging and valuing the involvement of mental health consumers, it is time to re-affirm its commitment to consumer participation.

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### Action 1: Enhance involvement of consumers in their own treatment and care

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Research studies indicate that consumers who understand their health conditions and who are actively involved in decisions about their own care are more likely to adhere to treatment regimes and have better health outcomes. It is especially important for mental health consumers to develop a sense of control over their illness and recognise trigger factors and early warning signs of relapse.

Consumers have said that they need more information about what constitutes 'good practice' in the management of their conditions, so that they can be more active partners in their own treatment and care planning. Clinicians, too, need support to develop new ways of working with consumers, and engaging them in ways that are sensitive to their individual needs and respect their dignity.

#### Immediate Response

The Department will, in the context of developing a new consumer participation policy (see below), develop formal guidelines on the involvement of consumers in their own treatment and care.

#### Future Priorities

The Department will, over the next five years:

- Identify and publish core service standards so that clinicians, consumers and carers have a common understanding of what is expected from mental health services.
- Provide training for clinical staff in involving consumers in their own treatment, and working with consumers to develop relapse prevention strategies.
- Introduce a consumer self-rating measure, as part of the implementation of routine clinical outcome measurement.

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### Action 2: Encourage and support consumer participation in service planning and review

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Although there are many examples of good practice in this area, greater consistency is needed in how services involve consumers in service planning, monitoring and review. Processes for obtaining consumer input into the training of mental health professionals, and service planning at the Government level, also need to be strengthened.

#### Immediate Response

In 2002–03, the Department will continue to support consumer involvement in mental health service planning and development by:

- Developing a comprehensive policy framework for consumer participation at both the local service and government levels.
- Developing clearer guidelines for employment of consumer consultants in adult mental health services, and examining the need to extend this program to CAMHS, APMHS and PDSS services.

### **Future Priorities**

In developing and implementing the mental health workforce plan, the Department will:

- Work with tertiary education providers to support consumer involvement in relevant training courses.
- Provide opportunities for consumer input to in-service staff training.

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### **Action 3: Protect consumer rights**

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Victoria has a strong commitment to the protection of consumer rights. Based on recent consultations with mental health consumer representatives, the Department has identified a number of strategies to ensure that the rights of mental health consumers are broadly understood and upheld in everyday service practice.

### **Immediate Response**

In 2002–03, the Department will develop an effective framework for managing complaints and identifying practice and systemic issues in response to concerns about the current approaches to handling of complaints from mental health consumers and carers.

### **Future Priorities**

Over the next five years, the Department will:

- In partnership with consumers, provide training and information on consumer rights to staff of clinical and PDSS services.
- Develop and pilot best practice projects to improve understanding of consumer rights and associated standards of care, in partnership with consumers, carers and service providers.
- Develop and implement measures to assist consumers to be more aware of their rights.
- Expand the current audit and review functions of the Office of Chief Psychiatrist.
- Involve consumers in mental health quality review processes.

## Improving Carer Participation and Support

The increased emphasis on community-based services has resulted in greater responsibilities for the carers of people with mental illness. This is acknowledged in the provision of a range of services designed to support families and other carers of people with a mental illness. These services include: the carer crisis support program, planned respite care, mental health carer support workers, and mutual support and self-help services.

In the next five years, there will be further strengthening of support services for carers, and effort made to improve understanding and acknowledgement of carer contributions. The development of formal systems for carer involvement in mental health policy and planning, at both the Government and local service levels, will also be a high priority.

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### Action 1: Encourage carer participation

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In recognition of the importance of carers as partners in mental health care, the Department will take further action to encourage the involvement of carers in treatment and care planning.

In a recent study of older people with mental illness, lack of family support was found to be the most significant indicator of the need for hospitalisation. This reflects the enormous contribution that carers make to outcomes for people with mental illness.

### Immediate Response

Existing guidelines relating to carer participation and support will be reviewed and consolidated into a new policy statement on the role and needs of carers. This document will identify formal structures and consultation mechanisms to support carer involvement in policy and service development.

### Future priorities

The Family Sensitive Training (FaST) program, which focuses on the needs of families where a person is diagnosed with a mental illness, has had success in improving staff responsiveness to carers. Access to this training will be improved across the mental health system, and opportunities will be created for carer input to staff in-service training programs.

The development of a carer consultant program, as noted below, will also facilitate carer involvement in the planning, delivery and evaluation of local mental health services.

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### Action 2: Improve information and support for carers

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One of the most important ways the Department will support carers will be to improve access to supported accommodation for people with mental illness (see page 22) and to provide access to sub-acute services following intensive inpatient care (see page 22). This will give people more choice about their level of involvement as carers, and will help ease the burden when people with mental illness are not well enough or able to be cared for at home.

In addition, carer support funds will be used more flexibly to respond to carers' need for more and better information about mental illness and mental health services, including carer resources and support networks.

Parents of children and adolescents with mental illness have been identified as a particular group needing improved support services. Effective treatment of children and adolescents is influenced by the parent's capacity to identify the mental health issues, access the appropriate services and participate in the delivery of planned interventions. Parents also play a critical role in minimising adverse impacts on other children in the family.

### **Immediate Response**

In 2002–03, the Department will:

- Encourage mental health services to make greater use of carer resources.
- Publish and disseminate a carer information package.
- Prepare user-friendly information about mental health services for inclusion in the telephone directory.
- Maintain an up-to-date service directory on the Internet.
- Review other ways of improving mental health information and referral.
- Support research on the needs of carers of people with high prevalence disorders.<sup>15</sup>

### **Future Priorities**

Future priorities for improved carer information and support are:

- The extension of carer consultant programs.
- Expansion of respite care services.

Specific priorities for parents of children and adolescents with a mental illness include improved parenting support programs and provision of respite care for other children in the family.

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<sup>15</sup> *Beyondblue* funding.

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# Making it Happen: Leadership, Support and Structural Change

The development and implementation of new mental health service initiatives will occur in the context of long-term planning, to ensure the future viability of the service system and to manage the growing demand for mental health services.

As part of this work, the Department will address a number of structural and funding issues that currently limit the effectiveness of the mental health system. The Department will also take an active leadership role in mental health service planning, service monitoring and evaluation, and the provision of information, support and guidance to the mental health sector.

The following section describes strategies that will position the sector to make the best possible use of Victoria's investment in mental health.

## Long-Term Planning for Mental Health Services

In 2002–03, the Department will develop a comprehensive demand management strategy for mental health services in metropolitan and rural Victoria. The strategy will:

- Identify factors affecting service demand.
- Examine and profile consumer needs and pathways, including identification of levels of unmet and partially met need for mental health care, and consider ways in which specialist mental health services, other health, support and welfare services can work together to better respond to unmet need.
- Develop diversionary services and improved care arrangements.
- Develop need reduction strategies (such as prevention and early intervention) to reduce the incidence and impact of mental illness and the need for high-intervention services.

## Improved Capital Planning

In related work, the Department will commence the development of a mental health capital asset investment plan that will establish a coordinated and staged infrastructure maintenance and capital development program for mental health services. This program will support the maintenance of safe work environments, plan for current and future service needs and accommodate changes to service delivery and functions.

The capital plan will form part of an asset investment model for all health facilities across Victoria and will specifically address PDSS capital assets, supported accommodation issues and residential options for consumers, including those with a dual diagnosis.

## Refining the Mental Health Service and Funding Model

As mentioned on page 8, there are several structural issues, including the need for better approaches to service funding and resource distribution, that require attention to ensure the longer-term sustainability of the public mental health system.

In response to these issues, the Department will:

- Refine the current resource allocation formula to further improve equity in the distribution of services. Particular attention will be given to rural weightings, due to the difficulties in providing access to psychiatrists and other clinical staff in rural Victoria.
- Determine the use and configuration of catchments that provides the best outcomes in terms of

service management and consumer access to services. This is likely to include the formation of area clusters and improved cooperative arrangements.

- Develop benchmarks for planning and resource distribution.
- Refine existing key performance indicators, to improve the links between service activity and funding levels.
- Assess the feasibility of implementing alternative output funding approaches including casemix funding for mental health services.

## Clarifying the Role and Function of Key Service Types

The mental health system underwent a period of rapid development in the mid-1990s, with a number of new service types being established in a relatively short period. Recent consultations and reviews of mental health services have drawn attention to the fact that the use of some services may have changed or narrowed over time (often in response to demand pressures), resulting in a need to clarify or redefine their role, function and target group.

Priority will be given to clarifying the role, function and target groups of:

- The statewide Psychiatric Intensive Care Unit (PICU), Secure Extended Care Units, Community Care Units, and the Residential Rehabilitation Program. Examination of the respective roles of each of these service types will be followed by development of new service guidelines on the placement of people with severe, long-term mental illness.
- Specialist and statewide services. The Department will identify ways of improving consistency and access to these services, commencing with eating disorder, mother-baby, dual disability and personality disorder services.
- Child and adolescent mental health services, and the interface of these services with:
  - Adult mental health services.
  - Primary health, education and welfare services for children and adolescents.

## Improving Service Quality

In recent years, the Department has put considerable effort into developing quality assurance mechanisms, such as service standards, performance measures, quality incentives, and clinical and service reviews. In addition, a Mental Health Quality Assurance Committee, chaired by the Chief Psychiatrist, was established in September 2000 to formally monitor standards of treatment and care in health services and assist in the development of best practice guidelines. The Department will continue to place a high priority on these activities, and will increasingly emphasise a partnership approach to quality improvement, based on building stronger relationships with service providers. There will be a commitment to open exchange of information, feedback on service performance, and helping mental health agencies to develop as 'learning organisations'.

A key feature of quality improvement in the mental health area will be the extension of clinical outcome measurement, to all relevant Victorian mental health services. Outcome measurement has been used in a small number of services over recent years. In 2002–03, all remaining clinical services will receive assistance and training to support them in implementing routine outcome measurement, based on the use of established tools. This initiative will assist clinical assessment, case review and monitoring of treatment effectiveness. Introduction of a consumer self-rating measure will facilitate improved dialogue between consumers and clinicians. Aggregate outcome data will also provide

information for planning purposes at local, state and national levels. Separate initiatives will support the introduction of an outcomes focus in the PDSS and forensic mental health sectors.

In other quality improvement work, the Department will:

- Support staff training and education, and organisational change within mental health services.
- Use the Internet to regularly publicise 'best practice' initiatives.
- Establish mechanisms for regular consultation with service managers and senior clinicians.
- Set key performance indicators and benchmarks for service delivery, monitor performance of services against those benchmarks, and make the results publicly available.
- Refine current performance measures and the Quality Incentive Strategy.
- Streamline data collection and improve information systems to support service planning, delivery and monitoring.

## Strengthening Research and Evaluation

Consistent with its leadership role in biomedical research, Victoria also has a prominent role in mental health applied research and evaluation. Examples of investment in this area include:

- Support for the Mental Health Research Institute
- Creation of the Centre for Psychiatric Nursing Research and Practice
- Support for the Centre for Rural Mental Health
- Establishment of centres of excellence in Eating Disorders and Depression.

As a result Victoria is recognised for cutting edge research across the full spectrum of psychiatry, from neuroscience to health services evaluation.

The Commonwealth and State share funding responsibility for mental health research, with the primary responsibility for biomedical research residing with the Commonwealth. The State has primary responsibility for applied research and evaluation, as well as responsibility for operational infrastructure support for biomedical research institutes, which is funded through its public health program. In this context, the major focus for mental health funded research and evaluation will be the achievement of a strong evidence base to inform the development of effective service models and interventions. The Department, in partnership with research and academic institutes and specialist services, will focus on achieving a research agenda that delivers these priorities.

Specifically the Department will:

- Develop and implement an applied research and evaluation strategy (based on the priorities articulated in this document) that will contribute to achieving a comprehensive mental health research agenda. The strategy will have an emphasis on:
  - The social determinants of health, focusing on the links between lifestyle factors and mental health.
  - Evaluation of programs and services and identification of the most cost-effective service models.
  - Measuring unmet and partially met need in the consumer group.
  - Achieving an appropriate balance between specialist mental health interventions and promotion and prevention activities.
  - Identifying and addressing specific research gaps—for example, the impact of family dynamics and self-care approaches on mental illness.

- Expanding research activities to community-based, primary care and PDSS settings.
- Continue to support links with academic institutions, and further development of joint academic/clinical positions.
- Bridge the gap between research, evaluation and practice through improved communication of findings and their implications for practice to inform continuous service improvement.
- Consider new approaches, including the development of collaborative research partnerships, to broaden the scope of activity, better coordinate effort and inform policy and planning.

## Providing Clinical Leadership to the Mental Health Sector

There was a widely held view amongst participants in recent mental health consultations that the Mental Health Branch of the Department should have a higher profile in providing ‘clinical leadership’ to public sector mental health professionals. Participants thought that this role should include communication of new information about effective treatments and service models for people with mental illness.

Stronger clinical leadership will be provided by:

- Developing and publishing new clinical practice standards and guidelines.
- Sponsoring training programs and ‘best practice’ forums on evidence-based interventions for mental illness.
- Linking the results of clinical reviews to policy and program development.

## Enhancing Service Coordination and Integration

Coordination and integration of various parts of the mental health service system is crucial to providing ‘continuity of care’ for mental health consumers—people should be able to move between service elements as their needs change, and receive the most appropriate response at a given time.

Similarly, stronger linkages between mental health, primary care and other relevant public and private services are needed to respond in a coordinated way to the full range of consumers’ health and support needs.

In order to improve the coordination and integration of services, the Department will:

- Work with mental health services to improve discharge planning and transition processes between elements of the system.
- Improve service linkages and service capacity through the development and the possible use of area clusters.
- Work with other service providers (particularly child protection, juvenile justice, homeless, housing, aged care, disability, and drug treatment services) to develop complementary guidelines for assessment, referral and case management of people with mental health problems and operational protocols for crisis intervention.
- Further develop operational protocols with police and ambulance services, together with any relevant training, as new service directions are implemented.

# Appendix One: The Mental Health Service System

Clinical mental health services in Victoria are provided on an area basis, and include adult mental health services, child and adolescent mental health services, and aged persons mental health services.<sup>16</sup>

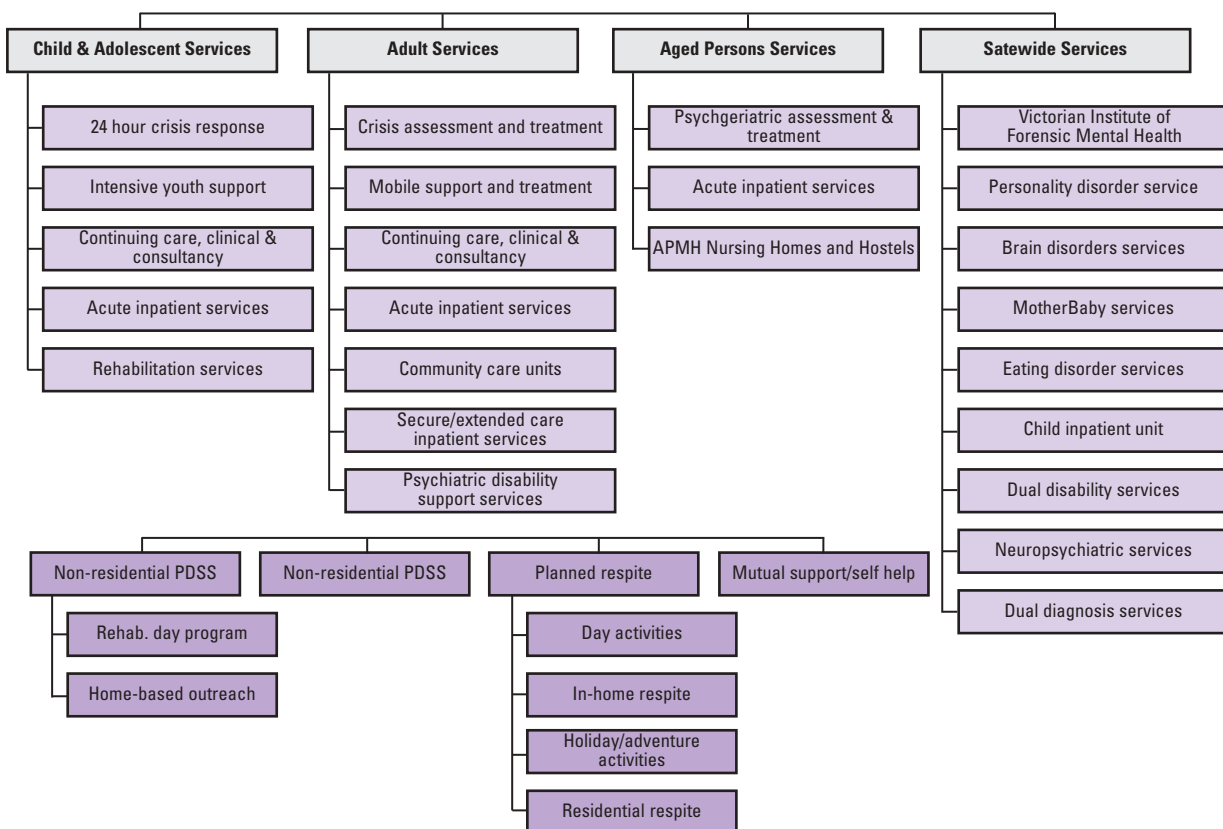
Service providers also have access to a range of statewide services such as specialised mother and baby units, eating disorders units and neuropsychiatry.

All area mental health services (AMHS) have been mainstreamed with general health services. Each provides a range of services or functions which in the case of adult mental health services, includes an acute inpatient facility and crisis assessment and treatment, continuing care and mobile support and treatment services.

Adult area mental health services have access to Community Care Units, which provide a community-based, clinically supported residential service and Secure Extended Care Units that provide longer term treatment and care in a clinical inpatient setting.

Psychiatric Disability Support Services (PDSS) are available across Victoria and provide a range of community-based services, including rehabilitation, outreach, respite and residential services.

The components of the current mental health service system are shown below.



16. There are 13 AMHS for Child and Adolescent Mental Health Services; 21 for Adult Mental Health Services; and 17 for Aged Persons Mental Health Services.

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# Appendix Two: Mental Health Service Descriptions

## Child and Adolescent Mental Health Services (0–18 years)

The key service elements of the Child and Adolescent Mental Health Services (CAMHS) system are as follows:

### Community Child and Adolescent Mental Health Services

These services provide assessment and treatment of children and adolescents experiencing significant psychological distress and/or mental illness and their families. Treatment may include crisis assessment, case management, family therapy, parent support, individual therapy, group therapy and, when necessary, medication-based treatments.

### Intensive Mobile Youth Outreach Services (IMYOS)

These services provide mobile intensive mental health case management and support to adolescents who display substantial and prolonged psychological disturbance, have complex needs which may include challenging, at risk and suicidal behaviours, and who have been difficult to engage utilising less intensive treatment approaches.

### Acute Inpatient Services

These services provide short term assessment and/or inpatient treatment for children and adolescents who have a severe emotional disturbance which cannot be assessed or treated in the community. They are usually located with general hospitals.

## Adult Mental Health Services (16–64 years)

The key service elements of the Adult Mental Health Service system are as follows:

### Primary Mental Health and Early Intervention Teams

These services provide consultation and liaison and education and training to primary health services that treat and support people with high prevalence disorders, especially depression and anxiety. They also support primary health services in the identification of emerging mental health disorders in their clients and the provision of early intervention services. The primary mental health and early intervention teams may also provide short-term treatment and assessment.

### Continuing Care Services

These services provide assessment, treatment and consultancy services and case management to people with a mental illness needing continuing treatment and care in the community. They also provide an initial assessment for people requesting assistance where a CAT service is not required.

### Mobile Support and Treatment Services (MSTS)

These services provide intensive long-term outreach support to people in the community with substantial and prolonged severe mental illness and associated disability. These services operate over extended hours, 7 days a week.

### Dual Diagnosis Services

These services provide training, education and consultation to agencies delivering mental health or drug and alcohol services to improve the health outcomes of people with a mental illness and substance use issues.

## **Crisis Assessment and Treatment Services (CATS)**

These services provide urgent assessment and short term intensive treatment throughout the community to people in crisis due to a mental illness. This includes assessing the most effective and least restrictive client service options and screening all inpatient bed admissions. CATS provide treatment and support for people whose acute mental illness can be managed in the community with intensive outreach support as an alternative to hospitalisation. They also respond to people presenting at immediate risk of suicide. CATS operate 24 hours, 7 days a week.

## **Acute Inpatient Services**

These services provide short-term inpatient management during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in a community-based setting. These units are located with acute general hospitals. People admitted to an inpatient service directly from the community are usually assessed by a CAT service.

## **Community Care Units**

These services provide medium to long-term accommodation, clinical care and rehabilitation for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide the residents with 'home like' accommodation where they can learn or re-learn everyday skills necessary for successful living in the community.

## **Secure Extended Care Inpatient Services**

These services provide medium to long term inpatient treatment and rehabilitation to clients who have unremitting and severe symptoms of mental illness together with associated significant disturbance which inhibit their capacity to live in the community.

## **Aged Persons Mental Health Services (65 years +)**

The key elements of the Aged Persons Mental Health (APMH) service system are as follows:

### **Aged Persons Mental Health Teams (formerly known as Psychogeriatric Assessment Treatment Teams)**

These services provide community-based assessment, treatment, rehabilitation and case management for older people, thereby preventing unnecessary hospitalisation and minimising the length of stay in acute inpatient facilities.

### **Acute Inpatient Services**

These services provide short-term inpatient management during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in a community-based setting. These services are located with other aged care facilities and/or general hospitals.

### **Aged Persons Mental Health Residential Services**

These services provide a range of inpatient services to clients who cannot be managed in the general aged care system due to their level of persistent cognitive, emotional or behavioural disturbance.

APMH nursing homes and hostels specialise in caring for older persons with a mental illness and provide long-term accommodation, ongoing assessment, treatment and care of residents, rehabilitation and respite care. They are designed to have a familiar, homelike atmosphere, and residents can participate in cooking and other supervised activities.

## **Psychiatric Disability Support Services**

Psychiatric disability support services provide specialist services and programs for people primarily in the 16 to 64 year age group with psychiatric disabilities. They aim to create opportunities for both recovery and rehabilitation, are community-based and include a range of service types, including the following:

### **Psychosocial Rehabilitation Day Programs**

Assist people with severe psychiatric disabilities to improve their quality of life, participate in everyday living activities, and live successfully at an optimal level of independent functioning in the community. This objective is achieved through the development of social and living skills in a group context, through centre-based and community access programs.

### **Home-Based Outreach**

Provides support to clients living in their own homes, whether the home is a private dwelling, rooming house, Supported Residential Service, or Office of Housing house, unit or flat. Training in social and living skills is provided in the resident's home, with a focus on activities and interactions of everyday life.

### **Residential Rehabilitation**

Residential rehabilitation provides intensive psychosocial rehabilitation and support in group accommodation prior to residents living independently in their own setting. The emphasis is on developing or regaining skills to enable each resident to deal with daily living activities, developing resident's confidence to commence or continue schooling, training or employment, as well as supporting positive contact by the residents with their family and friends.

### **Planned Respite**

These services provide a short-term change in environment for a client and a break for carers, and include both formal and informal psychosocial rehabilitation components. Planned respite services may involve day activities (including social and recreational), in-home support, holidays and adventure activities, and residential components.

### **Mutual Support and Self Help**

These services provide information and peer support to people with a mental illness and/or their carers through shared experiences and coping strategies, providing information and referral services, and promoting community awareness.

