
***Because Mental Health Matters:
A new focus for mental health and wellbeing in
Victoria***

Consultation Report, August 2008

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1. Introduction

Over nine hundred people attended eleven consultation forums hosted by the Mental Health and Drugs Division and their regional colleagues. One day forums were held in each of the regions with the North & West Metropolitan Region also having a state wide focus. Two additional half day forums, one for consumers and one for carers were also held. Across all of the forums there was good representation of specialist mental health services, including clinical and PDRSS with strong presence of those from the adult, CAMHS and PDRSS areas. The forums were well attended by a large number of representatives of community based services from areas such as drug and alcohol; disability; housing and homelessness; aged care; children youth and family services such as maternal and child health; and, primary health including divisions of general practice, community health and primary care partnerships. The forums also attracted a good number of representatives from justice, the police and ambulance services. Indigenous workers were present at some of the forums but not all, and were not present in large numbers. There was uneven attendance by those from education with there being no representatives present at a few of the forums. This absence was noted at these forums with comment made that the engagement of education was critical if the effort in prevention and early intervention was to be successful. Peak bodies such as VCOSS and Carers Victoria and professional associations and unions were also present at some of the forums. More than fifty consumers and eighty carers participated in the forums.

For each of the forums, participants were able to select two topics for detailed discussion and well as having an opportunity to provide their overall opinion on the vision, key concepts, principles and strategic directions contained in *Because Mental Health Matters*. A set of specific questions relating to each of the topics guided these discussions. All of the discussion was recorded and participants also had the opportunity to complete additional comments sheets. The detailed responses from the forums are contained in the appendices.

2. Key Consultation Themes

2.1 Overview Comments

There was very broad endorsement of the intent of the reform and the strategic directions outlined in *Because Mental Health Matters*. There was particular support for the emphasis on promotion and prevention and the notion of a three pronged approach to early intervention - early in life, early in prevention, early in episode - was seen to be critical. It was agreed that the proposed shift from a medical model to a social health frame, with the involvement of a broader range of services, will deliver better outcomes to service users. There was also strong support for integrated service responses that require services to work with each other in providing the necessary service responses. A consistent theme across all forums was that initiatives identified in the strategy should be built around local partnership approaches with the Department providing the necessary level of prescription to support consistency in service delivery along with necessary investment of resources.

There was recognition that more than investment in partnerships is required to develop integrated service solutions.

The development of a strong prevention focus will mean supporting the effort of those program areas that are positioned and have expertise in this area. Similarly, part of the focus on early intervention signals a much stronger connection to the work occurring in the early years with a redefining of the role and scope of CAMHS. Such reforms are supported as is the development of capacity for lead agency care co-ordination. A review of the CAT team's role and scope was consistently called for along with a strengthening of the role of PDRSS. While there may not have been conclusions drawn regarding organisational governance arrangements, there was a consistent call for the governance of the budget of AMHS to be altered with a strong interest in the establishment of regional mental health boards.

The current arrangements to manage the critical interface between ambulance and police and mental health services when responding to the needs of a person in crisis and the interface between mental health and justice services will require more than partnership

solutions. There will need to be the redefining of roles and potentially new service elements. There was repeated interest in the presence of mental health nurse practitioners and the expansion of nursing roles across the specialist and community based service system. There was support for the consultation paper's emphasis on a stronger accountability and outcomes focus; the critical importance of workforce development; and, the use of research to inform practice.

There was a call for some topics to be dealt with more fully in the final strategy. It was thought that the place of consumers and carers has to be given greater weight. The Human Rights Charter was not sufficiently reflected and more commitment has to be made to a service delivery approach where consumers are central and the role of carers is properly recognised. There also has to be substantial investment made into the consumer and carer workforce and a much stronger approach to the participation of consumers and carers in policy development, service planning and evaluation. It was thought there was insufficient focus in the paper on the voices and interests of those with enduring serious mental illness and there has to be a stronger focus on streamlining the system with access being a priority.

While the focus in *Because Mental Health Matters* on workforce and affordable housing were commended, each was seen to be pivotal to the success of the reform and, as such, require greater weight in the final strategy. It was also thought there was insufficient reference to older persons with a mental illness in the paper and the focus on the role of primary health was too narrow in scope. A further view was that the consultation paper did not demonstrate sufficient understanding of the needs of Indigenous people or people from CALD backgrounds for culturally sensitive interventions and support. There was also a call for increased funding flexibility and funding arrangements that take better account of growth corridors and rural needs. At each of the rural forums there was interest in the final strategy better demonstrating a better understanding of the health inequalities to be found in rural Victoria; the different service delivery challenges of rural regions compared to metropolitan regions; and the service responses that have been developed in rural regions to address both.

There was also a call for a greater emphasis on the private system, including GPs and private psychiatrists. This means that the State and Commonwealth will have to better align their investments if there is to be a coherent mental health service system developed. A similar whole of government alignment needs to occur if the early intervention and prevention objectives are to be realised. This is a key leadership task for government. There is an expectation that the final strategy will contain evidence of progress in these directions.

It was thought that the reform will need smart marketing and some attention should be given to the format of the strategy. The front end of the strategy could be crisper than it currently is. There was some questioning, for instance, of the need for both key concepts and principles and how these should be best formatted. Some work should also go into the language and definitions used so that there are common understandings of terms such as early intervention, prevention, early intervention, recovery, treatment and primary health care. This focus on language and definitions will have to continue during implementation so that common understandings and frameworks are developed.

Finally, while the directions outlined in the paper are strongly supported there are serious reservations whether the level of resources and investment required to implement those directions will be delivered. Without significant additional investment and strong leadership the strategy will struggle to realise its intent. Effort has to be directed towards not just service developments and integration strategies but also strategies designed to support cultural change and the realisation of the principle of shared responsibility.

2.2 Prevention

Across all of the forums the focus on prevention was strongly supported. Some were cautious in their support; they did not want to see funding being moved from the specialist mental health services to resource this area. At the other end, there were a few who did want to see such a shift arguing that a reallocation of resources was required if we are to develop sustainable and significant shifts in the mental health of the community. The vast

majority however, indicated they wanted adequate investment across the continuum and, as such, welcomed the prevention direction.

A key message was that prevention responses at a single level will not work. There have to be interventions at the systems, community and individual level. There is a need for performance indicators across all government services to show social inclusion outcomes. There has to be a much stronger commitment to funding based on outcomes and service investment based around evaluation and evidence. This would mean that initiatives such as *Kids Matter* and other mental health prevention programs in schools would be supported. All service systems need to be involved in mental health prevention and promotion. Responsibility should cover the continuum from the Commonwealth, State and local government to service providers. State Government should take a leadership role in partnership with local government. There needs to be a whole of government approach such as that used for 'Go for Your Life'. There is an advocacy role for agencies such as Beyond Blue and VicHealth has a role to play. The private sector, businesses and unions, also have a role to play. It would be helpful if there was a map that shows what is happening across on the bigger scale so that it becomes easier to determine what to build on and what not to duplicate.

At the community level we need to broaden the settings for mental health promotion with effort being put into ensuring more marginalised communities are not excluded. We need to develop specific and opportunistic approaches for marginalised communities such as the elderly, ethnic communities, people who are homeless and young people out of school. There has to be investment in building the capacity of the community to promote mental health within their communities. This means developing strategies to engage the community in other settings such as cultural and religious communities, sporting clubs, community groups, established networks, including the elderly. We have to develop new approaches that move beyond an exclusive reliance on government funds. We need to encourage and enable communities to be supportive of each other and people with a mental illness, so that people will take responsibility for each other. We need community building strategies that involve local government. It is also important to see schools as a key setting for promoting mental health. There is an opportunity to look at and build on the suicide prevention in schools activity and the 'Wellbeing Centre' at Geelong Grammar.

The best way to bring together resources and expertise in health promotion and mental health is to have more long term funding and commitment based on success measures that are flexible. The system needs an 'innovation pool' of funding to bring about change rather than State Government developing project funding briefs and tenders that agencies submit on. There should be support for the 'doers'. Investment should also be driven by evidence of what works. There is a need for strategic partnerships. PCPs have been a good avenue for this, but PCPs need to expand beyond the primary health care system.

As well as looking at overseas models, there is a range of existing initiatives that can be built on. These include:

- Community and neighbourhood renewal site activity
- Strengthening, evaluating and improving PCPs.
- VicHealth's research and evidence base
- Health promoting schools' framework and school focussed youth service
- Local governments – Positive Ageing Plans, Municipal Public Health Plans, Early Years Plans, Active Service Model.
- Community participation projects e.g. Men's Sheds, Community Gardens
- AHPACC program to promote Indigenous mental health

In developing strategies it is important to not just focus on social connection but to also focus on economic participation and reducing discrimination. There should be work place support around key transitions such as returning to work. Employees can be supported with information and employers need skill enhancement to manage clients with mental health issues. We need to promote the value of the contribution of people with mental illness, as has been done with older employees.

Enhanced public awareness of mental illness has to be a key strategy. It is critical that a positive image of the contribution people with a mental illness make to society is communicated. People who have recovered from mental illness should be put into the

spotlight to promote messages that help to reduce the stigma of mental illness. Along with this it will be important to invest in the education and training of workers and religious leaders as well as more broad based community education programs.

Finally, it is essential that the reform emphasis on mental health promotion does not get lost. It requires continued effort and dedicated long term funding.

2.3 Early Intervention

It was acknowledged that the proposed focus on infants, young children and their families was critical. It will require more emphasis on community development and community partners at the local level. It means stronger early childhood integration and a focus on local government involvement with an emphasis on area based planning. There was a strong call for an increase in the number and variety of programs that educate and support parents. It was thought there is an opportunity to take the learnings from 'mind matters' and 'kid matters' and expand these types of programs. The CASEA program was also frequently raised. Some suggested an earlier Take 2 service is needed. If there are to be shared care modalities and multi service plans then there will need to be attention to access and referral arrangements, secondary consultation practice and outreach service models. Workers in universal services need access to mental health first aid training so that they are able to identify mental health issues and refer with greater confidence.

There was strong interest in key work being undertaken on the development of common frameworks and language to assist services in becoming part of an effective system of care. Sectors need, for instance, to share frameworks for assessment and intervention

Approaches to integration differed across forums. Some consultation groups had an interest in the development of one stop shops especially at the secondary level where there would be a broad service mix that uses a skilled workforce capable of dealing with many co-morbidities including drug and alcohol issues. Others didn't support a hub, co-location approach but instead were interested in services being provided across universal, secondary and tertiary platforms based on the presence of consultation, training and support. In their thinking, there would be initiatives aimed at building the capacity at each tier of service, with a focus on service referrals and linkages using both federal and state investments. There would also be strong monitoring across transitional points with capacity for flexible planning. Some consultations went further than co-location and suggested there should be a re-examination of organisations re governance and sharing resources with the possible amalgamation of services.

Most consultations agreed that streams of care should not try to go across a 0-25 year age span but there were different views regarding where the age cohorts should divide. There was consensus though, about ensuring there was a smooth transition across whatever the age cohort divides were.

There was a strong theme of needing investment in youth friendly mental health programs that understand the support needs of young people and provide responses that work. This will mean more assertive outreach models and having programs that bring the young people in. Headspace, for example, should be improved and extended. It was noted that while schools are important so are a range of other services. The 'Re-connect' program was mentioned in this context as was the Sweden 'Youth Services Framework'. The consumer forum had a particular interest in this area and was interested in increasing programs for young people that work such as SHARE, ROCKET and Orygen type services. Consumers are interested in better transition experiences for young people when they move to adult services and services that will support young people in finding and maintaining work or maintaining connection with their schooling.

There was a concern that whilst eating disorders require a specialist service response the heavy emphasis of this in the proposed strategy and consequent investment should not come at the expense of other issues that need attention. Some of these issues included the need for increased capacity within CAMHS to respond; the development of specialist positions that can work alongside secondary services such as the FaPMI program; and, services for young people who have parents with a mental illness such as the PATS programs which were defunded and not replaced.

Apart from these resource or service type bids there was a general emphasis on an increase in the capacity of community based services. This should occur on the basis of recurrent funding, not 12 months time limited grants and be based around increasing long term funding for programs that are working well. There was also strong interest in increasing flexible and needs based funding approaches, such as is available for Headspace and Take 2.

There was significant variation in the responses to the two strategies outlined in the consultation paper targeting vulnerable young people. A few of the forums supported both strategies. A number of forums though, indicated that investment in the existing service system was what was required. The key task was to co-ordinate services more adequately than occurs now. The strategies should therefore be about increasing funding to services already working with the most vulnerable young people rather than putting in an additional expert service layer. This has to be accompanied by partnership development along with the tools required to support integrated care in a partnership arrangement.

One forum identified two problems with the proposed strategies. Firstly, they call on schools and general practitioners to refer when they are already over burdened and stressed. Secondly, specific specialist services aren't funded sufficiently to respond.

Two forums suggested particular arrangements they would like to see implemented. One described their preferred option as being the development of a CAMHS consultation service that can be mobile across a region and provide primary and secondary consultation to all services, providing in situ collaborative assessment, risk management, support and planning. The other forum did not support a separate service but did want to locate case management within community based services rather than in specialist mental health services so that case coordination would be provided by those who have good knowledge and expertise of generic services.

Other forums were less interested in how services might be developed or reconfigured and were more interested in describing service characteristics. There was interest in the development of specific services and/or responses that reach the population that are not engaged with services and their communities. This means assertive outreach by actively going to where young people. Engagement is a key therapeutic intervention. There also has to be a hybrid mix of personnel in services such as mental health workers in homelessness services. There have to be the necessary tools; workforce development; and, partnerships with specialists so those at the front end undertaking assessments have the services behind them to support long term goals. Service delivery has to be flexible using a range of service options and based on what best suits the person. This means there has to be an opportunity to purchase services as needed.

While there was a strong view that investment in services was the key issue that had to be attended to, there was a counter view that there had to be some fundamental questioning of existing service provision. 'There are serious questions to be asked about whether the existing services are functioning and whether they need revamping'. There has to be a strengthening of the specialist mental health services involved with young people to ensure they have the capacity to treat following assessment. A number of groups commented that they didn't want to lose the specialty nature of mental health in the broadening of the service system so that in achieving breadth, depth must not be lost.

There has to be investment in training service providers working with young people so they actively and assertively engage with young people. And there needs to be cross cultural training to develop competence in working with Indigenous clients and people from difference cultural backgrounds.

There are particular issues with the shortage of youth workers in rural areas. Also work has to occur with the community given the level of stigma and discrimination vulnerable young people experience. There have to be messages regarding the value of young people and the normalising of mental health issues in the community.

2.4 Responding to people in urgent need

At each of the forums, this topic attracted large numbers with specialist mental health workers, police and ambulance officers active in the discussion. There was a sense that the

problems of the current system were well known and have been the subject of previous discussion between the parties. There was interest in significant reform with an examination of key roles, a review of current practice and significant additional investment.

Overall there was good support for a central telephone number although there were concerns about how it would work in practice. Carers, police and ambulance were particularly supportive of this proposed initiative. It was thought access could be further enhanced through the establishment of a complimentary computer system across the state to allow remote access to patient data for triage-patient history. There also needs to be community education regarding triage and the pathways into the service system.

There was a consistent call to review the CAT team's role. There was keen interest in their capacity being increased; for workers to be available on a twenty four seven basis; and, for them to be located closer to communities that use them and co located with generic services. Comment was made that too frequently now services are not able to access CAT teams for the necessary secondary consultation. There was interest in the broadening of the definition of the groups they will work with; investment in their development so they have stronger assessment and treatment skills; and, a significant shift in the culture of teams in working in partnership with other services and providers. The location and access of CAT workers was raised in each of the rural forums. The lack of access was seen to be driving increased involvement of police, ambulance and emergency departments.

There was also interest in more clearly identifying those who are increasingly problematic for health services, the police and ambulance. It was also thought that someone who is aggressive due to alcohol and drug issues requires a different response to those who are psychotic. They don't fit the CAT eligibility criteria yet there is a need to work out a better response to them. One group suggested that we have lost some good features of the old system that provided places for asylum for people who want protection, an opportunity to withdraw, or to rest. This feature is only available for the most severely ill. There is a need for step-up and step-down facilities where people might present in crisis and out of control who might not have a mental illness but do have a short term need for support and assistance. In a number of rural regions there was a call for a partnership strategy with rural health services, area mental health services, general practitioners, police and ambulance services for the more effective management of this group. There was concern that a risk adverse approach was driving current responses with the result that this group is increasingly being taken away from or diverted from the local health service by police or ambulances to the emergency department where the area mental health service is located. This approach is increasingly placing stress on police and ambulance and is resulting in the call for mental health specific retrieval teams. In Gippsland there was interest in the range of providers coming together every six months to review cases and examine everyone's systems and processes by considering questions such as what worked well, what did not and how can we do better. The success of this approach relies on local capacity and commitment to implement the required improvements.

The need to improve triage was emphasised at a number of forums with suggestions such as the out posting of staff and using the learnings of the PACER trial to inform further investment.

There was extensive discussion on the importance of earlier involvement to prevent crisis. It was thought earlier involvement needs commitment by both specialist mental health services and community based services to a different approach. At the Horsham forum, for instance, there was a view that, if local services worked together with their communities, they could reduce the need for crisis responses.

Workforce development and partnership approaches were seen as key to improving responses to people in urgent need. There was interest in joint training, partnership development and improved systems for information sharing. The presence of a contact person with specialized skills in mental health as part of police and ambulance services in each region or the co location of specialist mental health workers with police and ambulance was also proposed.

Training on mental health for all staff including police, ambulance and emergency department staff was frequently raised.

It was thought that emergency departments could be improved by attention to the development of specialist aged and adolescent contact points and the design and installation of specialist consultation and assessment areas in emergency departments. There was also a call for additional resources to emergency department CAT teams who believe they are equipped to do the work but are insufficiently resourced to manage the demand. Training and education of emergency staff in mental health and dual diagnosis was stressed. It was thought there could be better use of technology to resolve procedural difficulties between MAS and emergency departments. There were some who expressed scepticism about the capacity of mainstream emergency departments to provide an effective emergency psychiatric response. They wanted to see the establishment of dedicated psychiatric emergency departments. Carers' interest was simple; they want a reshaping of responses at emergency departments so that people attending know they will get a response.

A number of groups expressed an interest in reducing the reliance on general practitioners for people in urgent need. Their capacity to respond and be accessible given GP shortages in rural areas was seen as a key issue. There was a call for legislative changes to section 10 which is seen to be unwieldy. The legislative review should give consideration to the role and powers of ambulance and police. There was also interest in CAT services having the authority to section people as occurs in the United Kingdom where mental health nurse practitioners have that power. An investment in mental health nurse practitioners would also assist in supporting the current demand pressures on general practitioners. There was a call for a review of the availability of emergency beds in hospitals for out of area transfer patients.

2.5 Specialist Care

The point was made that adults with severe mental health problems will continue to require the range of bed based and community specialist services that are currently available. Earlier intervention and increased focus on children and young people will not eliminate severe mental illness in adults; therefore investment in services for people with severe mental health problems must be viewed as an ongoing priority. Acute inpatient care should not be considered a last resort or a failure of community care. It should be an option of choice when appropriate and necessary to provide best treatment and care.

There was strong support for service integration through the use of shared care and treatment plans developed in partnership with consumers and their carers. It will mean investment in a common data management system and IT and greater attention to care planning and care coordination. It also means having a full range of community based services to meet people's needs so that people are able to live and function in place. It also means there has to be genuine consumer participation. They have to be central in the decisions regarding their treatment if we are going to be serious about destigmatisation of the person with the mental illness and respond to carers' interest.

A number of forums called for case management and care coordination to be moved to sit with the PDRSS sector. Care coordinators should have access to flexible, individualised brokerage funding, which can be tailored to individual need. Clinical care management would remain the responsibility of specialist clinical mental health services.

There was also a call for developing a service system that is responsive to a broader range of clients. Particular mention was made of people with severe personality disorders; those with alcohol and drug issues; and people from culturally and linguistically diverse backgrounds, especially refugees. Culturally responsive service delivery was flagged with a need to work in partnership with aboriginal controlled organisations and community leaders to develop services that respond appropriately to the needs of the Indigenous community. Support and partnership development with Indigenous health workers was identified as an important strategy. The specific needs of women were raised in a number of forums with reference to the UK where there are gender exclusive areas in psychiatric facilities and women's crisis centres. There was a view across all forums that the current responses to older people with a mental illness are inadequate. There is a lack of investment in research and in a skilled workforce able to respond appropriately to the

needs of this group. The lack of services means that people are not being diagnosed, managed or treated appropriately. The example was given at a forum of one person who was that day being moved out of her community and away from her family in rural Victoria to the other side of Melbourne in order for her to have permanent suitable mental health accommodation. There was a consistent call for the final strategy to given greater prominence to service delivery for older people with a mental health illness.

It was noted that the crisis focus will be difficult to shift. There was universal support for the reform intent of having adequate well resourced and interconnected services so that no-one gets turned away. The constant challenge raised was that of moving from this intent to implementation. Some emphasis was placed on finding the incentives to shift the concern about risk assessment processes to a focus on ensuring clinical practices are therapeutic and client centred rather than risk management driven and institutional. Investment in additional capacity across specialist and community based services was identified as critical at every forum. Without this investment services will struggle to meet demand and provide high quality services.

Greater capacity for assertive outreach to engage with specific marginalised groups; for secondary consultation and support, including specialists being located in community based services; stronger engagement of GPs; and, for enhancement of the practice nurse role along with an increase in the use of nurse practitioners were all identified as important strategies. It was thought there was potential for counsellors in community health to have a greater role along with other areas in community health services. A number of forums considered that the role of the PDRSS sector should be reviewed and strengthened over time so that it plays a more central role in early intervention (early in episode) and in recovery. This will mean addressing their access to specialist mental health services such as Spectrum and Forensicare. Access to specialists for client assessment and secondary consultation is especially problematic for all rural and regional service providers. Increased use of technology does offer some promise along with attention to the funding formula applied to mental health service investment across regions. There has to be some consideration of a weighted formula that takes account of a range of issues in delivering services in a rural region.

There was interest in more clearly describing the roles and responsibilities of services into the future. Comment was made, for instance, that acute inpatient care should not always be the last resort, but should be based on clinical indication, risk assessment and the best interests of the client.

The consistent theme was one of having a set of services that take shared responsibility for working in partnership with consumers in the development and delivery of person centred plans and treatment. Services have to include public and private mental health and community based providers including general practitioners. This will require a community based mental health system with the following characteristics:

- Triage provided through a single point of entry that provides a response to the question: What is available and where do I need to go?
- A local catchment based response built on relationships between local organisations who work together.
- A stronger partnership between PDRSS and clinical services with a shared prevention approach and the use of shared recovery care plans. At present there are inadequate responses to the management of risk. Both PDRSS and clinical services are not aligned in their response to risk and there is a lack of planning.
- An assertive outreach response.
- Increased alcohol and drug responses in local areas. The alcohol and drug environment needs to be safe and have access to psychiatry for consultation.
- Address rural and remote issues by considering what service model will fit and moving away from the current funding-per head, per capita approach.

There has to be comprehensive planning, into the system at any entry point, with all services connected and coordinated well where the roles of all providers are respected and directed to the needs of the whole person and their carers.

Workforce development, clarity of roles and expectations, investment in partnership building activity, an increased emphasis on practice knowledge and sharing; along with

stronger reporting and accountability systems were all seen as key to delivering the required change.

2.6 Complex Clients

There was wide support for a care coordination and lead agency role. It was noted, however, that without attention to additional investment in support services and access to affordable housing it will struggle to be effective. While most forums saw the need for a specialist lead agency, a few suggested the lead agency role should change depending on who has the relationship and greatest service involvement with the person. There was also concern that the role should extend to the aged care sector. Area mental health services were seen as critical to the development of care coordination whatever the model and wherever the lead role exists.

For the role to be successful the following were seen to be important:

- Care coordination has to be accompanied by brokerage funds with packages attached to people.
- The system needs to have a common assessment, referral pathways, a referral tool and appropriate clinical governance, including service delivery agreements.
- Coordination must include discharge and re entry outlined in clinical recovery plans. There have to be multiple agencies working to one individual service plan.
- The role has to be adequately funded and service coordination and service compliance needs to be linked to service provision and outcomes for the client.
- Investment in IT systems to support care coordination. There have to be common data systems which facilitate information sharing.
- A clear mandate for the care coordinator to work with all agencies with agencies providing the required information and level of engagement. It requires a multi disciplinary team approach. Care coordination requires effective sustainable working partnerships. The existing care coordination arrangements are based on goodwill, often at the worker level. There may need to be a change in the legislation and funding to mandate working arrangements. The exclusion criteria are a concern. There are different eligibility criteria and a difficulty in getting the agencies to cooperate. The emphasis on 'no wrong door' is critical.
- Developing approaches that can support both voluntary and involuntary clients.

Across the whole of the service system there has to be effort be put into the development of a common framework for viewing clients. There should also be opportunities for joint assessment and individualised flexible funding from a shared pool to be applied as required. Existing mechanisms happen quite well but are dependent on personalities and individuals. There is not a systemic approach. While PCPs are a potential partnership platform they are variable in relation to their profile on issues such as mental health and housing.

There was general agreement that the assumptions and directions outlined in the consultation paper in relation to housing and support were correct. Access to safe, secure and affordable housing is fundamental to mental health preservation. It needs to be accompanied by services that are geared to support people with mental health issues and scaled according to individual needs. There also has to be an appreciation that once long term housing is achieved there will usually be a continued need for support. This means developing support responses that allow clients to move in and out of support arrangements according to their changing needs.

Innovative housing options should be investigated, invested in, trialed and replicated. The proposed lead tenant model is seen as positive. Wintringham is a great model for aged housing since it links support and secure housing. It may be time to challenge the notion that rooming houses and caravan parks are not suitable accommodation. Congregate housing could work with the right level of support and regulation. The State has to take more responsibility and support agencies purchasing motels and large blocks of housing to use for crisis accommodation and reallocate HEF toward this type of housing. The barriers to people exiting SECU's and prisons accessing public housing due to segment one eligibility criteria have to be addressed. Similarly, the use of being 'housing ready,' a euphemism for being 'drug free' and 'clean', as a means of excluding clients with mental health and drug and alcohol issues from public and transitional housing, has to be tackled.

Housing models and solutions have to be geared not only to singles but also to families and couples. At the Hume Forum it was suggested that DHS has a role in ensuring that housing associations liaise and deal with the homelessness service sector. In the region there should be the development of the four sub-regional service planning groups based on the LASN model, to undertake the necessary research to know reliably how many are homeless; determine their housing and support needs; and, use this information to inform housing association planning and support responses.

There is a need to develop a better relationship between mental health services, SAAP and PDRSS, particularly in regard to secondary consultations and shared care. Joint training, partnership and support activity between the homelessness and the mental health sectors should be undertaken to develop a true partnership. Homelessness services are willing to take a support role but they want more access to the expertise of people in the mental health system for either secondary consultation or an actual assessment, when it is evident that the mental health needs of the client are beyond the capacity of the expertise of the support worker. Homeless entry points need additional resources and supports to provide a key mental health worker who is involved and accessible.

Finally, the lack of affordable housing not only impacts on the health and recovery of a person with mental illness but is a risk factor for people acquiring a mental illness. Consideration has to be given to housing and support being seen as early intervention strategies to reduce the onset of mental illness.

It was thought there was a significant opportunity for an improvement in the current responses provided to people with mental illness involved in the criminal justice system. There was a call for stronger partnership approaches across Governments and policy leadership. Government has to demonstrate leadership by putting an increased emphasis on the diversion of people with complex mental health issues away from prison and away from courts. There is a need for specialist courts for mental health that focus on community based service

The gaps between drug and alcohol and mental health and the justice system also have to be addressed. Significant attention has to be given to ensuring people get linked appropriately to community services upon exiting prison. There has to be earlier and easier access, for instance, to drug treatment programs. There also need to be better housing responses, so that, for example, people are able to suitably progress through Thomas Embling Hospital. Currently, people remain as there are no available beds in the community. Consideration should be given to the development of a suitable mental health assessment model, such as the Canadian model.

There needs to be better case planning between agencies and information sharing between police, courts, prisons and mental health services. Discharge plans should have to compliment parole plans and perhaps parole plans should look more like a MACNI plan. There was strong interest from workers from both custodial and mental health services for a greater emphasis on integrated service responses. There was a view that the service models both within youth justice and for young people exiting youth justice could be applied to the adult population. It was noted that in the absence of coordinated service responses at transition points, such as community to prison and prison to community, transition effectively means that a whole lot of services that were available are no longer available.

While most of the suggested improvement strategies targeted transition points, such as prisoners having a mental health and drug assessment as soon as they enter prison, there were others that focused on the potential opportunity of the criminal justice system being an identifier and linker of people with mental illness to services. There could be a targeted mental health assessment strategy, for instance, for people held in police cells for the first time. There was also support for investment in prevention programs such as the 'No to Violence' men's behavioural change program that receives mandated clients as part of non-custodial sentences. There was interest in a central case management system, where mental health services follow the person through the justice system using a consistent case worker. The lack of capacity of forensic mental health services was highlighted with rural services in particular having to develop improvised responses.

The difficulty of rural mental health services responding appropriately is exacerbated by the inappropriate placement of people exiting from prison in isolated and unserviceable areas where a city level follow up on a non-custodial order is expected but not possible given the lack of clinical forensic expertise. There need to be regionally based forensic mental health specialists.

2.7 Workforce

Workforce was consistently identified as a key priority across all the consultation forums. A knowledgeable, skilled and sustainable mental health workforce was regarded as being critical to realising the reform directions.

A key element in the development of a workforce strategy should be understanding what the future workforce profile will look like. There are likely to be new or expanded roles in areas such as specialist employment consultants; role expansion for mental health nurses; increased numbers of nurse practitioners, and there will be specialist mental health workers embedded in community services. There will be an increased use of telemedicine and a stronger multidisciplinary team approach. A number of forums indicated there should be an examination of whether the existing specialist model is sustainable. A key challenge, for instance, is the attraction of psychiatrists to rural and remote Victoria. It was thought there is an opportunity to respect the specialist component and, at the same time, grow the interest and competence of other disciplines to create a sustainable mental health service system. This would include reviewing the current discipline practice boundaries and considering, for instance, whether PDRSS staff should be developed to take on case management and specialist rehabilitation roles. There was limited discussion of the proposed Mental Health Worker role. Comment was made that it may impede the potential of current services to develop holistic approaches and it may be preferable to place specialist workers with other agencies.

There was interest in the development of statewide core competencies for the workforce including PDRSS staff, consumer and carer consultants and clinical staff. There was a consistent call for much stronger investment in workforce development using these core competencies as a base

A number of forums were interested in the development of a Victorian Centre of Excellence in Mental Health Care accompanied by training clusters where the focus is on service impact. The training clusters would have responsibility for the development of a regional workforce strategy that incorporates the clinical, non-clinical and community based sectors and supports innovation and collaboration. Workforce development strategies that should be considered were:

- Training for non mental health workers building on the mental health first aid package.
- A formal structure for student placements. There could, for instance, be a student unit that is multi disciplinary and centrally located in an area.
- Strengthening peer support, clinical supervision, mentoring programs, cross-sectoral rotations and leadership development.
- Develop reciprocal placements and exchanges by staff from different sectors and services in an alliance program.
- Establish mentorships for aspiring middle managers.
- Ensuring that training provision is focused on promoting evidence based practice.
- Supporting staff participation in development opportunities through fully funding the back filling of positions.
- Investment in the support and training of Indigenous mental health workers along with the development of partnerships with mainstream workers.

There is a need to provide encouragement and increase the accountability of the university sector to prepare appropriate trained graduates. There should be a closer relationship between mental health services and universities on curriculum development and student placements so that a common understanding about what might constitute base level training for undergraduates in various disciplines is developed. The inadequate focus on mental health competence in nurse training was raised in a number of forums.

Consumers and carers emphasised that, if there is to be a real partnership with consumers and carers, it will only occur when there is significant investment in the consumer and

carer workforce. It was thought demonstrated commitment to the carer and consumer workforce was a major omission from the consultation paper. In terms of the consumer workforce priority has to be given to:

- Wage parity in order to achieve a sustainable and viable workforce
- Development of career pathways and a delineation of the different roles needed within the consumer consultant workforce. Systems advocacy is a different role from client advocacy. There is also a role for consumer consultants in the areas of education and research. Each of these roles requires different skill sets and should be provided by people who have the necessary skill and training in these areas.
- Investment in the training and upskilling of consumer consultants. This means development of pre-entry training such as a TAFE diploma along with continued investment in the knowledge and skill development of consumer consultants, just as would occur with other worker roles in mental health services.
- Value consumer teachers and support them. We need consumers to be involved in the training of the non-mental health workforce.

The lack of wage parity across AMHS, PDRSS and community sectors and the lack of portability or flexibility of employment arrangements that encourage movement across sectors were seen as two key challenges that need to be addressed. There is also a need to recognize our dependence and reliance on overseas trained staff. We have to give attention to salary competitiveness, working conditions, relocation assistance and cultural assimilation.

The PDRSS sector came in for special commentary. The SACs Award was not seen to be adequate and the workforce is not well supported or mentored with a need for particular attention being given to improving pre-entry training. The level and content of current pre-entry training is not adequate.

Rural workforce recruitment and retention challenges were also frequently raised. There are key workforce gaps across a number of disciplines. It was thought rural recruitment and retention could be supported through incentives and rewards such as bursaries at university level for students in mental health; payment of HECS debt for graduates from rural areas who return to work in rural areas; payment of the training program for private psychiatrists who are then required to work in rural areas; additional funding to support rural placements; tax deductions for rural staff; and, providing graduates working in rural areas with an internship or funded mentoring. Workforce development could be enhanced through increasing specialist staff mentorship of non-specialist rural staff through greater use of video conferencing and Skype, networked learning, and on line course delivery.

2.8 Partnerships

Development of an outcomes framework was widely supported. There was a consistent view that the system needs such a framework to drive service accountability and to inform clinical practice, training and education. The challenge will be to develop outcomes that are meaningful to the workforce, to consumers and carers and to the community. Consideration needs to be given to the type, sensitivity and validity of outcomes measures that encompass consumer, service and broader community levels. Those that referenced the outcome measures described in the consultation paper supported them. Some groups were interested in service quality measures, such as how many people were seen, and called for external clinical audit processes and strong external monitoring of service performance. Others were interested in moving away from service delivery measurement and moving towards measurement of outcomes such as recovery rates and level of service satisfaction. It was noted that the place of consumers and carers in this thinking is critical. There have to be quality of life measures and measures on consumer and carer satisfaction which will mean more than the use of formal discharge surveys and might require the use of a third party such as La Trobe. There should be the inclusion of measures around social connectedness. Some thought the framework should include mental health KPIs for divisions within DHS and for all government departments.

To have an effective outcomes framework and to deliver on that framework, the issue of the impact of federal and state funding and parallel service investment on service delivery has to be addressed.

There was some interest in the possibility of linking into existing data sources and collections, such as those of the Commonwealth to produce additional Victorian data reports.

While the development of an outcomes framework is a key challenge another key challenge is to embed data entry into practice. There has to be the development of a culture that supports and values data collection. DHS was seen to have a key role in coordinating data collection, translating it into meaningful information and disseminating it in a way that fosters improvement. The data should be transparent and shared across services and with carers and consumers.

Currently, mental health services have a culture that does not value research. There is poor staff understanding of the need for research and the use of tools such as HONOS. There has to be a commitment to well funded independent research where research knowledge is shared and disseminated. Research should be informing policy and supporting practice development. An investment is needed in new knowledge generation. If we are to be serious about research then there should be a commitment to ten per cent of the total mental health budget being allocated to research. A research clearing house and collaborative arrangements with a university were mooted. A number of forums supported the idea of a centre of excellence that had strong connections to the field and a mandate to support service quality improvement through disseminating research.

In determining who should lead and participate in governance arrangements for mental health services, it was noted there needs to be clear distinctions made around clinical governance and issues under the Mental Health Act versus financial, operational and corporate governance. A number of forums promoted the development of regional mental health boards that would have responsibility for area based planning. The boards would have broad cross sector representation, with representatives from specialist mental health services, community based services, consumers, carers and the community, to undertake planning and to determine the allocation of area funds for local service improvements and enhancements. There was much discussion about existing governance arrangements. As one regional forum pointed out their governance environment is very complex; not only are there a number of governance entities such as PCPs, divisions of general practice and mental health alliances, there is often more than one of each of these governance types within a region. There was a reluctance to develop yet another governance body but at the same time there was no clear consensus regarding the most appropriate structure. PCPs, mental health alliances and care in your community governance bodies were the most frequently identified as being suitable platforms from which to build the right regional structure governance. Most forums had a preference for local areas determining their structures to enable them to set local priorities and plan together. They saw DHS's role as a leadership one where the regional office is active in the governance entity and the Department provides resources and offers guidance to support the emergence of a suitable regional governance arrangement. One forum suggested the way forward would be to fund a regional pilot of a structure that delivers common governance.

Regardless of the governance or organisational arrangements there was a consistent call for a much stronger collaborative approach to planning, to funds allocation and to service delivery. There was strong interest in an increased capacity to take a regional view with sufficient regional funding flexibility to develop services that take account of the characteristics of the region. This would be accompanied by a centrally driven emphasis on accountability; with many calling for funding to be linked to performance and outcomes. While the benefit of partnership approaches were frequently mentioned, there was interest in a number of forums for co-location and hub service models and in some forums a call for amalgamations. While most forums noted the importance of choice others thought there had to be some questioning of the number of PDRSS and community based providers in a catchment, particularly in metropolitan regions. They were interested in less service fragmentation and thought that partnerships would struggle to be successful if this was not addressed. There was a consistent call for the recognition that partnership activity took time and investment had to be made into resourcing partnership activity.

While there was no consensus on the placement of the services that make up the mental health service system, there was some exploration. At one forum, for instance, they thought the question needs to be asked whether there should be a stand alone mental

health service, given that an acute bed based service should not be the main focus of a community based recovery model. They went on to identify three possible models. One was a community health model which mental health sits within. This would be more integrated and appropriate given most services are already being delivered out in the community. A second model was an acute bed based one with clear linkages. It would provide seamless services for the person who is unwell with the right relationships between all providers who interface with the client, including family, police, ambulance etc. The third model was a whole of mental health service, with full integration to fit community need and to be accompanied by flexible funding models. A number of forums indicated that the mental health service model has to be established first and then organisational form and budget decisions can follow. There was also a consistent call for the area mental health service budget being guaranteed for the use of mental health services with transparency in the budget and its use. It was thought that if area mental health services remain in acute health, there have to be different governance arrangements to manage resource allocation and service delivery of area mental health services.