



# **Because mental health matters:**

**A new focus for mental health and wellbeing in Victoria**

**Response to the Victorian Government Green Paper**

**by**

**Mental Illness Fellowship Victoria**

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## ***Executive Summary***

Mental Illness Fellowship Victoria supports the transformative agenda articulated in this Green Paper. The strategy builds on previous phases of reform and offers logical and evidence-based directions for the future.

We endorse the vision of a specialist public mental health service system that supports and increases community tenure for people with mental illness. Through measures that free up capacity within this system and strengthen linkages with other sectors, greater opportunity to receive service will be created for people who are currently excluded.

We strongly support the paper's preference for a system in which acute beds are supported by varieties of non-hospital bed options, delivered collaboratively by both the clinical and PDRSS sector. We endorse the strategy to develop greater community involvement in provision of CCU's and SECU's, thereby enabling clinical staff to be redeployed into other care settings. We also firmly endorse the expansion in PARC facilities. Our vision for the future includes a transfer of acute bed-based services across to models of joint clinical-PDRS management, which provide flexible services in community settings, enabling recovery and social inclusion.

Measures to increase service access are positive, with the proposed statewide telephone triage potentially simplifying service access and enabling diversion of inappropriate requests. Equally however we are concerned to ensure that the goal of providing 24 hour emergency face-to-face response is not abandoned, either through ongoing involvement of the CATS or alternatively via new procedures involving police.

Although low prevalence illnesses are less amenable to prevention, we support the major role projected for prevention strategies across the board – in universal settings, throughout the primary health and other service systems, and within the specialist public mental health sector itself. Through prevention strategies a proportion of current mental illness can be precluded, and through effective early intervention the severity of illness can be significantly moderated. Prevention strategies show promise for improving the appalling general health profile of people with mental illness, for ameliorating the negative experiences of carers, and finally for increasing community understanding and acceptance of mental illness.

Early intervention strategies also attract our strong support, including the greater involvement and capacity-building of the universal health and education service system for children. We believe that the child and adolescent mental health system should be restructured to align services for younger children more closely with community health, although adolescents and young adults are proposed to be covered by adult services. The challenge is identified for PDRSS services to work with younger age groups.

The Green Paper adopts a wide view of the social determinants of mental illness, rightly acknowledging the adverse impacts on mental health of housing insecurity and poor quality. We approve the paper's proposal that community housing be increased, and we enthusiastically endorse the measures suggested to enable people with varying support needs to be maintained in independent housing, viz graduated Home-Based Outreach Support packages. Our preferred model for community housing takes account of consumer choice, and is non-congregate, interspersed into ordinary community landscapes.

Curiously the Green Paper does not acknowledge to quite the same extent as housing, the positive preventive role of education and employment. Our experience in provision of nationally-recognised courses and open employment, confirm that these promote social inclusion and have a

profound impact on wellbeing. We strongly urge the Department to build expansion of education and employment programs into the reform plan.

Although it canvasses measures for consumers and carers, the Green Paper's targets for their expanded involvement in the mental health system fall short of what we would have preferred. The impact that specialist family-education (e.g. 'Well Ways') can have on carer and consumer experience, has been positively evaluated and should be rolled out much more widely across the sector.

We would see consumers and carers as having a significant contribution to make as peers and as employed professionals in the workforces of specialist public mental health services of the future. We would also regard specialist public mental health services as well-placed to demonstrate flexible workplace accommodations for people with mental illness as employees.

We endorse proposals for increased care coordination for complex clients, and would urge that attention be given to a group often overlooked: people with serious illness living at home with ageing parents.

MI Fellowship strongly supports voluntary organisational alliances that grow from a common vision regarding improved client-centred services, such as the Opening Doors initiative. However we have reservations about other alliance models, particularly those that are imposed within catchments and apply to all funded agencies. Similarly, we do not support any measures to rationalise the service sector that touch organizational governance arrangements.

In conclusion, MI Fellowship is genuinely impressed by many aspects of the Green Paper, and looks forward to the further development of its exciting proposals.

# 1. Overview

*About MI Fellowship*

Mental Illness Fellowship Victoria provides a range of services for people with low prevalence disorders (schizophrenia, bipolar disorder, personality disorder and other severe mental illnesses) and their families. Working in partnership with consumers and family members, we provide psychosocial rehabilitation, employment, education, health promotion and advocacy programs across the metropolitan area and in several regional areas.

We submit that this Green Paper offers the basis for a long term plan that could be truly transformative of the mental health system in Victoria, and establish it as a world leader in best practice mental health services.

*Increasing system capacity*

We share the fundamental objective of the paper, which is to increase the capacity of the community and primary care systems to support the clinical sector in delivering services earlier, in less intrusive settings, and in ways that are much closer to the preferences of people with mental illness, their families and friends.

Mental health services and wider services in the health, education, employment and justice systems, must be prepared to collaborate in innovative models that share resources and responsibilities for the benefit of people with mental illness.

We agree that the key problem with the current mental health system is that it is acute and crisis orientated and overburdened at the expense of early intervention, relapse prevention and recovery. This means the current system does not meet the needs of many and contributes to social exclusion and marginalization of people with mental illness.

*Client-centred services and increasing community tenure*

We submit that the best conditions for day to day illness management and recovery, are provided in community settings where people feel at home, in control, and connected to their households and neighbourhoods. It follows that the framework of public specialist mental health services should be oriented towards preservation of people with mental illness in their own places and communities. Fundamental principles of reform are that services should be client-centred, and they should increase community tenure.

*Alternative, community-based bed options*

We endorse the Green Paper's position that there be growth in alternative, community-based bed options.

*New PARCs and changes in management of CCU's*

To achieve greater community tenure for people with mental illness, structural changes and resource re-allocations are required: Increased community management of CCU's will reduce institutional aspects of this accommodation and enable the clinical staff currently taken up with these units to be redeployed into other parts of the service system. Construction of more PARC's will take pressure off acute beds. More HBOS funding packages, directed to clients in the community, will in the longer term prevent the very severe and dependent illnesses that characterise those currently housed in SECU's.

Our experience in collaborative projects such as Opening Doors, well demonstrates the capacity of non-government, PDRS organisations, to successfully partner with clinical services to provide innovative, positive treatment environments.

<i>More housing stock</i>	More housing stock for people with mental illness is required, to enable them to remain stably housed with services flexibly provided at home, as required. This will also create exit points for people to move out of overburdened treatment services, thus freeing capacity for others requiring interventions.
<i>Involvement of consumers and carers</i>	People with mental illness, their families and friends, must have an influential role in service planning, design and delivery. Indeed, we submit that people with mental illness and family members - two groups that have a unique insight into and understanding of the experience of mental illness - ought to be developed to form the future workforce, not only in positions of peer consultants, but also in every professional discipline represented in the mental health workforce.
<i>Need for more attention to general health status of people with mental illness</i>	On the negative side, we submit that the paper seems to overlook the broader health needs of people with mental illness and that much more rigorous attention needs to be given to this. People with mental illness have substantially poorer health outcomes than the general population in almost every aspect of health. Death rates are higher and incidence of cardio-vascular illnesses, cancers and diabetes are much higher in this population. Obesity is an issue often exacerbated by psychotropic medications. Dental and general health needs are often overlooked. We submit that there needs to be a comprehensive strategy to combat this neglect. We regard it is a significant oversight that it seems to receive so little attention in this otherwise substantial package of reforms, and we urge greater attention to it as these reforms are translated into policy.
<i>Wider vision of prevention and early intervention</i>	We approve the strong emphasis provided to prevention and early intervention, but we do not believe that the paper goes far enough. We see the prevention power of increased community tenure through participation in employment and education, as crucial to reduction in mental illness. We would like to see far greater attention provided in the forthcoming White Paper to both these domains of social inclusion.
<i>Population health approach may overlook low prevalence disorders</i>	We are concerned that for low prevalence groups, there may be unintended consequences of 'population health' approaches. The Green Paper's enthusiasm for a 'more rationally based system of care which makes the best use of all available resources to maximize population health gain' (p.15), must be balanced by the moral obligation to continue to alleviate the significant impact of mental illness through delivery of ongoing services.
<i>Slowing in growth in demand</i>	We also have questions regarding the speed at which improvements in service system access and capacity can be achieved. In view of the likely continuing incidence of severe mental illnesses, combined with projected increases in prevalence of other disorders such as depression along with overall population increases, we would regard a slowing in growth in demand to be a more plausible outcome than reduction in prevalence.
<i>Community-delivered bed-based services</i>	If high levels of demand persist in at least the short to medium term it is imperative that there be immediate increased access to a variety of community-delivered bed-based services. The evidence of major current unmet need is stark; early intervention strategies including increases in PARC beds and growth in Home-based Outreach packages are urgently required alongside redevelopment of the role and management of CCU's.

*Designation of lead agency and changes to governance*

Other points of difference with the Green Paper's proposed solutions, relate to its proposals for system reform via designation of a single or lead PDRSS agency per AMHS area, and measures affecting the governance of provider organizations.

We identify three distinct issues here. First is the problem that in a pluralistic service system, some small service provider organizations may have marginal viability and lack the capacity to participate in service development. We regard rationalisation of the service system to address this problem as the prerogative of government however we view this as best pursued via the powers explicit in funding contracts.

A second issue relates to service access: Since fragmentation and complexity in the service system block entry, there is a need for simplification and increased visibility of entry points. However designation of lead agencies or changes in service governance arrangements such as forced amalgamations are not of themselves a response to this issue. The paper's canvassing of other proposals such as the Statewide Telephone Triage service proposed, have greater promise.

A third possible rationale for these types of system reform, is the need to achieve real 'continuity of care' and to bring about better management of people with chronic serious illness in the community. We share the objective of increasing collaboration among service providers, but we submit that this outcome will not be achieved through imposed measures. Rather, innovation and best practice are more likely to emerge when organizations decide that collaboration is the means through which they can achieve better services. The driver for inter-agency collaboration must be improvement in services for consumers. The role of government is to create the conditions for organizations to recognize a common vision for client-centred services, and then to facilitate their collaboration to achieve this.

*Outcome measures*

Our doubts regarding the scope for reduction in prevalence leads us to be wary of this as the top outcome measure. However we agree that a well-functioning mental health system will result in reductions in mortality, morbidity and comorbidity. We strongly agree that 'economic', 'workforce', and 'community' participation measures, and reductions in incidence of marginal behaviours such as criminal and antisocial behaviours, are centrally relevant to questions of service effectiveness.

*Conclusion*

These differences aside, MI Fellowship congratulates the government for the far-reaching and transformative proposals contained within this Green Paper. These proposals have the potential to position Victoria's specialist public mental health system as a world leader, and we look forward to the development of policies and implementation plans.

## 2. Focus Areas

### 1 Prevention

#### **Goal 1.1 Creating wider opportunities for promoting mental health in local communities**

##### *Health promotion*

We endorse the application of integrated health promotion approaches to increase knowledge and control over individual health behaviours, and thereby to prevent forms of ill health.

We would like to see mental health promotion as a primary prevention activity across universal settings, and commencing from an early age.

We also support the application of health promotion in specific settings such as work places and education environments, to eradicate discriminatory provisions that exclude people with mental illness. We encourage the Department to consider those organizations involved in PDRSS programs which also offer employment and education services, as a potential providers of health promotion in workplaces and education campuses. Pilot programs in these areas of practice would be welcomed.

##### *Secondary prevention*

In relation to people with low prevalence mental illnesses, we agree that the scope for *primary* prevention is more limited owing to the fact that genetic factors play a significant role in these illnesses. However given the evidence of poor general health status among people with mental illness<sup>1</sup> there is a crucial need for health promotion approaches targeting both consumers and their service providers in the mental health services sector. Education to increase healthy behaviours and self care and to prevent further deterioration and reduce risk factors, is vital in relation to both mental and other illnesses.

##### *Families and friends of people with mental illness*

In relation to carers of people with mental illness, we strongly support expansion of educational health promotion approaches.

In 2007 Mental Illness Fellowship of Australia conducted a national survey of 2,268 people<sup>2</sup> to identify the top priority issues for people with mental illness and their families. After housing and employment, consumer and family education and support was identified as the number 3 priority issue of concern.

We submit that specialised interventions are required due to the particular challenges that mental illness poses to families and because of the considerable stigma that still surrounds mental illnesses, especially the spectrum of psychotic illnesses. Too often consideration of carers and their needs end up with services that offer 'support' alone.

We submit that specialised educational interventions are required that provide

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<sup>1</sup> VICSERV (2008), Inequalities in Health and the Health Policy Context, Working Paper 1.

<sup>2</sup> Mental Illness Fellowship of Australia, (2007) 'Australians talk mental illness 2007', Submission to Federal Political Parties.

families with accurate, up-to-date information about the causes and treatments of mental illnesses and the mental health system, that build families' coping strategies and that provide and build a support network.

Families need access to information and education that is sensitive to the lived experience of caring, that offers a peer supportive social network and that models health promotion and recovery for family members from the impacts of mental illness.

Education and health promotion programs that are facilitated by trained and educated carers, that are run for multi-family groups thereby building a support network, and that are run outside of clinical services where families often feel undervalued, are an area of priority for families of people with mental illness.

There are few such health promotion programs around that have been evaluated for effectiveness and impact. The World Fellowship for Schizophrenia and Allied Disorders (WFSAD) in a recent publication identified six programs worldwide that included Australia's Well Ways<sup>3</sup> and that met the criteria for evidence-based practice:

- Well Ways*
  - Well Ways is a family health promotion and education program specifically designed for carers of people with mental illness. It has been extensively impact-evaluated over the past six years, and has shown consistent reductions of depression and anxiety in carers who participated in the program.
- Duo*
  - In 2002, MI Fellowship introduced 'Well Ways Duo', a program targeting carers of people with dual diagnosis. Again, the program offers information, skills and opportunities for personal development that assist carers to move beyond reaction and confusion towards positive resolution.
- MI Recovery*
  - 'MI Recovery' is a health promotion and personal development program now in the final stages of piloting prior to being offered widely to people with mental illness. The program fosters understanding, acceptance and personal empowerment and creates a supportive peer network for people recovering from mental illness.

Despite our efforts to achieve recurrent funding, financial support for these health promotion activities have been difficult to obtain in the mental health sector. We welcome the broad interest now being expressed in mental health promotion programs, and urge the Department to consider the need for these approaches for groups affected by low prevalence conditions.

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<sup>3</sup> Froggart et al. Families as Partners in Mental Health Care: A Guidebook for Implementing Family Work. World fellowship for Schizophrenia and Allied Disorders (WFSAD): Canada, 2007, 11. Six programs worldwide are identified, in Canada, Europe, United Kingdom, United States, WFSAD delivered in developing countries, and Australia's Well Ways

## **Goal 1.2 Strengthening social inclusion efforts to protect and reduce inequalities in mental health**

We strongly support integration of explicit mental health promotion strategies into existing social inclusion initiatives, such as Best Start or Neighbourhood Renewal programs.

### *Stigma*

We believe that social exclusion in relation to people with mental illness must be understood and addressed in terms of the concept of 'stigma', or the application of negative stereotypes and discriminatory behaviours towards those with a perceived difference. 'Personal contact' between people with mental illness and others has been identified as the most effective strategy to reduce stigmatizing attitudes toward those with mental illness.<sup>4</sup> This evidence base informs a range of social inclusion strategies that we conduct including our annual street festival, the Open Mind Fiesta.

There is still considerable scope in the Green Paper to develop a stigma analysis and a stigma-reduction strategy, and we would welcome a deeper treatment of this issue in the forthcoming White Paper.

### *Education and social exclusion*

There is also scope for some much more specific social inclusion initiatives in relation to arenas from which people with mental illness have been traditionally marginalised. In other sections the Green Paper addresses the need for increased housing and employment initiatives, however nowhere in the paper is sufficient recognition given to 'education'.

Since onset of many mental illnesses occurs during the period from adolescence through to young adulthood, disruptions to education could be predicted. Evidence from the Low Prevalence Study Group of the National Survey of Mental Health and Wellbeing<sup>5</sup> suggests that nearly half of people with these serious mental illnesses failed to complete schooling. Poor educational attainment associates with poorer social outcomes. We submit that educational failure arises through lack of provision within the educational system to accommodate special needs arising from mental illness, and that this exclusion then becomes a powerful determinant of ongoing social disadvantage.

### *Registered Training for people with mental illness*

MI Fellowship has successfully operated an RTO targeting people with mental illness, and we have seen our graduates regain aspects of community tenure that previously would have been beyond their reach (viz a job, a place in further education). We submit that strategies such as provision of educational opportunities for people with mental illness, and positive measures to promote participation of people with mental illness in mainstream educational settings, are essential social inclusion strategies. We further submit that organizations in the PDRS sector are well-placed to instigate these social inclusion strategies.

## **Goal 1.3 Reducing the risk factors for poor mental health associated with substance misuse**

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<sup>4</sup> Corrigan P and Lundin R (2001), Don't Call me Nuts – Coping with the Stigma of Mental Illness, Recovery Press, Illinois

<sup>5</sup> Jablensky et al (1999), cited in VICSERV (2008), Inequalities in Health and the Health Policy Context, working Paper No.1: Health.

We regard adolescents and young people aged up to 25, as the priority target group for prevention programs in relation to substance misuse.

The proposal of close collaboration between mental illness services and other service systems targeting vulnerable families and young people, is supported. We would see services where these groups first present for help, as appropriate sites for screening, health education and community development action. The Commonwealth 'Headspace' initiative emerges as a very positive model for bringing about collaborative practice among agencies and an accessible service hub. Program models that provide for intensive or prolonged involvement with young people, such as residential rehabilitation, also provide good opportunities to reduce behavioural risk factors.

As outlined above, we have developed a health promotion and support program for families of people with dual diagnosis (Well Ways 'Duo'). We would welcome opportunities to provide this program more widely as part of a concerted effort to reduce broader risk factors in families arising from a member's substance misuse and mental illness.

***Goal 1.4 Renewing Victoria's suicide prevention focus through a wider range of government programs***

The proposal to build capacity for suicide prevention through introduction of a more systematic focus on mental health promotion, is supported. This should be widely available from both universal platforms (e.g. schools, maternal and child health, local government youth services), and also targeted services such as PDRSS providers.

*Specialist Family Education as a suicide prevention strategy*

We submit that providing evidence-based education programs for people with mental illness and families, that assist people affected to understand mental illness and its impact, is in itself an effective suicide prevention strategy. The fact that 10% of people diagnosed with schizophrenia complete suicide within ten years of diagnosis make this group and their families a high priority target. We submit that the funding of education and support programs that develop coping and management skills for both people with mental illness and their families are urgently needed.

Equally, social inclusion measures such as education and employment programs for people with mental illness, must also be acknowledged to have suicide prevention effects.

**2 Early Intervention**

**Goal 2.1 Strengthening capacity for early identification and intervention through universal services, including early childhood services and schools**

We support the Green Paper's intention to redevelop the service system for 0-25 year olds, to increase early identification and streamline interventions for younger people. To be truly effective, these interventions must be family-focused and address a range of causal and maintenance factors in the child's life.

We share the vision of 'assessment and developmental monitoring' by universal services, backed up by 'comprehensive professional development and systematic secondary consultation programs' provided by specialist mental health services.

*Additional resourcing for wrap-around care*

Significant resources and support will be needed for Victorian primary and secondary schools to deal effectively through time with children displaying a range of early problem behaviours including social skills deficits. The concept of 'wrap around care' for children and young people at risk is attractive, however delivery of this will require additional resources besides professional development and secondary consultation. Additional staff positions will be required – such as enhanced welfare, allied health or nursing - to work with families to ensure that children needing pathways into specialist mental health services, actually achieve these opportunities. These positions would rightly be placed either with community health or within the schools system.

**Goal 2.2 Providing earlier and age-appropriate treatment and support to children and young people with emerging or existing mental health problems and their families**

*Services for children 0-15 years*

We support the continuation of the model for specialist mental health services for young people where for children (0-15 years), main service provision is community based and organized according to age cohorts. Age groups that reflect natural developmental stages should apply, e.g. 0-5, 6-9, 10-12, 13-15 years.

*Care in the community for children*

We see no place for children aged 15 years and less, in inpatient, acute care settings. Rather, children experiencing serious mental illnesses should be cared for in community settings (e.g. a PARC facility), supported by intensive clinical treatment in-reached services.

*Integrate CAMHS into community health*

Rather than maintain separate CAMHS organizations for children we prefer the integration of CAMHS-type functions into community health. Community health services have strong existing capacity to respond to the needs of families with young children (e.g. Child Allied Health teams that complement regional Specialist Children's Services). As a local service platform, community health is very well horizontally integrated into both other primary care and universal services (e.g. GP's, schools and local government children's services), and vertically into secondary and tertiary health services.

Where possible, it would be a system improvement for the catchment boundaries of community health children's mental health services, to be aligned with the boundaries of Area Mental Health Services.

*Services for older*

For older adolescents (16+), we share the concern that development to maturity continues until age 25 or so. We favour distinction of services into age cohorts

*adolescents and young adults*

16-18, 19-21 and 22+ years, in single-gendered groups. We believe that these specialist services with an adolescent/young adult orientation and facilities, should be linked organizationally as a group with Adult Area Mental Health Services. Again, we favour PARC-like facilities for treatment as opposed to inpatient wards

*Limitations to early intervention*

Given the compelling need for earlier intervention to detect and respond to mental illness among children and young people, there is a significant reason to widen the scope and operation of PDRSS organizations so that they have greater involvement with younger age groups.

*Family-centred practice*

In relation to provision of support for families and engaging families in early intervention we support the intention to embed 'family-centred practice' into mental health services. The theory and practice models of family-centred work need to be conceptualized and offered within a 'recovery' framework that supports the young person's individuation and assumption of independence. In the development of our specialist family education modules ('Well Ways' and 'Well Ways Duo') we have wrestled with some of these conceptual challenges and would welcome the opportunity to do further work on this in partnership with other organizations.

### ***Goal 2.3 Delivering appropriate mental health support for particular groups of vulnerable young people***

Provision of mental health services to vulnerable young people is a priority that would be best met through a flexible, multidisciplinary team response.

*Teams integrated into community health or PDRSS*

We support the concept of a Multi-service Intervention Response Team (MIRT) model that brings together several service types and provides outreach to young people who frequently will be homeless. The Pathways model provides some useful principles for the design of such teams targeting vulnerable young people. The teams would need links with YSAS, homelessness services, education and employment services, and council/community health youth services. Integration of peers into these teams would assist in active engagement of vulnerable young people.

Location of these teams is important: PDRSS services could be an effective home base, providing as they do outreach into community and linkages into both clinical and rehabilitation services. If CAMHS services are integrated into community health, then this platform would also be suitable.

Whilst in general we do not support congregate living models for adults with mental illness, our practice with young adults in residential rehabilitation suggests that group programs for young people can provide a very effective milieu for rehabilitation and personal development. We would suggest that residential facilities for young people house no more than 12 at any one time.

### ***Goal 2.4 Building stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem***

We endorse measures to increase early detection and intervention for children of families where a parent has a mental illness.

Community Health Child Allied Health teams emerge as a logical place to site responsibility for provision of these specialist programs. Given the need for specialist understanding of children’s developmental and nurturance needs it is desirable that staff working with children of parents with mental illness or AOD problems, have ready access to secondary consultation.

### 3 Access

#### **Goal 3.1 Providing access to ‘right time, right place’ mental health care by making it easier for people to obtain mental health information, referral and advice**

#### **Goal 3.2 Improving the efficiency and effectiveness of psychiatric triage in specialist mental health services**

*Achieving a 24/7 assessment response*

We concur with the Green Paper that current arrangements for 24/7 telephone triage, assessment and crisis response, are problematic at several levels: lack of community knowledge regarding entry points, variability among AMHS in the responses offered, and inadequate linkages between AMHS and the primary care system.

There is scope for improving the accessibility of the mental health system through simplification of entry points, use of standardized tools for telephone assessment and triage, and education to increase community understanding regarding service functions. We can also see benefits from freeing up capacity in the CAT teams to increase responsiveness to local needs for urgent community treatment.

*Ensuring that urgent calls are triaged for response*

The proposed telephone triage service has value in offering a first port of call for access into the system. It also has a function to “screen out” and refer on to other services. It is imperative that the 24/7 telephone service be able to adequately identify clients that require specialist hospital triage and CAT services. Our experience suggests that a proportion of the large volume of calls currently being ‘triaged out’ are inappropriate – i.e. they should not be being triaged out in this way but should be included for urgent CAT assessment.

It is difficult to foresee how a telephone triage service could ‘manage some urgent referrals over the telephone pending a centre-based appointment’ (p.72). It may however be possible for greater use to be made of ‘community mental health centres for urgent business-hours assessments’ (p.73).

*Lack of services to refer to*

It also needs to be acknowledged that there is a lack of appropriate alternative services to refer people to – especially in rural areas and after hours.

The further development of community-based and managed bed options will serve to decrease emergency demand, as will the continued growth of home based outreach support packages that are available to people living independently in the community.

*Same day face-to-face response*

We see it as imperative that we continue to strive for capacity for a 24/7, same-day, face-to-face assessment response for *all* people with urgent mental health

problems.

*IT connectivity*

An important factor that influences service access for consumers, and referral among agencies, is information technology. It is vital that services are resourced and supported to fully engage with electronic systems to facilitate efficient communication and inter-agency referral.

***Goal 3.3 Creating an integrated emergency service system that can respond effectively to people experiencing a psychiatric crisis***

We assume that the Green Paper's proposal regarding a statewide telephone triage system is predicated on an intention to redevelop other parts of the emergency system to offer rapid and effective responses to people in mental health crisis.

*Role of CAT teams*

We acknowledge that there is presently a tension within CAT teams between their roles in assessment and in short-term intensive treatment in the community to prevent inpatient admission.

Given the agreed emphasis on early intervention, any measures that could possibly lead to a reduction in assessment/early detection capacity must be avoided. As stated, we do not support any reduction in availability of 24/7 responsive, face-to-face assessment service in the community; on the contrary, we regard this as a goal that has yet to be achieved. This level of response is available to people experiencing physical health crises, and ought equally to be available to those with mental health emergencies.

If the role of CAT teams in face to face 'crisis assessment' is to be reduced, we need to have other skilled emergency responses able to be deployed.

*Involvement of Police*

Victoria police are underskilled in dealing with psychiatric crises. The results of this are sometimes fatal. We have been advocating for change in this regard for many years and in 2006 piloted police training with 600 officers in Region 3. Further roll-out of the training was postponed when Victoria Police included response to psychiatric crises in its top 10 priority list. The results of the subsequent police enquiry are extremely concerning. The proposed way forward is 'in-house' and excludes ongoing input by people with mental illness, their families and community-based mental health workers. There is a grave danger in leaving police education about mental illness to psychiatry, since police do not need to know how to diagnose or treat symptoms. They need to be able to recognise behaviours that suggest mental illness and how best to manage those behaviours to achieve safe outcomes. De-escalating crises is a needed skill. Knowing how to talk to someone experiencing psychosis is a basic, vital skill.

*Memphis model – Crisis Intervention Teams*

Successful, evaluated models exist internationally. The Crisis Intervention Teams model (Memphis model) has proven successful in many sites in the US, and a model based on this ought to be piloted and subsequently implemented throughout Victoria.

In the Memphis model approach interested officers within the city police force, undergo additional training in understanding mental illnesses and treatments. These officers are dispersed throughout the city's police stations. When crisis calls are logged, the designated 'Crisis Intervention Team' (CIT) officer in the area

of the call, responds. This officer uses their heightened knowledge of mental illness and skills in communication and response, to de-escalate the situation and achieve a collaborative outcome with the person with the mental illness. Importantly, although the emergency response has been made by Police, the person with mental illness is transported to a variety of treatment centres as appropriate (not police or justice centres and not necessarily emergency departments of hospitals). Officers in the CIT maintain records of their contacts with people with mental illness, and patterns have emerged whereby the person with the mental illness actually requests particular officers. An important component of the model is involvement of consumers and carers as partners in the education of police and the operation of the model.

The identified benefits of the Memphis model of police intervention, include:

- Crisis response is immediate
- Arrests and use of force has decreased
- Under served consumers are identified by officers and provided with care
- Patient violence and use of restraints in the ER has decreased
- Officers are better trained and educated in verbal de-escalation techniques
- Officer's injuries during crisis events have declined
- Officer recognition and appreciation by the community has increased
- Reduced stigma and perception of danger attached to mental illness
- Less "victimless" crime arrests
- Decrease in liability for health care issues in the prison
- Relief to an overburdened criminal justice system
- Cost savings.

We understand that a model similar to the Memphis model is being developed for NSW Police. We would welcome an active role in the development of a similar model in Victoria and will continue to advocate strongly for action on this issue.

In relation to reducing the pressure on emergency departments, MI Fellowship's fundamental position is that system pressure must be relieved through the creation of alternative bed-based options and exit points into stable and secure long-term housing.

*ED Diversion beds*

We support the development of Emergency Department Diversion beds for people who would not usually use public mental health beds. These beds could potentially meet needs of some of those who are currently underserved. PDRSS and clinical services could collaborate in the provision of these short-stay beds.

## 4 Specialist care

### **Goal 4.1 Building a more proactive system of specialist community-based mental health that is geared to early intervention, relapse prevention and recovery**

#### *Integrated community-based care*

We strongly endorse the objective of achieving closer integration of clinical, rehabilitation and primary care services in order to improve continuity of care and treatment outcomes for consumers.

We welcome the emphasis on interventions that address the wider issues impacting on recovery (such as housing and general health status) and concurrent health issues (such as substance misuse).

We support the vision of integrated community-based care, where people are supported seamlessly to move from predominantly clinical to PDRSS-lead care as they improve. Continued availability of slow-stream services for those with enduring and relapsing illness is also essential.

#### *Building primary care (GP) capacity*

In relation to primary care, GP capacity needs to be developed if GP's are to assume a greater role in care of people with serious illness. Further work should be undertaken to ensure the development of a stronger treatment relationship between people with mental illness and GP's, e.g. through discharge planning. GP's need to have access to both crisis assessment and response and secondary consultation, to manage people with active symptoms. Capacity-building of the primary care sector might involve AMHS and Primary Mental Health Early Intervention Teams respectively. We also support the deployment of Nurse Practitioners in GP clinics, using Commonwealth funds.

In our experience, at the point of entry to PDRS service approximately 50% of participants have stable relationships with GP's, many having had recent experience only with hospital services. However the majority of PDRSS participants who have been with MI Fellowship over a period of 3 years, have established effective relationships with GP's who have learned to support them in managing their illness. This example illustrates the capacity of GP's to assume a greater care role with people who are managing well and are integrated into community services.

#### *Structural and cultural change*

In relation to reforms within the specialist mental health sector, we agree that these need to be both structural and cultural. A key change for which we advocate in the next section, is a shift in the management and delivery of CCU beds to free the capacity of clinical staff to achieve other service outcomes.

#### *Lead PDRSS agency*

We do not support the strategy of 'developing a clearer designation of a single or lead PDRSS agency per AMHSS to reduce fragmentation of effort and progressively build capacity ...' (p.78). We are cautious regarding government measures to influence governance arrangements or the service system status of funded organizations. Given the additional resources injected into the mental health sector by non-government organizations with separate fundraising capacities (such as MI Fellowship), their stakeholder status needs particularly to be respected.

*Effective service alliances*

We contend that service systems are bio-diverse, containing webs of relationships and distributed knowledge that together comprise the local 'safety net'; Better long term outcomes will result from change led from within and by the system - informed, consultative processes that engage stakeholders in decision-making. Our experience of the Opening Doors program indicates that strong alliances can develop from organizations within a defined catchment identifying common philosophies and goals and a mutual interest in collaborating to achieve these. In the Opening Doors model, organizations maintain their sovereignty. Consumer benefit – achieving client-centred services - needs to be the defining motivator for service alliances.

We also see that the proposed designation of a lead agency could lead to some of the problems of monopoly. At the moment the conditions under which MI Fellowship participates in the sector, combined with our specific organizational culture and style of strategic leadership, have enabled us to contribute significant innovation to the PDRSS field. We need to beware that the conditions for this kind of healthy innovation are not stifled through imposition of structure and regulation on the service system.

*Alignment of boundaries*

The lack of alignment of catchment boundaries must be acknowledged as a problem that exacerbates access to services (fragmentation and confusion regarding service entry points) and continuity of care (referrals across catchments and regions). We support measures to simplify and align service catchments, provided these are pursued consultatively and negotiated via individual FASA's with funded services.

***Goal 4.2 Accessing a wider range of bed-based care options that are well integrated with both clinical and social supports***

*Additional community-delivered bed-based options*

We submit that to take pressure off the whole system and enable the longer term strategies of prevention, early intervention and diversion to take effect, additional community-delivered bed-based options are required.

We strongly support the intention to facilitate discharge from acute care through creation of other bed-based options and forms of support to people in independent housing.

*75% reduction in acute care beds*

Our vision for the future is a reduction in acute hospital-based beds by as much as 75%, with these being re-allocated into collaboratively-delivered options such as CCU's or PARC's. We see as crucial to support these changes a significantly enhanced primary care sector, and availability of flexible home-based outreach support. This in turn will be backed up by increased housing options and wider employment, education and general health policy and practice that ensure social inclusion of people with mental illness.

*Reduced length of stay*

We support the intention to reduce length of stay for those who could be managed at facilities other than acute inpatient services. Likewise, the possibility of increasing throughput in SECU's and CCU's through multiple strategies including extended use of intensive HBOS, is endorsed. (We would also expect these HBOS packages to be available to the broader care system.)

*Changes to CCU's*

We submit that the approach to management and delivery of CCU beds needs

urgent reform. The current operating model of CCU's tends to be symptom-focused rather than recovery-focused. We advocate for a radical remodeling of CCU's, with 33% funding for clinical interventions being directed to clinical services and the balance directed to PDRSS or community health for the provision of psychosocial rehabilitation. Management of CCU facilities would be collaborative, shared between clinical services which would retain admission rights, and PDRSS or community health. We submit that the Shepparton CCU is a strong example of the practicality and merit of this proposal.

*Growth of PARC services*

We support continuing development of PARC services and expansion in their 'step-up' function, as well as closer alignment of these services with community-based clinical and PDRSS mental health services.

The commitment to establish a further four PARC facilities in Melbourne will further alleviate pressure on acute beds and facilitate closer integration between clinical and other services. We argue for continued expansion of PARC facilities in the future, and advocate that any new PARC facilities need to be designed and operated according to criteria of 'client-centredness' rather than the imperatives of organizational risk management.

Some new PARC models being developed appear to reflect outmoded aspects of institutional care, such as congregate living, or an overriding concern with clinical risk. In our view the living environment is part of the treatment, and needs to be planned accordingly. 'Recovery principles' should inform PARC development into the future, and we envisage a role for both clinical and PDRSS services collaborating to ensure both the management of clinical risk and client independence. We also submit that there is more flexibility with single-unit, non-congregate accommodation since people with diverse symptoms and care needs can still be admitted concurrently.

In summary, we approve many of the directions outlined in relation to expanding non-acute bed-based options, and we see a strong role for community-based organizations in taking up some of the challenges posed. We would like to see firm targets for some of the changes proposed, including redevelopment of CCU's across the state.

***Goal 4.3 Improving consumer and carer experiences, making sure that expectations with regard to access, rights, equity and respect are met***

*Need for specific strategies for increased consumer and carer involvement*

MI Fellowship strongly endorses the Green Paper's commitment to move forward the agenda of involvement of people with mental illness and their families across the board, including increased involvement in individual treatment decisions through to greater involvement in planning and management of services. We would hope to see in the forthcoming White Paper specific strategies and funding building the direct involvement of people with mental illness and families in decision-making and implementation .

It is noteworthy that carers are considered as resources for the system rather than individuals having their own needs. It is critical that carer health and welfare be part of the strategy development.

Strong organizational leadership needs to be fostered to bring about this change to increase consumer and carer involvement. This can be supported through requirements built into FASA's, for funded services to demonstrate progress against this goal.

*Centre of expertise in consumer issues*

The intention to develop a centre of expertise for consumers and carers is supported. It would be useful if the current specific consumer and carer bodies were incorporated into these developments. This centre of expertise regarding consumer issues rightly belongs within a university structure, but with a firm practice base in existing community organizations. William Anthony at the Center for Psychiatric Rehabilitation at Boston University has written extensively about consumer involvement in recovery, and this has had international impact. Other significant work on consumer participation in health services has been developed by the Health Issues Centre at La Trobe University in Melbourne.

Outputs from this centre need to be piloted in the practice sector and mechanisms developed to ensure broader systems reform and culture change.

*Consumer and carer education*

The Green Paper canvasses improved skill enhancement and education as mechanisms through which consumer and carer experience can be improved. As outlined elsewhere in this response, MI Fellowship strongly advocates for peer education, and propose our programs 'Well Ways', 'Well Ways Duo', and 'MI Recovery', as examples of how peer education can be developed and implemented.

*Other impacts on consumer and carer experience – education and work*

The challenge to improve consumer and carer experience must address a wide range of social determinants including general education and employment. Stark evidence of systematic disadvantage of people with mental illness exists in relation to both these areas: A 1999 study of 3,800 Australians with psychotic disorders aged 18-64<sup>6</sup> found that 72% were unable to describe a regular occupation (including paid work, study, home duties, parenting and other vocational roles) and nearly half had not completed their schooling or gained any post-school qualifications. It is vital that the reform agenda addresses these structural determinants of disadvantage and social exclusion.

*Registered Training for consumers*

MI Fellowship provides an RTO program to offer nationally recognised training for people with mental illness. Our Certificate programs in General Education for Adults are available from 3 Victorian sites, and since 2005, 98 people with mental illness have graduated. We also offer an 'open employment' program targeting people with mental illness. This is provided from 6 sites and to date we have placed over 200 people in ongoing employment, with a very high rate of tenure across this group. In our view it is unacceptable that these programs are few in number and have no sustainable source of income. It is imperative that the whole of government approach be taken to include education to this group. Current education funding sources are limited and this organisation competes for RTO hourly funding from ACFE. Only one program has been funded in four years through this source. We have funded courses in Frankston and Shepparton through philanthropic contributions and untied fundraising monies.

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<sup>6</sup> Jablensky et al (1999), cited in VICSERV (2008), Inequalities in Health and the Health Policy Context, Working Paper 1: Health.

*General health status of consumers*

Improving consumer experiences is also linked with gains in overall health status of people with mental illness. Research emerging over recent years in Australia points to the significantly poorer health status of people with mental illness compared to the rest of the population: People with severe mental illness are at increased risk for a range of chronic physical health conditions such as 'heart disease, diabetes, respiratory diseases, obesity and infections'<sup>7</sup>. Moreover, their rates of mortality are 2.5 times higher than the general population (3 times higher for people with schizophrenia)<sup>8</sup>.

Poorer health status on the part of people with mental illness, is attributed<sup>9</sup> to two factors: First, barriers to resources necessary to achieve and maintain good health, such as housing, employment, adequate income, and education. The second factor relates to reduced access to services that support health, such as cost, inaccessibility, inappropriateness, lack of awareness, discrimination, or a combination of factors. To these can be added the problem of widespread behaviours among people with mental illness, that carry high health risks – smoking, alcohol and other drug use, obesity and poor diet, and underactivity/lack of exercise<sup>10</sup>.

*Improving consumers' poor health status*

There is a clear need for action to improve the physical health status of people with mental illness, and implicated here are providers of physical health services as well as workers in the mental health system who resource and link people with mental illness into wider health services. Education for health service providers and greater accountability for the physical health outcomes of people with mental illness, is necessary alongside targeted prevention and early intervention strategies to detect and treat physical health conditions within this population.

There is a need for collaboration between PDRS and primary care programs offering screening, health education and health promotion, to ensure that these programs reach the population of people with mental illness living in the community. Equally, clinical services offering mental health treatment are well placed and have a professional obligation, to more effectively extend their health care, to people with mental illness. Arguably there is a need for culture change across the board in specialist public mental health services including clinical services, towards holistic health practice models.

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<sup>7</sup> Lawrence D, Holman CJD and Jablensky A, (2001) *Duty to Care: Preventable Physical Illness in People with Mental Illness*, Perth: University of Western Australia.

<sup>8</sup> VICSERV (2008), *Inequalities in Health and the Health Policy Context, Working Paper 1: Health*

<sup>9</sup> VicHealth, (2008) 'Burden of Disease due to health inequalities' and 'Key influences on health inequalities', Melbourne: Victorian Health Promotion Foundation

<sup>10</sup> VICSERV (2008) *ibid.*

**Goal 4.4 Tailoring services for clients with particular needs, especially forensic clients, including both bed and community-based support**

People reach forensic services because the system has failed them. Many of the strategies in the Green Paper can serve to avert this outcome. However, acknowledging this situation, PDRs and other support services need to be developed to ensure that their entry processes do not exclude this client group.

**5 Complex Clients**

In considering the strategies put forward in this section of the Green Paper, we strongly submit that these strategies ought not to be considered appropriate only for clients with complex needs. Coordinated approaches to treatment, access to stable and affordable housing, tailored flexible support linked to housing, ought to represent standard practice right across the spectrum of clients in specialist mental health services.

**Goal 5.1 Promoting a more coordinated and tailored approach to people who require support from multiple services**

It is heartening that this proposal foresees intensive home-based outreach in the community. It is through this mechanism that early intervention in illness can make a difference to the service system.

*People with severe MI living with aging parents*

However, it is unclear whether the two categories that have been highlighted in the Green Paper (p.90) clearly annunciate the group of people with severe and enduring mental illness who are living with aging family members who are barely coping. This strategy is one of the critical elements in this reform package and must include individuals who are experiencing a period of destabilisation whether it is early or late in illness trajectory. This intervention is essential to prevent homelessness and minimize the development of chronic disabilities.

We believe that this is a potentially effective strategy to address those people who currently have long stays in SECU and CCUs.

*Alliances and partnerships*

Comprehensive care planning is achieved through a focus on consumer needs. It can be achieved within one agency or by multiple agencies. Formal alliances between agencies can focus on organizational issues rather than focusing on clients needs, particularly if they alliance has been imposed and participation is obligatory. While alliances are particularly useful in strengthening the knowledge within service systems, they do not necessarily deliver on client outcomes.

An additional difficulty with alliances and partnerships is that they may not include a broad enough range of services: Employment and education services, for instance, are typically not included. Therefore the conversation is too narrowly focused on health considerations.

*Continuous case management*

Experience from the Homeless & Drug Dependency Trial, piloted in emergency accommodation services, suggests that the idea of a key primary case worker can be effective. This worker follows a client over a long period of time, regardless of what services that client is accessing, and is thus able to effectively track that person's case history, avoiding duplication of services and ensuring continuity.

This primary key worker role can come from any part of the system, but must have funding attached.

**Goal 5.2 Improving access to stable and affordable housing, together with appropriate and scaled support to reduce homelessness and sustain tenancies**

*Housing First* There is ample evidence that if housing and tailored housing support is prioritised, substantial outcomes can be achieved. The ‘Housing First’ model in the US, originating in New York, has demonstrated both the effectiveness and cost-effectiveness of providing affordable, secure and permanent housing, where support can be tailored to a person’s needs and support withdrawn when no longer needed, leaving the person where they are with secure community tenure.

*Consumer choice* Housing must embed consumer choice. Specifically, where a person has a connection to a local community, through family, services or interests, this should be accommodated where possible. Consumer choice should also extend to whether a person wants to live alone, with a partner or with a family, not being determined by services’ housing programs. Currently, many housing options include sharing house with other users of services. This is ineffective and creates considerable conflict.

Housing should be dispersed throughout the community, not concentrated in specific areas.

*Support to enable community tenure* Too often, the term ‘housing models’ leads to discussions that are not client focused, but system-focused and aimed at minimising cost. The simple truth is this: People with mental illness need the same things in a house that every other person needs – a bedroom, a bathroom, a kitchen, a toilet and a living and dining room. What differs is the support people need to stay in their home.

*No Congregate housing* We submit that congregate models of housing are ineffective because they are extremely costly (the exception to this is congregate care for younger adults). Transitional housing that attempts to develop people’s independent living skills is also problematic when secure and ongoing housing is required.

The vast majority of people with mental illness can live independently. Our current housing services and models result in services underestimating the capacity of people to live independently because they are denied the opportunity.

As a matter of moral obligation as well as effectiveness, we submit that a housing strategy that increases stock and makes available affordable secure, and permanent housing to people with mental illness, ought to be seen as an indispensable plank in the current reform package.

*Expansion in home-based outreach* We support the progressive expansion and differentiation of home based outreach support into the four levels outlined. This strategy is consistent with the principle that people can have their support where they are in the community, and at the intensity they require. It also contemplates the service intensity diminishing and the service moving on, not the person . The person stays in the community environment with all the supports and community connections that have been established.

Our continued concern remains that this service is seen to be necessary only for clients with complex needs. We submit that this service ought to be available to all people who use specialist care services.

**Goal 5.3 Focusing on the needs of people from particular vulnerable and disadvantaged groups**

*Dual diagnosis* We submit that the current direction of the Department in joining together mental health and alcohol and other drug sectors is an appropriate recognition that substance use issues are more often than not a comorbid issue with mental health and ought not to be considered unusual. There is considerable work yet to be done in integrating these sectors.

*CALD communities* The most pressing issue regarding particular vulnerable and disadvantaged groups is CALD communities and indigenous communities who are under-represented in help seeking in all aspects of health.

We submit that whilst it is vital to provide information about the availability of services and what they do in culturally appropriate ways in all languages, the good practice required to work with people from different cultures is the same as good practice required to work effectively with any person. This is not to downplay the considerable challenges of working with ethno-specific groups, but to underline that good practice in working with any person ought to demand a sensitivity to that person's cultural beliefs, to how they construct a meaning for what they are experiencing (many people with schizophrenia for instance do not consider they are sick), to their experience of family, faith, how they value independence, how they consider work and what their individual life goals are. This represents good practice with any person regardless of their cultural background.

Having said that, considerable effort needs to be made to ensure growing understanding of workers in the sector of the influence of different cultural perspectives of mental illness. Specific strategies ought to be put in place to promote access to services for ethno-specific groups. Pathways into the mental health workforce for members of these communities ought to be a priority to increase knowledge and sensitivity from within the sector. The same can be said for indigenous communities, and this needs to happen at local levels respecting that indigenous communities are essentially local and need local responses.

*ADEC's submission* We enthusiastically endorse the excellent submission and recommendations put to you by Action on Disabilities within Ethnic Communities regarding strategies to better engage people belonging to CALD communities.

**Goal 5.4 Maximizing the individual's potential for recovery by supporting their social and economic participation in community life**

*Education and employment for people with mental illness* MI Fellowship is passionately committed to provision of alternative pathways beyond rehabilitation, for people with mental illness moving towards recovery and social inclusion.

We provide both vocational education (nationally recognized training) and open-market employment programs. Although targeting people with mental illness, in both instances these programs offer opportunities to move closer to mainstream community life.

We therefore strongly endorse the Green Paper's aim to maximize the involvement of people with mental health in the workforce, and to continue to build on state government initiatives in the employment area in conjunction with the Commonwealth.

MI Fellowship has developed a unique model of evidence-based employment service that is closely integrated with clinical services to enable rapid job placement following illness episodes. It also offers flexible post-placement support. This service has strong functional links with both the PDRSS services of MI Fellowship and our education; moreover, participants have access to experience in a social firm.

We would be pleased to participate in further elaboration of employment and education strategies for the White Paper.

## **6 Workforce**

### ***Goal 6.1 Building a knowledgeable, skilled and sustainable specialist mental health workforce with an ensured supply***

Workforce shortage is an increasing issue across many sectors in Australia, including health and particularly mental health. Traditional disciplines including psychiatry and psychiatric nursing, have struggled to adapt to greater emphasis on community based services. Social workers, Occupational Therapists and allied disciplines have become increasingly important. Specific knowledge of mental health within these disciplines remains an issue.

#### *Rates of pay*

Pay scales in this sector make it difficult to retain quality staff. Even compared with community health, the mental health workforce is poorly paid. Taxation benefits through salary sacrificing go some way to mitigate this, but it would be better if salaries were adequate in themselves. According to the Green paper (p39), an average worker in the PDRS sector will cost \$88,400 in 2008/9, compared with an average cost per worker of \$196,444 in inpatient, community residential and ambulatory services.

#### *Consumers and carers as future workforce*

While the growth of consumer and carer consultancy roles in services is a welcome development, consumers and carers ought to be seen as the future workforce in mental health. Consideration ought to be given to creating special affordable (subsidised) pathways for consumers and carers to be trained and qualified in psychiatry, psychiatric nursing, psychology, occupational therapy, health promotion and social work so that they hold real positions of power and influence in mental health services. In addition to having professional expertise, such a workforce would be passionate, committed and sensitive to the needs of its clientele.

#### *'Reasonable accommodations' for people with mental illness*

The mental health workforce also needs to be leaders in developing 'reasonable accommodations' for people with mental illness and family members in the workforce. Legislated standards are now in place for people with physical disabilities, including requirements for wheelchair ramps. This is a testament to the work that has been done within the broader disability sector and by people with physical disabilities to have their needs recognized to continue to participate in the

workforce and in the community generally. Such achievements have not been replicated for people with psychiatric disability.

*Evidence-based best practice*

Mental health services need to take the lead in establishing evidence-based best practice for employing people with psychiatric disability and establishing standard reasonable accommodations. Similarly, for those caring for someone with psychiatric disability, flexible workplace arrangements are necessary to accommodate times when more intense caring is needed.

We urge the government to take a lead in funding projects that seek to establish best practice in this area. Findings can then be more widely disseminated into the broader workforce.

## **7 Partnerships**

### **Goal 7.1 Designating local area partnerships to drive population based service planning and coordination across the continuum of mental health**

*Alliances for information sharing, and planning*

Local area partnerships in the form of alliances are an important intersectoral collaboration for information sharing and for organizations gaining mutual trust. Partnerships do effective work in population based health planning. Partnerships work when agencies come together to consider local needs and imperatives and to agree on strategies to meet unmet need. This has been effective in some, but not all areas. A lack of clarity around their function has sometimes hindered their effectiveness.

*Statewide approach to common intake and assessment*

In some areas, agreements around access have been achieved. Alliances can be effective in agreements around common intake and assessment tools, but we submit that this would be better achieved at a statewide level, which has greater capacity than to build across the workforce and sector.

Alliances could fruitfully be used in knowledge management and dissemination, ensuring that all stakeholders are aware of local projects in which they may have an interest and contribution. Alliances also have a facilitation role in building relationships.

*Service delivery*

We submit, however, that imposed alliances (e.g. based on service catchments) do not, and cannot, deliver services. Whilst alliances have been funded, service organisations often remain unresourced to deliver projects that are agreed priorities in a local area. Moreover, participating in alliances as a service organisation is exceptionally time consuming and therefore expensive.

We submit that alliances at local levels have a vital role to play in the ways described above, that frameworks need to be specified for them to function effectively, and that organizations delivering specific outcomes for identified local projects need to be funded to do so.

A factor that impacts on agencies and on alliances, is the differences in perspectives discernible in the Department, particularly between head and regional offices. To build and participate in alliances, funded organizations need consistent policies and procedures from DHS.

*Primary Care Partnerships and low prevalence mental illnesses*

Regarding specific partnership initiatives, we submit that in primary care partnerships, mental health fares poorly in gaining priority status, competing as it is against a range of general health disorders for attention. Some PCPs have picked up early high prevalence disorders as an area of interest but rarely have they picked up low prevalence disorders as an area of priority. Moreover, there is little communication between PCPs and mental health alliances.

*Care in Your Community Initiative*

We note with some dismay the complete absence of PDRS representation in the pilots of the 'Care in your Community' initiative at the steering committee level and very little presence in the implementation level. As a significant provider in the Southern Metropolitan region, we might have expected some role in the development of the 'Care in Your Community' initiative in this region. We regard the absence of PDRS at all levels of these initiatives as a significant oversight.

We also note the absence of broader service system agencies, beyond health - such as education, employment and housing - in both PCPs and Care in Your Community initiatives and submit that this can only suggest a narrow health focus will result.

Whilst we can see the value in structured partnership arrangements at a local level, we submit that current arrangements fall short of the mark, are too loosely configured, and leave mental health and the PDRS sector within mental health still peripheral.

We submit that there is an important role for the Department of Victorian Communities to play in this area to ensure that effective local partnership initiatives include a broad range of service types that have as their aim consumer-focused outcomes and a responsible use of precious resources.

***Goal 7.2 Reconfiguring public mental health service structures to align age-related and PDRSS components, facilitate links with general health structures and allow specialist roles to develop***

*Alignment of catchments*

Given the complexity of human services and service systems, and multiple sources of funding for service delivery in Australia (including the Federal system) there seems to be no ideal way to configure catchment areas. Health, emergency services, employment, housing, education, local government and various other systems have vital roles to play in building Victoria's community. It is unrealistic to expect that aligned catchment areas of all these services is achievable.

In mental health, what is desirable is that where alignments are not possible, effective strategies are developed to manage the differences. What is also desirable is that catchments are considered flexible, so that people do not miss out on services because they live on the wrong side of a street. Flexibility agreements should be entered into for cost transfers where an adjacent area has provided services to people where the adjacent area is overburdened.

22 Area Mental Health Services in Victoria is probably too many and amalgamations ought to be considered. Alignments ought to be made across CAMHS, Adult and Aged services and PDRSs.. Being predominantly NGOs, PDRSs are multi-dimensional and often receive funding contracts from both state and commonwealth governments, local government, philanthropic and private

sources. Alignments of boundaries within the specialist public mental health system would facilitate clearer care pathways within this sector for all participants, however would need to be matched with arrangements for interfacing with the other sectors that have a role to play in assisting people with mental illness.

*Complimentary approaches – PDRS and clinical services*

As outlined earlier in this submission, we do not favour changes in the service system to attribute to any provider ‘lead agency’ status within an alliance area. Nor do we support the merging of PDRS and clinical provider governance arrangements. We regard the risk management approaches of PDRS and clinical providers as complimentary, with PDRS services seeking primarily to build community tenure and AMHS services primarily concerned with managing clinical risk. These approaches are best kept separate; the tension between them is healthy and to the benefit of the client.

*Sustainable alliances grow from goal to improve client services*

We submit that sustainable integration and service coordination comes not from unified governance, but through service projects and pilots where each partner is sure of their responsibilities and risks and clear what each partner is responsible for delivering. Each organisation must be responsible for the quality of their services. This can be neither shared nor delegated. Organisations must retain their separate identity and sovereignty.

### ***Goal 7.3 Embedding accountability for outcomes associated with mental health into funding and reporting systems at all levels, including general health and social support services***

*Reduction of prevalence cannot be an outcome*

We are doubtful about having the reduction of prevalence of mental illness as an outcome measure, given that resources do not meet current demand – by a long way.

Whilst the proposed measures include social determinants of health, we submit that what data is collected and what is then done with that data is the most likely mechanism to achieve better outcomes. For instance, we submit that at intake into mental health services, the following questions ought to be asked and the data collected: Where are you living? Are you employed? Further, what action did the service take to address any needs that arise from this? What were the outcomes? In other words, system response and effectiveness ought to be measured. Currently, AMHSs have no requirement to collect this data. Consequently they do not, so service plans do not reflect needs in this area. This, we submit, would change practice and produce better outcomes.

Broader health outcomes seem to have been overlooked in the outcome measures of the Green Paper. Given the well-documented poor physical outcomes for people with mental illness, described elsewhere in this submission, these need to be included.

### ***Goal 7.4 Creating an organized statewide research and knowledge management capacity to provide a robust evidence-base on mental health interventions***

*R&D integrated into organizational practice*

Mental Illness Fellowship Victoria has a research and development program principally aimed at researching the effectiveness of our interventions. This is usually done in partnership with a university. Our Well Ways family education

program, for instance, is in its second phase of evaluation and has ethics approval through Latrobe University's Ethics Committee. We have worked on the project with the School of Social Psychology at Latrobe University.

*Need to increase PDRSS research*

We note that the list of research projects supported by the Victorian Government are exclusively biomedical or clinical in focus (with the exception, perhaps, of beyondblue). We can see no evidence in the further thinking of a vision for research in the PDRS sector.

Despite the growing evidence in the international literature of the effectiveness of particular models of psychosocial interventions, Victoria has not offered any leadership in this regard.

*Need for investment in R&D*

If it is the government's wish to build a robust evidence-base for mental health interventions and to drive continuous quality improvement and cultural change through the sector, including PDRSs, it must invest in research that assesses systems and interventions within the system. The PDRS sector must be resourced to engage in research with university partners to build the evidence-base to drive practice change.

### ***Goal 7.5 Driving continued strategic policy development, alignment and accountability at the statewide level***

*Need for policy development groups*

We support the concept of high level policy development groups with some reservations. Some overarching or 'bird's eye' view of the effectiveness of the mental health system as a whole is useful, but the greatest challenge for such a group or groups is how to effect real operational change.

For instance, to deliver best practice in employment, collaboration between the Commonwealth Department of Employment and Workplace Relations and the Victorian Department of Human Services is essential to ensure funding and delivery of services are not at cross purposes, but even these collaborations require an effective mechanism for operationalising change.

*Specific and limited foci*

We submit that to be effective, such groups need specific and limited foci. For example, the role of emergency services in responding to psychiatric crises: A high level group considering this issue needs representation from Victoria Police, people with mental illness, families of people with mental illness, CAT teams, AMHS and PDRS input. Best-practice models of intervention would be investigated and a plan established. But how is the implementation of this plan to be overseen? We submit that if such a plan is left to be operationalised by police alone, normal police protocols will prevail and remain resistant to change. We would be enthusiastic about the formation of a high level policy group focusing on this issue.

We note in the possible groups foreshadowed that a group focusing on complex needs and vulnerable groups is envisaged, looking at social inclusion, employment and stigma. We urge, once again, that these are vital areas for consideration not just for vulnerable groups and complex clients, but for all users of specialist mental health services.

*Other areas for policy groups –*

Employment, housing and education are other focus areas that could benefit from some high level thinking and work plans, given that, although the evidence

*employment,  
housing and  
education*

regarding the social determinants of health place them as central to achieving good mental health, they are still very much peripheral to the mental health service system.