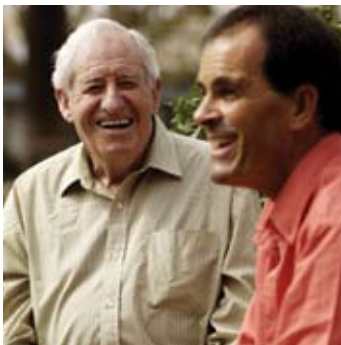
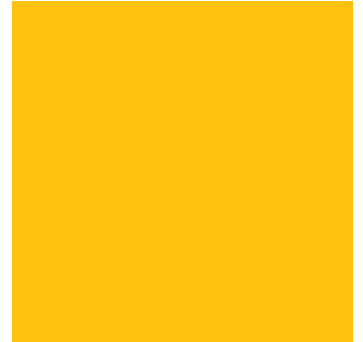


# Because mental health matters



## Victorian Mental Health Reform Strategy 2009–2019



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# Because mental health matters

Victorian Mental Health  
Reform Strategy 2009–2019

## Premier's message



Mental health and wellbeing is essential for a satisfying, productive life. Our government is committed to supporting Victorians to achieve good mental health, and to assisting people who experience mental health problems to recover and thrive. The new Victorian mental health strategy is a critical step towards achieving these goals.

Mental health is an issue for the entire community. Most people will feel the impact of a mental illness at some time in their lives, either through their own experience, or through family or friends, or in the workplace. The new Victorian mental health strategy provides the leadership that Victorians have requested in mental health - focusing on the need to intervene early in life, early in illness and early in episode.

In August last year, I was privileged to host a roundtable on mental health. This forum brought together mental health professionals, health service providers, police, magistrates, business leaders, educators, researchers, people affected by mental illness and their carers. The clear message arising from the roundtable was that we need new approaches to mental illness and its impacts on our community.

*Because mental health matters* sends a strong message that Victoria is determined to achieve better social and economic outcomes for people with mental illness, their families, carers and friends. This reflects the principles underpinning A Fairer Victoria, Victoria's action plan to reduce disadvantage and strengthen social inclusion.

Effective and sustainable reform of our mental health system, to address the deeply ingrained social and economic disadvantage that often accompanies mental illness, requires open and ongoing engagement with all stakeholders, and a whole-of-government approach.

*Because mental health matters* is based on wide consultation and draws on national and international best practice. It acknowledges the fundamental role that all parts of government at all levels can play in facilitating reform. It invites collaboration and partnerships with consumers, non-government organisations and the private sector. It is an agenda for the long term, not a quick fix.

Importantly, this strategy puts people at its centre to ensure that we strive to provide support for maintaining mental health, quality care when people become ill and support for recovery.

Through this ambitious ten-year plan, Victoria will remain at the forefront of the national momentum to tackle one of this country's most challenging health issues.

A handwritten signature in black ink, appearing to read 'John Brumby'. The signature is stylized and fluid.

**The Hon. John Brumby**  
Premier

## Minister's foreword

Since launching the consultation paper on Victoria's new mental health strategy in May last year, I have in turn been humbled, saddened and inspired by the experiences people have shared in response to the paper.

Several voices in particular resonated for me through the process.

Ben, a young man recovering from psychotic illness, spoke passionately about wanting the chance to have a real job but lacking the ongoing support to make this possible.

Debbie, a young mother suffering post-natal depression, voiced her feelings of isolation and alienation from family and friends, but also of being too ashamed and unsure where to seek professional help.

And Sue, a middle-aged professional woman, expressed frustration in her search for help for her elderly father with early stage dementia whose deepening depression was threatening his ability to remain at home.

We can and must do better for these people and many other Victorians.

Our consultation confirmed the importance of a new agenda that gives mental health the priority it demands. It highlighted the momentum for change that exists in our community and the message that just doing more of the same will not be adequate to meet emerging challenges.

Victoria has a well-earned reputation for progressive mental health policy and quality services, so we are building on solid foundations. Yet there is more to be done to achieve a better service experience for those affected by mental illness and better outcomes for the whole population.

Prevention, early intervention, recovery and social inclusion lie at the heart of the new agenda.

We need greater focus on fostering and maintaining good mental health and wellbeing, and providing earlier support – for children and young people, and for adults before their problems become acute. At the same time we must ensure that effective services are available in the right settings to those who have enduring need or are in crisis.

We must also create a more cohesive response to mental health that addresses the overall needs of an individual and is not constrained by barriers between providers.

This new mental health strategy embraces the roles of many sectors and services across the community and the whole-of-government, emphasising that mental health is everyone's business.

The strategy maps out a long-term agenda for the next decade. It includes aspirational goals as well as concrete proposals for action.

Implementation of this agenda is already starting, including a range of initiatives supported in the 2008-09 State Budget. Yet reform will not be achieved by new investment and service redevelopment alone. It will require significant collaboration, cultural change and better use of our human resources.

I look forward to working in partnership with all stakeholders to deliver on this vision and honour the voices that have been so strong and articulate in their advocacy for a new era in mental health.



A handwritten signature in black ink, which reads "Lisa Neville". The signature is fluid and cursive.

**The Hon. Lisa Neville MP**  
Minister for Mental Health



# Contents

<b>Premier's message</b>	<b>2</b>
<b>Minister's foreword</b>	<b>3</b>
<b>Overview</b>	<b>7</b>
<b>Summary of key strategy proposals</b>	<b>13</b>
<b>Part one</b>	<b>19</b>
<b>1. The vision for mental health</b>	<b>21</b>
1.1 Vision and strategy	21
1.2 Expected outcomes	24
<b>2. Challenges and opportunities</b>	<b>29</b>
2.1 Drivers for change	29
2.2 Key aspects of the reform challenge	32
<b>3. Strategy development and implementation</b>	<b>41</b>
3.1 Consultation on <i>Because mental health matters</i>	41
3.2 Strategy implementation	42
3.3 Evolving policy context	43
<b>4. A better response for all Victorians</b>	<b>47</b>
4.1 Consumers and carers in the specialist service system	47
4.2 Gender and mental health	47
4.3 Children and young people	48
4.4 Older people	49
4.5 Aboriginal communities	49
4.6 Culturally and linguistically diverse (CALD) and refugee communities	50
4.7 Gay, lesbian, bisexual, transgender and intersex (GLBTI) communities	51
4.8 Co-existing disability	51
4.9 Offenders and victims	52
4.10 People with multiple and complex needs	52
<b>5. A balanced, networked service system</b>	<b>55</b>
5.1 Balanced	55
5.2 Networked	56
5.3 Funding approaches	58
5.4 Particular components of the service system	58

<b>Part two</b>	<b>65</b>
<b>Reform Area 1: Promoting mental health and wellbeing</b>	<b>67</b>
<b>Reform Area 2: Early in life</b>	<b>75</b>
<b>Reform Area 3: Pathways to care</b>	<b>85</b>
<b>Reform Area 4: Specialist care</b>	<b>91</b>
<b>Reform Area 5: Support in the community</b>	<b>103</b>
<b>Reform Area 6: Reducing inequalities</b>	<b>115</b>
<b>Reform Area 7: Workforce and innovation</b>	<b>125</b>
<b>Reform Area 8: Partnership and accountability</b>	<b>137</b>
<b>6. Appendices</b>	<b>145</b>
Appendix 1: Submissions to consultation paper	145
Appendix 2: Victorian policy contexts	147
Appendix 3: The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders	153
Appendix 4: Glossary of terms	157
<b>7. References</b>	<b>165</b>



## Overview

### *Why do we need a new mental health strategy?*

Today we recognise that mental health problems have a deep and far-reaching effect on our society, much more so than previously understood. Supporting good mental health and minimising the human and societal costs of mental illness is an increasingly vital challenge for us all.

Victoria is recognised nationally and internationally for many progressive and innovative developments in the delivery of mental health services. Over the past decade, service enhancements have improved the experience of treatment and care for many Victorians with mental health problems (see Box 1).

More people are now supported in community-based facilities, acute care is co-located with general hospitals and many individuals receive much of their mental health care from primary health services.

We have some world-class specialist services, and innovative programs connected to settings such as schools and homeless support. At the same time, the system has worked on many fronts to provide the social supports that are the prerequisites for effective rehabilitation and recovery for people with mental health problems.

These achievements are the result of investment by the State Government in public mental health services and partnerships with a network of non-government agencies. They are also the result of the efforts of a dedicated workforce and some inspiring leaders.

And yet, as Part One of this document argues, it is time for a shift in our thinking on mental health. This means looking at the mental health needs of the whole of our population, and at the social determinants of mental health and mental illness. It means considering mental health and mental illness as everyone's business.

In order to meet the needs of those affected by mental health problems, we must have a comprehensive, balanced and forward looking framework for mental health to take us into the next decade. This should be underpinned by a positive, well-targeted approach to improving population outcomes, and a whole-of-person approach to meeting the treatment and support needs of consumers, families and carers.

To this end, this strategy outlines reforms based on the core elements of prevention, early intervention – in life, illness and episode – recovery and social inclusion.

This will make a difference to Victorians by:

- helping people with mental health problems earlier, thereby avoiding harmful individual and social impacts
- providing easier access to the most effective treatments, be it in a public mental health service or elsewhere, for a greater range of people, before they become acutely unwell or go into crisis
- offering longer term, holistic support to sustain people in the community, drawing seamlessly on all relevant health and community services
- fostering a culture of service delivery and community support that is based on acceptance, respect and the chance to achieve individual wellbeing and personal goals.

This document sets out a vision and agenda for a new phase of reform, building on previous progressive developments and on Victoria's widely acknowledged leadership in this area. It aims to help us invest in the most effective interventions to deliver the health, social and economic benefits that are valued by individuals and the community.

### Box 1

Victoria has been a national leader in implementing progressive improvements to the treatment and care for people with mental health problems.

We have built on the state's early move to deinstitutionalisation and mainstreaming of services, and introduced innovative community-based care.

These developments provide a solid platform for future reform. Consolidating and connecting many of the excellent local initiatives will be an important early step in the process.

Amongst Victoria's key achievements in mental health since 2000, the government has:

- Opened 65 extra **acute inpatient psychiatric beds**, with further increases in progress, to address critical gaps in the service system.
- Consolidated the role of **Psychiatric Disability Rehabilitation and Support Services** to support the transition to, and maintenance of, independent living for people with severe and enduring psychiatric disability.
- Enhanced **Emergency Department mental health services** to assist hospitals to respond more effectively and efficiently to mental health presentations.
- Established 68 **step up/step down prevention and recovery care (PARC) beds** to provide intensive short treatment options for consumers recovering from an acute episode, or prevent avoidable admission to an acute inpatient facility. The government is committed to providing an additional 70 PARC beds.
- Invested in new **prevention and early intervention programs**, including children's conduct disorder programs and youth early psychosis services, in order to reduce the severity of mental illness and its long-term health and social impacts.
- Developed a framework and built capacity for **dual diagnosis services** to better support young people with co-existing substance abuse problems.
- Introduced **Primary Care Mental Health Teams** to support GPs and other primary care providers to recognise and treat mental health problems and disorders more effectively.
- Strengthened its response to **people with a mental illness who are homeless**, by targeting psychosocial rehabilitation support and clinical support to homeless services.
- Established **education and training clusters** to improve workforce quality, recruitment and retention by providing mental health staff with ongoing professional development.
- Created over 500 **postgraduate nursing scholarships and established 70 specialist graduate positions.**
- Implemented **Community Health Counselling Services** to increase access to supportive counselling, casework and specific therapeutic interventions for socially disadvantaged people.
- Supported VicHealth in its pioneering work in **mental health promotion** built on identification of the key determinants of mental health: social inclusion; freedom from discrimination and violence and access to economic resources.
- Introduced the **Court Integrated Services Program** linking defendants to support services such as drug and alcohol treatment, crisis accommodation, disability services as well as mental health services.

### *How is this strategy different from previous plans?*

This strategy differs from previous Victorian mental health strategies in three important ways.

#### **Firstly, it takes a whole-of-community and whole-of-government perspective.**

This means bringing together, under a common framework, the diverse range of situations in which people need assistance with mental health problems. It is not just about mental health services reaching out to other services but about building the capacity of multiple sectors to prevent and respond to mental health problems, recognising the complex interrelationships mental illness has with other health and social problems.

The increase of people with mental health problems in our prisons and homeless services, for example, reflects an increasing prevalence of mental illness, a failure of health services to intervene before the illness causes social harm and inadequate prevention or early intervention within the justice and homelessness support sectors. Each of these perspectives needs to be taken into account.

#### **Secondly, it covers programs and services that respond to people experiencing the spectrum of mental health conditions.**

Effective support for people experiencing the most severe mental health problems remains central to the state's response. We recognise, however, the need for the state, in conjunction with the Commonwealth Government, to maintain a balanced effort responding to the needs of Victorians with a range of mental health problems at various levels of severity from anxiety, depression and conduct disorder, to personality disorders, serious eating disorders and schizophrenia.

We recognise that mental health problems develop in complex ways over many years. By investing earlier when the illness is less severe, we can decrease the overall disability burden associated with many conditions and their lifelong impacts on the ability of individuals and their families to participate in the community.

We also need to address the fact that some Victorians with moderate to severe mental illness, combined with other entrenched health and social problems, fall through the gaps between services. The state has existing involvement in the lives of many of these people – especially those in our education, justice, homelessness and community care systems – and is often well placed to arrange for their mental health needs to be addressed as an integral part of their overall care.

#### **Thirdly, the strategy is fundamentally about partnerships and shared responsibility.**

A mental health system for the next decade puts partnerships at the centre of effective prevention, treatment and care. This includes partnerships between all levels of government, between the public, private and non-government sectors, and, importantly, between mental health services and consumers and carers.

### *What will change?*

This strategy aims to achieve a more positive, inclusive experience for all consumers, together with their families and carers. This will be achieved through a mix of service development and redesign, strengthening of the workforce, delivery partnerships and service coordination, better use of information technology and a shared commitment to whole-of-person care.

The government's existing \$880 million annual investment in specialist mental health services provides a crucial base for this effort. The dedicated workforce delivering these services is equally important.



Reform also requires concerted change in the culture of service delivery to achieve a more welcoming, participatory service environment that is sensitive to diversity.

Over the next decade, effort across the eight Reform Areas detailed in this document will aim to deliver:

1. Larger scale, sustained prevention and mental health promotion activities in selected community settings.
2. Expanded effort to provide early support to children and young people, in partnership with universal services including schools.
3. Clearer and swifter pathways to care that are responsive to a greater range of clients and not dependent on people being in crisis.
4. A wider range of treatment options, with bed-based services as one element which can be matched to individual needs including options for those involved in the justice system.
5. More organised, tailored approaches to coordinating care for those needing longer term support to live successfully in the community, with greater focus on housing and workforce participation.
6. Improved social and emotional wellbeing for Aboriginal people and their families and better outcomes for a number of other specific population groups through the provision of culturally responsive care.
7. A refocused, flexible and sustainable workforce and a systematic drive to adopt effective, evidence-based practice.
8. Strengthened governance and local service coordination and planning partnerships bringing together clinical, psychosocial support and primary health providers.

#### *A vision for the next decade*

The directions and proposals outlined here have been informed by a large number of discussions and feedback from stakeholders. More broadly, they reflect the increasing prominence of mental health as a focus of community concern and a policy priority for governments at all levels.

Consultation clearly confirmed that stakeholders – consumers, carers and service providers alike – are ready for more focused change and that there is a need for different approaches as well as continued growth.

The strategy builds on the sea change in approaches to mental health marked by the Council of Australian Governments (COAG) National Action Plan on Mental Health in 2006, and is informed by a range of significant recent reviews at state and national levels.

In a dynamic environment for Commonwealth–State relations it is critical for Victoria to have a strong set of directions for service development together with strong local networks within which funding and services can be effectively integrated.

*Because mental health matters* sets out a wide range of proposals. Some are well developed and can be implemented confidently in the short term; others require further consideration, development and testing. Implementation is commencing with seeding initiatives totalling \$128 million over four years funded in the 2008–09 State Budget.

All measures proposed require careful monitoring and evaluation. For these reasons, ongoing processes for driving reform are a critical part of this strategy. A new Victorian Mental Health Reform Council is proposed to assist in achieving the new vision.

**Part One** of this document provides an overall framework for the reform program, including information on the outcomes we want to achieve, the principles that should inform change, the key population groups to be targeted and an outline of roles and responsibilities across services and sectors.

**Part Two** of the document provides detailed proposals for change in the eight Reform Areas. While the concerns of these areas overlap, the structure responds to the views of stakeholders on the best way to understand and progress improvements to the key elements of our mental health system.



## Summary of key strategy proposals

The strategy is structured around eight Reform Areas, details of which are set out in Part Two of this document.

The following list outlines the key proposals from each of these areas. Each proposal represents a potential set of actions that will be considered as implementation progresses over the life of the strategy.

These proposals do not imply the commitment at this point of specific additional financial or human resources. In many cases, action will be dependent on normal government budget processes and negotiation with the Commonwealth Government and other partners.

More detail on the proposed staging of action can be found in Part Two and in forthcoming Action Plans.

### Reform Area 1: Promoting mental health and wellbeing – preventing mental health problems by addressing risk and protective factors

- Bring together a flagship ‘mental health promoting schools and early childhood settings’ action framework to build resilience and protective factors, and complement healthy eating, physical activity and drug education to create a healthy living and healthy minds approach.
- Support evidence-based workplace programs to promote positive mental health and wellbeing for delivery across the public and private sectors. These would focus on building coping skills and organisational ability to deal with stressors in the work environment.
- Contribute to social inclusion policies and programs including those addressing discrimination, family violence, homelessness and joblessness, via local government, Primary Care Partnerships, and Neighbourhood and Community Renewal.
- Develop education and awareness campaigns and planning ongoing efforts through a range of media to highlight the risks to mental health associated with problematic alcohol and drug use, especially binge drinking, cannabis and amphetamine use.
- Renew our suicide prevention plan, *Next Steps: Victoria's suicide prevention action plan*, using the new national framework to strengthen our ability to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention.
- Develop the expertise and capacity of relevant workforces to use evidence in designing and implementing mental health promotion, a catalogue of interventions that represent best practice in addressing risk and protective factors and determinants and build on the Mental Health Promotion short course to create locally relevant applied skills training related to interventions.

### Reform Area 2: Early in life – helping children adolescents and young people (0–25 years) and their families

- Deliver more accessible, earlier intervention for children and young people by redeveloping services within a 0–25 years framework that improves continuity of care, fosters age appropriate responses for children and young people, and builds partnerships with primary health, early childhood services, schools and a range of community services.

- Organise and improve skills in the school health and welfare workforce, particularly school student support officers, to confidently promote mental wellbeing, identify emerging mental health problems, facilitate access to more specialist intervention where required and provide follow-up support.
- Provide easily accessible help for young people (12–25 years) with emerging moderate or severe mental health conditions through a network of youth service hubs, co-located with general health, drug treatment and youth support services (working with Commonwealth supported headspace sites wherever possible).
- Build on Youth Early Psychosis Services within the reconfigured youth stream of the reconfigured 0–25 years service to further develop early intervention in accordance with international best practice pioneered in Victoria and elsewhere.
- Establish a new statewide framework for consistent specialist care for young people with eating disorders. This would work towards better provision of locally coordinated treatment and care, with back-up from regional resources and statewide expertise, and access to inpatient care if required.
- Provide tailored, flexible services to highly vulnerable young people who have experienced significant abuse and trauma – especially those involved with youth justice, the Children’s Court, child protection and youth homelessness services.
- Proactively support families where mental health problems may be damaging family relationships and putting children at risk. This will connect mental health and alcohol and drug treatment services with Child FIRST sites so that family support interventions are provided when required.

### **Reform Area 3: Pathways to care – streamlining service access and emergency responses**

- Create more accessible information, advice and referral services that can assist people with a broad spectrum of mental health problems, including a 24/7 call line for the general public.
- Promptly assess and proactively assist those who need a mental health service to access appropriate care through the development of centralised psychiatric triage in area mental health services.
- Promote the use of general practice and community health services as key providers of primary mental health care, and a key referral point into private and public mental health services.
- Better support people experiencing psychiatric emergencies through more closely coordinated mental health and police emergency responses, targeted to periods and locations of high need.
- Introduce new models for short stay units at major hospitals or in community-based facilities for people experiencing a mental health crisis including those with substance use problems, as an alternative to emergency department presentation and inpatient admission.

### **Reform Area 4: Specialist care – meeting the needs of adults and older people with moderate to severe mental illness**

- Actively promote consumer self-determination and carer and family inclusive practice, including a peer support function to help consumers and carers navigate the extended mental health system. Consumer and carer participation in broader service planning and governance will be encouraged and facilitated.



- Work towards better availability of community-based specialist mental health services to adequately meet the needs of Victorians of all ages with severe and enduring mental health problems and psychiatric disability, underpinned by workforce reform and improved practice.
- Explore the creation of specialist mental health services, delivered through selected community health services, to meet the needs of adults and older people with moderate mental illness who are socially, economically or geographically disadvantaged.
- Work towards an equitable distribution of core provision of inpatient, sub-acute, rehabilitation and recovery beds based on underlying population needs. This will include the availability of acute and Secure Extended Care beds in areas of rapid growth and locations that are currently under resourced.
- Assist older people with an emerging or existing mental health problems by enhancing aged persons' mental health services capacity to provide secondary consultation, training and short term shared care to primary health services and mainstream residential aged care facilities.
- Over time, develop new and expanded alternatives to inpatient care for adults and older people with severe mental illness, such as greater access to sub-acute Prevention and Recovery Care services and intensive in-home treatment and support for older people.
- Give priority to the physical health of people with severe mental illness through an assertive program of targeted health promotion, systematic screening and access to chronic disease management programs.
- Strengthen the capacity of prison health services to improve longer-term mental health outcomes for prisoners as part of the new Justice Health model. This will be complemented by new medium security forensic mental health beds and enhanced capacity of community based clinical and PDRSS services to support people with a forensic history.

#### **Reform Area 5: Support in the community – building the foundations for recovery and participation in community life**

- Support people with severe mental illness and multiple needs, and their carers, through designated care coordinators who will lead the development and implementation of a comprehensive care plan. Standard elements of these plans would include clinical, psychosocial rehabilitation, general health care and social support services.
- Give people with enduring psychiatric disability who are homeless or at risk of homelessness greater access to individually tailored packages of psychosocial outreach support linked to a range of secure and affordable long-term housing options.
- Explicitly consider the needs of people with mental illness, alongside people with other complex needs, as part of the planning and allocation of new and existing social housing, including that provided by Housing Associations, and new housing and support models.
- Create clearer linkages between specialist employment services and specialist mental health services (clinical and psychosocial rehabilitation). This may include co-location or provision of specialist employment workers on an in-reach basis in specialist mental health services.



- Foster partnerships between business groups, public sector organisations, PDRS services, exemplar employers and training providers to create training and employment opportunities, and promote ‘employer readiness’ for people with moderate to severe mental health problems.
- Promote community acceptance and inclusion of people with mental health problems in social and recreational activities through public awareness initiatives and partnerships with local government and non-governmental organisations (NGOs).
- Explore new approaches in the criminal justice system to divert people with mental illness from custody. This may include a mental health court list, to provide assessments, brokerage funding and referral to community-based services, and enhanced advocacy and support to victims, suspects and offenders at early stages of their contact with courts.
- Strengthen the capacity of pre and post release transitional programs to address mental health, alcohol and drug, housing and other complex problems that affect the ability of prisoners to re-integrate into the community (as part of the Corrections Demand Management Strategy).

#### **Reform Area 6: Reducing inequalities – responding better to vulnerable people**

- Provide Aboriginal people living in metropolitan Melbourne with culturally supportive social and emotional wellbeing and recovery services delivered through new collaborative arrangements between the Victorian Aboriginal Health Services (VAHS), Victorian Aboriginal Community Controlled Health Organisations (VACCHO), local Aboriginal organisations and mental health services.
- Explore, with VACCHO and selected Aboriginal Community Controlled Health Organisations, a coordinated local prevention, early identification and intervention program targeted to young Aboriginal people aged 10–25 years at risk of, or experiencing, poor social and emotional wellbeing.
- Strengthen the capacity of mental health, disability and primary health services to identify, assess and treat people with a mental illness and co-existing disability by improving secondary consultation and creating a ‘no wrong door’ approach to the needs of this group.
- Achieve more culturally responsive services for culturally and linguistically diverse (CALD) and refugee communities through workforce development and strengthening the Cultural Portfolio Holder positions in specialist mental health services.

#### **Reform Area 7: Workforce and innovation – improving capacity, skills, leadership and knowledge**

- Pursue a sustained recruitment and retention program that attracts students and re-entry workers, targets rural students and international mental health workers, supports postgraduate studies, and facilitates joint academic/service appointments, public/private employment arrangements and re-engagement of retirees to teach and mentor less experienced staff.
- Initiate a program of mental health workforce redesign, based on an assessment of core competencies required to deliver best practice mental health care and better align existing roles and skills with overall reform directions.

- Explore the creation of an Institute for Mental Health Workforce Development and Innovation to drive workforce development and cultural change. This body would consolidate the work of separate specialist centres of excellence, define core competencies and training needs, facilitate training rotations across sectors and lead adoption of evidence-based practice.
- Consider as part of the above Institute, the development of a collaborative Centre of Excellence for Consumers and Carers as a focus for consumer and carer-led research and workforce development.
- Bring together a coordinated rolling program of training for staff in health, justice, education, housing, homelessness and other community service sectors to improve mental health literacy, effective early identification, referral and follow up.

#### **Reform Area 8: Partnership and accountability – strengthening planning, governance and shared responsibility for outcomes**

- Use broad-based local mental health partnerships, and the *Care in your community* framework, to undertake population needs assessment, service planning and outcomes monitoring. This would draw on the capacity of Primary Care Partnerships and other local collaborations for particular functions.
- Develop new monitoring and accountability arrangements based on a shared whole-of-system outcomes framework incorporating health and social indicators that reflect broader individual and community goals.
- Bring Child and Youth, Adult and Aged specialist mental health services under common governance arrangements and boundaries aligned with general health service areas.
- Work towards the establishment of Mental Health Boards or Committees to sit under Health Service Boards. These will bring together clinical, psychosocial and primary health services, with consumer and carer representation, for joint oversight of a defined range of services and functions.
- Establish a statewide Mental Health Reform Council to bring together all sectors that are central to progressing reform. Implementation and further work on particular reform priorities would be supported by a number of Partnership Groups bringing together government and non-government stakeholders.





# Part one

## Mental Health Reform Strategy 2009–2019

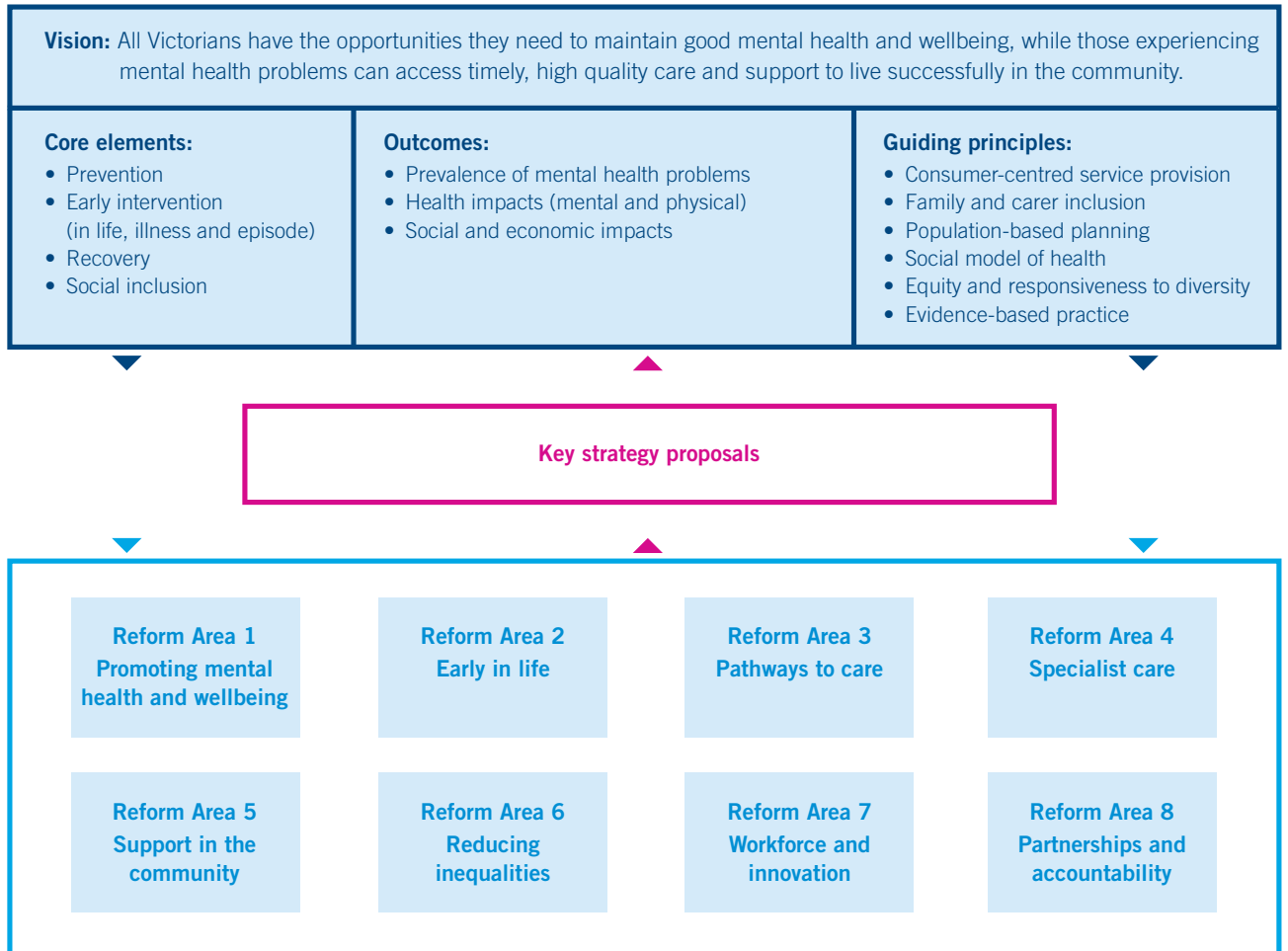


Figure 1: Relationship between vision, core elements, guiding principles, outcomes and reform areas.



# 1. The vision for mental health

## 1.1 Vision and strategy

The Victorian Government's reform vision is centred on the importance of mental health to the fabric of our society – to our family life, our relationships, our workplaces and our communities.

We recognise good mental health as a critical element of our overall health and wellbeing at every stage of life. This means that mental health should be promoted and protected as seriously as physical health, and that mental health care must be an integral part of our wider healthcare system.

We need to approach mental health problems as both a cause and a consequence of a wide range of other health and social problems.

Our mental health response must embrace a broad spectrum of conditions, from anxiety, depression and conduct disorders, to personality disorders, eating disorders and schizophrenia. Some conditions clearly arise in response to life events and environments – hence are more amenable to prevention – while others are chiefly organic in origin. In both cases there can be major debilitating impacts on people's lives.

Our vision for mental health in 2019 is that:

**All Victorians have the opportunities they need to maintain good mental health, while those experiencing mental health problems can access timely, high quality care and support to live successfully in the community.**

This means a society in which:

- Victorians have a good understanding of the factors that affect mental health and are able to help themselves, families and friends to maintain good mental health and wellbeing within a supportive social, economic and cultural environment.
- All mental health services operate within a culture that upholds rights, equity and respect for consumers and carers, and are responsive to diversity in terms of rurality, ethnicity, indigeneity, gender and sexuality.
- People of all ages, including children, adolescents and older people, are better able to access early and effective advice, treatment and care for the mental health problems that affect them – without having to be in crisis.
- Those Victorians with severe mental health problems have access to a stepped range of care options that provide them with the least intrusive care, and include emergency response and acute medical care when required.
- Those particularly vulnerable Victorians involved with other parts of our justice and social care systems – including disability, housing and homelessness, drug treatment and child protection – have clear access to tailored mental health support and care.
- People living with enduring mental illness are supported to participate in the community and the workforce as fully as they aspire to, without stigma or discrimination.
- The physical health care needs of people with severe mental health problems are systematically met, and the unacceptably large gap in life expectancy between this group and the general population is significantly narrowed.

Mental health is more than the absence of mental health problems; it is 'a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and is able to make a contribution to his or her community'.<sup>1</sup>

‘Those who suffer from mental illness have many choices taken from them due to their illness that people in the community take for granted. Often the loss of choices in employment, education, family and housing add to the suffering...’  
– a consumer consultant

This vision for mental health and wellbeing in Victoria is built on the core elements of Prevention, Early intervention – early in life, illness and episode, Recovery and Social inclusion (see Box 2).

Progress in achieving this vision will be based on the principles of: consumer-centred service provision, population-based planning, a social model of health, equity and responsiveness to diversity, family and carer inclusion, and evidence-based practice (see Box 3).

At the core of our strategy must be well targeted interventions that seek to have real impact on a person’s illness and life trajectory.

Realising the vision also depends on stronger partnerships across sectors, designed to foster shared responsibility to prevent mental health problems from emerging or escalating, and to assist those affected by mental health problems in a range of settings such as schools, sporting clubs, prisons, homelessness services, child protection and aged care.

Central to achieving the vision will be a balanced and networked mental health system within which individuals can move easily between levels of care and between types of providers as their needs change. The specific characteristics of this system and its component parts are outlined further in Section 6 below.

Reduction of suicide is a key target and will be addressed through multiple elements of this strategy. The strategy also advocates a more integrated approach to people with mental health problems and problematic substance use, recognising the significant and complex interrelationships between these issues.

## Box 2: Core elements of the reform strategy

### Prevention

Recognising the potential to prevent or delay the emergence of certain types of mental health problems and to prevent a range of negative outcomes associated with poor mental health, including physical health problems. Actively promoting positive mental health through broad policies and community settings is a core part of effective prevention efforts.

### Early intervention

Responding early in life, early in the course of a mental health disorder or illness, and early in an episode of illness, to reduce the risk of escalation, have positive impact on the pattern of illness and minimise the harmful impact on individuals, their families and carers and the wider community.

### Recovery

Promoting access to client-centred treatment and ongoing support that aims to achieve real change and the best possible individual outcomes. Recovery-focused care should foster independence and the capacity of affected individuals to achieve their personal goals and lead meaningful and productive lives.

### Social inclusion

Destigmatising mental illness and promoting the fullest possible participation of people with mental health problems, their families and carers in the community, recognising the impact of multiple types of disadvantage. Social inclusion is also a critical element in preventing mental health problems in the population at large and those identified as at risk.



### Box 3: Guiding principles for reform

#### **Consumer-centred service provision**

Recognising that the interests and preferences of consumers should inform all aspects of service development and delivery, addressing the full range of needs that contribute to a person's long-term overall health and wellbeing. The aim is an equal and active partnership between consumers and professionals based on rights and responsibilities, respect and empowerment.

#### **Family and carer inclusion**

Involving carers and family members in care planning and delivery, respecting their lived experience, knowledge and the care they provide, and responding to their increased vulnerability as a result of their caring role.

#### **Population-based planning**

Planning services on the basis of the needs of, and impacts on, the whole community (and defined sub-groups), and across the spectrum of severity. This approach will help ensure that effort is invested where the greatest benefits can be realised, while maintaining a clear focus on those with the most intense and urgent needs for support.

#### **Social model of health**

Acknowledging that mental wellbeing is determined by social and psychosocial as well as biological and medical factors. This suggests a greater focus on risk and protective factors such as housing, employment, socioeconomic status, education, family and peer relationships, together with the impact of trauma, stigma and discrimination.

#### **Equity and responsiveness to diversity**

Recognising that social and economic disadvantage and discrimination can contribute to and exacerbate mental health problems and hinder recovery; and that the diversity of the Victorian community requires a range of approaches and supports focused on rurality, ethnicity, Aboriginality, gender and sexuality.

#### **Evidence-based practice**

Developing responses based on identified client needs and the best available evidence on effectiveness through research and evaluation to inform practice knowledge, ensuring that the system can respond rapidly to new knowledge when it becomes available.

'...we, his family, provide our son with a very high level of support, supplemented by the care that he receives through the public system, but the lack of accommodation severely compromises his life opportunities...' parents and carers of a young man with bipolar disorder

## 1.2 Expected outcomes

Mental health reform needs to be driven by a set of agreed outcomes, regular monitoring of progress, and accountability structures that provide transparency on what is being achieved.

The priority reform outcomes must reflect the key interests and concerns of stakeholders, especially those of consumer and carers, and apply at both individual and community levels.

The proposed mental health outcomes framework provides a shared basis for planning – across the various levels of the service system, across government programs, and across agencies and sectors at the local level – and for monitoring how things are improving. It will help assess the impact of current investments and inform decisions about new investments.

Coupled with new structures that bring together key players in mental health at a local level, the outcomes framework will facilitate benchmarking across areas and targeting of resources to address identified gaps in local service provision.

### *The mental health outcomes framework*

In line with national health performance frameworks, the proposed mental health outcomes framework will provide the basis for a set of agreed mental health indicators and measures across three levels, each of which covers a number of defined domains:

#### **Level One: Health and community outcomes**

Population surveys and other data will be used to assess achievement over time of agreed population outcomes, such as reductions in prevalence of mental health problems, level of disability associated with mental health problems and associated economic and social impacts.

These shared high-level outcomes will form the basis for agreement across government agencies and funded organisations on the improvements that their individual and joint efforts are intended to achieve for people who have, or are at risk of, mental health problems.

#### **Level Two: Determinants of mental health**

Indicators at this level will be used to assess how a range of risk and protective factors impact on the mental health and wellbeing of Victorians. This element of the framework draws on an integrated biopsychosocial model of mental health and illness.

Some are determinants that can cause or trigger a mental health problem and apply to people generally; others relate to factors that can exacerbate an individual's mental health problem or will support their recovery.

#### **Level Three: Performance of the service system**

This level of outcomes pertains to local services and programs both individually and collectively and will include indicators on how efficiently they are delivering outcomes for consumers and carers. This should provide an integrated overview of the effectiveness and value for money of mental health and associated resource investments and will involve the use of new and existing measures.

Indicators at this level should also reveal how service culture is changing and how the experience of clients and their families and carers is improving.

At the local level, the various outcome measures will provide a mechanism to:

- identify and share best practice across the relevant service systems
- support performance benchmarking at the individual service level
- enable the identification of specific service weaknesses
- support the development of strategic cross-agency responses to address local needs.

The outcomes framework will also provide a mechanism to identify and profile differences in access and health inequalities experienced in geographical areas and in specific population groups (for example, Aboriginal communities).

Inclusion of social determinants of mental health in the outcomes framework acknowledges the importance of factors beyond the purview of the mental health service system in achieving desired mental health outcomes.

The table below outlines a preliminary set of proposed outcomes at all three levels of the framework. These will be further developed in the early stages of strategy implementation and regularly reviewed to ensure continued relevance to mental health reform.

Indicators and progress measures will be developed for each of the nominated outcomes, drawing predominantly on existing data, and including age, gender, ethnicity and geographical location wherever possible. It is not intended that the outcomes framework impose a new data burden on services or programs.

Details of the accountability structure to oversee the outcomes framework are provided in Reform Area 8.

## Mental Health Outcomes Framework

### Level 1: Health and community outcomes

Domain	Proposed outcomes
Prevalence and severity of mental health problems	<ul style="list-style-type: none"> <li>• Less mental illness in the community</li> <li>• Less psychiatric disability in the community</li> <li>• Fewer psychiatric crises</li> </ul>
Community and economic benefits	<ul style="list-style-type: none"> <li>• Increased community understanding and acceptance of mental illness</li> <li>• Increased employment</li> <li>• Increased school completion and participation in further education and training</li> <li>• Less crime and violence</li> <li>• Increased participation in community life</li> </ul>
Health and wellbeing	<ul style="list-style-type: none"> <li>• Increased life expectancy in people with mental health problems</li> <li>• Decreased levels of psychological distress in the community</li> <li>• Lower rates of suicide and self harm</li> <li>• Improved social and emotional health and wellbeing of children and young people</li> </ul>

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## Mental Health Outcomes Framework

### Level 2: Determinants of mental health

Domain	Proposed outcomes
Tackling social and economic disadvantage	<ul style="list-style-type: none"> <li>• Increased housing security and reduced homelessness</li> <li>• Improved social and family connections</li> <li>• Increased workforce participation</li> <li>• Increased participation of young people in education or employment</li> <li>• Increased support for carers</li> </ul>
Freedom from discrimination and violence	<ul style="list-style-type: none"> <li>• Increased acceptance of diversity</li> <li>• Less discrimination particularly against vulnerable groups, including people with mental illness and children</li> <li>• Less victimisation and/or abuse particularly against vulnerable groups, including people with mental illness</li> <li>• Increased community perception of safety and security</li> <li>• Fewer people experiencing prolonged family violence, especially children</li> <li>• Less bullying among children and adolescents</li> </ul>
Service access	<ul style="list-style-type: none"> <li>• Increased proportion of the population with mental health problems receiving mental health care</li> <li>• Increased proportion of people with a co-occurring mental illness and substance misuse disorder who receive coordinated mental health care and drug treatment services</li> <li>• Increased proportion of schools with health/welfare staff trained in mental health issues</li> <li>• Improved support for people with a mental illness involved with the justice system, including greater access to specialist legal representation and advocacy</li> </ul>
Health knowledge and behaviours	<ul style="list-style-type: none"> <li>• Improved mental health literacy across all population groups</li> <li>• Improved health behaviours (for example, smoking, diet, exercise, alcohol use) in people with a mental health problem</li> <li>• More positive self-image and sense of identity, particularly among vulnerable groups</li> <li>• Improved parenting skills of parents with a child/adolescent with a mental health problem</li> </ul>
Environmental factors	<ul style="list-style-type: none"> <li>• Improved resilience to, and support to cope with, environmental stressors, such as drought, climate change, workplace stress, family breakdown</li> </ul>

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## Mental Health Outcomes Framework

### Level 3: Service system performance

Domain	Proposed outcomes
Effective	<ul style="list-style-type: none"> <li>Achieves desired outcome</li> </ul> <p>For example, achievement of client's recovery goals, increased mental health literacy for key population groups</p>
Appropriate	<ul style="list-style-type: none"> <li>Is relevant to the client's needs and based on established standards</li> </ul> <p>For example, clients receive age-specific care, interventions are based on documented best practice</p>
Efficient	<ul style="list-style-type: none"> <li>Achieves the desired result with the most effective use of resources</li> </ul> <p>For example, outputs are consistent with current industry benchmarks</p>
Client-focused and carer-inclusive	<ul style="list-style-type: none"> <li>Is respectful to people and client orientated, for example, respect for dignity, confidential, culturally sensitive and appropriate, opportunities for client participation, treatment/support in the least restrictive environment</li> </ul> <p>For example, services comply with the Charter of Human Rights, reduction in consumer complaints</p>
Accessible	<ul style="list-style-type: none"> <li>People can obtain treatment/support/care at the right time and right place irrespective of income, geography or cultural background</li> </ul> <p>For example, service access for rural clients</p>
Safe	<ul style="list-style-type: none"> <li>Identifies potential risks of an intervention/action or environment and either avoids or minimises them</li> </ul> <p>For example, risk management plans in place</p>
Continuous	<ul style="list-style-type: none"> <li>Provides uninterrupted, coordinated care/support/services across programs, practitioners, organisations and levels over time</li> </ul> <p>For example, discharge practices, protocols between programs</p>
Capable	<ul style="list-style-type: none"> <li>Provides services based on skills and knowledge</li> </ul> <p>For example, mental health skill level for GPs and school health and welfare staff, agency accreditation</p>
Sustainable	<ul style="list-style-type: none"> <li>Has the capacity to provide sustainable infrastructure, such as workforce, facilities and equipment; is innovative, and responds to emerging needs</li> </ul> <p>For example, projected life of equipment and building fabric, number of undergraduate training places</p>



## 2. Challenges and opportunities

### 2.1 Drivers for change

#### 2.1.1 The mental health of Victorians

An estimated 19 per cent of the population is affected by a mental health problem in any 12 month period – equivalent to around one million Victorians in 2008. Twelve per cent of the population is estimated to have mild to moderate problems; four per cent to have moderate to severe illness; and three per cent to have severe mental illness.

Over the next ten years, on the basis of population growth alone, the numbers of people in each of these categories will increase as shown below:

Estimated prevalence of mental health problems in Victoria<sup>2</sup>

	2009	2019
Mild to moderate 12%	630,000	690,000
Moderate to severe 4%	210,000	230,000
Severe 3%	160,000	170,000
<b>Total</b>	<b>1,000,000</b>	<b>1,100,000</b>

In reality, by 2019 these numbers are likely to be higher given a range of factors including the ageing of the population.

These prevalence figures are supported by the Victorian Population Health Survey 2006, which found that three per cent of Victorians 18 years and over were at very high risk of psychological distress.

The survey identified low levels of education and workforce participation, low-income, poor physical health and a previous diagnosis of depression or anxiety as risk factors for high levels of psychological distress. Increases in the number of people subjected to any of these risk factors are likely to lead to an increase in mental health problems.

Mental illness can be debilitating. The Australian Institute of Health and Welfare (AIHW) estimated that in 2003, 5.2 per cent of Australians had a disabling psychiatric condition, with nearly half of these people severely or profoundly limited in their capacity to perform core daily activities.

Of people with a psychiatric disability, only 28 per cent were in the workforce – the lowest labour force participation rates of any disability group.

In comparison with the general population, people with severe mental illness have significantly higher rates of physical health problems including major chronic conditions such as heart disease, diabetes and cancer. Recent US research showed that mental health service consumers die on average 25 years earlier than the general population.

Some of the key impacts of mental health problems on individual Victorians and their communities are reflected in Box 4.

#### 2.1.2 Accessing mental health care

Action is needed not only to address the current needs of the Victorian population but to plan for the projected numbers of people likely to be seeking help for mental health problems in ten year's time.

Not everyone with a mental illness seeks a mental health service. However, of those people who actively seek a service, too many people do not receive help due to factors including the complexity of their needs, the cost of accessing private services, or the lack of public or private services in their locality.

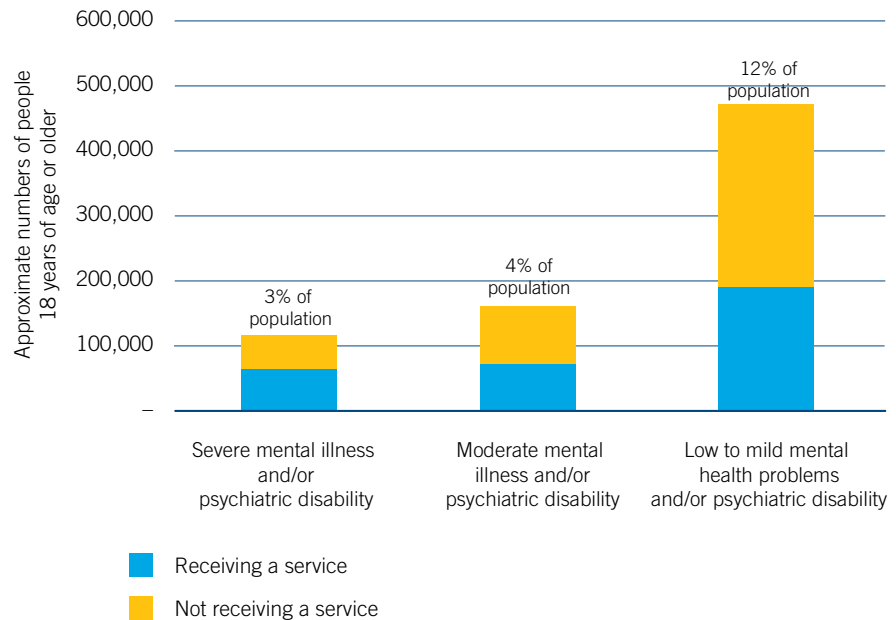


Figure 2: Estimated proportion of unwell people not receiving care<sup>3</sup>

Although 19 per cent of the population will have a mental health problem in any one year, only 12 per cent report seeking help for a mental health related problem. Of those with a mental health disorder in the last year, 25 per cent will have accessed a general practitioner, 13 per cent a psychologist and 8 per cent a psychiatrist.

At the same time, Victoria’s community health counselling services currently deliver some 270,000 hours a year of counselling to around 60,000 clients.

Over 59,000 people (about 1.1 per cent of the Victorian population) accessed public specialist mental health services in 2007–08 – nearly 13,000 or just over 20 per cent of them requiring a hospital bed. Given the targeting of these services, this means that more than half of the estimated three per cent with severe mental illness did not seek or did not receive a specialist service.

Sixty-nine per cent of people admitted to adult acute inpatient units are there on an involuntary basis at some stage during their stay. Factors driving this high level of involuntary admission, and the increasing number of people on Community Treatment Orders, will be examined in a review of the Mental Health Act undertaken early in the lifetime of this strategy.

Some 12,000 people each year – chiefly those with more severe and enduring mental illnesses and psychiatric disability – also receive a structured service from the funded PDRSS sector, delivered through non-government community-based agencies.

Overall, the level of mental health service coverage varies with type of condition. The Boston Consulting Group estimated that 44 per cent of people with severe psychotic disorders such as schizophrenia or bipolar disorders were not receiving mental health care. By comparison, 60 per cent of people with high prevalence disorders such as mild or moderate anxiety or depression accessed mental health services.



This strategy has a major focus on meeting the needs of those who currently fall through the gaps in service provision, particularly those who are not severely ill enough to be prioritised for specialist services but who are either at an early stage of their illness or who have concurrent health and social issues that put them at risk.

In summary, we have a public specialist mental health service that is focused on providing treatment and support to a relatively small proportion of the total number of Victorians with mental health problems and only at certain points in the illness pathway. This system cannot on its own be expected to provide the intensity of treatment and coverage that is, ideally, required across the population of severely affected individuals.

At the same time, a number of other services are playing important roles in meeting mental health care needs, although these are not always well connected with each other and with the public system. This limits our ability to develop an accurate picture of the overall service access pattern for those needing mental health care.

#### Box 4: Key impacts of mental health problems in Victoria

- Around 3 per cent of the Victorian population is estimated to have severe mental illness in any one year. Despite the low socio-economic status often associated with such illness, less than half of this group accesses public mental health services.<sup>4</sup>
- Mental illness is the largest single contributor of disability burden in the population, and accounts for 70 per cent of the disease burden in young people.<sup>5</sup>
- At least 30 per cent of public mental health consumers also experience harmful drug and alcohol use.<sup>6</sup>
- Suicide accounts for 16 per cent of all deaths of young people aged 15 – 19. Over ten per cent of people with a severe mental illness commit suicide within ten years of diagnosis.<sup>7</sup>
- People with severe mental illness die from major physical health causes – including heart disease, cancer and diabetes – at some 2.5 times the rate of than the general population.<sup>8</sup>
- The estimated cost of mental health problems to Victorian society is \$5.4 billion a year, of which \$2.7 billion relates to lost productivity and workforce participation.<sup>9</sup>
- People with a mental illness have some of the lowest employment participation rates of any group with a disability. Only 25 per cent of working-age people with a psychotic disorder are in the workforce.<sup>10</sup>
- Over 25 per cent of Victorians on a disability and sickness benefit have a moderate or severe mental illness.<sup>11</sup>
- Almost half of those brought into police custody have some history of mental illness and 17 per cent are current clients of public mental health services.<sup>12</sup>
- At any one time Victorian prisons hold around 1150 people with a diagnosed mental illness (28 per cent of prisoners) including 500 with psychosis and 700 with depressive conditions.<sup>13</sup>
- During the 12 month period 2007–2008, 38 per cent of parents placed in out of home care were identified as having mental health problems at the time when these children's needs were initially assessed by Child Protection.<sup>14</sup>
- At least 30 per cent of people who are homeless have identified mental health problems. Over half report having developed their mental health problems after becoming homeless.<sup>15</sup>

‘...our overwhelming need is to be listened to regarding our very ill children, and for respect, empathy and caring’ – carer

## 2.2 Key aspects of the reform challenge

Despite progressive growth and many innovations in mental health related services over the past decade, some significant gaps and imbalances have emerged. As a result, we are missing important opportunities to improve the lives of many Victorians with or at risk of mental health problems.

While strengthening core services remains important, the wide consensus is that just investing in more of the same will not yield the benefits we need to see.

The consultation paper which preceded this strategy outlined the major challenges for a reform strategy. These were largely confirmed during the consultation period, with additional emphasis on:

- the importance of delivering services that are recovery orientated and are informed by consumers’ and carers’ perspectives and recognising the need for culture change to one that empowers those who use services
- the impact of key demographic challenges including population ageing and the social and cultural diversification of the population
- the need to better respond to a fuller range of mental health conditions including higher prevalence problems such as anxiety and depression, and lower prevalence conditions such as eating disorders and personality disorders.

The key challenges are set out below.

### 2.2.1 Improving the experience of consumers, families and carers

Improving the experience of consumers, carers and families has a direct impact on treatment and recovery outcomes. This starts with improved access to services and the ability of consumers and their carers to navigate the service system.

More fundamentally, we need services where:

- rights and responsibilities are respected
- consumers and their families and carers are involved in decisions
- treatment and support is tailored to meet individual needs
- the social and cultural diversity of consumers is recognised and responded to appropriately.

At the heart of effective responses to consumers is a service system that offers recovery-oriented treatment and care that aim to change the course of an illness and improve life chances, rather than being focused on stabilisation and palliation of symptoms.

One of the overarching principles must be to reduce the use of seclusion and restraint practices. Importantly, decisions on these matters should always be taken in the context of the goal of maximising recovery potential as much as the need to manage risk.

### 2.2.2 Economic and social participation

Mental health problems reduce the capacity of some individuals to gain and retain employment. While having an often devastating impact of the individual this also has a broader negative economic impact.

As Figure 3 shows, the likelihood of non-participation in the workforce increases with each level of severity of illness. The non-participation rate of 72 per cent for those with schizophrenia is a major concern, although the 54 per cent participation of those with moderate levels of psychiatric disability accounts for a similar total amount of lost productivity given the greater numbers of people concerned.

We need to understand that the ability to work or to participate in education and training is often determined in part by the way these problems emerge and recur over the life-course. Other factors affecting workforce participation include stigma, discrimination, lack of appropriate supports and opportunities, and a complex specialist employment service system that is not generally tailored to people with mental health problems, particularly those with severe mental illness.

Social isolation can cause and compound mental health problems. The challenge is therefore not just about getting individuals back to work, but about educational completion in young people, and involvement in recreation, sport, cultural activity and other aspects of community life, underpinned by access to affordable, secure housing. Community attitudes and ability to accept those with mental illness and avoid stigmatisation are critical in meeting this challenge.

*'I found the main barrier to a person with mental health problems finding and keeping work is the reoccurring episodes. The illness interrupts your daily life' – a consumer consultant with bipolar disorder*

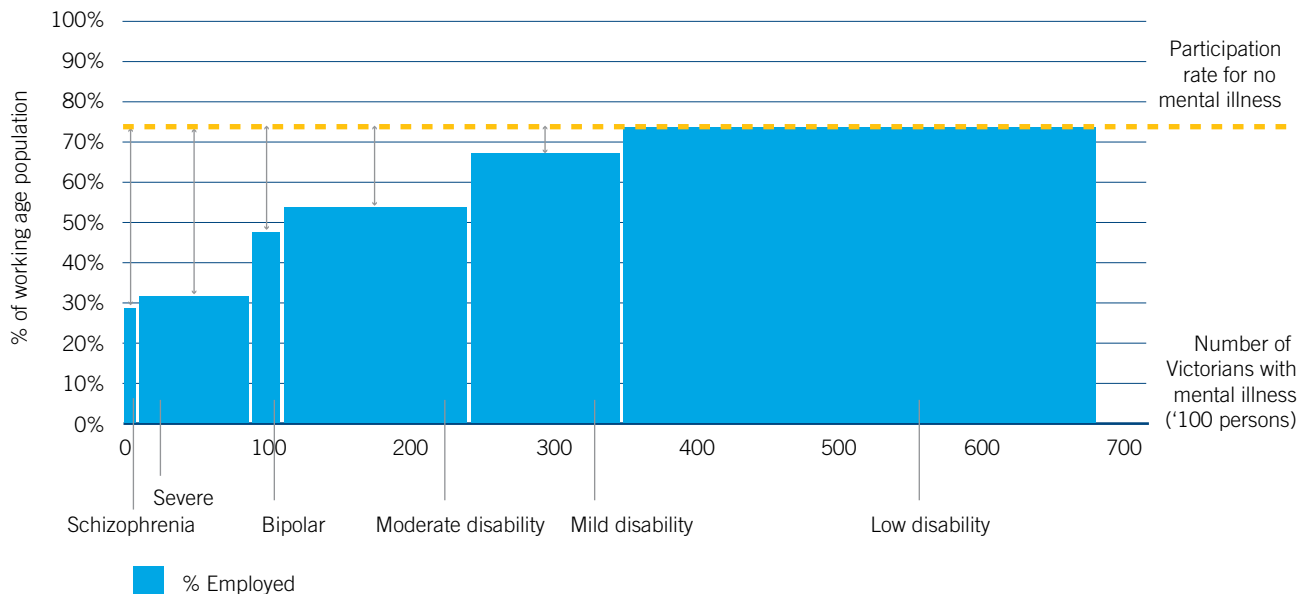


Figure 3: Workforce participation among working age Victorians by severity of mental illness (% persons, '000 persons)<sup>16</sup>

Greater economic participation not only has benefit for individuals but leads to greater overall productivity. In 2006 the Boston Consulting Group (BCG)<sup>16</sup> estimated the economic cost of mental health problems in Victoria to be some \$5.4 billion each year. A key task for any serious reform is to reduce these financial impacts.

Combining expert advice on potential intervention outcomes with analysis of costs and benefits, BCG estimated that a one per cent reduction in disability burden would require an investment of \$26 million per annum. This in turn would yield an annual net financial gain of \$7 million to society – from a combination of increased revenue from economic participation, reduced fiscal outlays and increased business profitability, even before any social and individual benefits were taken into account.

While further analysis is needed of the way these returns flow across sectors and levels of government, it is clear that there is a strong economic case for investment in effective models of prevention and care (see Figure 4).

There is a positive economic case for investment taking into account fiscal benefit and other impacts on GDP based on 1 per cent reduction in health burden

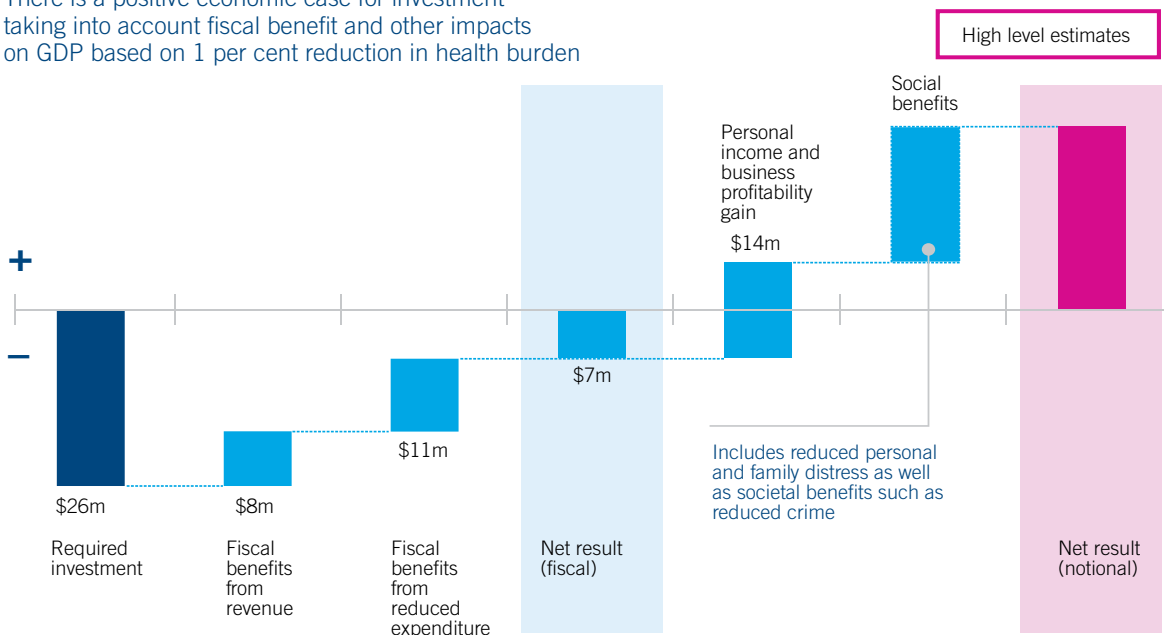


Figure 4: Positive case for economic benefit<sup>18</sup>

### 2.2.3 Pressure on specialist services

Demand pressures on specialist public mental health services are considerable. Services have continued to provide quality care and made many adjustments to cope effectively with demand. Yet measures such as the rate of involuntary admissions, bed occupancy levels, and emergency department waits remain a cause for concern (see Figure 5).

These figures are the result of multiple factors in both supply and demand. It is clear that the problems they reflect require new approaches and creative solutions.

In a pressured system focused chiefly on the severely ill, entry thresholds mean only the most unwell are admitted. A key challenge exists to address the situation experienced by too many consumers who are not being assessed as sufficiently unwell to access a service response from a specialist mental health service.

Too many people progress to a state of crisis and significant acuity because they have not been able to access an effective intervention at an earlier stage. At the same time, our service system offers an uneven response to people whose mental health problems are not severe enough to meet current thresholds for specialist services, but whose needs are complicated by other social problems and co-morbidities.

The supply of trained mental health workers is a critical pressure point and addressing it appropriately will be vital to the sustainability of the service system.

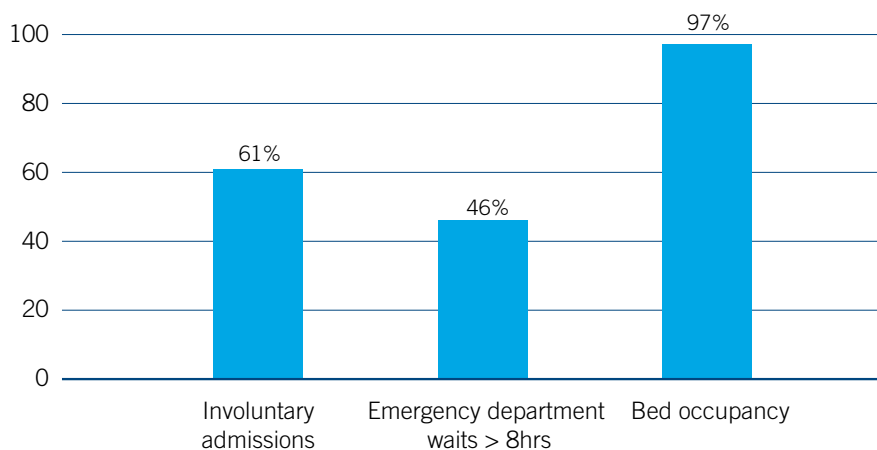


Figure 5: Key measures of service demand in public mental health services in Victoria<sup>19</sup>

### 2.2.4 Matching responses to population need and potential benefit

Victoria does not systematically apply a planning model that links service responses to prevalence of mental health problems across defined areas. Nor do we currently link benchmarked levels of provision to expected benefits at a population level.

This results in some unevenness in service capacity across the state, particularly for certain outer suburban and rural areas. It also results in many people falling through gaps between services, often because they do not fit the criteria for access to a service, even where there are considerable potential gains for the individuals and their families and communities.

Investments need to be more systematically based on our knowledge about the spectrum of mental health conditions, and on analysis of where the greatest potential exists to achieve health gains for particular conditions – whether that is through primary prevention, early intervention or longer-term treatment.

This will give us confidence in estimates of the prevalence of different mental health conditions, and that we are providing the appropriate mix of mental health and social support services for a given population.

A key measure for evaluating the success of reform will be ‘health gain’, or the reduction in the burden of disease attributable to mental health problems (see Figure 6). In order to achieve these gains, we need to progressively reorganise our total service response – including public and private services – to reach people experiencing a wider spectrum of mental health problems and deliver more effective interventions in a way that is better planned than current approaches.

Research suggests that, with the right mix of services and targeting, more overall benefit can be achieved. For example, the widely acknowledged Tolkein II framework, derived from broad expert input, starts from a needs-based and costed analysis of the likely prevalence of major mental illnesses, to model a stepped care approach in which individuals receive the least intense and intrusive intervention consistent with effective outcomes for their particular condition.

When applied to Australian figures, Tolkein II suggests that a combination of changes to service delivery and marginal investment could produce significant gains in the proportion of the affected population seeking and receiving treatment, and the amount of health gain achieved. The possibility of positive gains provides a compelling argument for Victoria to investigate a population-based service planning model of this kind. Such a linking of investment, evidence based service provision and measurable outcomes should progressively become a key part of the way we develop our service system.

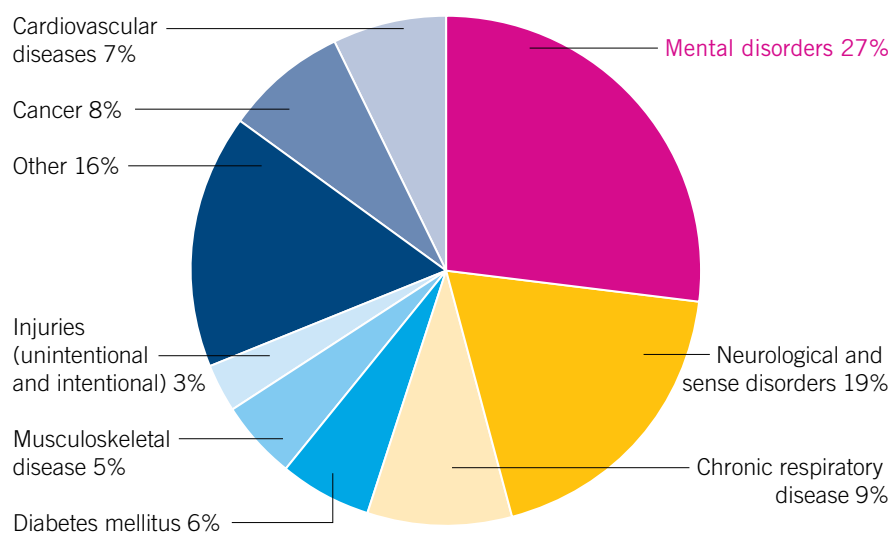


Figure 6: Burden in years lost as a result of disability by disease category, Victoria 2001<sup>20</sup>

### 2.2.5 Helping people early in life

Despite the quality services provided by the specialist mental health sector and many universal services, we are not in general responding widely and early enough to mental health problems in children and young people.

With some 75 per cent of diagnosed mental health problems emerging before the age of 25, and 14 per cent of people aged 12–17 experiencing such a problem each year,<sup>21</sup> efforts to reach more young people more effectively must be a priority and new models are clearly needed.

Data on both public specialist services and MBS-funded services show significant deficits in service provision, particularly for young children and in early adolescence (see Figure 7). Currently, only one in four young persons experiencing mental health problems receives professional help – and only 50 per cent of those with the most severe problems.

As shown in Figure 8, the later a young person receives help from a service, the more likely it is he/she may require one or more hospital admissions. By intervening early, there is the opportunity to reduce the severity of illness experienced and the distress associated with hospital admission.

The challenge here is both about impacting on long-term patterns of illness, and attending to the problems being experienced in childhood and youth. In both cases, the costs of not acting are significant future risks to health, educational attainment and quality of life.

Organising services to provide age appropriate interventions for children and youth, in accessible, attractive community settings is critical to shifting this pattern. Fostering resilience and mental health promoting behaviours, along with good parenting and supportive communities, are equally, if not more, important.

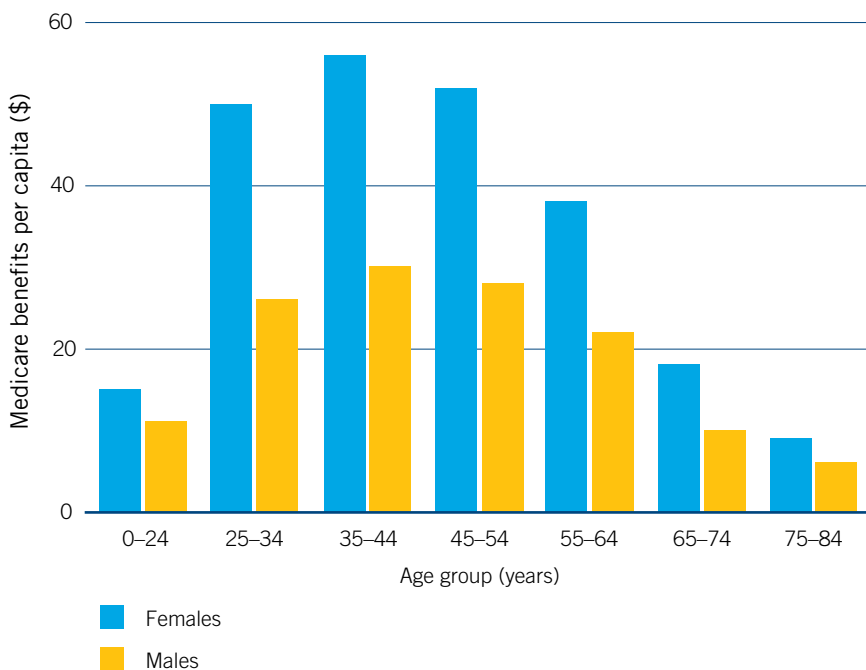


Figure 7: Commonwealth-funded MBS expenditure per capita

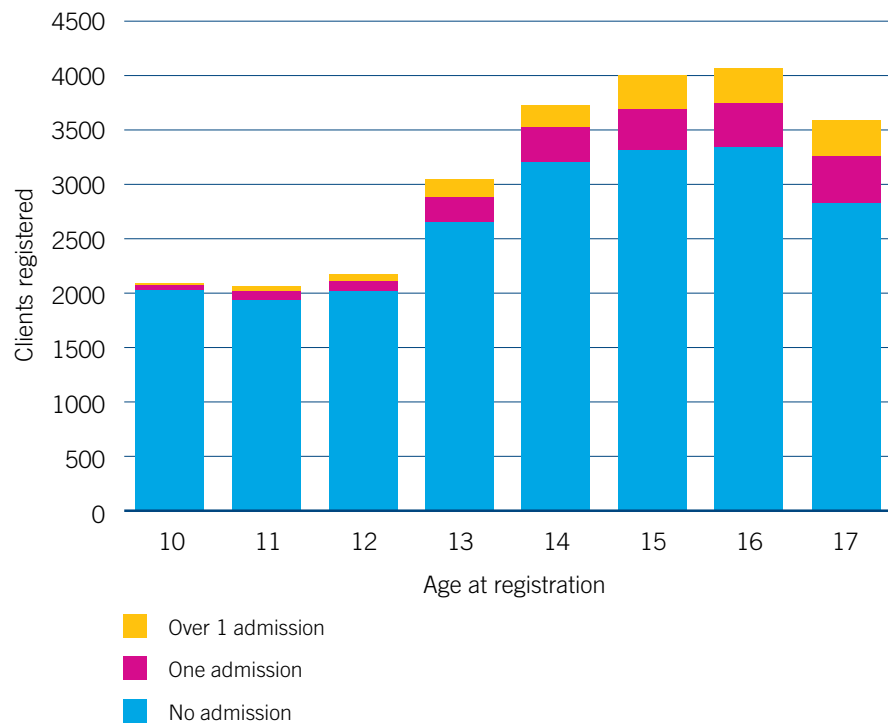


Figure 8: CAMHS registrations since 2000–01 by admissions, age<sup>22</sup>

Services also need to focus on young children in light of evidence of the increasing rates of emotional and conduct disorders over the past two decades. Left untreated, 50 per cent of these problems persist into school years and become mental health disorders. Interventions in this area need to draw on the now well established science underpinning the importance of brain development and socialisation in early childhood, particularly the first three years.

Research relating to the continuing development of the brain throughout adolescence adds to the argument for more focused age-appropriate models of care through to young adulthood.

Pioneering work in Victoria through the Orygen Research Centre, borne out by overseas studies, shows that assertive, specialised early psychosis intervention models not only produce significantly improved outcomes for young people, but are significantly more cost effective than standard outpatient and inpatient treatment options.<sup>23</sup>



### 2.2.6 Focus on social determinants

The evidence for investment in primary prevention of mental health problems has been growing steadily over recent years. In Victoria, VicHealth's research shows clear relationships between key social determinants and mental health problems, chiefly expressed in the form of psychological distress, stress, anxiety and depression.<sup>24</sup> Factors implicated include poverty, discrimination, violence, unemployment and isolation.

Groundbreaking work conducted in Victoria has shown that intimate partner violence contributes significantly to the burden of disease associated with anxiety, depression, eating disorders and suicide in affected women.<sup>25</sup>

High job stress has been found to be a factor in a significant proportion of cases of depression in working men and women. This body of evidence is a powerful driver for interventions that prevent or ameliorate the impacts of these and similar social determinants.<sup>26</sup>

### 2.2.7 Impact of mental illness in the broader service sector

The effects of mental health problems are seen every day by police, courts, housing and homelessness support services, primary health care providers, child and family services, youth services, aged care facilities, alcohol and drug services and in community settings such as schools and sporting clubs.

All these services and settings report a significant level of prevalence, visibility and complexity of mental health problems (see Figure 9).

The challenge is to reduce the numbers of people with mental health problems becoming involved with services such as homelessness and the criminal justice system. We also acknowledge that we need to increase the capacity of those working in these and other services to identify the emergence or escalation of mental health problems and to facilitate access to appropriate referral and support.

At the same time, mental health services need to better recognise that mental health problems are often one part of a complex set of issues facing individuals. This complexity, rather than mental illness symptoms alone, will need to be considered in determining the service response offered.

Investment in state-funded support programs can reduce the usage of more expensive and intensive services downstream. For example, post release support programs that address a prisoner's holistic needs, including their mental health needs, have been found to be highly effective in reducing recidivism rates (up to 70 per cent reduction). Thus a program costing around \$10,000 per person can avoid a cost of \$75,000 per annum per prisoner.<sup>27</sup>

Similarly, provision of psychosocial support linked to community housing has been shown to reduce hospitalisation by up to 90 per cent in a group previously averaging up to 65 days in hospital each year. One unit of public housing at around \$6,000 a year, linked with \$15,000 of psychosocial support, is significantly less expensive than a hospital bed at around \$40,000 (based on a stay of 65 days).

The value of these kinds of investments will be further increased by building the capacity of justice, education, family welfare and other service systems to identify clients experiencing mental health problems and intervene early.

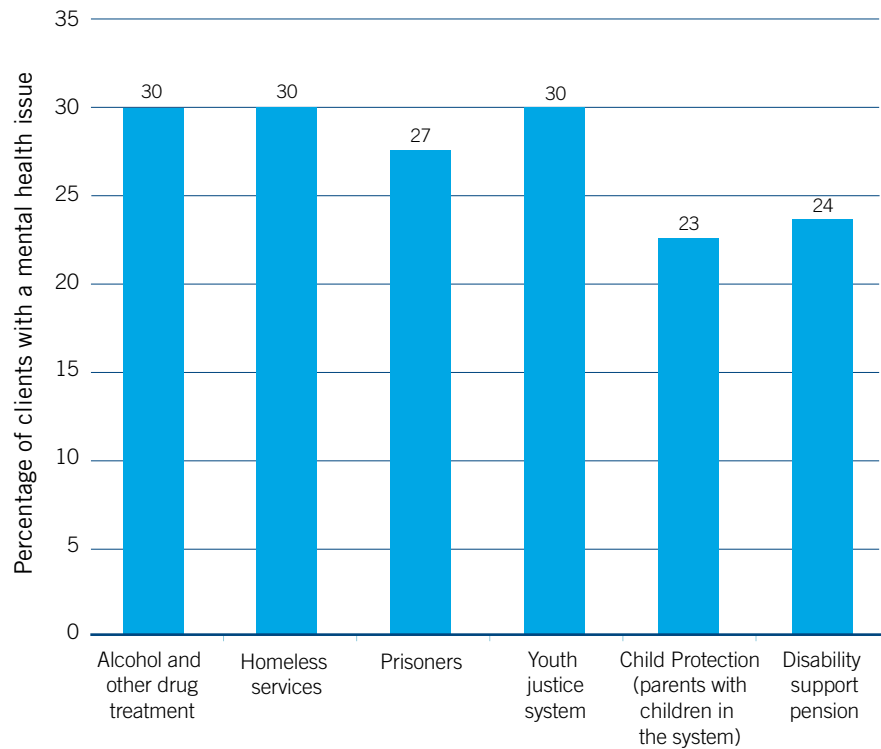


Figure 9: Proportion of mental health clients involved with other social programs<sup>28</sup>

### 2.2.8 Problematic substance use and physical health problems

The number of people with mental illness and co-morbid physical health problems is of increasing concern. National and international evidence suggests that people with severe mental illness die on average 25 years earlier than the general population. Deaths of people with mental illness attributable to common physical health conditions are some 2.5 times the average in the general population.<sup>29</sup>

This unacceptable situation is associated with various factors ranging from poverty and compromising health behaviours – including problematic substance use and high rates of smoking – through to barriers to accessing general health care and treatment, and unhelpful divisions within our healthcare system.

The association between mental health problems and problematic alcohol and other drug use poses particular challenges. Having one of these problems substantially increases a person’s risk of developing the other. Their combined effect not only increases the difficulty of treatment and recovery, but leads to higher risk of physical health problems, social isolation, homelessness, violence, crime and victimisation. The ways in which this can occur are complex and require effort at all levels from health promotion to early intervention and integrated approaches to treatment.

## 3. Strategy development and implementation

This strategy is the culmination of a process that began with the creation by the Victorian Government of a new ministry for mental health in November 2006 and has involved a partnership between many agencies across government. It builds on the foundations laid by previous state reform policies and programs, including the deinstitutionalisation and mainstreaming achieved by the mid 1990s, the system of area mental health services put in place under the 1994 *Framework for Service Delivery*, and the 2002 plan *New Directions for Victoria's Mental Health Services* which sought to strengthen the capacity of specialist services to respond to consumer needs across the illness pathway.

In late 2007, the Minister for Mental Health, the Hon. Lisa Neville MP, commissioned a range of preliminary consultations with external stakeholders to test initial directions. This led to further refinement of government thinking and the publication in May 2008 of the consultation paper *Because mental health matters*.

### 3.1 Consultation on *Because mental health matters*

The government undertook consultation on *Because mental health matters* between June and August 2008. Around 1200 people attended a range of consultation events and over 240 written submissions were received from organisations and individuals representing many different sectors and interests (see Appendix 1 for details).

Feedback from the consultation events and in written submissions engaged with the full range of issues raised in the consultation paper. Many examples of current good practice, successful partnerships and promising service delivery programs were advanced as worthy of consideration for wider dissemination.

We also heard many personal accounts of what it means to live with mental illness, about the pressures of caring for people with mental health problems, and of the experience of working in different parts of the broad mental health system.

Consumers provided powerful reminders that a mental health strategy should reinforce consumer participation and drive cultural change so that consumers receive person-centred care and are treated with respect at all times.

Carers also gave clear messages that they needed to be included in treatment and care planning for the person they care for, and be respected for the knowledge they bring to the process.

The overwhelming response was that the broad directions of the consultation paper were on the right track. There was enthusiasm for reform, a feeling that there was an opportunity to be grasped, and a strong commitment from providers and consumers alike to continue to work to improve the quality and culture of services.

Stakeholders strongly endorsed the emphasis on prevention and promotion, and the three-pronged conceptualisation of early intervention – early in life, in illness and in episode – while stressing the need for early intervention strategies across all age groups.

In consultations, stakeholders sought reassurance that services for people experiencing severe and enduring mental illness would not be diminished in the shift to a preventive approach and a broader conception of the mental health service system. The episodic and, in some cases, chronic nature of mental illness was stressed, underlining the need for long-term support for some people.

Mental health services for some population groups were generally thought to require more consideration in the final strategy including older people and people from culturally and linguistically diverse communities.

There was also a clear message that the fuller participation of consumers and their carers and families in decisions about treatment and care, and in the planning and governance of services, must be a fundamental outcome of reform.

Other prominent themes in the feedback:

- Strong agreement with proposals to reconfigure children and young people's services, within a broader 0–25 years framework, and for the integrated delivery of youth-specific mental health services in a community setting with other health and social services.
- Recognition of the physical health needs of people with mental health problems, and the risks to mental health associated with physical illness were also identified as areas requiring urgent prioritisation.
- Emphasis on the need for significant, renewed and expanded action on affordable and appropriate housing, and on sustainable employment as prerequisites for mental wellbeing and recovery.
- Confirmation that workforce development is fundamental to the success of reform, including the refocusing of some roles and possibilities for different sharing of responsibilities and need for leadership to effect change in service culture.
- Need for stronger, consistent local partnerships with planning capacity linked to service development resources.
- Widespread agreement with the principle of a shared outcomes framework and clear accountability, and for the critical role of research into, and dissemination of, evidence-based practice.

While this document cannot do justice to the richness of input received in response to the consultation paper, we will continue to draw on the wealth of material as we move into detailed action plans and develop new or strengthened partnerships between government and key external bodies.

### 3.2 Strategy implementation

This strategy sets directions for change and development in policies, programs and services of the Victorian Government and its partners. It proposes a program of reform to be achieved in a staged way over a ten-year period. This will involve development of more concrete action plans, commencing in the first half of 2009.

To support this change process, a range of new structures for driving and monitoring implementation are proposed, including a statewide Mental Health Reform Council and new local planning and governance structures. These are detailed under Reform Area 8.

The Victorian Government recognises that further resourcing will be required over the life of the strategy to implement reform. This includes strengthening of core services which will often be a precondition for the reconfiguration and refocusing that is required to achieve reform. The availability of funding will be dependent on normal government budget processes and this will influence the staging and pace of change.

The resourcing of directions outlined in this document commenced in the 2008–09 State Budget, with \$128 million over four years being made available for a number of initial seeding developments. Particular emphasis was placed in the first instance on:

- piloting child and youth mental health service development;
- perinatal mental health screening and support as part of a national initiative;
- better pathways to mental health care including a telephone advice and referral line and enhanced psychiatric triage;
- expansion of acute care capacity for people with severe eating disorders; and
- extension of recovery support linked to secure housing, including new models of Supportive Housing.

### 3.3 Evolving policy context

This strategy can not operate effectively in isolation. Developments in mental health over the next decade will be dependent on a range of ongoing policy processes. This is likely to be a particularly dynamic time given changes occurring at a national level across the spectrum of policy domains relevant to mental health concerns. The reform strategy needs to remain open and flexible enough to accommodate these changes.

#### 3.3.1 National policy development

The COAG *National Action Plan on Mental Health* of 2006 marked an important development in national mental health policy. Complementing the Third National Mental Health Plan, it emphasised coordination between government, private and non-government providers to deliver a more connected and comprehensive system of care. The roles of primary health care and social support services were given new prominence.

As we move towards a fourth National Mental Health Plan, there is continued momentum for this kind of ‘joined-up’ approach.

Victoria is keen to ensure that changes in the division of Commonwealth and state responsibilities in mental health maximise opportunities for the reforms described in this strategy. This means ensuring that the division of roles supports seamless service delivery to consumers, facilitates local innovation, and better meets the overall needs of populations.

Victoria will seek particular collaboration with the Commonwealth on:

- ways to ensure better distribution of MBS-funded mental health services and the mental health practice nurse initiative
- more integrated funding and service development processes for community-based psychosocial support and aligned activity
- the future of local integrated youth services under the current *headspace* initiative
- ongoing efforts in suicide prevention and perinatal depression
- commitment to a new national mental health information development agenda
- development and improvement of inpatients and community mental health treatment facilities.



Emerging national policies on preventative health, social inclusion, housing and homelessness, and workforce participation will also be particularly important in supporting and refining the reforms outlined in this document.

### 3.3.2 Victorian policy linkages

A whole-of-government strategy for mental health clearly needs to embrace and work with a wide range of other state policies and strategies.

The Victorian Government's broad social policy framework provides a critical underpinning to ongoing developments in mental health. *A Fairer Victoria* has provided an important vehicle for harnessing commitment to action that improves the lives of disadvantaged Victorians. Recent moves to connect this to concerns about health inequalities, participation and productivity, and the way in which services are delivered, provide useful frameworks for mental health.

In the health policy sphere, the government's stated priority for chronic disease prevention and management is clearly relevant to mental health, both because mental illness can be a major chronic condition in its own right, and because it shares many common risk factors with the major chronic physical health conditions.

Premier Brumby's *Next Steps in Australian Health Reform* released in June 2008 will also guide developments in mental health. Aspects of this report relevant to mental health include the focus on prevention through local partnerships, providing the right care in the community, the importance of addressing health inequalities and the streamlining of roles and responsibilities. In particular, the report proposes that current Commonwealth funding for community mental health support should be managed by the state.

The other important health policy framework for mental health is *Care in your community*. Focusing on community-based care, this strategy promotes collaborative area-based planning in order to support a progressive shift to cross-agency delivery of health services in community-based settings.

In the mental health arena more specifically, it is important to note the concurrent review of the Victorian *Mental Health Act 1986*. This review, subject to separate consultative processes, will ensure that Victoria has an effective, contemporary legislative framework for mental health services.

The *Victorian Charter of Human Rights and Responsibilities* represents a fundamental anchor for this review and, more broadly, for the strategy.

Specific policies and strategies – existing or emerging – that are of particular significance to mental health include:

- *Vulnerable youth framework*
- *Restoring the Balance: Victoria's Alcohol Action Plan 2008–2013*
- *A new blueprint for alcohol and other drug treatment services 2009–2013*
- *Justice Statement II*
- *Blueprint for Education and Early Childhood Development*
- *Ageing in Victoria policy framework*

Within the Justice portfolios, the *Victoria Police mental health strategy (2007)* and the forthcoming *Justice mental health strategy* will provide specific vehicles for addressing the need for better support to adults and young people with mental illness who are engaged with the criminal justice system – whether as suspects, offenders, victims or persons in need of assistance.

A more complete list of current relevant policies and strategies is provided at Appendix 2. This will be kept up to date as new initiatives emerge over coming years. The need to maintain their close alignment with mental health reforms will be a key focus in the ongoing cross-portfolio management of mental health strategy implementation.





## 4. A better response for all Victorians

A critical aspect of mental health reform must be a broadening in our understanding of who our programs and services are for and how we can better respond to the diversity of mental health related need in the Victorian population.

### 4.1 Consumers and carers in the specialist service system

By 2019 we want people using mental health services of all kinds to be empowered in their individual journeys of recovery. We want all people affected by the experience of mental illness to be respected as members of the Victorian community.

We also want carers and families to be actively included in decisions about care, and valued for the important role they play in supporting someone with mental health issues. We also want to see carers and families receiving advice and support services, including respite care and peer support, to promote their wellbeing.

This strategy promotes an approach based on genuine consumer and carer participation in all parts of the service system – recognising the distinct needs of both groups. It also acknowledges that consumers and carers have a wealth of experience to contribute to the development of policy and the delivery of services.

Of central importance is the way that the specialist services are delivered to the consumer. We want to see welcoming services that are centred on negotiating and supporting the recovery.

Carers too need to be more consistently included in treatment and planning, and have their views valued and their needs acknowledged. Assessment of carers' needs, and appropriate referrals to carer support services, including referrals to respite services need to be an important part of the work of mental health professionals.

Achieving these outcomes will require:

- strong and continued leadership within government and mental health services
- the development and embedding of a philosophy of recovery in service culture and practice
- strategies to drive systemic cultural change including performance measures that measure consumer and carer participation.

Each Reform Area is underpinned by this drive to improve the lives of consumers, carers and their families. Improving consumer and carer participation in specialist services is specifically addressed in Reform Areas 2 and 4.

### 4.2 Gender and mental health

While most mental health problems affect both men and women, there are some important differences in the way men and women experience mental health problems at different stages of life. Gender also differently determines the likelihood of men and women seeking help for mental health problems.

#### 4.2.1 Men

While mental health and mental illness in men is an under-researched area, we know that:

- Men between 20–24 are almost five times more likely to commit suicide than women of the same age. The rate of suicide is also higher in men aged 45–54, and those aged 75 and over.<sup>30</sup>
- Onset of schizophrenia in men is typically earlier and men with schizophrenia typically have poorer outcomes compared to women.<sup>31</sup>
- Men are less likely than women to use mental health services, meaning that disorders go undetected and can therefore increase in severity.<sup>32</sup>

'...it is yet to be recognised that what a carer does is effortful, time consuming and financially burdensome...'  
carer for a 25 year old with severe mental illness



Higher rates of problematic substance use in younger males, work stress and family breakdown in middle aged males and social isolation in older males are all contributing factors to poor mental health and wellbeing.

Many men find it difficult to ask for help, for mental health problems in particular. Treatment of mental illness often requires the disclosure of private feelings and a relinquishing of control. This and a perception of having 'failed', may be at odds with traditional male identities and notions of masculinity.

These themes illustrate the need to target men in some age ranges as at significantly higher risk of suicide (Reform Area 2), and to use settings like the workplace to promote mental health and wellbeing (Reform Area 1).

#### 4.2.2 Women

Women have a higher prevalence of mood disorders and anxiety than men, with prevalence highest in women aged 18–24 years and anxiety disorders highest in women aged 45–54 years.<sup>33</sup>

A violent partner and/or experience of physical and sexual abuse have a significant impact upon women's mental health. As many as one in five women will experience some form of violence from their partner.<sup>34</sup>

This highlights the need to work towards an integrated approach for services catering to women who experience violence and mental health problems (Reform Area 1).

Peri- and post-natal depression has significant impact upon women's mental health (Reform Area 2). Post-natal depression affects approximately 13 per cent of mothers, and perhaps another 30 per cent have some other form of psychological distress before or after childbirth.<sup>35</sup> These problems can often go undetected.

Women with pre-existing severe mental illness may face significant problems during pregnancy, with implications for both the mother and the unborn child. Schizophrenia and bipolar disorders – and the medications used to treat them – are associated with an increased risk of pregnancy complications.

### 4.3 Children and young people

While most children and young people have good mental health, a significant proportion will experience some form of mental health problem before they reach early adulthood. It is estimated that one in seven children and young people aged between four and 17 are affected, rising to one in four 18–24 years olds.<sup>36</sup>

More than 75 per cent of all severe mental health and substance abuse problems commence before the age of 25, with the first episode of serious mental illness most likely to occur in the period from 16–25 years. Suicide accounts for approximately 20 per cent of all deaths of young people aged 15–24 years.<sup>37</sup>

This strategy places significant emphasis on better meeting the needs of children and young people, both for the longer term life outcomes that better early intervention will bring, and in recognition of the real difficulties experienced by many children and young people as a result of early emergence of mental health problems.

While mental health problems can affect children and young people from all backgrounds, life circumstances including having a parent with a mental illness, homelessness, problematic substance use and experience of trauma, abuse or domestic violence, put some at greater risk. The mental health needs of these highly vulnerable young people are a key focus in this strategy.

## 4.4 Older people

The Victorian population is ageing, with both the number and proportion of older Victorians increasing significantly. It is estimated that by 2011 790,018 Victorians will be aged 65 or over, and by 2021 there will be 1,106,646.<sup>38</sup>

Older Victorians are also a diverse population. In 2006, 26 per cent of Victorians over the age of 65 were born in non-English speaking countries.<sup>39</sup>

The proportion of older Victorians living in regional Victoria is greater than in metropolitan areas and it is estimated that the rate of increase in the proportion of older people living in rural and regional Victoria will be twice that for in metropolitan areas.<sup>40</sup>

Reducing isolation and increasing social inclusion are important ways to prevent depression and anxiety in older people, and represent an important challenge for mental health promotion (see Reform Area 1).

A number of specific reforms are proposed over the life of the strategy which build the capacity to support older people to remain at home or in residential accommodation rather than in acute inpatient services (see Reform Area 4).

## 4.5 Aboriginal Communities

Many Aboriginal Australians have significant mental health issues that are linked to experiences of grief, loss and trauma. Aboriginal people conceptualise mental health as part of social, spiritual and emotional wellbeing. Mental health and general health services therefore need to be sensitive to the cultural meanings and needs of Aboriginal people.

Over a quarter of Aboriginal people are reported to have some form of mental illness.<sup>41</sup> Higher rates of self harm and suicide in Aboriginal communities are indicative of poorer mental health outcomes in Aboriginal Australians compared to the general population.<sup>42</sup> Higher rates of problematic alcohol and drug use are additional challenges to the maintenance of social, spiritual and emotional wellbeing.<sup>43</sup>

Aboriginal Australians also experience higher unemployment, financial stress and lower levels of educational attainment. They are more likely to live in poor quality housing than non-Aboriginal Australians. All of this has profound impacts on social, spiritual and emotional wellbeing.

The Victorian Government is committed to the national goal of closing the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. Strategies to improve the social, spiritual and emotional wellbeing of Aboriginal people, their families and community are addressed in Reform Area 6.

#### 4.6 Culturally and Linguistically Diverse (CALD) and Refugee Communities

Victoria has a diverse population, with 24 per cent of Victorians being born overseas. Over a third of this group come from non-English speaking countries.<sup>44</sup> Culturally and linguistically diverse (CALD) groups often have poorer mental health outcomes compared to Australian-born people, typically presenting to services when their illness is more severe and experiencing higher rates of involuntary treatment (see Figure 10).<sup>45</sup> Access to culturally competent mental health care remains a key issue for CALD communities (see Reform Area 6).

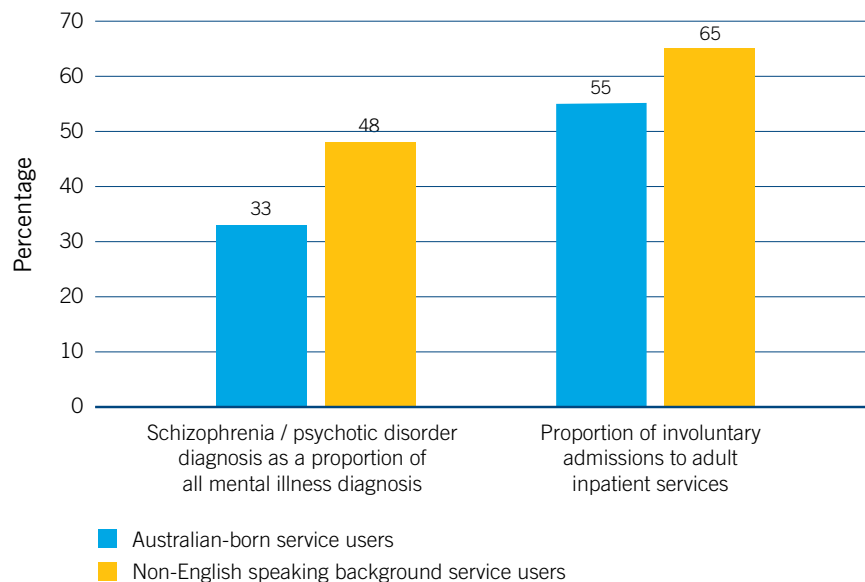


Figure 10: Diagnosis and care characteristics for non-English speaking background consumers compared to Australian-born consumers<sup>46</sup>

Victoria is also seeing increased numbers of people arriving as refugees who often have mental health issues due to traumatic experiences in their homeland. Refugees are also younger – over half of humanitarian entrants are under the age of 20<sup>47</sup> – so child and youth mental health and primary health services need to be sensitive to the needs of refugee communities.

By contrast, in the broader CALD community, 26 per cent of people are 65 years of age or older,<sup>48</sup> although this figure is closer to 50 per cent in some of the more established CALD communities. A key issue for many of these older people is lack of English proficiency.<sup>49</sup>

Victoria’s CALD population is also becoming more dispersed across the state.<sup>50</sup> This challenges primary health and mental health services in regional and rural areas to provide culturally appropriate care for new populations in their communities.

Nearly half of all CALD Victorians report having experienced some type of discrimination based on their ethnicity or nationality.<sup>51</sup> Depression, stress and anxiety, and increased levels of problematic substance use have all been linked to the experience of discrimination. Efforts to produce better mental health outcomes for people of CALD backgrounds must include strategies to promote social inclusion and acceptance of cultural diversity.

## 4.7 Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI)

There is a significant body of research that links the experience of discrimination and abuse for GLBTI people to the onset of mental health problems.<sup>52</sup> Gay and lesbian people are at higher risk of anxiety, depression, self harm and drug and alcohol misuse.

Same sex-attracted youth are vulnerable to homophobic abuse, which in turn is related to high rates of self harm, problematic substance use, suicide, depression and anxiety. Research shows that GLBTI people can face additional stress at life transition points.

Key reform directions include mental health promotion activities affirming GLBTI identities, anti-discrimination and social inclusion are outlined in Reform Area 1.

Reform Area 2 outlines ways in which we could improve capacity in schools to promote mental wellbeing and identify and intervene earlier in mental health problems. This would aim to incorporate better overall support for same sex attracted youth, building on the government's *Supporting sexual diversity in schools* framework.

Discrimination encountered in health services has a negative impact on the care-seeking behaviour of GLBTI people. A Victorian survey found that over 20 per cent of people in same sex relationships had experienced discrimination in mental health care settings because of their same sex relationship.<sup>53</sup>

Continuing education and training of mental health professionals, as outlined in Reform Area 7, should also aim to embed the understanding of issues relating to GLBTI people, and proactive and inclusive practice, to improve outcomes for this group.

## 4.8 Co-existing disability

Although all people with mental health problems and co-existing disability require services tailored to their needs, those with mental health problems and co-existing intellectual disability, Acquired Brain Injury, or Autism Spectrum Disorder face particular challenges. The first of these is often the initial recognition of mental health issues in people with these disabilities.

International studies have found that mental health problems in people with an intellectual disability are three to five times more common than in the general population.<sup>54</sup> It is estimated that there are some 14,000 Victorians with both intellectual disability and mental health problems and that over ten per cent of specialist mental health service clients are also clients of Disability Services.

Research indicates that people with an Acquired Brain Injury are more likely than all other disability groups to have co-occurring mental health problems, problematic substance use and physical health conditions.<sup>55</sup>

We need to build the capability of the primary health, disability and mental health services to identify, treat and manage people with these co-existing problems. Providing clearer service pathways through improving partnerships between key service providers is a key direction in Reform Area 6.

‘...for the mentally ill, imprisonment is another, and worse, form of institutionalisation’ – a carer

#### 4.9 Offenders and victims

People with a mental illness are over-represented in the justice system, as offenders, victims and people in need of assistance.

A recent survey of individuals detained in police cells revealed that nearly 50 per cent had previously been engaged with the public mental health system, and 17 per cent were current clients.<sup>56</sup>

Mental illness is three to five times more prevalent among prisoners than in the general community. Just over 25 per cent of newly remanded prisoners have a mental illness, with the prevalence of schizophrenia or bipolar disorder almost ten times greater than the general population and the prevalence of depression at least 50 per cent higher than the general population.<sup>57</sup>

People with mental illness are 59 times more likely to be victims of theft, around ten times more likely to be victims of violent crime or violent sexual assault, and six or seven times more likely to be the victim of homicide than the general population.<sup>58</sup>

As in the general population, the full range of mental health problems will be seen in those involved with the justice system, from mild to moderate depression and anxiety to psychosis. Mental health problems might predate a person’s contact with the criminal justice system, or may emerge during, or be exacerbated by, involvement in the system.

There is a critical need to better address the needs of people with mental health problems who become involved with the justice system at all points of contact: at arrest or apprehension, in police custody, at court, during community-based orders, in prison, and at all transition points.

There are some people, such as those with severe mental illness, who we should increase our efforts to divert from police custody, the courts and prison by providing enhanced community based forensic services (Reform Area 5). For people who receive custodial sentences, we recognise the need to provide an increased range of appropriate mental health services.

While up to 50 per cent of people with severe mental impairments in the community have co-occurring alcohol and drug abuse problems,<sup>59</sup> within the criminal justice system, rates of dual diagnosis are significantly higher.<sup>60 61</sup> Studies show that problematic substance use and mental impairment are independent risks for future offending, and when these disorders occur together, there is a much greater risk of re-offending.<sup>62</sup>

In order to minimise the risk of relapse and re-offending we need to provide more effective bed- and community-based options for people with mental health problems emerging from the criminal justice system (Reform Area 4) and better coordination between different clinical and social support agencies (Reform Area 5).

#### 4.10 People with multiple and complex needs

Human services delivery is increasingly about the management of multiple and complex needs as they present in an individual. Mental health problems are frequently a key element of this complexity.

People are increasingly routinely presenting to mental health services with multiple health and social problems such as physical ill health, alcohol and drug dependency, and housing and employment needs. At the same time, mental illness is an increasingly common presentation in clients of other social care services and the justice system (see Figure 9, p40).

People with multiple and complex needs are seen in the separate services, but often without any coordinated intervention to address the relationships between the individual's multiple problems. In some cases their multiple problems mean this group will shuttle between different services in a chaotic manner, with the risk that they end up falling between the gaps of the current system.

Failure of the service system to deal, in a coordinated and individualised way, with the multiple and complex needs of the whole person can lead to repeat psychiatric crises and hospitalisation, entrenched homelessness, poor physical health, school failure and unemployment, frequent interactions with the police, and increased risk of incarceration. Research also suggests that people with multiple and complex needs have higher levels of non-adherence to treatment, of relapse and suicide, and have fewer social supports.

While definitions of 'multiple and complex needs' vary, of the 60,000 clients registered with area mental health services in a year, just over 60 per cent are considered to require some level of care coordination. Around half of this group need sustained coordination due to the severity and complexity of their problems.

The Victorian Multiple and Complex Needs Initiative (MACNI) provides a tailored response to a limited number of clients identified as warranting time-limited, intensive intervention. Data on people who meet the eligibility criteria for MACNI to date show that 85 per cent had a mental disorder, often coupled with alcohol or drug dependence, intellectual impairment or Acquired Brain Injury.

People with multiple and complex needs may also be clients of innovative programs such as High Risk Tenancies, Youth Homelessness Hubs, Integrated Family Violence, and Court Integrated Services, which aim to coordinate elements of care across services. Yet many more people do not have their needs met in a coordinated way.

An important emphasis of this strategy is to make better use of both mental health specific and other types of care coordination processes (see Reform Area 5).





## 5. A balanced, networked service system

Mental health care and support necessarily involves a complex array of services. The aim of this strategy is to develop a more coherent overall system of care that meets the needs of consumers and carers.

In addition to the delivery characteristics outlined earlier in this document, the mental health service system we want to see develop under this strategy should have the following features. It should:

- form a coherent 'extended mental health system' that meets the needs of local populations
- is more easily understood and navigated by consumers, carers and by those who work in the broader service system
- have accessible community mental health services at its centre, with reduced reliance on acute inpatient stays
- be delivered in partnership with universal and targeted health and social care services
- refers people easily between parts of the service system with each part providing the least intensive and intrusive intervention possible
- embrace mixed models of public, non-government and private (MBS-funded) service delivery
- retain the core concept of defined catchment populations for purposes of planning, but allow greater choice for consumers
- make it easy for consumers to move between levels of care, between public and private sector providers and, where warranted, between areas
- see the coordinated response to multiple health and social needs as core activity, not as an additional task.

Achieving this requires two fundamental processes – balancing and networking.

### 5.1 Balanced

Balancing means the service system has the right mix of inpatient and community-based care and of clinical and psychosocial capacity.

We need to establish a more comprehensive mental health service system that plans for optimal coverage of the estimated prevalence for all main types of mental illness.

While growth is needed in all parts of the service system, the reforms proposed in this strategy suggest a particular focus on:

- gaps in inpatient and secure rehabilitation capacity in certain geographic areas
- consistent access to 'intermediate' or sub-acute care, in non-hospital settings
- community-based early intervention for all ages
- wider availability of MBS-funded GPs and psychologists working in a range of community settings
- capacity to respond to the needs of people with the range of mental health problems and those who have coexisting problematic substance use and/or significant physical health needs.

'...meeting the needs of the community is also a matter of clear and consistent communication, and the coherent representation of the system and its component part.' – mental health advocacy group

Community-based services will be at the centre of the mental health service system. They will be the setting where people will most frequently receive care. Rather than only providing the follow up capacity after people have had acute treatment, we propose that community-based services would have the capacity to intervene early in their episode of illness and thereby reduce demand for acute care. Community-based services would also manage most of the key partnerships with primary health and social care providers.

Community-based mental health services should be carefully integrated with other health and welfare services in accessible community settings sited in well-designed buildings.

A well-planned program for improving infrastructure is crucial. Mental health services will be an integral part of the government's forward capital planning for health services. This will embrace acute, rehabilitation and recovery facilities. The aim must be for facilities, particularly inpatient facilities, that offer a more attractive, welcoming environment for consumers, carers and staff.

## 5.2 Networked

A clearly established formal partnership between clinical services, psychosocial support and primary health care should be at the core of the network.

A key feature of the proposed reforms is the networking approach implicit in a number of service platforms, including state-funded Primary Care Partnerships and Commonwealth-sponsored headspace youth collaborations. Supporting such platforms to fully embrace roles in mental health as an integral part of local service systems is a priority.

Among other benefits, this will open the door for the state to invest selectively and strategically in meeting the mental health needs of those with less severe but still debilitating mental health conditions.

The roles of different components of this system will be defined in terms of their capacity to provide particular elements of treatment and support, and the level of specialisation offered, rather than the 'ownership' of particular groups of consumers.

Some services, such as GPs, see consumers across a very wide spectrum of levels of need. The roles they play and level of interaction they have with other providers will depend on the severity and complexity of the consumer's problems, as with any health condition.

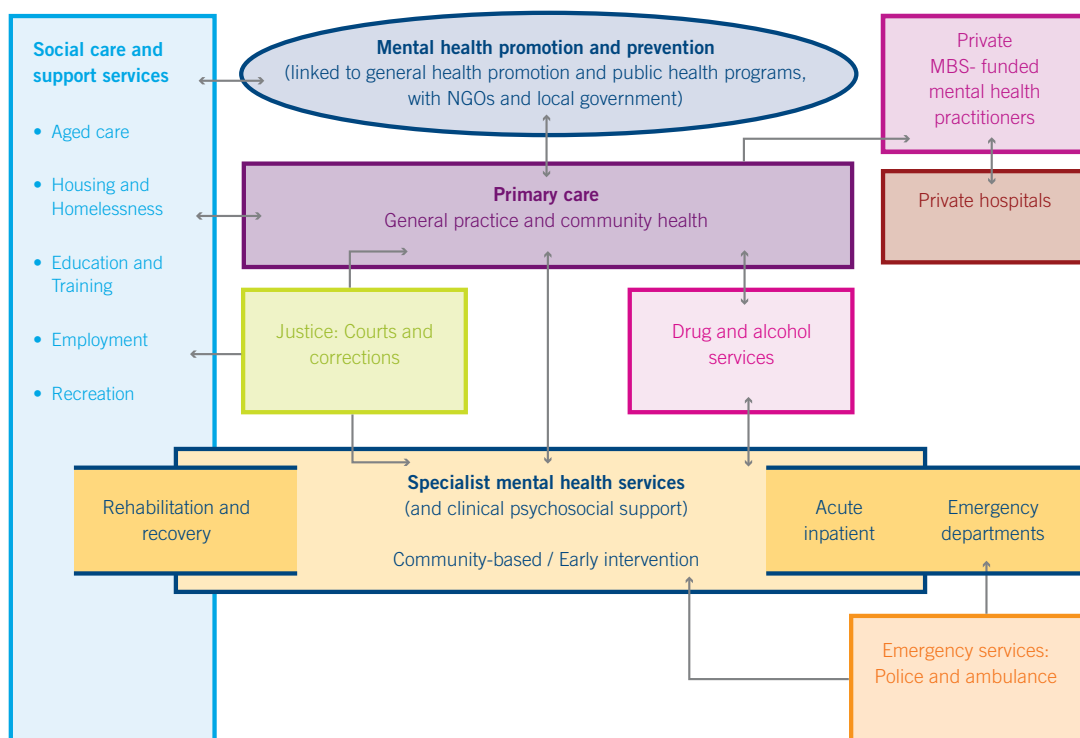
Police and court assessment services will necessarily have less sharp boundaries drawn around what constitutes a mental health problem, because by their nature they must respond to problematic behaviour, rather than on the basis of defined mental health conditions.

The development of strong partnerships between police, courts and community-based mental health services will further support the early and effective diversion of individuals from the criminal justice to the health and other service sectors, thereby increasing the likelihood that they will gain the stability and support required to remain living in the community. Similarly, strong partnerships between mental health services and other support services such as housing and homelessness services are essential to positive outcomes.

The ‘no wrong door’ approach fostered in relation to mental health services and alcohol and drug treatment services is an important principle that should be extended to other combinations of mental, physical and social health issues.

As Figure 11 suggests, the general scheme for mental health service networks should embrace:

- a clear role for universal services and public health programs in promoting positive mental health,
- a more recognised central role for primary health providers,
- a permeable connection between clinical mental health, psychosocial recovery and acute health services, and
- greater input from and interaction with social care agencies at all levels.



**Note:** This diagram is not primarily intended to illustrate consumer pathways. Rather, it describes the relationships between sectors in a broader mental health service system, and is a guide to help identify where alignment between services and sectors is required.

Figure 11: A balanced and networked service system

The exact composition of the network will vary from area to area. A key task in the initial stages of implementing the reforms will be to produce detailed mapping of networks in each area.

Service coordination will be a key factor in making all these components work together effectively to provide a coherent experience for the consumer. Commitment to use common well tested coordination tools and processes, such as those developed through the Primary Care Partnership program, will be critical.

### 5.3 Funding approaches

Changes to the way in which government funds mental health and associated services will be considered as the strategy progresses.

It is acknowledged that there are potential distortions and an inadequate focus on quality, performance and outcome issues in current funding arrangements. A commitment to moving towards output based funding is an important step in improving resource use efficiency and accountability.

Within core mental health services, government intends to move towards use of tailored population needs models, linked to guidance on cost-effective interventions, in order to drive greater achievement of health gain through strategic resource allocation across defined populations.

We also need to address the lack of connection between the funding for some of the different elements of treatment and care across the consumer pathway. Ultimately, we want to see a more integrated and transparent approach to the way funds are applied across all components of the service system, and a capacity for more flexibility in combined and cross-sectoral purchasing.

Individualised funding with greater availability of brokerage funds has a clear place for people with enduring care and support needs. Development of approaches that involve greater control of resources by an individual consumer (or a third party able to organise services for an individual) will depend on further advances in care coordination and stronger local networks of providers.

### 5.4 Particular components of the service system

#### 5.4.1 Mental health promotion

There is considerable mental health promotion activity in Victoria delivered across a multiplicity of sectors, settings and levels of government (including Department of Human Services regions and local government).

This includes the leadership efforts of the Victorian Health Promotion Foundation (VicHealth), integrated health promotion planned and delivered through Primary Care Partnerships involving many local community agencies, and the important mental health promotion work of statewide and national NGOs.

The Commonwealth Government provides an important leadership and funding role in a number of aspects of this work, such as *MindMatters* and *KidsMatter* schools' resources, and through the National Suicide Prevention Strategy.

Reform Area 1 details proposals that the government is considering to develop leadership and consolidate the mental health promotion workforce to create a stronger, more sustainable effort in this area. While this should be a core part of overall health promotion and public health programs, we also need to ensure closer partnership between mental health promotion workers and mental health professionals.

## 5.4.2 Specialist mental health care

### Public specialist mental health services

Victoria's specialist public mental health system is delivered by area mental health services (AMHS) under the governance of public health services. AMHS provide services ranging from acute and secure inpatient facilities to community-based residential or ambulatory services.

Public specialist mental health services will remain the cornerstone of quality mental health treatment, providing a first-rate acute mental health service response to people who are very unwell and have the most intense care needs.

In addition to the crucial business of stabilising people's mental health after an episode of illness, and providing clinical support for their recovery processes, there needs to be a rebalancing of the role of specialist services so that an early intervention focus – in life, illness or episode – is more central to their efforts. We also want specialist services to have the capacity to develop more in-depth expertise in a range of particular conditions, focusing at the more severe end of the spectrum.

There is a need to improve service continuity between public specialist mental health services and the other components of the broader system. We need to formalise links between the public specialist mental health, the psychosocial recovery and the primary health sectors, and to connect these as whole with other parts of the broader mental health system. Further detail is provided in Part Two (Reform Area 8).

### Private mental health specialists

The recent expansion of MBS items means that psychological therapies are now accessible using MBS rebates, via a GP or psychiatrist referral. This is a welcome addition to the range of treatment options. Private psychiatrists and psychologists, however, are unevenly distributed and are very scarce in rural areas.

This strategy aims to develop the scope for sharing roles between public and private providers and improving access to these services outside the metropolitan area. Stronger arrangements that support consistent quality and sharing of professional expertise across the public system and private hospitals that offer psychiatric care are also important.

### Psychiatric Disability Rehabilitation Support Services

The Psychiatric Disability Rehabilitation Support Services (PDRSS) sector operates under a broad recovery framework, adopting a whole-of-person approach and a model of care that stresses the importance of social factors in mental health and wellbeing. The sector is governed by NGOs and other community agencies and funded to deliver a range of community-based services.

We expect that over coming years this sector will consolidate its role and become a more equal partner with specialist clinical services in the overall system of mental health care, and a central part of the social inclusion thrust of reform. Over time, this will require capacity building and changes to staffing profiles. As a result of these changes and other factors, the name PDRSS may no longer be adequate – a new name emphasising psychosocial recovery might be more suitable.

The strategy signals the need for the PDRSS sector to be more closely coordinated with clinical services, without losing its distinctive approach. This will be assisted by joint planning, professional training and development, and shared management of some activities.

The sector will be supported and encouraged to build on the strength in its diversity and local focus, while working to become less fragmented and clearer about the scope of its activities. A sound evidence base should underpin effective psychosocial support and sector development.

The sector is well placed to play stronger roles in a wider range of rehabilitation and intermediate 'step-down' care (both bed based and outreach), and in care coordination for consumers needing sustained care and support. There are also opportunities for the PDRSS sector to be more active at the 'front end' of the care pathway, delivering early interventions that help avoid the need for acute services.

#### **Other community support services**

Under the *COAG National Action Plan on Mental Health 2006–2011*, the Commonwealth Government expanded its commitment to the provision of community mental health support services, complementing the expanded access to MBS items for mental health treatment. This focused on improved continuity of client care through initiatives such as Personal Helpers and Mentors, and Support for Day-to-day Living in the Community.

These services have been implemented through a wide range of NGOs in Victoria, including PDRSS. Over coming years, we would seek to ensure that these services are effectively integrated with other State or Commonwealth-funded programs, including psychosocial recovery, carer respite and more generic services such as Home and Community Care, to provide more effective holistic care to people with mental illness.

### **5.4.3 Primary health**

#### **General practice**

General practice is most often the first point of contact for people experiencing mental health problems. Indeed, a significant proportion of patient visits to a GP are for mental health related issues.

A number of recent Commonwealth initiatives have improved the capability of GPs to care for those with mental health problems. This includes the development of mental health care plans and referral patients for MBS-rebated psychological therapies (where private practitioners are available).

General practice will play an increasingly vital role in the early identification of emerging mental health problems, and in ongoing management of patients' mental illness.

Importantly, GPs often build relationships with families. With the right support they will be well placed to identify early signs of parenting difficulties or child behavioural problems that may lead to the emergence of mental health problems. The strong role GPs play in providing care to older people also means that they will be a core part of mental health responses for this group.

The emphasis in this strategy on improving the physical health of people with mental illness also underlines the importance of the GP's role in the overall health care of people with mental illness.

We want to see GPs widely recognised as a key access point to mental health services. With better understanding of the appropriate referral pathways, GPs can refer patients to community health counselling services, specialist clinical mental health services and psychosocial support services.

Furthermore, with better access to secondary consultation, care coordination and discharge planning support through Commonwealth-funded Mental Health Nurses, state-funded Primary Mental Health Teams, and from psychosocial support as well as clinical services, GPs can also provide continuity of mental health care, even for people at the severe end of the mental illness continuum (see Reform Area 4).

### Community health services

Community health services provide a range of general health services (including chronic disease management), and family, welfare and social work services targeted to disadvantaged people who may have difficulty accessing and/or paying for general practice and other services.

The accessibility of community health services, and the fact that they are already providing disadvantaged sections of the population with multiple services in one location, means they can be an important platform for a truly community-based mental health response.

Counsellors based in community health services support people to better manage life events that may affect their mental health and wellbeing, and are targeted to people with multiple and complex problems who do not necessarily have mental health problems that require specialist services.

Community health counselling services signpost clients to mental health and other health and social support services and are therefore an important 'entry point' to mental health care. As detailed in Reform Area 4 and elsewhere in the strategy, we want to see community health services consolidating their role in mental health by:

- providing a platform for counselling and psychological services aimed at people with moderate mental health problems and multiple social needs
- providing sites for co-location of mental health services with general health, drug and alcohol, dental health and other services
- being able to respond to the physical health and chronic disease management needs of people who also have mental health problems
- taking a key role in Primary Care Partnerships and other local planning and coordination partnerships.

#### 5.4.4 General hospital services

Public general hospitals play a vital role in providing physical health care to people with mental health problems both on general wards and in their emergency departments. This requires that they work more flexibly with people with mental health problems so that they receive the necessary monitoring, follow up and continuity of care.

We want general hospitals to be better equipped to identify mental health problems and link people with the right specialist mental health services, psychosocial supports, and with GPs. As part of better care coordination, general hospitals will be a vital element in the effort to improve the physical health of people with mental health problems.

The consultation and liaison function, addressing the mental health issues of patients in hospital for physical health problems, is a highly valued aspect of hospital inpatient care and should be further strengthened in conjunction with specialist mental health services.

We will continue to need a mental health response from emergency departments staffed by a workforce able to identify mental health and co-morbid problems, and treat and refer people appropriately. We also aim, however, to reduce the pressure on emergency departments through proposed early intervention strategies, better access to mental health services and a more effective response to people in urgent need (see Reform Area 3).



#### 5.4.5 Drug and alcohol treatment agencies

An estimated 30 per cent of people using alcohol and other drug (AOD) treatment services have received a mental health service. A greater percentage will present with symptoms of anxiety and depression. Approximately 45 per cent of those accessing adult mental health services have co-morbid mental health and drug and alcohol problems. The rates of co-morbidity are greater for those in police custody and other parts of the justice system. They are also higher in the Aboriginal population.

Victoria has a diverse AOD treatment sector, which is largely community-based and encompasses prevention, early intervention, harm reduction and a range of treatment services. These treatment services include counselling services, withdrawal, residential and community-based and a number of longer stay residential rehabilitation options.

The sector is funded by both the state and Commonwealth and offers services delivered through community health centres, hospitals and via NGOs, in addition to specialist statewide services.

The Victorian Dual Diagnosis Initiative supports the development of better treatment practices and collaborative relationships between mental health services and alcohol and drug services. We want to mainstream this approach to develop a service system where the capacity to respond to those with dual diagnosis is core business, whether the client first accesses a mental health or a drug and alcohol service. This is requiring the development of local networks, staff training, and access to consultation and shared care arrangements.

We are also in the process of equipping AOD services to respond effectively to the large proportion of their clients who have, or are at risk of, mild to moderate mental health problems, particularly anxiety and depression. Screening for such problems is now expected as a routine element of practice. This will enable earlier intervention where the presence of a co-morbid problem has been identified.

The role of AOD services is further detailed in Reform Areas 2 and 4.

#### 5.4.6 Early childhood and schools

Early childhood services and schools play an important role in promoting social and emotional wellbeing, and identifying and responding to emerging behavioural and mental health problems amongst children and young people. Maternal and child health nurses, early childhood education and care staff, teachers, and student welfare staff are critically important in recognising problems early and providing support to children, young people and their families.

We want to see a more integrated approach to prevention, early identification and intervention through our universal services. Building on existing programs, our aim is to better equip early childhood services and schools to systematically recognise and respond to social, emotional and behavioural problems in children, and emerging mental health problems in young people.

As set out in Reform Area 2, early childhood services will be better linked to a broad range of health and wellbeing supports and working arrangements for school-based student support programs reviewed to provide young people in schools with better access to the services they need, including child and youth mental health services.



### 5.4.7 Justice Health

The Department of Justice and Department of Human Services agreed to establish the Justice Health Unit in the Department of Justice, commencing operation in July 2007. The unit was established to improve the effectiveness of the delivery of health services and programs across the Justice system. Justice Health is responsible for the full range of health services, including mental health services, across courts, prisons, and community correctional services. It also leads health prevention and promotion activities, undertakes research, and provides guidance to health professionals and others working in the justice system.

Justice Health is leading the Victorian Justice Health Services Project on behalf of the Department of Justice. It is envisaged that this project will result in a single lead service provider to deliver, or coordinate the delivery of, the vast range of mental health and health services and programs within the justice system. This will facilitate the effective linking of health services within the justice system with mainstream mental health and health services, thus ensuring continuity of care for people in contact with the justice system, whether in the community or in custody (see Reform Area 4).

### 5.4.8 Aged care services

Victoria's ageing population presents significant challenges to aged care services including residential aged care services and, home and community care (HACC) services that support older people to live at home and access community resources. General practice is an important provider of physical and mental health services to older people, while specialist aged person's mental health teams provide community-based assessment, treatment, rehabilitation, case management and inpatient services.

There are acknowledged complications in identifying mental health problems that might be a consequence of ageing and physical health problems, of conditions such as dementia, as well as of social isolation and economic disadvantage.

Reform Area 4 details plans to better connect aged care services to mental health services by increasing the capacity of aged persons mental health specialists to offer in-reach into residential aged care facilities and secondary consultation to GPs.

HACC, residential aged care staff, and GPs should be equipped to identify mental illness, intervene early, manage and refer older people with mental health problems. Greater flexibility regarding age criteria in the transition between adult and older persons specialist mental health services will enable older people to continue to attend adult services, and people who prematurely experience age-related conditions to access aged services, where appropriate.

#### **5.4.9 Housing agencies**

The Department of Human Services is responsible for the delivery of housing assistance to low income Victorians via public housing, affordable rental housing managed by community agencies – including housing associations – crisis and transitional housing, and Neighbourhood Renewal. The department is also responsible for homelessness assistance and new forms of social housing related support services and community building initiatives.

Through better partnerships between mental health, public housing and housing associations we will plan for improved access to housing stock suitable for people with mental health problems, linked with suitable support.

This will continue to be underpinned by home-based outreach services, which provide tenancy assistance and tailored levels of rehabilitation support to people with severe mental illness in their homes. As outlined in Reform Area 5, there is a need to consider ways in which we can support people with mental illness in a wider range of housing situations, including private rental, supported residential service (SRS), social housing and rooming houses.

#### **5.4.10 Employment services**

Employment services are mainly delivered through the Commonwealth-funded Job Network, a national network of private and community organisations dedicated to finding jobs for unemployed people, particularly the long-term unemployed.

The Disability Employment Network (DEN) provides time-limited specialist assistance to job seekers with disabilities, including psychiatric disabilities, who require support to find and maintain employment.

As outlined in Reform Area 5, there is a need to make vocational training, education and employment a more central part of recovery and rehabilitation planning. The placement of specialist employment workers in mental health services and investment in ongoing support programs will improve workforce participation for people with mental health problems. Additionally, work needs to be done with employers to counter stigma and encourage them to employ people with a mental illness.

## Part two



## Reform Area 1: Promoting mental health and wellbeing

Preventing mental health problems by addressing risk and protective factors

<b>Goal 1.1</b>	Lead an organised and collaborative effort to promote positive mental health in targeted community settings
<b>Goal 1.2</b>	Promote a socially inclusive society to strengthen recognised protective factors for mental wellbeing
<b>Goal 1.3</b>	Renew Victoria's suicide prevention focus through a wide range of government programs
<b>Goal 1.4</b>	Reduce the risk factors for mental health problems associated with substance misuse

### Key outcomes:

- improved mental wellbeing and reduced levels of psychological distress
- reduced prevalence of anxiety, depression and other preventable disorders
- more inclusive communities, with increased levels of social and economic participation and improved acceptance of diversity
- reduced prevalence of risk factors relating to substance abuse and suicide

### Towards 2019

By 2019 we want Victoria to be recognised as a world leader in mental health promotion. The development of the Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders will pave the way for this reputation (see appendix 3).<sup>1</sup>

The Victorian Government is committed to:

- assisting Victorians to have a good understanding of the factors that affect mental health
- promoting supportive, social, economic and cultural environments that enable Victorians to help themselves, families and friends to maintain good mental health and wellbeing
- establishing mental health promotion as a core responsibility of the whole-of-government and a fundamental part of Victoria's overall approach to mental health
- developing a cohesive, focused and coordinated effort in close collaboration with key partners
- aligning mental health promotion with other chronic disease prevention initiatives to create an innovative and comprehensive approach to healthy living and healthy minds.

By 2019 we want to see measurable improvements in protective factors and reductions in risk factors for mental health in line with the goals for this section.

Victoria has a strong foundation in mental health promotion, including exemplary programs and research. VicHealth has played a leadership role in establishing the determinants of mental health. We want to see this role sustained and translated into practical guidance for wide implementation across relevant sectors, as well as support for further innovation.

1. The Charter was being developed out of the 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders held in Melbourne in September 2008. The Charter outlines the principles for best practice in promoting mental health and preventing mental illness, and sets out the actions that both decision-makers and people working in mental health promotion can take to advance mental health outcomes.



There is a range of other resources and initiatives across government and non-government organisations which are driving mental health promotion action, such as mental health promotion officers based in child and adolescent mental health services, Primary Care Partnerships and community health services. We want to see these resources joined in a cohesive effort to tackle priority mental health promotion goals.

### Reform directions

Many of the mental health problems that contribute the most to burden of disease – particularly depression and anxiety – can be influenced through effective prevention activity to reduce risk factors and build protective factors. In addition, mental and physical health are interdependent and an expanded and focused effort on mental health can therefore contribute to better health outcomes overall.

While the causes of psychotic illness are not fully understood, there is emerging evidence that points to the association between prevalence of psychotic illness and social environments. Factors such as minority status, social isolation and urban stressors appear to be implicated in the increasing incidence of these conditions in certain areas. This adds to arguments for prevention strategies based on social inclusion.

As shown by the work of the World Health Organisation and by VicHealth, there is growing evidence about the kind of interventions that can be effective in particular settings. This evidence supports organised programs based on positive concepts like resilience, focus on multiple risk and protective factors, peer and family engagement, good follow up and integration with mainstream health promotion and community support.

Success in other population health issues (such as tobacco consumption and road safety) shows us that visionary leadership, sustained investment, clear outcomes and coordination of effort across multiple sectors, settings and levels of government are vital to effective prevention.

At statewide level, an informal partnership group will be set up to foster leadership and collaboration on mental health promotion and prevention. This will help align effort across sectors to achieve the commonly agreed outcomes.

The group will bring together government departments and agencies involved in funding and delivering mental health promotion. This would be expected to include the Department of Human Services, the Department of Education and Early Childhood Development, the Department of Planning and Community Development, as well as VicHealth, the McCaughey Centre for the Promotion of Mental Health and Community Wellbeing, beyondblue and other bodies making broad contributions in this area.

### Goal 1.1 Lead an organised and collaborative effort to promote positive mental health in targeted community settings

A planned and proactive cross-sectoral approach to achieve greater population coverage in mental health promotion should be based in the everyday environments where people live, work and learn. In the short to medium term we want to see an expansion of initiatives that have developed innovative approaches but are currently limited in reach.

#### Schools and early childhood settings

Childhood and youth is a critical time for laying the foundation for mental health, as 75 per cent of mental illnesses manifest before the age of 25. Good quality mental health promotion programs throughout early childhood (0–8), middle years (8–16) and youth transitions (16+) can contribute to positive emotional development.

Schools and early childhood settings play an important role in influencing mental wellbeing. The principle underlying effective mental health promotion in these settings is that programs need to operate at a number of levels, including social and emotional learning for children and young people, skills development for the workforce, support for parents, and positive school and early childhood environments.

In Victoria there are some excellent examples currently in operation of innovative individual programs addressing different issues. Examples of programs relevant to positive mental health include school-based respectful relationships programs and policies for anti-bullying and acceptance of diversity.

Government is keen to explore how an overarching ‘mental health promoting schools and early childhood settings’ framework could bring this work together into a more cohesive effort and deliver a consistent mental health promoting approach across schools and early childhood settings. It would complement healthy eating, physical activity, sexual health and drug education programs, to strengthen a healthy living and healthy minds approach.

Initially, an assessment of the current extent, reach and capacity of relevant programs would be undertaken to determine where there are gaps, and where there are opportunities to expand successful approaches.

From this, the initiative would bring together action in a coherent framework to promote positive mental health. Important elements could include supporting children and young people to recognise and understand what influences mental wellbeing, building the skills needed for individual resilience and self-help, and assisting schools and early childhood settings to develop positive and safe environments.

Action to promote positive environments through acceptance of diversity and inclusiveness are critical to building self-esteem and confidence. These in turn are important protective factors for positive body image and will complement the eating disorders work in Reform Area 2.

The initiative would support and build on national programs, including *MindMatters*, *KidsMatter* and professional learning in relation to social and emotional competencies.

Importantly, a consistent framework for schools and early childhood settings about how to promote mental health would enable them to assess the appropriateness of the local uptake of specific initiatives (such as the Royal Children’s Hospital’s Festival for Healthy Living program).

The new *Early years learning and development framework* and early childhood workforce strategy, a part of the Blueprint for Education and Early Childhood Development, will support mental health promotion. In early childhood settings, guidelines and professional development resources and training will be developed to provide early childhood education and care workers with the skills required to build the competencies to support and enhance children's wellbeing and development.

At a regional level, we want to see mental health promotion officers work to support these initiatives and connect them to other prevention activities. These initiatives would also be linked with the local mental health promotion activities being undertaken by Primary Care Partnerships and community health services.

### **Workplaces**

Workplaces have an important role in promoting employee mental health and wellbeing, as well as reducing risk factors for poor mental health. Workplaces can also have a powerful influence on protective factors through modelling equitable, respectful relationships and acceptance of diversity.

Workplace stress is a growing concern, with the number of stress-related claims almost doubling between 1996 and 2004.<sup>63</sup> WorkSafe Victoria has piloted stress prevention programs in the public sector and additional models involving beyondblue and the McCaughey Centre are being trialled.

We want to encourage and support evidence-based workplace programs to promote positive mental health and wellbeing for delivery across the public and private sectors, building individual capacity and skill development as well as tackling stressors in the work environment. This could involve working with partners such as beyondblue and the McCaughey Centre and build on WorkSafe Victoria initiatives such as stress prevention programs and the newly established WorkHealth program.

### **Other community settings**

In the medium to longer term we will explore mental health promotion approaches through other settings and organisations such as sporting and recreational clubs, post-secondary school settings, the arts, emerging information and communication technology settings and the online environment.

We will also consider how programs to promote mental wellbeing can be integrated with programs that focus on physical health and wellbeing for older people and carers. To support this, mental health would be more explicitly built into policy frameworks for positive ageing to support older people in communities.

We want to see a core set of evidence-based resources developed for people working in mental health promotion, including a catalogue of interventions that represent best practice in addressing risk and protective factors and determinants. VicHealth will continue to be a key resource for innovation and best practice advice in relation to what works best in mental health promotion.



### Goal 1.2 Promote a socially inclusive society to strengthen recognised protective factors for mental wellbeing

Research shows that people's mental health can be significantly affected by the extent to which they are included in society and connected to others. Whether people work, have housing, can utilise basic services, and have friends, family and other social supports can influence their mental health and wellbeing. Factors that have been shown to negatively influence mental health include violence, discrimination, poverty and homelessness.

Action to address this area needs to occur through a broad range of programs. It is as much about building an understanding of mental health impacts into non-health programs as it is about specific mental health promotion initiatives. This should include a statewide strategic effort to strengthen protective factors, support for local interventions, the consolidation of resources at a regional level, and workforce training.

At a statewide level, we will contribute to the development and implementation of policies and programs that advance social inclusion factors linked to mental health. The focus will be on tackling discrimination, prevention of violence against women and children, homelessness, joblessness, refugee settlement and building community resilience broadly.

Victoria's policies and programs in this area include *A Fairer Victoria*, the *Charter of Human Rights and Responsibilities*, the Victorian family violence reforms, the *Victorian Indigenous Affairs Framework* and the *Refugee Health and Wellbeing Action Plan*. We want to develop a more explicit emphasis on mental health in the outcomes measures of any new policies and programs.

This action will complement the specific initiatives included in Reform Area 6 related to Aboriginal people, people with a mental illness and co-existing disability, and people from culturally and linguistically diverse backgrounds, including refugees. An understanding of the gender and life stage differences across these population groups will also inform effective initiatives.

At a regional and local level, we will support interventions that facilitate workforce participation, social participation, anti-discrimination, violence prevention and build community resilience in recognition of the significant contribution these make to mental wellbeing at an individual and societal level.

Priority action areas include:

- enhancing the ability of Primary Care Partnerships and community health agencies to deliver interventions through better evidence and evaluation support, and sharing of practice across the system
- supporting local governments through Municipal Public Health Planning to influence local environments and community engagement processes
- supporting local initiatives that have demonstrated positive impacts on protective factors for mental health, such as Neighbourhood Renewal and Community Renewal, and develop further mental health promotion activities in these initiatives
- developing and using shared outcomes and indicators to drive a coordinated mental health promotion effort across government.



We want to see prevention staff, including mental health promotion officers, supported to work together to combine expertise, align prevention initiatives and undertake coordinated planning and priority setting at the regional level. This recognises that efforts to promote mental health can benefit physical health and similarly that prevention programs for chronic disease can improve mental health. It will also assist in forging links, partnerships and alliances across settings, organisations and communities.

In the longer term we will continue to develop expertise and capacity of the workforce in the health, community, education and other sectors to use evidence in designing and implementing mental health promotion. We want to build on the now well-tested Mental Health Promotion Short Course to create locally – and, where appropriate, culturally-relevant applied skills training related to interventions.

We also want to see further research conducted to increase knowledge, continued trialling of innovative interventions, and evaluation of existing programs, so we can better understand what works, and for whom, and apply this to local settings and communities.

### **Goal 1.3 Renew Victoria's suicide prevention focus through a wide range of government programs**

There is a continued need to strengthen our focus on suicide prevention. While the 2006 Australian Bureau of Statistics' data on suicide deaths display a continuing overall decline in suicides since its peak in 1997, there are certain high risk groups and geographical areas where the decline is less apparent.

Indigenous Australians, people living in rural and remote areas, people who have previously attempted suicide or engaged in self-harm and men are of particular concern. There is also a continuing need to be able to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention.

The mental health promotion strategies to strengthen resilience and social inclusion as outlined in Goals 1.1 and 1.2 will be an essential part of addressing some of the risk factors for suicide.

In addition, action in this area will include renewing our suicide prevention plan, continuing interventions focusing on at risk groups, and strengthening pathways between services.

We will renew our suicide prevention plan, *Next Steps: Victoria's suicide prevention action plan*, using a new framework released as part of the National Suicide Prevention Strategy. The *Living Is For Everyone* (LIFE) framework (2008) provides a revised national platform for the planning and provision of activities aimed at suicide and self harm prevention in Australia. This framework encourages the use of evidence-based approaches, building resilience at the individual and community level and improving evaluation criteria and methodology.

We will expand our knowledge of best practice in suicide prevention interventions, particularly for at-risk groups such as Aboriginal people, people who live in rural and remote communities, older men and same sex-attracted youth.

We want to increase the understanding of individuals and communities to recognise and respond to early warning signs, risk factors and tipping points for suicide. This includes building the capacity of schools, workplaces, and local communities to identify quickly and rapidly develop effective prevention strategies when patterns emerge. We also want to increase the understanding of those who work in the mental health sector, general practice, and the alcohol and drug sector to identify and respond to warning signs, including the development of assessment tools.

In the longer term, work will be required to strengthen the pathways between clinical services and support services – including the police, emergency departments and telephone counselling services – for individuals who attempt suicide or self harm, and their families. We need to improve arrangements to enable those involved in early response to input into suicide prevention planning.

### **Goal 1.4 Reduce the risk factors for mental health problems associated with substance misuse**

Substance misuse is a significant risk factor for mental health problems. For example, recent research suggests that 80–90 per cent of dependent amphetamine type substances users are concerned about some aspect of their mental health, most commonly depression.<sup>64</sup> Substance misuse also has an impact on mental health protective factors such as freedom from violence, the positive functioning of families, and is linked to suicide. There are common risk factors for both poor mental health and substance abuse, which should be tackled together.

We will develop a new collaborative and coordinated approach to preventing substance misuse and consequently promoting good mental health and wellbeing. Key elements of the approach may include community awareness campaigns, linking drug education and mental health promotion in schools, encouragement of workplace programs which target higher risk groups, and joint approaches to substance use prevention and mental health promotion in sports programs. This work will be informed by the Victorian Drug and Alcohol Prevention Council.

In the short to medium term we will conduct community awareness campaigns to highlight the risks to mental health associated with alcohol and other drug use. There are three specific priorities:

- An alcohol awareness campaign, targeting young people about the dangers of binge drinking and its harmful consequences on mental, physical and social health.
- A mental health and cannabis use campaign highlighting the links and dangers for mental health associated with cannabis use.
- Consideration of targeted awareness campaigns and other key actions for prevention, early intervention, treatment, workforce development and law enforcement through a whole-of-government Amphetamine Type Substances Strategy.

Over the longer term our efforts will broaden to include education and raising awareness through a range of media.

The proposed ‘mental health promoting schools’ framework referred to in Goal 1.1 would build on existing well-established drug education programs both in terms of increasing the skills of students, teachers and parents, and acting to promote healthy and safe environments. Any future school resource development would be encouraged to include activities that help increase students’ awareness of the risks associated with poor mental health, particularly in relation to cannabis use.

Prevention activities in the workplace referred to in Goal 1.1 would be encouraged to include a focus on key occupational groups, such as shift workers in hospitality, transport and entertainment industries, that are at higher risk than others for developing mental health and substance abuse-related issues.

We want to build on existing screening tools to support alcohol and drug workers to assess the mental health status of clients and intervene to prevent and address the high prevalence of depression and anxiety.

We also want to explore the potential to extend programs focused on problematic substance use to promote good mental health. For example, the Australian Drug Foundation's Good Sport Program, which provides a good basis for a broader healthy minds and responsible alcohol use program.

Building on successful web sites that provide information on substance misuse and healthy minds (such as the Somazone program, initiated by the Victorian Government and now run by the Australian Drug Foundation), we want to support the development of online self help tools to allow people to get help for their problems and to reduce the risk of substance abuse and mental health problems. The use of new technologies has the potential to reach a broad range of people who can access information and self help in their own timeframe and according to their needs.

### Key strategy proposals

Actions to be considered over the life of the strategy include:

- Bringing together a flagship 'mental health promoting schools and early childhood settings' action framework to build resilience and protective factors, and complement healthy eating, physical activity and drug education to create a healthy living and healthy minds approach.
- Supporting evidence-based workplace programs to promote positive mental health and wellbeing, for delivery across the public and private sectors. These would focus on building coping skills and organisational ability to deal with stressors in the work environment.
- Contributing to social inclusion policies and programs including those addressing discrimination, family violence, homelessness and joblessness, via local government, Primary Care Partnerships, and Neighbourhood and Community Renewal.
- Renewing our suicide prevention plan, *Next steps: Victoria's suicide prevention action plan*, using the new national framework to strengthen our ability to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention.
- Developing education and awareness campaigns and planning ongoing efforts through a range of media to highlight the risks to mental health associated with problematic alcohol and drug use, especially binge drinking, cannabis and amphetamine use.
- Developing the expertise and capacity of relevant workforces to use evidence in designing and implementing mental health promotion. Developing a catalogue of interventions that represent best practice in addressing risk and protective factors and determinants. Building on the Mental Health Promotion Short Course to create locally relevant applied skills training related to interventions.

## Reform Area 2: Early in life

Helping children, adolescents, young people (0–25) and their families

<b>Goal 2.1</b>	Strengthen early identification and intervention through universal services, including early childhood services, primary health care and educational settings
<b>Goal 2.2</b>	Provide earlier and age-appropriate treatment and care for children, adolescents and young adults with emerging or existing mental health problems and their families
<b>Goal 2.3</b>	Deliver targeted mental health support for particular groups of highly vulnerable young people
<b>Goal 2.4</b>	Build stronger, more resilient families where there is risk related to mental health and drug and alcohol problems

### Key outcomes:

- reduced prevalence of mental illness in the community
- reduced rate of severe, moderate and mild psychiatric disability
- reduced prevalence and severity of eating disorders
- increased participation of young people with mental health problems in education and training
- improved health and wellbeing of dependent children who have a parent with a mental illness
- reduced incidence of family breakdown and relationship breakdown
- reduced substance use, unemployment, homelessness and involvement with criminal justice system (as victims or offenders)

### Towards 2019

By 2019 we want to see a larger proportion of children and young people, with a broader range of problems and disorders, receiving help. This will involve local early intervention responses and timely intensive treatment for those with more severe and complex problems.

We want to see children and young people with emerging mental health and drug and alcohol problems identified and receiving help earlier. We want to see a greater focus on assisting those with more enduring problems and disorders to continue their education, take up employment and remain well connected to their families and communities. This will contribute to longer term positive life outcomes.

We want to see young people with mental health concerns accessing help in youth-friendly settings equipped to respond to a range of health and social issues. At school, they will have access to health and welfare professionals with capacity to identify emerging mental health problems and provide frontline and follow-up support in partnership with specialist mental health services.

The organisation of treatment for psychosis and other serious conditions should reflect the need to intervene at an earlier stage of illness for better long-term individual and social outcomes.

Specialist mental health services need to have capacity to address both the problems that affect infants and children, and those that specifically affect adolescents and young people. This would be best facilitated through dedicated service streams planned and managed within a broad 0–25 years framework.

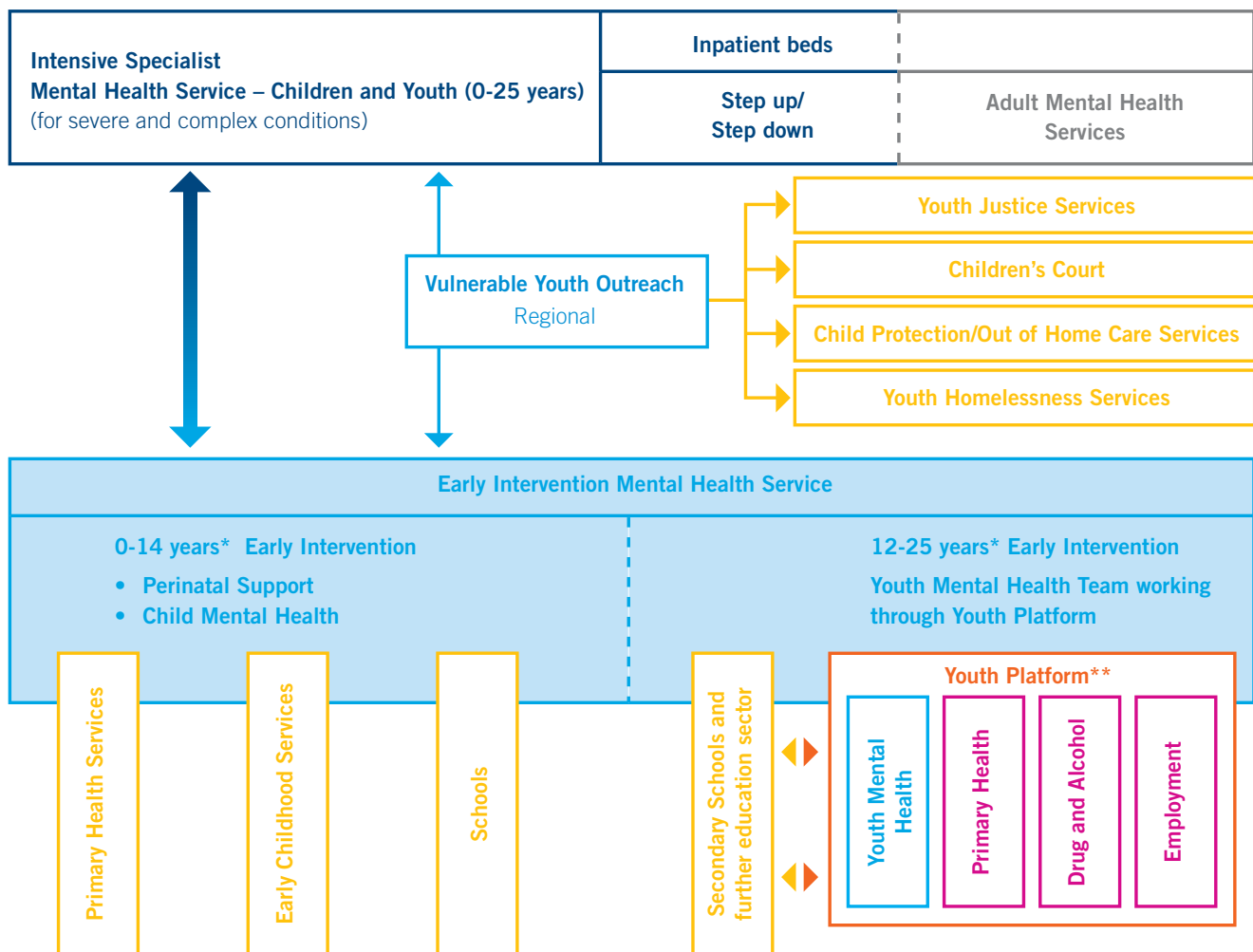
We also want to see those highly vulnerable young people involved with child protection, out of home care, the Children's Court, youth justice, or who are homeless receiving a better care response through flexible outreach provided via services they use and trust.

The strategy recognises the central role of families and carers in the lives of children and young people. Parents and carers will play a more central role in care planning and their needs for information and support will be better met. The changing roles of families as children and young people grow and develop will be better recognised and reflected in treatment and recovery approaches.

The particular needs of children and young people who have a parent with a mental illness will also be addressed.

To achieve this vision, we will work towards a significant redevelopment of services within a 0–25 framework that emphasises continuity of care and fosters age appropriate responses for children and young people. This broader system of care will retain intensive specialist mental health services while developing community-based early intervention services built on partnerships between mental health services and a range of local community services.

Figure 12: A new area-based service configuration: Child and Youth Mental Health Services (CYMHS)



\* The overlap in age between child and youth early intervention services recognises the need for flexibility in deciding the most appropriate service response for the 12-14 group.

\*\* This could be a headspace site or a similar collaboration between state and Commonwealth-funded services.

## Reform directions

### Goal 2.1 Strengthen early identification and intervention through universal services, including early childhood services, primary health care and educational settings

Childhood, adolescence and young adulthood, are critical periods of development, involving many changes and challenges. We recognise that children and young people may need specific types of support as they navigate a range of critical life transitions such as entry to kindergarten, entry to primary and secondary school, and school leaving. These important transition points provide opportunities where children and young people can be better supported, and those with emerging problems provided with the help they need so problems do not escalate.

Universal services, including maternity and early childhood services, schools and primary health services, have a critical role to play in the early identification and response to social, emotional and behavioural problems in children, and in emerging mental health problems in young people, including drug and alcohol use. They should be well equipped to systematically recognise and respond to these issues in the following groups:

- expectant mothers (including perinatal support)
- infants and young children
- parents
- school aged children and adolescents
- older adolescents and young adults.

#### Perinatal support

Perinatal support and care services will be strengthened to enhance early identification of mothers and expectant mothers who are experiencing distress, depression, anxiety or other mental health problems. Enhanced training in identifying mental health problems will be provided to the spectrum of care providers working with new mothers. These include midwives, maternal and child health nurses, general practitioners, nurses and Indigenous health workers. Pathways for referral will be developed so that women identified as being at risk of depression or other mental health problems will have access to appropriate services.

The first stage of strategy implementation will involve a comprehensive approach to identification of and response to mental health problems among pregnant women and mothers, as part of a new national program focusing on pre and post-natal depression.

#### Early childhood settings and schools

Under the reforms being considered, children and young people with social, emotional and behavioural problems, developmental and language disorders (including Autism Spectrum Disorder), and mental health problems such as anxiety and depression, would be identified earlier. These children and young people would be able to access appropriate services in a timely way, supported by a comprehensive and coordinated system of professionals.

Young children experiencing difficulties with social and emotional development should be supported through earlier intervention within a range of services regularly used by their families. These include maternal and child health services, child care settings and kindergartens, and primary health services. Stronger partnerships and direct links between targeted early intervention and specialist mental health services, early childhood services, primary health services and paediatricians are important to promote appropriate support to young children and their families.







Better education and support for parents of a child or adolescent displaying behavioural, social or emotional difficulties is central to effective early intervention. We want to see parent education, advice and support provided from a range of community settings, and follow up programs for parents requiring additional skills and strategies to respond to their children's behaviour. Programs would offer practical advice, peer support and coaching to equip parents to manage a child or adolescent's behavioural or mental health concern.

We will work to better equip early childhood services and schools to identify and support children with social, emotional and behavioural difficulties, and adolescents with emerging mental health problems. We want to see the development of shared training and professional development opportunities across the education, health and mental health sectors. We want to see the development of resources and training for early childhood and school teaching and support staff in basic detection and management of child and adolescent mental health concerns.

We will build on our achievements and experience in establishing CAMHS and Schools Early Action (CASEA) programs, which identify and treat children with developing disruptive disorders.

School Student Wellbeing staff including student support services officers (SSSOs) school psychologists and social workers, primary welfare officers, student wellbeing coordinators, and school nurses will play a greater role in identifying and responding to child and adolescent mental health issues. They will support schools to deliver appropriate interventions and arrange for individual children and young people and their families to receive ongoing support and longer-term follow up when it is needed. SSSOs will also work in partnership with child and youth mental health services. Partnership will involve joint assessment, joint care planning and management. Referrals to the most appropriate services and levels of care will be undertaken.

In each region, designated SSSOs will provide leadership and the primary link to child and youth mental health services. Opportunities for joint training, regional and local service planning, and collaborative practices between child and youth mental health services and the SSSO workforce will be pursued.

#### **Improving outcomes for Aboriginal children, young people and their families**

In all the above directions, we want to see due attention paid to the specific issues faced by Aboriginal children, young people and their families. Consideration will also be given to integrated prevention, early identification and intervention strategies specifically for Aboriginal children and young people, using culturally sensitive approaches to build resilience and promote protective factors (see Reform Area 6).

### **Goal 2.2 Provide earlier and age-appropriate treatment and care to children, adolescents and young adults with emerging or existing mental health problems and their families**

Children and young people experiencing a range of social, emotional, behavioural and mental health problems will receive more effective and consistent support and treatment.

Flexible, age appropriate, recovery-focused services will be provided in a range of settings (see Figure 12). Families will be involved in care planning and management. The new child and youth focus in mental health services will extend the upper age from 18 to 25. A broad 0–25 service framework will allow better follow through and facilitate balanced capacity to support children's and youth services.



A partnership approach will be developed in working with children and young people across a range of services, including maternity and early childhood services; primary health services; schools; child and family support services; the youth, sport and recreation sector; and vocational services.

We want to pursue new ways to deliver effective early intervention for children aged 0–14 years, through early childhood services and schools. We will also work towards establishing a network of new youth hubs for young people aged 12–25, building on the success of innovative youth services, including Jigsaw Youth Health Services, Orygen Youth Health (including the Early Psychosis Prevention and Intervention Centre) and headspace.

We are currently seeding reform in this area by funding the child and youth redesign demonstration projects. These will help us understand how service developments might best be undertaken to assist in the implementation of our child and youth reforms over the coming years. Commencing in 2008–09, this first stage of strategy implementation will focus on improving outcomes for children and young people aged 0–25 through the reform, expansion and better integration of mental health services funded by state, Commonwealth and local government.

#### **New early intervention mental health response for children**

Evidence on the importance of brain development and socialisation in early childhood, particularly the first three years, will inform our approach to early support for children experiencing social and emotional difficulties.

We will work towards the establishment of a more clearly focused early intervention mental health response, delivered through local services attended by children and their families. This will be backed up by specialist mental health expertise as required.

Drawing on elements of existing child and adolescent mental health service (CAMHS) resources, this new approach would involve working through primary health services, early childhood services and schools to deliver more timely assessment of children with social and emotional difficulties, including conduct and behavioural disorders, Autism Spectrum Disorder, anxiety, phobias and depressive disorders. Primary health services, early childhood services and schools would have access to specialist advice on management of identified problems, referral and treatment. Sub-regional mental health teams working in community locations would provide secondary consultation, training, and in-reach collaborative care.

#### **New youth early intervention platforms**

Over 75 per cent of mental illness and substance use disorders commence before the age of 25, yet it is estimated that only one out of every four young people experiencing mental health problems receives professional help. Young people often find it difficult to seek help for a range of different reasons, including feeling embarrassed, alienated or worried about confidentiality. We recognise the importance of creating services that are accessible, engaging and non-threatening for young people seeking help and support.

In the medium term we will work towards developing a network of youth service hubs for young people aged 12–25 years, with emerging, moderate and more severe mental health problems. Through this model, young people would be able to access a range of services and supports in a welcoming environment encompassing general health, mental health, drug and alcohol issues, housing, employment and education.

The youth hubs would initially build on headspace sites or similar collaboration between the Victorian Government and the Commonwealth, and will be integrated into a broader system response for 12–25 year olds, with clear links to public specialist mental health services (see below). Youth hubs would take a shared-care approach, drawing on a network of MBS practitioners and state-funded mental health programs.



This approach builds on Victoria's success in providing innovative services for youth, including the Early Psychosis Prevention and Intervention Centre, Orygen Youth Health, and Jigsaw Youth Health Services.

### **Child and youth specialist services**

Our mental health system should be designed so that children and young people experiencing severe and complex problems and disorders that require treatment in acute services receive age-appropriate tailored responses from infancy through childhood to adolescence and young adulthood. To achieve this we aim to progressively redevelop intensive specialist mental health services, staffed by clinical teams drawing on the expertise and resources of current CAMHS and adult services, and augmented where possible by sessional paediatricians and specialists in adolescent medicine. New streamlined models of care will be encouraged, and consumers and carers of different ages will be involved in service planning and evaluation.

As part of this redevelopment, we will encourage more systematic approaches to the assessment and/or treatment of children experiencing complex social, emotional, behavioural and developmental problems, including those with Autism Spectrum Disorder and concurrent mental health problems and disorders, will be encouraged. This should be based on children and young people receiving ongoing care and support from existing locally-based services including primary health and early intervention services (as proposed above) through more effective shared care arrangements.

In accordance with local and international evidence on effective early treatment, we will pursue best practice models of care, building on the experience and resources in the Youth Early Psychosis Services. This should include youth-specific responses across intake, crisis, community, inpatient and residential care. Permeable and negotiable transition points between youth specific services and the adult system will be incorporated into this new approach (see also to governance changes outlined in Reform Area 8).

We want to see strengthened youth dual diagnosis responses within and between mental health and alcohol and other drug services, including delivering better integrated community and bed-based treatment responses.

Models of care for young people will also be expected to integrate clinical and psychosocial dimensions of support, better linking treatment with psychiatric disability and support services. Supporting young people to continue in, or reconnect with, education and employment and to access stable housing, should be seen as critical components of all youth mental health responses.

### **Systemic response for young people with eating disorders**

Eating disorders are associated with depression and anxiety, drug and alcohol problems, chronic physical illness, and higher mortality through physical health complications and suicide.

We want to see young people and their families receiving more accessible, responsive and effective treatment and support, particularly in the early stages of illness. It is also important that they are confident that their level of care can be rapidly escalated if required.

We will develop a statewide framework with a systematic hierarchy of treatment responses, including strengthened prevention and early intervention approaches, and intensive specialist mental health services and acute medical services for those with more severe and complex problems. This approach builds on the recommendations of the *Eating Disorder Mapping Project* and the *Linking together: Treatment of eating disorders in Victoria* report from the Ministerial Advisory Committee on Mental Health.

The framework will emphasise the importance of coordinated, multidisciplinary responses to eating disorders from primary, acute and longer term support services. It will acknowledge the importance of an integrated focus on both physical and mental health at each treatment stage.

Under this framework and the potential reforms outlined earlier in this section, local primary health services would be supported by child and youth mental health services in identifying young people with eating disorders, and in the management of care planning and care coordination.

Local child and youth mental health services would collaborate with regionally-based multidisciplinary teams, including paediatric, medical and dietetic services, to provide specialist eating disorder expertise to enable children and young people to be better supported in the community. Young people with eating disorders and their families would be assisted to access regional or cross-regional community day programs, family interventions, and recovery services.

To complement these arrangements, we are keen to explore the potential for a consolidated centralised statewide program to provide specialised secondary consultation, and coordinate specialist inpatient treatment services linked to comprehensive community-based recovery and support.

Using this new service arrangement, best practice treatments and innovative treatment models could be more effectively researched and promoted. The statewide program would work in partnership with the Centre for Excellence in Eating Disorders (CEED) and other eating disorder organisations to provide a base for collaborative research.

Ongoing mental health promotion initiatives which increase the protective factors and reduce the risk factors related to poor body image (see Reform Area 1) would complement this approach.

It is widely acknowledged that the onset of eating disorders usually occurs in late childhood and early adolescence; however the chronic and enduring nature of eating disorders means that problems often extend into adulthood. Under the framework, capacity and expertise in the treatment of adult eating disorders will be built into regional specialist eating disorder services to support area mental health services to provide ongoing recovery-based treatment and care and meet the needs of adults experiencing ongoing eating disorders.

The first stage of strategy implementation commences in 2008–09 through boosting paediatric eating disorder services at the Royal Children's Hospital, Southern Health and Austin Health.

### **Support to families of children and young adults with emerging and existing mental health problems**

We want to see the promotion of family-focused interventions as central to service provision. Services will provide timely and accessible information and education to families and carers about different types of mental health problems. Families and carers will be involved and engaged in treatment and recovery planning.

We will work towards the systematic development of a range of supports for parents, carers and siblings in recognition of the impact of mental health problems on families more broadly. Appropriate linkages to respite and counselling services can greatly assist in supporting the wellbeing of carers and families.

Consumer and carer participation models will be redeveloped. We will strengthen mechanisms for the involvement of young people, family members, and carers in broader service design and evaluation so that programs and services are better aligned with their needs.

New arrangements will reflect the changing roles and needs of families and carers in the lives of children and young people as they grow and develop.

### **Goal 2.3 Deliver targeted mental health support for particular groups of highly vulnerable young people**

Some children and young people face extremely difficult challenges that impact on their mental health. Deeply distressing experiences of family violence, sexual abuse, and trauma are risk factors associated with the development of mental health problems. Young people who are homeless, involved with child protection, the Children's Court, out-of-home care or youth justice are at a far greater risk of experiencing mental health and substance abuse problems.

Highly vulnerable young people who are living with untreated mental health problems are particularly at risk of self-harm and suicide. Their lives are often unstable and chaotic; they can experience low levels of trust, making it difficult for them to access appointment-based services in clinical environments. Their difficulties lead to poor engagement with school, often progressing to disengagement. Addressing the needs of these highly vulnerable young people as quickly as possible is critical.

To address these issues, we will review how mental health and related services to these groups could be consolidated and enhanced, building on the success of Intensive Mobile Youth Outreach Services and the Take Two Intensive Therapeutic Service. The intention would be to focus capacity to deal with the impacts of trauma and abuse, while facilitating clear referral pathways for highly vulnerable young people in need of intensive treatment and support by specialist mental health services. Regional coordination to plan the deployment of workers and facilitate information sharing in relation to common clients would also be important.

We want to see young people who are at risk of, or experiencing homelessness, and who have mental health and drug and alcohol problems receiving a better care response from both clinical and psychological support services in collaboration with youth transition hubs established under the *Youth Homelessness Action Plan*.

### **Goal 2.4 Build stronger, more resilient families where there is risk related to mental health and drug and alcohol problems**

Around 17,000 children and young people have a parent with a severe mental illness who is registered as a Victorian public mental health patient. Children of parents with a mental illness are at greater risk of experiencing a mental health problem later in life; however, there is good evidence that early intervention programs can reduce risks. Alleviating stress related to parenting can reduce pressure on families and promote recovery. Providing parenting support for parents with a mental illness and/or substance abuse problem can help build resilience and protective factors in children.

The first stage of strategy implementation commencing in 2008–09 will see the expansion and broadening of the *Families where a Parent has a Mental Illness* initiative to include parents with a drug and alcohol problems and delivery of support in partnership with Child FIRST sites.

We will work towards greater availability of intensive family support services to families where children have spent time in care. Intensive parental engagement and support can enhance the capacity of parents to safely care for and meet the developmental needs of their children, and facilitate the reunification of children when children are placed in out of home care. This could involve providing intensive supports to families where children have spent time in care and greater use of therapeutic and professional services which address the range of emotional needs and problematic, high risk behaviours of abused and 'at risk' children and young people.

Family therapeutic interventions delivered under the *Victoria's Alcohol Action Plan*, will provide assessment, specialist family-based counselling, group work and ongoing case management to young people and their families. This will improve engagement in alcohol treatment, family functioning and long term health and well being outcomes.

### Key strategy proposals

Action to be considered over the life of the strategy includes:

- Delivering more accessible, earlier intervention for children and young people by redeveloping services within a 0–25 years framework that improves continuity of care, fosters age appropriate responses for children and young people, and builds partnerships with primary health, early childhood services, schools and a range of community services.
- Organising and improving skills in the school health and welfare workforce, particularly school student support officers, to confidently promote mental wellbeing, identify emerging mental health problems, facilitate access to more specialist intervention where required and provide follow-up support.
- Providing easily accessible help for young people (12–25 years) with emerging moderate or severe mental health conditions through a network of youth service hubs, co-located with general health, drug treatment and youth support services (working with Commonwealth-supported headspace sites wherever possible).
- Building on Youth Early Psychosis Services within the youth stream of the reconfigured 0–25 years service to further develop early intervention in accordance with international best practice pioneered in Victoria and elsewhere.
- Establishing a statewide framework for consistent specialist care for young people with eating disorders. This would work towards better provision of locally coordinated treatment and care, with back-up from regional resources and statewide expertise, and access to inpatient care if required
- Providing tailored, flexible services to highly vulnerable young people who have experienced significant abuse and trauma – especially those involved with youth justice, the Children's Court, child protection and youth homelessness services.
- Proactively supporting families where mental health problems may be damaging family relationships and putting children at risk. This will connect mental health and alcohol and drug treatment services with Child FIRST sites so that family support interventions are provided when required.





## Reform Area 3: Pathways to care

### Streamlining access and emergency responses

<b>Goal 3.1</b>	Provide access to 'right time, right place' mental health care through better mental health information and streamlined referral pathways
<b>Goal 3.2</b>	Promote primary health services as a key access point for mental health care and referral
<b>Goal 3.3</b>	Improve the efficiency and responsiveness of psychiatric triage in specialist public mental health services
<b>Goal 3.4</b>	Build a robust, integrated emergency service system to respond effectively to people in urgent need

#### Key outcomes:

- increased proportion of people with emerging or established mental health problems who receive mental health care
- reduced proportion of people with a mental illness experiencing a psychiatric crisis
- reduced wait times in emergency departments for people who need admission to an acute inpatient bed
- reduced rate of suicide associated with mental illness

### Towards 2019

By 2019 we want to see wider, more accessible and easier to navigate pathways to mental health assessment, treatment and support. Whether they enter through primary care, psychiatric triage, a hospital emergency department or crisis intervention, people of all ages will have improved access to timely, skilled, psychiatric assessment, appropriate treatment interventions and advice, and clear and supportive referral to the right follow-up care.

Over time, we want to see a sustained reduction in the proportion of people with a mental illness experiencing a psychiatric crisis. This will be assisted by better capacity in all mental health services to assertively intervene early in the development of an illness or episode to prevent deterioration and avert preventable crisis where ever possible (see Reform Area 4).

The community should have easy access to mental health information, advice and referral and streamlined referral pathways, using up-to-date information technologies.

General practice will play a key and assertive role in providing mental health care and in facilitating access to a range of other mental health providers. This will build on the increased skills and networks resulting from the recent expansion of Medical Benefits Schedule (MBS) mental health items.

We want to see general practice and community health services better able to access expert specialist advice to assist them to manage people with mental health problems, including those with more severe presentations. This will be supported by clear referral pathways to and from specialist mental health services.

We want to develop an accessible and streamlined psychiatric triage service system with 24/7 capacity to promptly assess people who are unwell and proactively help them to access appropriate mental health care.

We will explore ways to redevelop our emergency response system so that people in urgent need receive timely, assertive and responsive care in the community. This should involve refocusing Crisis Assessment and Treatment (CAT) services to provide short-term intensive care in the community for people who are acutely unwell, and improving the capacity for CAT, police and ambulance to respond in a more coordinated way to people requiring emergency care.

We will consider new models to improve the experiences of people with a mental illness presenting to emergency departments (EDs) and reduce preventable ED presentations. This will include consideration of new service models for people with mental health presentations requiring short term acute care, including those with co-occurring drug and alcohol misuse problems.

## Reform directions

### **Goal 3.1 Provide access to 'right time, right place' mental health care through better mental health information and streamlined referral pathways**

The general community has a limited understanding of mental illness, what type of services will best meet their needs and where they might seek help. This is compounded by a lack of clear, consistent information on the range of mental health supports available in their community and the complex nature of the specialist mental health service system.

Evidence suggests that a high level of entry point demand is misdirected to specialist mental health services, which creates frustration for individuals, their carers and referral agencies and delays in accessing a suitable treatment response.

In response to this issue we will, over the short term, develop advice and referral services that respond to a broad spectrum of mental health problems, including a 24/7 information, advice and referral call line for the general population. This new service will direct people to appropriate mental health services based on their assessed need such as general practice and other primary health care services, specialist psychiatric triage and emergency departments.

This initiative will be delivered in conjunction with an information strategy involving the internet and local directories.

Over the short to medium term, we will facilitate the more effective referral and movement of people with mental health problems between general health and specialist mental health services, through the use of tested service coordination platforms and tools, such as those developed by Primary Care Partnerships.

We will look for opportunities to continue to build the capacity of general practice and community health services to better identify, treat and refer people with mental health problems, particularly children and older people, through the provision of secondary consultation, training and support (see Goal 3.2).

### **Goal 3.2 Promote primary health services as a key access point for mental health care and referral**

There is a significant gap in access to mental health care in Victoria. It is estimated that just over half of people with a moderate mental illness receive no treatment in any one year due to social and economic disadvantage or because their needs are in excess of what can be managed by primary health services alone.

In response to this issue, consideration will be given to the possibility of providing new mental health treatment and psychosocial support services in Community Health Services targeted to adults and older people with moderate to less severe mental illness who are falling between the gaps of the state and Commonwealth-funded mental health system.



These services would operate as a partnership between referral agencies, particularly adult and aged area mental health services and general practice, and provide opportunities for shared care. They would also use MBS-funded practitioners wherever possible (see Reform Area 4).

General practice is a key point of entry and referral, including to other primary health services and private Medicare-rebated services, and GPs are an integral part of the individual's treatment and care team.

The capacity of general practice and community health services to identify, treat and refer people across the spectrum of mental health disorders, will continue to be strengthened through secondary consultation and advice, training and short term shared care provided by dedicated primary mental health practitioners employed by area mental health services.

Over the medium term, we would hope to see the target group for this specialist function broadened to support primary health services to better identify and support older people with emerging or existing mental health problems.

We will continue to connect general practice and community health services into local mental health service networks to facilitate more effective shared care planning, improved discharge planning from emergency departments and acute inpatient units, develop clearer and more streamlined referral pathways and improve access to specialist consultation and advice.

### **Goal 3.3 Improve the efficiency and responsiveness of psychiatric triage in specialist public mental health services**

While the 24/7 information, advice and referral call line discussed above is expected to reduce, over time, the current high level of entry-point demand on specialist public mental health services, reforms are also required to improve access to, and the responsiveness of, psychiatric triage services located in this service sector.

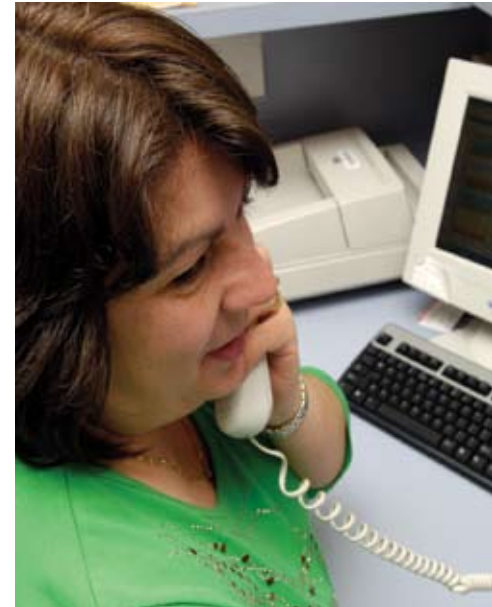
Area mental health services currently provide 24/7 access to telephone based psychiatric triage and a face-to-face crisis response when required. Building on this capacity and expertise, we will seek to implement reforms that will shift the orientation of psychiatric triage from that of 'gate keeper' to the specialist mental health service system to a 'referral portal' that proactively links people to the right care and supports local referral agencies and service networks.

To achieve this we will, in the short to medium term, build a centralised 24/7 telephone triage function in area mental health services to provide a timely, initial assessment and proactively support people to access the mental health care that best meets their assessed needs. This will also improve the capacity of psychiatric services to provide secondary consultation, expert advice and support to referral agencies, including police and ambulance.

This system enhancement would provide a single point of access for the public and referrers with the efficiency of a single roster of staff.

Further, we will work towards a triage/intake system that is able to:

- provide expert assessment for all age groups, drawing on age relevant expertise as required
- coordinate/facilitate face-to-face same day/next day intake assessment
- coordinate access to inpatient beds within the specialist mental health service system
- deliver evidence-based best practice triage assessment, including better integrating social, health and clinical risk assessment into triage practice.





Over the longer term, we would like to see triage clinicians able to access electronic patient records from anywhere in the state (subject to client consent) and real time data on inpatient bed availability. This would support triage clinicians to make informed decisions, including the better management of risk and advice to CAT, police and ambulance on the most appropriate crisis response.

### **Goal 3.4 Build a robust, integrated emergency service system to respond effectively to people in urgent need**

#### **Responding more effectively to people in urgent need**

A specialist mental health service system with the core capacity to intervene early in the illness and episode pathway will assist consumers to maintain symptom stability and support their recovery. This capacity is critical to averting preventable crisis and the need for emergency interventions.

The 'step up' function of sub-acute Prevention and Recovery Care (PARC) services will also be strengthened as part of a strategy to avert preventable crisis (see Reform Area 4).

The failure to break the repeated cycle of crisis that is experienced by some individuals increases the risk of developing or exacerbating other forms of disadvantage such as problematic substance use, unemployment, homelessness and involvement in the criminal justice system as victims or offenders.

Crisis Assessment and Treatment services often do not have the capacity needed to provide short-term assertive treatment in the community for people experiencing, or escalating to an acute episode due to high demand for urgent assessments which are frequently caused by problematic alcohol and drug use. As a result, opportunities for early intervention as illness escalates are missed, resulting in increased demand for crisis interventions including police and ambulance call outs, ED presentations and hospitalisation.

This pressure is exacerbated by the need to manage risk and worker safety due to changing expectations and standards relating to occupational health and safety and increased substance misuse in the community and associated risk of violence. Paramedics report difficulty handling people with challenging behaviours and an increase in aggression and assault by patients.

To address these issues we will seek to redevelop our emergency response in the community so that it is more effective and provides more options to people in urgent need.

This will be complemented by a continued commitment to the delivery of a crisis management function in area mental health services focused on providing short-term assertive and intensive care in the community during the acute phase of the person's illness. Over the medium term, we will explore ways to further enhance this function, as the impact of improved triage and other measures take effect. We will also continue to ensure the provision of adequate face-to-face assessments when people are in crisis, referral to appropriate services and expert advice to ambulance and police.

We will explore options for the integrated management of people experiencing a mental health crisis. In particular, we are keen to see the development of coordinated community responses by mental health clinicians and police that can provide a quicker, more decisive response to people in urgent need.

People who might be experiencing a psychiatric crisis and are a danger to themselves or others – often drug/alcohol affected – need a safe place to withdraw and a comprehensive assessment of their mental health needs. It is recognised that detention in the restrictive environment of police custody is generally inappropriate and contrary to the objectives of the *Mental Health Act 1986*. Alternative responses to the needs of this cohort may include short stay units (see below).

Current mental health training for police and ambulance, including advanced training and refresher courses, will be reviewed and expanded where necessary, to better equip all personnel to support people with a mental illness and/or substance use problem.

### **Emergency departments**

Research has found that a significant number of people attend the ED because they are unable to access a general practice or mental health service outside normal business hours, or they use the ED as their preferred management site. Improving access to specialist mental health treatment and care after hours and targeted provision of specialist mental health services to people with moderate to less severe mental health problems would also help alleviate this problem (see Reform Area 4).

Due to acute inpatient bed shortages, a significant proportion of people experiencing an acute illness continue to wait in excess of eight hours in ED for admission. The ED, which is designed for rapid triage, acute treatment and throughput, is not the right environment to provide extended periods of care to people who are mentally ill, or experiencing intoxication.

Further, there is a revolving door of apprehension, admission and release for people brought to the ED by the police. The police are particularly concerned about people taken into the care of police under s.10 of the *Mental Health Act 1986* because they have threatened self harm or suicide but who on presentation to the ED, are assessed as not requiring admission to an inpatient bed.

In response to this issue, we will give consideration to expanding the capacity of mental health clinicians in EDs to provide proactive follow up when people with mental health presentations leave either the ED or acute inpatient unit, including referral to general practice and improved linkages to specialist mental health care. At risk individuals not admitted to an acute inpatient bed will be a priority target group.

A number of hospitals have established short stay units to provide care for people who are medically unwell and are expected to require care for less than two days. Some service models allow clients to be directly admitted to the short stay unit via the specialist community mental health clinic, avoiding the need for ED attendance.

We will evaluate short stay unit service models to determine the value of expanding this service to other psychiatric units. Contingent on the outcomes of this evaluation, we will support the establishment of flexible short stay units at major hospitals for people experiencing a psychiatric crisis, intoxication and or other co-morbidities who require assessment, treatment and care for up to 48 hours. This service model would include capacity for follow-up care post discharge.

In progressing ED enhancements and short stay units, consideration will be given to building up specialist mental health capacity, including expertise in addiction medicine, in selected metropolitan EDs with high levels of mental health presentations.

A more coordinated response is also needed to people presenting at ED with mental health and co-existing medical conditions. Health screening is particularly important as some behavioural disturbances are attributable to physical illness.

In response to this issue, we will seek to improve the coordination between medical and psychiatric assessment, diagnosis and treatment planning by expanding aged and adult Consultation and Liaison in hospitals. We will also give consideration to providing training to general ED staff in the identification and management of people with mental health and alcohol and drug use problems.

In addition, we will seek to provide training to mental health clinicians in ED in the assessment of adolescents and older people, potentially supported by 'on call' access to specialist secondary consultation for these population groups.

### Key strategy proposals

Action to be considered over the life of the strategy includes:

- Creating more accessible information, advice and referral services that can assist people with a broad spectrum of mental health problems, including a 24/7 call line for the general public.
- Promptly assessing and proactively assisting those who need a mental health service to access appropriate care through the development of centralised psychiatric triage services in area mental health services.
- Promoting the use of general practice and community health services as key providers of primary mental health care, and a key referral point to private and public mental health services.
- Better supporting people experiencing psychiatric emergencies through more coordinated mental health and police emergency responses targeted to periods and locations of high need.
- Evaluating new models for short stay units at major hospitals or in community-based facilities for people experiencing a mental health crisis including those with substance use problems, as an alternative to emergency department presentation and inpatient admission.

## Reform Area 4: Specialist care

Meeting the needs of adults and older people with moderate to severe mental health problems

<b>Goal 4.1</b>	Build a more responsive system of specialist mental health care geared to early intervention, relapse prevention and recovery
<b>Goal 4.2</b>	Provide a wider range of bed-based options that are well connected with both clinical and psychosocial rehabilitation services
<b>Goal 4.3</b>	Tailor services for prisoners and people with a forensic history to achieve improved outcomes
<b>Goal 4.4</b>	Foster an integrated response to people's physical health and mental health problems

### Key outcomes:

- increase in the proportion of people with severe and enduring mental illness accessing high quality specialist mental health care
- active participation of consumers, families and carers in treatment and care
- improved continuity of care
- increase in the proportion of people with moderate mental illness who are able to access mental health care
- reduction in need for crisis intervention
- reduction in the suicide rate associated with mental illness
- reduction in recidivism in people with mental health problems
- reduction in morbidity and mortality due to preventable physical health problems

### Towards 2019

By 2019 we want to see a consumer-focused and carer-inclusive mental health system that effectively engages consumers and their carers in all decisions related to their treatment and care, and which actively involves them in service planning and development.

We want to see service cultures and practices that fully embrace the belief that positive change and recovery is possible, utilise the person's strengths, and empower the individual to take control of their life. This will be supported by contemporary treatment practices that will optimise the individual's ability to better manage their illness and minimise social and economic impacts associated with mental illness.

We want adults and older people with severe and enduring mental illness to be able to access timely integrated psychiatric care and psychosocial support early in the illness pathway to optimise recovery, prevent relapse and avert crisis. This first-rate specialist area mental health service and PDRSS response will be a partner to, and delivered collaboratively with, a broad alliance of primary health and social support services.

We want specialist mental health services to have the skills, competencies, and capacity to provide an integrated response to people with a mental illness and co-morbid substance use problem.

We aim to broaden our current focus to provide targeted support to those people with more moderate to severe mental health problems who, due to their social and economic disadvantage and/or the relative complexity of their mental health and other needs, are falling through the current gaps in Victoria's mental health service system.



We will continue to build a system which can provide timely access to high quality, age-appropriate acute inpatient care for adults and older people who are the most unwell, while continuing to diversify and expand community-based alternatives and taking a new approach to coordinating the treatment, care and social support needs of these population groups.

By 2019, we want to have significantly improved the life expectancy of Victorians with severe mental illness. This will be achieved by working in partnership with primary health services to monitor their physical health, prevent illness and provide prompt access to appropriate medical care when needed as an essential, and standard, part of the individual's mental health care.

We will also build the capacity of the community-based clinical and psychosocial mental health services to better support forensic clients, and more effectively manage the risk sometimes associated with this cohort. We will also work to improve the ability of prison mental health services to intervene earlier in the illness and episode pathway.

## Reform directions

### Goal 4.1 Build a more responsive system of specialist mental health care geared to early intervention, relapse prevention and recovery

#### Improving participation for consumers and carers

In order to better meet the needs, rights and expectations of consumers, carers and families, a new service paradigm is needed based on the principles of empowerment, self-determination and partnership.

Consumers of specialist mental health services and their carers have told us that they want a person-centered, holistic and recovery oriented approach to their treatment and psychosocial rehabilitation needs. They also told us that to be effective, treatment and care plans must take into account their social and cultural context, their broader health and social support needs and the availability of informal support.

Consumers and carers must be active partners in treatment and care as well as valued partners in service governance, planning and evaluation. Most importantly they have the right to experience mental health and broader health and community support services that make them feel safe, and treat them with respect and dignity.

Strong and sustained leadership is required from government and within area mental health services, their auspicing health services, and PDRS services to embed the cultural and practice change needed to adopt this social model of care. To support this, focused training for mental health workers in recovery, and in culturally sensitive, and carer and family inclusive practice will be considered.

The role of consumers and carers in statewide coordination, service governance and the local mental health partnerships is discussed in Reform Area 8.

As part of a broader strategy to improve systemic advocacy, we are keen to see the continued evolution of the consumer and carer consultant program, or similar capacity, operating across the specialist mental health system for all ages. This will involve review of existing consultant programs to clarify their systemic advocacy role and identify what support is required at senior levels within area mental health services and across local service networks to better support this function.

Training and professional development opportunities will also be sought to improve the skills and competency of the consumer and carer workforce (see Reform Area 7).

Practical strategies, such as the systematic use of advance statements, greater independent representation at Mental Health Review Board hearings and improved access to advocacy and information on rights, will be considered in the review of the *Mental Health Act 1986*.

We want to see specialist mental health services actively addressing the support needs of families and carers through improved linkages and referrals to respite and counselling services. We will explore ways to enhance carer support services to progress this outcome.

In response to the difficulties consumers and their carers often experience in navigating the complexities of the mental health and broader health and community service sectors, consideration will be given to creating consumer and carer peer worker roles across specialist mental health services, and other settings such as primary health and statewide specialist services.

Action will be taken to make sure the evidence base for effective service delivery draws on consumer and carer knowledge and experience (see Reform Area 7).

#### **Strengthening access to specialist care**

A significant gap in access to mental health care currently exists in Victoria. In any 12-month period an estimated 44 per cent of Victorians with a severe mental illness, and 54 per cent of people with a moderate mental illness, do not receive a service from either the public or private mental health system.

Specialist adult and aged area mental health services are targeted to people with severe and enduring mental illness. Over the last 20 years even routine presentations to specialist public mental health services have become more complex with co-morbid substance use problems a prevailing characteristic of new clients. Many clients of the service system experience entrenched social disadvantage and a high level of co-existing physical health problems.

The adult and aged specialist mental health services struggle to effectively manage increasing and sustained service demand within existing resources, as evidenced by high bed occupancy and involuntary acute inpatient admission rates, and high case loads. This pressure is further exacerbated by the uneven distribution of core capacity across the state.

These factors combine to force entry thresholds up, requiring new clients to meet a high level of clinical acuity before they can receive a service response. For clients this translates into a treatment and care response that may be less timely, less intense and shorter in duration than they need.

The failure to systematically intervene early in the illness pathway results in relapse that could have been prevented in many cases, and subsequently propels people to crisis and the need for costly interventions which often involve police, ambulance services and hospitalisation. Repeated relapse over time may lead to enduring psychiatric disability and significantly reduces the individual's capacity for social and economic participation.

While Community Treatment Orders (CTOs) are an important element of community-based treatment, their increasing use is a cause of some concern. Other measures considered by this strategy to improve the capacity of the specialist mental health services system to respond to people with severe and enduring mental illness should improve levels of voluntary engagement, and reduce the overall need for CTOs. Further work will be undertaken to determine how best to reduce any overuse of CTOs.



In response to these issues a multi-level reform strategy is recommended. Consideration will be given to the following elements:

- **Work towards expanding specialist community-based mental health services** (including services such as Continuing Care Teams) to position the service system to adequately meet the needs of adults and older people with severe and enduring mental health problems and psychiatric disability. This will give the specialist system the capacity to provide a broad range of treatment and care interventions (including ‘talking therapies’) of the right intensity and duration, early in the illness pathway and in the illness episode.

We will also give consideration to the provision of new mental health treatment and psychosocial support services in community health services. This new service capacity would be targeted to people with moderate to severe mental illness who are socially, economically or geographically disadvantaged and/or whose needs are in excess of what can be managed by primary health services alone.

In addition, consideration may be given to funding selected community mental health clinics and/or community health services to operate on an extended hours basis to improve treatment and care for people with moderate to severe mental health problems when community-based mental health services are not open. This would also provide an after-hours referral point for the 24/7 information, referral and advice call line (see Reform Area 3).

- **Transforming service delivery** through a dedicated care coordination function targeted to people with severe mental illness and multiple service needs and a review of the case management function in clinical specialist mental health services (see Reform Area 5). This will be coupled with better integrated clinical and psychosocial support functions to enhance recovery. Job redesign and diversification within both service sectors also needs to be considered (see Reform Area 7).
- **Developing shared public/MBS funded mental health services** by supporting the co-location of these services in community based mental health clinics (with private clinicians working at least part time in the public system) to improve access to treatment and the delivery by private clinicians of some functions/interventions.
- **Improving the skills and competencies of the specialist mental health workforce** (see Reform Area 7). We will also seek to develop local expertise in the areas of trauma, personality disorder, dual diagnosis, co-existing disability and forensic mental health.

We will seek to develop a shared IT system to facilitate referrals and client record sharing (with consent) between clinical and PDRSS services, and with primary health services. Opportunities to align and streamline assessment and reporting requirements will also be identified (see Reform Area 7).



The further transformation of the adult and aged specialist mental health service system will be underpinned by an assertive program of systemic reform, cultural change, improved cross-sector collaboration and workforce reform which will involve:

- creation of capacity for some mental health specialists to be shared between metropolitan and rural area mental health services and for specialist clinical expertise to be co-located in selected PDRS and drug and alcohol treatment services
- strengthening operational linkages and alliances between area mental health and PDRS services to provide a strong platform from which to identify local priorities, undertake joint planning and service coordination (see Reform Area 8)
- strengthening cross-sector coordination and planning across mental health, primary health, justice and social support services (see Reform Area 8).

### **Aged persons mental health**

Aged persons mental health services and mainstream health and aged care services are expected to experience increased and sustained demand driven by the ageing population; the increased prevalence of depression and anxiety and organic conditions such as dementia; and the unknown impact of increased usage of alcohol and drug usage on an ageing population.

The entry point to specialist aged persons mental health services will be changed from 65 years to 70 years in acknowledgement that mental health problems in the ageing population are increasingly occurring later in life and to align with the age criteria generally used by Aged Care Assessment Teams. Access to adult and aged specialist mental health services will, however, be flexible regarding age criteria, so that people receive the right care in the right part of the service system (see Reform Area 8).

In order to meet current and future service demand, consideration will be given to progressively expanding the core capacity of the public aged persons mental health service system. Such a strategy would also provide this service sector with the capacity needed to intervene earlier and more intensely in the illness pathway and during an illness episode.

In line with this, consideration will be given to expanding sub-acute treatment options for older people with a severe mental illness, including services that provide intensive treatment in the home. This will avert the need for an inpatient admission in some instances and provide a 'step-down' function for older people leaving acute inpatient care.

Primary health and aged care services play a lead role in the early identification and treatment of older people with physical health and co-existing mental health problems.

Priority will therefore be given to providing the specialist aged persons mental health service system with a dedicated capacity to provide secondary consultation, training and short-term shared care to general practice and mainstream residential aged services and supported accommodation services. Such investment would also strengthen referral pathways for individuals who require specialist treatment and care (see also Goal 4.2 below).

Other social support services, such as Home and Community Care, will be supported to identify and appropriately manage older people at risk of, or with, mental health problems.

In addition, we will work with health services to ensure the most effective use of consultation and liaison services in major metropolitan and rural hospitals to support older people with medical conditions and co-existing mental health problems.



We will consider providing a targeted and integrated response to people who are ageing prematurely with severe and enduring mental health problems. Many of these people also have a co-morbid physical health problem, problematic substance use and/or a co-existing disability and pressing social support needs (see Reform Area 5).

#### **Goal 4.2 Provide a wider range of bed-based options that are well connected with both clinical and psychosocial rehabilitation services**

When a person with mental illness is acutely unwell they require timely access to high quality inpatient care, just as a person with an acute medical condition does. Prolonged wait times in emergency departments for people with a mental illness requiring admission are directly attributable to the availability of an acute inpatient bed.

In order to shape the future of adult and aged acute inpatient services, we will review how acute inpatient beds are currently used and by whom, investigate the factors associated with and influencing length of stay (such as clinical practice, logistics and system issues), identify the predictors for admission and readmission, and determine how to improve the efficacy of this service component.

Victoria's bed-based mental health services are currently unequally distributed across the state with some areas experiencing critical shortages in core bed capacity, particularly secure extended care units (SECU). The unequal distribution of core bed capacity is cited as a key reason why adult and aged area mental health services have not been able to meet aims of the *Framework for service delivery 1996*.

The issue of bed availability requires a multi level response. While continuing to support growth in overall inpatient capacity, we will give priority to developing alternatives to acute inpatient care and creating discharge options for long stay patients to reduce bed blockages.

Possible elements of this approach, which government will consider over the medium term, include:

- Further roll out across the state of sub-acute Prevention and Recovery Care (PARC) services followed by the selective expansion of this service model in areas of high need. As part of this strategy, the 'step up' function in this service model will be strengthened.
- Increasing the supply of secure extended care unit (SECU) beds targeted to areas that experience high demand for a secure response for high risk consumers.
- Expanding intensive community-based psychosocial/clinical support models, such as the Integrated Rehabilitation and Recovery Care service model, to support people with severe mental health problems to successfully move from SECU and community care units (CCU) into the community. This strategy will free upstream capacity in acute inpatient beds by providing improved access to SECU facilities for high-need long-stay patients.
- Developing short-stay bed options for people experiencing a mental health crisis, including those with problematic substance use, who require care for up to 48 hours (see Reform Area 3).
- Expanding transitional sub-acute care models for older people, for example intensive treatment in the home services, to reduce the need for inpatient admission and provide a 'step down' option when they leave inpatient care. Greater flexibility around age entry criteria for PARC services will also be promoted.

We will continue to maintain high quality specialist mental health residential care services for older people who are acutely unwell and who can not be adequately supported in mainstream residential aged care facilities.

Over the longer term we will seek to improve the treatment and care provided in mainstream residential aged care facilities to people with a mental illness, and reduce the need for admission to specialist aged persons mental health residential care or acute inpatient care.

To achieve this we will give consideration to strengthening the capacity of aged persons mental health services to provide clinical in-reach to clients in these service settings and secondary consultation and training to service providers.

Over the longer term a framework to benchmark the equitable provision of core bed-based services across the state will be developed. Outside of the provision of a suite of core services, new services will be prioritised to growth areas and locations identified as under resourced based on a population catchment analysis.

Bed-based rehabilitation provision will be realigned by encouraging the joint management of CCUs by adult area mental health services and PDRSS under a common psychosocial rehabilitation model. In line with this reform, local area mental health and PDRS services will develop an integrated intake point to rehabilitation bed-based services within a given catchment to streamline access and provide different rehabilitation options for clients.

Area mental health services will also be supported to diversify the use of their CCU beds including allowing some beds to have a sub-acute short-term rehabilitation function based on the assessment of local needs and priorities.

### **Goal 4.3 Tailor services for prisoners and people with a forensic history to achieve improved outcomes**

#### **Forensic mental health**

##### *Bed-based forensic mental health services*

The number clients committed by the court under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* to long-term forensic beds has increased, along with the transfer of prisoners requiring involuntary treatment.

As a result, Victoria's only bed-based forensic facility, Thomas Embling Hospital, is experiencing sustained demand pressures, evidenced by increasing lengths of stay and very high bed occupancy rates. Reduced throughput capacity at Thomas Embling means that the 16-bed acute assessment unit in the Melbourne Assessment Prison and prisoner mental health services are required to support people with increasingly high levels of acuity.

In addition, Thomas Embling has a very limited capacity to respond to the need for crisis containment and stabilisation of people displaying challenging and aggressive behaviours in acute inpatient and SECU services. Pressure is also being placed on SECU services to provide a secure response for this cohort on their release from Thomas Embling.

In the short term we propose handling this situation by designating selected SECU facilities to support high-risk forensic clients exiting Thomas Embling Hospital and those entering from area mental health services, and will review any resource implications that may arise.

A comprehensive solution in the medium to longer term would require some expansion of medium security forensic bed capacity. This would create throughput capacity in Thomas Embling and reduce the increasing pressure on SECU to provide a containment response to this cohort. This service function would also enable more prisoners with high needs to be stabilised before returning to the prison system.

The need to increase the capacity in high security forensic beds would be reviewed in the context of projected demand, taking into account the impact of any new medium security beds, improved prisoner mental health services, and a strengthened community forensic capacity.

Consideration may also be given to developing a specialist adolescent inpatient unit to meet the needs of young people in the criminal justice system and those who are unfit to plead or stand trial, or who display severe mental health problems and difficult behaviours.

#### *Community-based forensic capacity*

Public specialist mental health services provide treatment and care to ex-prisoners with severe mental illness and offenders on community-based orders. However, area mental health and PDRS services report difficulty in managing individuals with a forensic history, particularly when they are violent and exhibit highly challenging behaviour.

New approaches are needed to integrate forensic capacity into specialist youth and adult community mental health and PDRS services to better manage the behaviours and risks associated with this client group. These will be developed in collaboration with Forensicare, as the statewide specialist provider, and will be informed by a review of community forensic mental health services.

In line with this, consideration will be given to establishing 'forensic portfolio holder' positions in area mental health services. Clinicians with these portfolios would receive additional training and supervision to work with people with a forensic history. They would also provide secondary consultation to clinical mental health services, PDRSS, disability services, drug and alcohol treatment, and justice services to better manage the risks and behaviours associated with this cohort.

#### **Prisoner mental health**

The prison population presents with extremely poor health status and complex health needs.

The Corrections Victoria Prisoner Health Study found that the prevalence of all the major mental illnesses is higher in the prison population compared to the general population. Studies have shown that rates of severe mental illness, such as schizophrenia, are between three and five times higher in offender populations than the general community. The prevalence of severe depression is at least 50 per cent higher than in the general population.

Further, the study found that a very high percentage of prisoners have attempted suicide or otherwise engaged in acts of self-harm and that the prevalence of addictive behaviour is also very high.

The capacity of prison mental health services to improve the mental health of prisoners and their longer term recovery will be enhanced over coming years. This will involve strengthening their capacity to provide early intervention and treatment, addressing the fragmentation of service provision, and expanding access to transition programs as part of the Corrections Demand Management Strategy.

For offenders with a mental illness, including those with co-existing intellectual disability or Acquired Brain Injury, the provision of support at the transition from prison is critical in reducing the risk of re-offending. Nationally and internationally, there has been a shift towards using an integrated and holistic approach to support those exiting prison.

While there are transitional support programs for prisoners offering integrated and holistic support pre- and post-release, it is acknowledged that demand for services available in the community generally exceeds supply. Corrections Victoria will explore ways of enhancing these programs to address the increasing complexity of prisoner needs upon release from custody (see Reform Area 5, Goal 5.4).

#### **Goal 4.4 Foster an integrated response to people's physical health and mental health problems**

People with a severe mental illness die an average of 25 years earlier than the general population. Many of the causes of death are similar to the cause of death for all other persons and could be treated or prevented through access to effective health care and information.

This population group often suffers poorer nutrition and higher rates of dental decay compared to the general population. They are particularly vulnerable to chronic conditions like diabetes and cardiovascular disease, and the negative impact of weight gain and other health issues caused by some medication. Their physical health may also be affected by risk behaviours such as smoking and problematic alcohol and drug use.

The socio-economic disadvantage experienced by many people with severe mental illness directly affects their capacity to adequately care for their own physical health and to access or pay for private medical services. This is compounded by the reluctance of some primary health providers to treat this client group for their physical health conditions, due to a number of factors including the practitioner's level of training in mental health, the view that this group will likely not comply with treatment or that they are disruptive in a primary health setting.

The unacceptably high level physical health problems experienced by people with mental health problems and the resultant impacts on their quality of life and life expectancy highlights the need for fundamental change.

In response to this critical issue we will consider a multi-level strategy that will reduce preventable ill health and respond proactively to people of all ages with mental health and co-morbid chronic medical problems.

This could include targeted health promotion and prevention strategies to promote self-management and reduce health behaviours and risk factors associated with poor general health and illness, with initial priority given to targeted prevention approaches in the areas of smoking and obesity.

Responding to physical health issues should become an integral and standard part of treatment and support provided by clinical and PDRSS workers. Specialist mental health services should, subject to consent, routinely screen all clients for physical health disorders. Services will be expected to include physical health in consumers' individual care plans and proactively support their referral to, and engagement with, appropriate medical care.

This will draw heavily on the existing skills of mental health workers with general health training, although some further training may be required to develop workers' skills and competencies in physical health screening and the use of standardised tools.

Consideration will also be given to co-locating general practitioners and specialist practitioners such as diabetes educators in community mental health clinics to deliver an integrated mental and physical health care response and address the time and resource limitations for conducting physical examinations in mental health service settings.

Opportunities will also be sought to enhance education and training to clinicians working in a range of service settings to assist them to proactively screen for psychiatric and substance use disorders and better manage the physical health of patients with mental health problems and substance use problems.

To achieve this important goal, we will promote local collaboration between acute care, primary health and mental health services. In support of this, we will consider:

- Clearer guidelines to assist community health, drug and alcohol treatment services and general practice to determine when people with a medical condition and psychosocial issues require a mental health intervention and referral.
- Requiring primary mental health practitioners in area mental health services to play a lead role in supporting general practice to proactively manage the physical health needs of patients with mental health problems.
- Ways to facilitate access of clients with chronic disease and severe mental illness into established chronic disease management programs.
- Improved coordination between medical and psychiatric assessment, diagnosis and treatment planning in emergency departments and hospital wards through aged and adult Consultation and Liaison.

## Key strategy proposals

Action to be considered over the life of the strategy includes:

- Actively promoting consumer self-determination and carer and family-inclusive practice, including a peer support function to help consumers and carers navigate the extended mental health system. Consumer and carer participation in broader service planning and governance will be encouraged and facilitated.
- Working towards better availability of community-based specialist mental health services to adequately meet the needs of Victorians of all ages with severe and enduring mental health problems and psychiatric disability, underpinned by workforce reform and improved practice.
- Exploring the creation of specialist mental health services, delivered through selected community health services, to meet the needs of adults and older people with moderate to severe mental illness who are socially, economically or geographically disadvantaged.
- Working towards an equitable distribution of core inpatient, sub-acute, rehabilitation and recovery beds based on underlying population needs. This will include the availability of acute inpatient and secure extended care beds to areas of rapid growth and locations that are currently under resourced.
- Assisting older people with emerging or existing mental health problems by enhancing aged persons mental health services capacity to provide secondary consultation, training and short-term shared care to primary health services and mainstream residential aged care facilities.
- Over time, develop new and expanded alternatives to inpatient care for adults and older people with severe mental illness, including greater access to sub-acute Prevention and Recovery Care services and intensive in-home treatment and support for older people.
- Giving priority to the physical health of people with severe mental illness through an assertive program of targeted health promotion, systematic screening and access to chronic disease management programs.
- Strengthening the capacity of prison health services to improve longer-term mental health outcomes for prisoners as part of the new Justice Health model. This will be complemented by new medium security forensic mental health beds and enhanced capacity of community-based clinical and psychosocial support services to support people with a forensic history.







## Reform Area 5: Participation in the community

### Building the foundations for recovery and participation in community life

<b>Goal 5.1</b>	Promote a more coordinated and tailored approach to people with severe mental illness who require support from multiple services
<b>Goal 5.2</b>	Improve access to stable and affordable housing that is linked to flexible, scaled psychosocial rehabilitation support
<b>Goal 5.3</b>	Support participation of people with mental health problems in the workforce and other aspects of community life
<b>Goal 5.4</b>	Reduce involvement with the criminal justice system of people with mental health problems as victims or offenders

#### Key outcomes:

- improved continuity of care for people with severe mental illness and multiple needs
- reduction in the proportion of people with a mental illness who are homeless or living in tenuous housing
- improved participation in education and training and in the workforce
- improved social engagement and participation in community life
- reduction in proportion of people with a mental illness who are remanded or sentenced to youth and adult correctional facilities

#### Towards 2019

By 2019 we want to have built a strong foundation of social and economic policies and services to support recovery and address the entrenched social exclusion and disadvantage experienced by many people with a mental illness.

This 'platform for recovery' will ideally include:

- coordinated and tailored support for people who have a severe mental illness and multiple service needs
- access to stable, affordable and appropriate housing, linked to flexible and scaled psychosocial rehabilitation support, targeted to people with severe mental illness who are homeless or at risk of homelessness
- the provision of education and training and opportunities for meaningful employment
- opportunities for participation in the community through recreation and social activities.

Care coordination will be a core service response for people with severe and enduring mental illness and other multiple needs. A comprehensive care plan will be developed and delivered in collaboration with consumers and their carers and families.

Improved housing security for people with a mental illness will be achieved through alignment of mental health and housing policies emphasising the need for more direct pathways to appropriate long-term housing options accompanied by the right level of clinical and psychosocial support. Housing and mental health strategies will jointly promote a variety of housing and support models, including supported accommodation, for people with a mental illness.

Emphasis will be placed on intervening early to reduce the risk of homelessness and create permanent pathways out of homelessness. We will explore strategies to build the capacity of homelessness services to identify and support people with mental health and related problems and refer them to the right mental health care.

We want to see the coordinated and planned provision of vocational training, and longer-term, employment support services that are tailored to the needs of people with mental health problems to improve opportunities to participate in the workforce.

We will promote a more inclusive and accepting community through policies and programs in all state-funded services combined with organised efforts to reduce discrimination and educate the community about mental illness.

We will take action to significantly reduce the over representation of people with a mental illness involved with the criminal justice system whether as suspects, offenders or victims. We want to see concerted effort to divert people from the courts and custodial sentences, and to support people to successfully transition into the community from prison.

## Reform directions

### **Goal 5.1 Promote a more coordinated and tailored approach to people with severe mental illness who require support from multiple services**

Many people with severe mental health problems have multiple needs such as physical health, housing, drug and alcohol treatment and family support needs. In the absence of a coherent package of support these individuals are at high risk of falling through the cracks between services.

This can lead to repeated crises and hospitalisation, entrenched homelessness, poor physical health, school failure, unemployment, and a higher risk of incarceration.

In the short to medium term, the strategy proposes that steps be taken to create a dedicated care coordination function to proactively support clients who require a multi-service response. These clients would be those with significant issues across several life areas and a history of intractable problems who require a coordinated, tailored, multi-agency response involving a range of health and social support services.

In collaboration with the client and their carers and families, care coordinators would have the mandated responsibility for bringing together relevant services to develop a comprehensive integrated care plan. The standard components of this care plan would include clinical, psychosocial rehabilitation, general health and social support services (see figure 13).

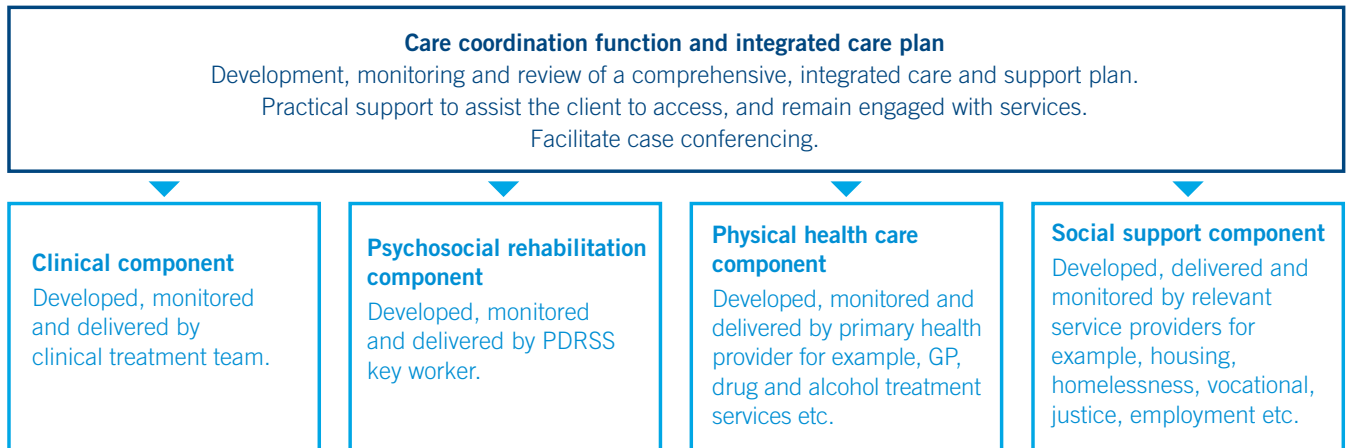


Figure 13: Proposed care coordination function

Each individual service provider would retain responsibility for delivering, and monitoring their agreed component of the care plan. Eligible clients for this service response would be identified through the area mental health/PDRS services alliances operating in each area.

A standard assessment framework would also be developed to identify the range of services required by an individual and form the basis of the care plan.

This new care coordination function would be based on the principle of person-centred care, self determination and choice and could include flexible brokerage funding. It would be subject to agreed minimum standards and supported by clear governance arrangements in respect of accountability, shared responsibility and risk liability.

The provider that delivers the care coordination function would be determined in discussion with local services in a given catchment area. The Department of Human Services regional offices would play a lead role in facilitating the inter-agency collaboration needed to support the delivery of this function.

Achieving multi-service collaboration and coordination will require a high level of sustained cross-sector planning, decision making and shared accountability for outcomes. The governance reforms and local area planning and partnership arrangements required to support this initiative, are discussed in Reform Area 8.

Over the longer term, we will explore potential information technology solutions to support cross-sector communication, information sharing and continuity of care.

The introduction of a dedicated care coordination function could reconceptualise the way care is coordinated for some clients with severe mental illness. In line with this the case management function currently undertaken by clinical specialist mental health services will be reviewed and reconfigured to focus clinical services on the planning provision, review and monitoring of clinical treatment and therapeutic interventions.

The new care coordination function would also provide ongoing support to people with a severe mental illness who are clients of time-limited programs, such as the Multiple and Complex Needs Initiative (MACNI).



Carers play a key role in coordinating care for people with mental health problems and have reported that the mental health and broader health and community support service systems are difficult to access and navigate. In response to this issue, and its attendant impact on self determination and self management for consumers, consideration will be given to creating consumer and carer peer worker roles across area mental health and PDRS services.

### **Goal 5.2 Improve access to stable and affordable housing that is linked to flexible, scaled psychosocial rehabilitation support**

People with a mental illness identify access to a stable and affordable home and support to sustain their housing as the most critical issue affecting their quality of life and capacity for recovery.

Without the foundation provided by stable housing it is extremely difficult for an individual to access and fully benefit from treatment and care, manage basic needs such as nutrition, maintain general good health, hold down a job or build and maintain social networks.

People with severe mental illness are at heightened risk of homelessness or housing insecurity. It is estimated that over 40 per cent of people with severe mental illness are homeless or housed in tenuous forms of accommodation, often interspersed with periods of hospitalisation and sometimes incarceration. Victorian research suggests that mental health problems frequently emerge or are exacerbated due to the experience of homelessness.

Gaps in the mental health service system place considerable pressure on housing and homelessness agencies. At the same time it is recognised that homelessness support agencies can play important roles in prevention and early intervention for mental illness.

The ability to deliver treatment and care to support people to live independently in the community is also affected by housing insecurity and housing shortages. Significant levels of unmet housing need persist despite action by the Victorian Government to provide priority access to public housing for people with mental health problems and increase availability of psychosocial outreach support linked to housing.

Government will explicitly consider the needs of people with mental illness, alongside people with other complex needs, as part of the planning and allocation of new and existing social housing, including that provided by Housing Associations and the development of new housing models.

In the short term, we need to align mental health and housing policy to better link the housing and the psychosocial rehabilitation and clinical support needs to people with a mental illness at risk of homelessness. This will include reviewing public housing allocation policy to facilitate improved access for people with a mental illness.

Over the medium term, we will seek to restructure and progressively extend the availability of tailored packages of psychosocial rehabilitation support linked to affordable housing options. These support packages would be targeted to people with severe mental health problems (particularly as they exit bed-based services and those living in housing such as rooming houses) to prevent and create permanent pathways out of homelessness. This service model would include provision for planned out of hours/weekend support and flexible brokerage funding.

Psychosocial rehabilitation support packages would be linked to a wider range of new and existing social housing options. The needs of people with severe mental illness will be explicitly considered in the planning of future social housing. We will also give consideration to planned growth in supported accommodation for people who, due to the profound and enduring nature of their psychiatric disability (including those with a co-existing intellectual disability or Acquired Brain Injury) require a highly structured home environment.

We will work with Housing Associations to explore the potential, in existing and new joint developments, to proactively identify properties to which psychosocial rehabilitation support packages can be linked. Mechanisms to create more affordable private rentals, such as leasing arrangements and targeted rental brokerage, will also be investigated and trialled to support people with a mental illness to secure and maintain private tenancies.

Pension-level Supported Residential Services (SRS) remain an important supported accommodation option for people with severe mental illness and psychiatric disability, and strategies to better link residents to clinical and psychosocial rehabilitation support (including in-reach support), primary health and other social support services will be explored in the short to medium term. This approach may also be applied to improve support to people in rooming house accommodation.

#### **Targeted support for people who are homeless**

People with severe mental illness who are chronically homeless require collaborative service models based on assertive outreach, delivered by multidisciplinary clinical, psychosocial rehabilitation and alcohol and drug treatment teams. Such service models have proved to be effective in reaching and supporting this highly marginalised group.

Over the short to medium term, consideration will be given to co-locating integrated service models of this kind in selected homelessness services. In addition, we will work to target Homeless Outreach Psychiatric Services (HOPS) to areas of high need including rural locations.

Opportunities will also be sought to pursue supportive housing models targeted to people with a history of homelessness and severe mental illness and other co-morbid issues, commencing with the Elizabeth Street supportive housing initiative in Melbourne's inner north.

The capacity of homelessness services to support people with a mental illness will also be enhanced through the provision of mental health training and education and improved access to timely clinical consultation and advice. As part of an early intervention response, homelessness services should be able to access an age appropriate mental health assessment in order to determine what treatment and psychosocial and other supports the client may require.

We will seek to foster improved understanding and linkages across the housing, homelessness and mental health sectors to improve the coordination of services to shared clients. Information exchange between these sectors will be improved in a way that respects client privacy while balancing the need for streamlined and timely referral processes.

### **Goal 5.3 Support participation of people with mental health problems in the workforce and other aspects of community life**

#### **Workforce participation**

Participating in the workforce has therapeutic, social and economic benefits, and helps to address the social exclusion often experienced by people with mental health problems.

While meaningful employment is a high priority for many people with mental illness, the employment participation rate for those with psychiatric disability is one of the lowest among all people with disabilities. We want to see attitudes shift to the view that people with moderate to severe mental illness can, with appropriate support, gain and retain employment.

Many people with mental health problems have experienced interruption to their education and employment history due to the episodic and enduring nature of their illness. The perceptions of some mental health professionals and employers, regarding the capacity of people with mental health problems to manage the challenges of employment, reduces their access to pre-vocational and employment opportunities.

Specialist mental health services will be actively encouraged to support their clients to achieve their pre-vocational and employment goals as an integral part of their treatment and recovery planning. This will include prioritising employment participation early in the treatment and recovery planning process and providing the support necessary for people to achieve their goals in this area.

While the Commonwealth Government continues to have primary responsibility for employment support the State Government also has a role to play in increasing the workforce participation rates of people who have mental health problems. To this end, we will explore employment participation strategies, targeted to young people and adults with mental illness, which complement national policy and programs.

We will seek to create clear linkages between specialist employment services and specialist mental health services by using the Individual Placement and Support (IPS) approach, which has proven to be effective in improving workforce participation rates for people with moderate to severe mental illness. We will seek to do this by exploring opportunities to co-locate, or provide on an in-reach basis, specialist employment workers in selected specialist mental health services.

We will also explore ways to work with employers to create 'employer readiness' to support them to employ people with mental health problems.

We will broker the creation of employment and training opportunities for people with moderate to severe mental illness through the development of partnerships with private business, public sector organisations, PDRSS agencies, training providers and identified exemplar employers.

In particular, we will encourage tailored employment and training programs for young people with emerging severe mental health problems through partnerships between youth specific services and employers interested in corporate social responsibility.

We want to involve relevant professional bodies and organisations in workforce programs, to educate employers on how to support people with more moderate mental health problems in the workplace. This could include taking a lead in promoting the employment of people with mental health problems through the public sector.

Social enterprises, such as those generated by the *Victorian Government's Social Enterprise Strategy*, have a discrete but valuable role in supporting some people with moderate to severe mental health problems to transit into open employment. We will encourage social enterprises that bring together a mix of employees facing particular challenges including mental health problems. Connections between Neighbourhood and Community Renewal programs, mental health services and non-government employment support agencies will be strengthened as one way to achieve this.

In addition, the Victorian Government will explore employment opportunities for people with mental health problems through Social Traders, the recently established community enterprise development agency.

Over the longer term, the state will work with the Commonwealth Government in:

- tailoring existing Commonwealth-funded employment support services to the specific needs of people with mental health problems (for example by enhancing post-placement support)
- improving access for people with mental health problems to Commonwealth specialist employment programs
- establishing processes that allow people who relinquish their Disability Support Pension to remain eligible for that pension if their job placement/support program has to be discontinued due to ill-health
- supporting employment service providers to develop local and innovative projects in partnership with training providers and community organisations and private businesses
- developing shared workforce participation targets for people with mental health problems.

We will also promote opportunities for people with psychiatric disability to be explicitly included in schemes such as Disability Works Australia, which provides a matching service for employers to find appropriate employees who have disabilities.

### **Promoting social participation and community connections**

Achieving the effective recovery and social participation of people with mental health problems requires a significant change in the attitude and behaviour of service providers and the broader community.

Negative stereotypes, prejudiced attitudes and discrimination – fed by the perpetuation of myths surrounding mental illness – have a significant impact on the social acceptance of people with mental health problems in their family and social networks, the broader community, the workplace and by some health and social support services.

To avoid the stigma surrounding mental illness, many people attempt to conceal their illness from their employers, family and community. The myths that surround mental illness in many cultures mean that individuals with a mental health problem may deny that they have a problem or that they need to seek help, reducing opportunities for early intervention.





Reducing the stigma associated with mental illness requires a comprehensive approach that targets the attitudinal elements of stigma – stereotypes and prejudice – and the behavioural manifestation – discrimination – at the individual, community and structural levels.

While some initiatives have been undertaken to address these issues, these need to be more targeted and sustained. To achieve this we will work towards improved collaboration between the three levels of government and relevant non-government organisations (NGOs).

Over the longer term, this issue needs to be tackled by an organised program to support community groups, NGOs and local government to develop sustainable and culturally appropriate social participation policies and practices that include, or are targeted to, people with mental illness.

People with a mental illness will also be supported to access general and specific advocacy support to protect their rights enshrined in the *Victorian Charter of Human Rights and Responsibilities*, the *Equal Opportunity Act 1995* and the *Federal Disability Discrimination Act 1992*.

Social isolation is a common experience for people with mental health problems. Meaningful relationships reduce social isolation and loneliness, assist people to cope with symptoms and the effects of their psychiatric disability, and can also offer a source of practical support.

Participation in sport, recreation and the arts can connect people with mental health problems into community life, and reduce social exclusion by providing a sense of belonging, social relationships, identity and purpose. We will foster partnerships with sporting, recreational and arts bodies to facilitate better access to a range of community activities that support people who are disadvantaged, including people with mental health problems.

PDRS services will continue to play a key role in proactively linking people with psychiatric disability into the local sporting, recreational and social services. The capacity of PDRS services to assist in this respect, especially for socio-economically disadvantaged clients, could be enhanced through the use of flexible brokerage funds discussed elsewhere in this document. PDRSS Mutual Support and Self Help services also have an important role here, as part of the support they offer to people with a mental illness to lead their own and others' recovery.

The Home and Community Care (HACC) Program, which provides funding for services that support frail older people, and younger people with disabilities has significant potential to assist people with a psychiatric disability to live independently and engage in their local community. This would ideally include building the capacity of HACC services to identify people with emerging or existing mental health problems, and provide appropriate support and referral.

#### **Goal 5.4 Reduce the involvement with the criminal justice system of people with mental health problems as victims or offenders**

There is a clear need to better support people with mental health problems who are in contact with the criminal justice system – in police cells, on community-based orders, at court and in prison – and, where possible, reduce their high level of contact with this system.

Proactively addressing the needs of prisoner, offender and victim populations at risk of, or with mental health problems, will require sustained effort and coordinated action across a range of services responsible for health, justice, housing and social support.



We know that access to mental health care, reduced dependency on alcohol and drugs, stable and affordable housing, employment and social supports all act as protective factors, reducing the risk of offending and re-offending behaviour, and victimisation.

People with a mental illness are significantly more likely to be victim of crime compared to the general population. They experience increased vulnerability, both at the time of the offence and throughout the criminal justice process. People may also suffer from a mental health problem, particularly post-traumatic stress disorder, as a result of criminal victimisation highlighting the need for early interventions to support victims of crime.

In addition, a lack of awareness of available services, and stigma associated with having a mental illness, act to prevent people from accessing legal and advocacy services, further perpetuating barriers to accessing justice.

A new Department of Justice response will be developed and delivered as part of the *Justice Mental Health Strategy*, positioning Justice as part of an extended mental health service system.

Over the short to medium term, consideration will be given to providing mental health first aid training for frontline personnel in all justice agencies, and mental health education and training for the legal profession across Victoria. This will enable these workforces to better identify people with mental health problems and refer them to appropriate services and support.

This should be supported by the development of a standardised, culturally-appropriate mental health screening and assessment tool to better identify and respond to the diverse needs of people with mental health problems engaged with the criminal justice system.

In the short to medium term, enhanced specialist court-based interventions and support programs targeted to offenders with mental health problems will be considered to divert this group from the criminal justice system where appropriate, reduce the risk factors associated with re-offending, and improve access to legal advocacy and representation.

This could include strengthening the availability of specialist legal advocacy services and improving access to appropriate mental health and social support for people with a mental health problem who are victims, witnesses, suspects and offenders, particularly at the time of first contact with police.

Consideration will be also given to piloting a specialist mental health list within the Magistrates' Court with the capacity to provide mental health assessments for treatment and sentencing purposes, with specialist training for the court team and dedicated brokerage funding to enable referral to appropriate community-based services.

Newly released prisoners often struggle to access the clinical, health and broader social supports they need. This directly impacts on recidivism rates, compromises public safety and increases the risk of hospitalisation, relapse to substance abuse, suicide and homelessness.

As part of the Corrections Victoria's Demand Management Strategy, we will explore ways of enhancing existing adult prison pre and post-release transitional programs to support prisoners to access and remain engaged with the range of services they need such as mental health treatment and psychosocial support, drug and alcohol treatment, housing and employment, to successfully re-integrate into the community.

Further, Corrections Victoria will give consideration to enhanced assistance and supervision for offenders with mental illness and intellectual disability on community-based court dispositions to increase the opportunity for these offenders to be diverted from prison to community-based orders.

This would occur in tandem with the strengthening of prisoner mental health services to better support people with emerging or existing mental health problems. Ways to enhance the capacity of specialist mental health services to support people with a forensic history and reduce the risk of re-offending behaviour will also be reviewed (see Reform Area 4).

The Department of Justice will also move towards a coordinated, integrated justice health service system across police, courts and community correctional services as part of a review of the delivery and availability of existing health and mental health services.

## Key strategy proposals

Action to be considered over the life of the strategy includes:

- Supporting people with severe mental illness and multiple needs, and their carers, through designated care coordinators who will lead the development and implementation of comprehensive care plans. Standard elements of these plans would include clinical, psychosocial rehabilitation, general health care and social support.
- Giving people with enduring psychiatric disability who are homeless or at risk of homelessness, greater access to individually tailored packages of psychosocial outreach support linked to a range of secure and affordable long-term housing options.
- Explicitly considering the needs of people with mental illness, alongside people with other complex needs, as part of the planning and allocation of new and existing social housing, including that provided by Housing Associations, and the development of new housing and support models.
- Creating closer linkages between specialist employment workers and specialist mental health services (clinical and psychosocial rehabilitation). This may include the co-location, or provision of specialist employment workers on an in-reach basis in specialist mental health services.
- Fostering partnerships between business groups, public sector organisations, PDRS services, exemplar employers and training providers to create training and employment opportunities and promote 'employer readiness' for people with moderate to severe mental health problems.
- Promoting community acceptance and inclusion of people with mental health problems in social and recreational activities through public awareness initiatives and partnerships with local government and non-governmental organisations (NGOs)
- Exploring new approaches in the criminal justice system to divert people with a mental illness from custody. This may include a mental health court list to provide assessments, brokerage funding and referral to community-based services, and enhanced advocacy and support to victims, suspects and offenders at early stages of their contact with courts.
- Strengthening the capacity of pre and post release transitional programs to address mental health, alcohol and drug, housing and other complex problems that affect the ability of prisoners to re-integrate into the community (as part of the Corrections Demand Management Strategy)





## Reform Area 6: Reducing inequalities

### Responding better to vulnerable people

<b>Goal 6.1</b>	Improve the social, spiritual and emotional wellbeing of Aboriginal people, their families and community
<b>Goal 6.2</b>	Improve outcomes for people with a mental illness and co-existing intellectual disability, Acquired Brain Injury or Autism Spectrum Disorder
<b>Goal 6.3</b>	Improve mental health outcomes for people from culturally and linguistically diverse and refugee backgrounds

#### Key outcomes:

- reductions in the inequalities experienced by Aboriginal and CALD communities and people with a co-existing disability
- better access to culturally responsive mental health care and disability support
- stronger partnerships with Aboriginal and CALD communities in the development of mental health care

### Towards 2019

By 2019 we want to have significantly closed the gap in health outcomes experienced by Aboriginal people, their families and community. Aboriginal people of all ages and their families should be better able to access the full range of mental health and broader health, social and welfare services available in the community. Concrete and decisive action will be taken to address the barriers – cultural or structural – currently preventing this.

Working closely with Aboriginal organisations and communities and building on existing knowledge and best practice, we will also identify and address critical service issues and gaps that require a specific response or a new way of working. Priority will be given to the development of culturally responsive services that focus on prevention, early intervention and recovery – delivered in ways that allow for local solutions and build on the strength, expertise and resilience that exists in Aboriginal organisations and communities.

We want to see a more integrated response to the needs of people with a mental illness and co-existing intellectual disability, Acquired Brain Injury or Autism Spectrum Disorder who, due to the nature and/or their level of disability, require coordinated care and supported accommodation options. We will continue to build the capacity of the mental health and disability service sectors to identify, appropriately assess, treat and support for this vulnerable population group.

We want to see improved mental health outcomes for people from culturally and linguistically diverse (CALD) communities, particularly refugees and older people from these communities who have, or are at risk of developing, a mental health problem.

This would be achieved through improving access to culturally responsive mental health services at earlier stages of illness and by enhancing the capacity of primary health services and workers in CALD community settings to identify, respond earlier to, and refer people with emerging mental health problems.



## Reform directions

### Goal 6.1 Improve the social, spiritual and emotional wellbeing of Aboriginal people, their families and community

Aboriginal people conceptualise good mental health as part of social, spiritual, emotional and physical wellbeing. Fostering cultural identity and connection to land, family and community is critical to this and underpins the need for a holistic culturally-based response that recognises the centrality of culture to wellbeing and promotes self determination.

Many Aboriginal individuals and communities experience higher levels of socio-economic disadvantage. Generations of Aboriginal people have experienced grief and trauma due to separation, loss of connectedness to land and place, intergenerational poverty and economic marginalisation together with discrimination and social exclusion. This has led cumulatively to poorer social, spiritual and emotional wellbeing for Aboriginal people and their families.

All sectors need to take a more systematic approach to addressing the range of factors that support good social and emotional wellbeing – such as employment, housing security and freedom from discrimination – in order to achieve sustainable improvement outcomes for Aboriginal people.

The design and delivery of effective culturally competent mental health services for Aboriginal people must be based on an understanding of their unique lived experience (including the impact of trans-generational trauma), their cultural perspective on health and wellbeing, and the interconnection between the individual, family and community.

Building on these principles, the strategy encourages culturally-based social and emotional wellbeing services and interventions, developed and delivered by Aboriginal organisations in partnership with local mental health services with the aim of promoting self determination, intervening earlier to optimise recovery outcomes and more effectively engaging Aboriginal people in mainstream mental health and social support services.

#### **Building partnerships**

Given the level of socio-economic disadvantage experienced by Aboriginal people reflected in housing tenure, income security, corrections and employment data it is critical that health, social support, housing, justice and mental health services work in partnership with Aboriginal organisations and communities.

To facilitate this we will explore ways to strengthen the capacity of Aboriginal organisations to actively participate in statewide and local planning and service coordination mechanisms (see Reform Area 8).

#### **Health promotion**

Consideration will be given to supporting targeted, culturally-appropriate health promotion efforts that foster social and emotional wellbeing within Aboriginal communities and promote community resilience. The needs of Aboriginal children and young people would be included in health promotion strategies involving schools (see Reform Area 1).

### **Improving outcomes for children and young people and their families**

While early intervention and equitable access to the full range of mental health services should occur for all age groups, priority attention needs to be given to children, young people and their families in order to prevent or reduce the severity of mental illness and its life impacts. This is particularly important for Aboriginal children and young people given that approximately 40 per cent of the Aboriginal population is under 25 years of age.

Breakdown in kin and family structures has had a significant impact on the emotional and spiritual wellbeing of some Aboriginal children and young people, particularly those in the child protection and youth justice systems. Research tells us that strong cultural identity and connection builds resilience and supports good social and emotional wellbeing.

Consideration will be given to developing a prevention and early intervention strategy for Aboriginal children, young people and their families. This may include:

- A prevention, identification and early intervention initiative targeted to Aboriginal young people aged 10–25 years at risk of or experiencing poor social and emotional wellbeing to be developed in collaboration with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and selected Aboriginal Community Controlled Health Organisations (ACCHOs).

This initiative would use culturally-sensitive health promotion approaches to build resilience and promote protective factors associated with wellbeing. It would also provide intensive case management to vulnerable young people demonstrating high risk behaviours (such as drug use), and those in child protection, out-of-home care, youth justice and adult correctional services. It would fast track their access to, and support ongoing engagement with specialist child and adolescent mental health services when required.

- Undertaking routine social and emotional wellbeing assessments linked to appropriate interventions as part of the support available to Aboriginal children entering out of home care.
- Supporting the development of Aboriginal social and emotional wellbeing programs in child and family welfare services in ACCHOs across the state, targeted to vulnerable children and young people.
- Strengthening the capacity of Victorian Aboriginal Child Care Agency to identify, assess and treat high risk children.

Meeting the needs of vulnerable Aboriginal children and young people will also be an integral part of the redevelopment of specialist child and adolescent mental health services (see Reform Area 2).

### **Improving access to social and emotional wellbeing services**

Aboriginal people living in metropolitan areas often experience difficulty accessing responsive mental health care and psychosocial support. In order to promote access to the full range of mental health care services across the continuum of need, we will work towards new culturally-based approaches which focus on prevention, early intervention and recovery.

In particular, work will be undertaken to develop a new metropolitan-wide social and emotional wellbeing service model in partnership with VACCHO, the Victoria Aboriginal Health Service (VAHS) and relevant Aboriginal organisations and mental health services.

We envisage this could consist of:

- A service 'hub' – drawing on, refining and expanding the current capacity in VAHS – which will provide an integrated social and emotional wellbeing response targeted to prevention, early intervention and recovery across the continuum of need.

The 'hub' would:

- provide a key point for coordinated intake, streamlined assessment and referral
- support metropolitan mental health crisis teams and the emergency services to provide a culturally sensitive crisis response in metropolitan Melbourne
- strengthen the capacity of VAHS to provide supervision and debriefing support to the Aboriginal mental health workforce in metropolitan Melbourne
- strengthen VACCHO's statewide training and education and workforce development role and capacity to provide cultural mentoring to staff in mainstream mental health, primary health, alcohol and drug treatment services in each partnership area
- resource partnerships and cross-agency planning between Aboriginal organisations and local mental health and social support services in metropolitan Melbourne
- promote the use of MBS-rebated psychological and allied health services.
- A 'spoke' element which will strengthen the capacity of relevant Aboriginal organisations in four designated partnership areas across metropolitan Melbourne. New positions will be created to identify people at risk of, or experiencing, mental health/social and emotional problems, and provide direct clinical and psychosocial rehabilitation support early in illness. Care coordination will be a key function of this service model, and will assist them to engage with mental health, primary health and other relevant mainstream services.

The scope of reform and capacity building needed to strengthen the provision of mental health care for Aboriginal people living in regional and rural Victoria will be informed, in the short term, by the outcomes of the review of the rural Koori Mental Health Liaison Officer (KMHLO) and Improving Care for Aboriginal Patients (ICAP) programs.

In all of the above developments, we will promote and support integrated approaches to Aboriginal people with mental health and co-occurring physical health and/or problematic substance use given the high level multiple co-morbidity in this population group. In line with this, KMHLO and ICAP workers based in rural hospital settings will be encouraged to work as teams.

We will also continue to explore opportunities for other mainstreamed approaches such as the specialist Aboriginal acute mental health inpatient beds at St Vincent's Hospital. Consideration will be given to the demand for dedicated Aboriginal acute inpatient services in other locations into the future. We will also examine ways to develop the cultural knowledge and expertise in mainstream acute inpatient services in order to improve local access for Aboriginal people.

Priority will be given to supporting Aboriginal people experiencing poor social and emotional wellbeing who are homeless or at risk of homelessness and those involved in the criminal justice system, either as offenders or victims (see Reform Area 5).

In the short term, Corrections Victoria will give consideration to implementing a statewide holistic pre and post release support program that is culturally sensitive to the transitional needs of Aboriginal men and women exiting prison. In the longer term, consideration will be given to how screening and assessment tools could be made culturally appropriate for Aboriginal people entering the prison system in order to identify their social and emotional needs.



**Workforce development**

Aboriginal mental health workers are also members of the community where they work and some may experience vicarious trauma. Given the challenges of their role, they require support to maintain their own social and emotional wellbeing.

In collaboration with VACCHO and key stakeholders, we will seek to develop an Aboriginal mental health workforce strategy to address supply and capacity issues, as well as building competency and long-term sustainability.

At present no formal mechanism exists to systematically drive Aboriginal mental health workforce development, quality improvement strategies or the identification and promotion of best practice. Nor is there a mechanism to create ongoing policy dialogue and exchange between Aboriginal organisations, mainstream mental health and social support services and education institutions.

In response to this, consideration will be given to the creation of an Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Centre or similar structure in consultation with VACCHO and other relevant stakeholders.

**Developing culturally responsive mainstream services**

Aboriginal people are often reluctant to access mainstream services due to a variety of factors. These include a lack of awareness on the part of services of the cultural dimensions underlying their presenting problem, previous experiences of racism and past policies of institutional discrimination and removal. Experiences of culturally-inappropriate mental health treatment and care can operate as a form of unintended discrimination and exacerbate a predisposition to poor social and emotional wellbeing in some Aboriginal people.

It is particularly important that universal services such as school and general practice are culturally-sensitive given their key role in the early identification, support and referral of Aboriginal people with emerging social and emotional problems. Schools that are culturally-sensitive, in particular can play a critical role in identifying and supporting at risk Aboriginal children and their families (see Reform Area 2).

The strategy will seek to adopt a 'cultural safety' framework that will see culturally sensitive practice as the norm in specialist mental health services. The notion of safety relates to how the client experiences a service; it occurs when a person feels they are welcome and safe to be themselves.

To facilitate this we will, in collaboration with VACCHO, consider implementing:

- Training and other capacity building strategies to support specialist mental health services to provide culturally-safe environments and improve their understanding of Aboriginal ways of working and healing. Opportunities for shared learning will also be explored to develop mutual understanding and trust between Aboriginal clients and specialist mental health services.
- A tailored social and emotional wellbeing/ mental health first aid course for mainstream health and social support services to improve their cultural competency and confidence.
- Advanced training for Aboriginal workers (such as ICAP, justice, housing and alcohol and drug treatment workers) to support them to identify, assist and refer Aboriginal people at risk of experiencing poor social and emotional wellbeing.

### **Building the evidence base**

As part of the broader applied research and evaluation agenda (outlined in Reform Area 7), specific attention will be given to identifying and promoting best practice interventions, models of care and service delivery approaches in Aboriginal mental health, and proactively translating this evidence into practice, program design and service delivery.

We will also seek to improve data collection and information management systems to more accurately identify and analyse the needs of Aboriginal people with social and emotional problems and track progress in addressing these needs, via culturally appropriate performance measures.

### **Goal 6.2 Improve outcomes for people with a mental illness and co-existing intellectual disability, Acquired Brain Injury or Autism Spectrum Disorder**

An estimated 14,000 Victorians have a mental health problem and an intellectual disability, of which 6,000 are estimated to be clients of both state-funded mental health services and disability services.

It is estimated that 1 in 45 Victorians have an Acquired Brain Injury (ABI). This population group is more likely than all other disability groups to have multiple conditions including mental health problems and problematic substance use.

This goal prioritises attention to people with a mental illness and co-existing disability, including intellectual disability, ABI or Autism Spectrum Disorder in recognition of the significant difficulties these population groups experience in accessing appropriate mental health treatment and care and broader social supports.

The key issues include:

- proficiency in the identification of mental illness in people with intellectual disability, ABI or Autism Spectrum Disorder
- the skill and proficiency of disability, specialist mental health, justice, general practice and other primary health services in the early identification, diagnosis, treatment and management of people with a mental illness and co-existing disability
- difficulty experienced by consumers, their carers and families in accessing services and navigating multiple service systems
- consumer access to key social supports, particularly affordable and appropriate housing linked to support.

In response to these issues we will seek to strengthen cross-sector partnerships, improve workforce capacity and develop a solid research and evidence base for best practice (see Reform Area 7).

In the short to medium term we will work towards designated co-existing disability portfolio roles within adult area mental health services. These portfolio holders would receive additional training and supervision to provide specialist assessment, treatment and care to clients with a severe mental illness and a co-existing disability. They would also provide secondary consultation to clinical mental health services, PDRSS, disability services, drug and alcohol treatment, primary health and justice services to assist them to support this group. Building mental health capacity in selected disability services-funded behaviour intervention programs will also be considered.

Partnership arrangements and linkages between specialist mental health and disability services will be strengthened at the local level to achieve a 'no wrong door' approach to the needs of people with a mental illness and co-existing disability. This will be supported by updating service protocols between mental health and disability services. We want to see expansion of joint training opportunities for specialist mental health and disability workers including staff rotations.

We will also explore new approaches to better provide expert assessment, secondary consultation and professional development to specialist mental health services, disability service providers and primary health services.

To improve the knowledge and skill set of our workforce we will, in consultation with educational bodies, expand the curricula content regarding mental illness and co-existing disability in relevant tertiary qualifications.

Many people with a severe mental illness and a co-existing disability require coordinated care to access multiple services, in addition to treatment and rehabilitation support. Priority will be given to improving the coordination of care of this population group (see Reform Area 5).

The level of permanent functional impairment experienced by people with severe mental illness and co-existing disability can make it difficult for many individuals to access and maintain stable housing without ongoing support. The housing and support models outlined in Reform Area 5 will also be targeted to this cohort.

We want to see the expansion of supported accommodation options for those who require varying levels of rehabilitation support in a safe, structured and stable environment (see Reform Area 5).

In response to the growing proportion of individuals in the criminal justice system with a mental illness and intellectual disability or ABI, we will explore approaches that divert this group from custodial to community-based orders. We will also give consideration to strengthening the capacity of the criminal justice system to provide treatment and support to people with a mental illness and co-existing disability while in custody and improve responses to this group in prisoner pre-and post-release support programs (see Reform Area 5).

### **Goal 6.3 Improve mental health outcomes for people from culturally and linguistically diverse and refugee backgrounds**

#### **Improving service access and responsiveness for CALD communities**

People from CALD and refugee backgrounds experience poorer mental health outcomes when compared to persons born in Australia and often present to mental health services at a later stage of illness. This highlights the importance of primary health, mental health and social support services recognising the signs of poor mental health in people with a CALD background and intervening earlier.

We want to improve the responsiveness of mental health services to the range of needs of people from CALD backgrounds and their families. Adoption of a cultural competency framework would mean culturally competent practice becomes a core skill in specialist mental health and primary health services.

As part of this framework, we will give consideration to:

- supporting designated cultural portfolio holders in specialist mental health services to establish and coordinate structures and processes to systematically plan for and address the needs of consumers and carers from CALD backgrounds



- reinforcing links between cultural portfolio holders and Health Service Cultural Diversity Plans to promote mental health issues
- building on the work of the Victorian Transcultural Psychiatry Unit (VTPU) and the Action on Disability within Ethnic Communities (ADEC), we will continue improving training for primary health care practitioners and mental health services to assist these sectors to better respond to the diverse needs of people from CALD backgrounds, including training in working with interpreters.

We want to explore ways to provide mental health literacy training to multicultural, ethno-specific and refugee agencies to improve their understanding of mental illness and help workers in these agencies to better navigate the mental health service system on behalf of CALD consumers. We will also explore opportunities to extend mental health literacy training to HACC services to enable earlier intervention in mental health problems experienced by older CALD people.

We want to utilise the wealth of understanding that ethno-specific welfare agencies have of their communities. In line with this, we will encourage practical partnerships between these agencies and specialist mental health services to facilitate culturally-specific input into clinical treatment and psychosocial rehabilitation plans. This may be supported by introducing flexibility in the application of existing funding, to allow certain funds (such as brokerage funds) to be expended on support provided through ethno-specific agencies, or possible inclusion in more formal consortia. Mental health training for ethno-specific agencies will assist them to play these roles effectively.

We will assess the extent to which the language needs of CALD clients are being met in specialist mental health services and address any gaps in provision, including the supply of interpreters trained to work in this service sector. We will also promote client and carer awareness of language services.

We will continue to build culturally competent area mental health and PDRS services and develop relevant indicators to measure the impact of such initiatives in providing culturally-appropriate services to CALD communities.

We will encourage area mental health service and PDRSS planning to more consistently consider the characteristics and needs of different cultural groups in their catchments, and plan and deliver services accordingly.

The participation of CALD and refugee consumers and carers in research and development projects will be encouraged. We will also promote greater diversity in the mental health workforce and greater recognition of the diverse needs of CALD carers, consumers and families (see Reform Area 7).

### Improving mental health outcomes for refugees and their families

Each year Victoria accepts over 3,500 humanitarian entrants. Refugees and asylum seekers typically experience extreme hardship in their country of origin and are at greater risk of developing post-traumatic stress disorder (PTSD) and associated disorders, such as depression and anxiety. The challenges of resettlement – understanding a new culture, separation from family, language difficulties, discrimination, accessing housing and gaining employment – can also have a negative impact on the mental health of refugees.

Typically, the first point of contact for refugees and other humanitarian entrants experiencing mental health problems are GPs and other primary health providers. We will work collaboratively with the Victorian Refugee Health Network and Divisions of General Practice to build capacity in the primary health sector to adequately respond to and appropriately refer refugees and asylum seekers presenting with mental health problems, particularly in rural and regional Victoria.

Additionally, we will help refugees and asylum seekers to recognise the signs of poor mental health and seek help earlier by working to improve the mental health literacy of these communities and de-stigmatise mental illness.

Refugees and asylum seekers who have experienced severe trauma present special challenges to treatment services, often requiring expert assessment and intensive treatment. We will give consideration to expanding the Victorian Foundation for Survivors of Torture so that it can better support these refugees in regional and rural Victoria.

### Key strategy proposals

Action to be considered over the life of the strategy includes:

- Providing Aboriginal people living in metropolitan Melbourne with culturally-supportive social and emotional wellbeing and recovery services delivered through new collaborative arrangements between the Victorian Aboriginal Health Services (VAHS), Victorian Aboriginal Community Controlled Health Organisations (VACCHO), local Aboriginal organisations and mental health services.
- Exploring, with VACCHO and selected Aboriginal Community Controlled Health Organisations, a coordinated local prevention, early identification and intervention program targeted to young Aboriginal people aged 10–25 years at risk of, or experiencing, poor social and emotional wellbeing.
- Strengthening the capacity of mental health, disability and primary health services to identify, assess and treat people with a mental illness and co-existing disability by improving secondary consultation and creating a 'no wrong door' approach to the needs of this group.
- Achieving more culturally responsive services for culturally and linguistically diverse (CALD) and refugee communities through workforce development and strengthening the Cultural Portfolio Holder positions in specialist mental health services.





## Reform Area 7: Workforce and innovation

### Building skills, leadership and knowledge

<b>Goal 7.1</b>	Build a sustainable, flexible and dynamic specialist mental health workforce that operates as a highly respected part of the broader health and community services sector
<b>Goal 7.2</b>	Develop work practices and cultures in mental health services that support high quality, effective, consumer-focused and carer-inclusive care
<b>Goal 7.3</b>	Systematically improve the mental health competency of other key workforces in the community
<b>Goal 7.4</b>	Create an organised statewide research and knowledge management capacity to provide a robust evidence base on mental health care

#### Key outcomes:

- an adequate and sustainable supply of skilled mental health workers
- a valued and respected mental health workforce
- quality care that respects the rights and dignity of consumers and carers
- interventions grounded in a strong evidence base
- effective frontline response for people with mental health problems across a range of sectors

### Towards 2019

The implementation of many of the strategic directions identified in the mental health reform strategy are contingent on the development of robust, adaptable and skilled workforces with the sufficient capacity to maintain and expand service delivery and respond to the changing and diverse needs of consumers.

By 2019 we want to have a specialist mental health workforce (clinical and psychosocial) where all are valued and professionally supported throughout their careers.

We will support ongoing training and development to equip the mental health workforce with the necessary skills and competencies to perform their roles now and in the future. We will encourage mental health services to adapt and innovate to make the best possible use of people's skills, talent and capacity while delivering high quality care. This may include role diversification and redesign to provide greater flexibility in team structures and increased opportunities for staff to move between sectors.

The workforce will provide high quality, safe and supportive treatment and care that is culturally responsive and meets the treatment and psychosocial rehabilitation needs of the people and communities it serves. Good understanding of the needs of consumers, their families and carers will drive the education and training of mental health workers, professional practice and broader service planning and delivery.

We also want to see innovative leaders committed to excellence in service delivery, and improved quality outcomes for consumers, families and carers. They will inspire students and health professionals to pursue careers in mental health.

We will work towards building the capacity of workers in broader health, justice, education, housing and homelessness service sectors to more confidently identify, support and refer people with mental health problems.

Workforce policy, planning and best practice in service delivery should be underpinned by a solid evidence base. This will be informed by an applied mental health research agenda coupled to the evaluation of service models and initiatives.

Statewide and national collaboration will drive mental health workforce development, consolidating the innovative work currently undertaken across the state, and facilitating the translation of evidence into practice.

Progress in all these goals will depend on the engagement of broader health and community workforce bodies, and a stronger voice for mental health issues within all relevant training, education, accreditation and quality assurance structures.

## Reform directions

Victoria's specialist mental health workforce is highly committed to the provision of expert treatment and care of people with severe and enduring mental illness and psychiatric disability. Building on this foundation we will work with specialist mental health services and professional bodies to strengthen and secure the current workforce, and position it to deliver the vision articulated in the mental health reform strategy.

A Mental Health Workforce Strategy Committee has been established to oversee the implementation of a workforce sustainability strategy. The committee's report will directly inform the workforce action plan being developed as part of the mental health reform strategy.

Victorian mental health workforce policy sits within national mental health, health and community services workforce policies. Mental health workforce issues need to be considered in health and community workforce planning at both the state and national levels to provide opportunities for leveraging workforce initiatives.

With this in mind, we will progress discussions with the Commonwealth Government regarding opportunities for collaboration on various workforce activities, including service delivery through public/private partnerships, to address workforce shortages in skills and localities.

As part of these processes, the strategy will consider ways to:

- **secure a sufficient supply** of mental health workers to maintain service delivery levels in the short term and accommodate service growth over the longer term
- **distribute and organise the workforce** that meets the needs of consumers and provides equitable access to mental health care
- **create good working environments** that are safe, collaborative, supportive and stimulating for staff
- **support ongoing learning and skills development** to equip the clinical and psychosocial rehabilitation workforce with the knowledge, skills and competencies needed to respond effectively to the changing and diverse needs of consumers
- **support service adaptation and innovation** to optimise the efficient and effective use of people's skills, talent and capacity, including the development of new roles and the redesign of some existing roles
- **promote client-centred workforce cultures** that are responsive to the needs and expectations of consumers and carers. This will include active learning and an openness to new ways of working informed by recovery principles
- **support general health, justice and community services** to develop the core competencies and confidence needed to identify, support and refer people with mental health problems.



## Goal 7.1 Build a sustainable, flexible and dynamic specialist mental health workforce that operates as a highly respected part of the broader health and community services sector

### Secure supply

We will regularly model our future workforce requirements, taking into account population growth and distribution, and the current and projected staff levels required in each professional category, to meet the planned development of services. We will work with the Commonwealth Government to work towards a sustainable supply of adequate training places to meet these workforce projections.

### Recruitment

As an early part of a sustained, comprehensive recruitment strategy we will consider implementing a marketing campaign to attract students in secondary schools, undergraduate years and overseas graduates to a career in the mental health field. The campaign would identify the opportunities for career development in mental health care. Study could be supported through scholarships and cadetships.

With the introduction of more generalist curricula, many potential mental health workers receive inadequate opportunity to experience mental health service provision. We will explore ways to improve the mentoring of students as they are introduced to mental health care and support. Discussions will also be held with education, training, registration and credentialing bodies to include mental health placements in any training rotations.

In the short term, we will actively support the targeted recruitment of international staff to address pressing workforce shortfalls, particularly medical graduates in rural areas, while seeking over the longer term to reduce overall reliance on overseas graduates. Sponsorship of pre-examination preparation for trainees may be considered to improve pass rates of urgently-needed professional groups. We will also investigate ways of facilitating professional registration of overseas recruits in discussion with professional bodies.

Furthermore, we will pursue ways to encourage mental health professionals that no longer work in the public specialist mental health service system to return. This may be supported by the development of a refresher training program for accelerated re-entry, incorporating professional supervision and mentoring in the workplace to fast track the updating of skills.

We will build on the Victorian Government's *Strengthening Community Organisations* initiative to facilitate the transition of suitable workers from other sectors to the mental health workforce by improving the portability of benefits, the transferability of qualifications through identification of core competencies, and the development of bridging courses to reorient existing knowledge and skills to mental health service provision.

### Retention

Retaining experienced mental health workers across all sectors is critical to maintaining and expanding quality service delivery. Experienced mental health workers also play a key role in providing leadership, supervision and mentoring.



As part of a comprehensive retention strategy aimed at attracting and retaining senior professionals in specialist mental health services we will:

- explore flexible employment options to improve work/life balance and articulate career paths with more discipline-specific roles
- actively promote a mix of public/private employment opportunities, including staff rotations
- explore opportunities for the creation of advanced worker roles. These will enable experienced staff to further develop specific expertise and act as role models for less experienced or skilled staff
- consider providing incentives for post-graduate study, including post graduate scholarships
- support opportunities for expanded roles, research participation or joint practice/academic appointments
- explore the impact of different industrial awards on retention across different elements of the mental health workforce.

We propose to support new workers entering the specialist mental health workforce by developing a standardised induction and orientation training program. As part of this dedicated program, new workers could be provided with mentoring for the first 12 months of employment in order to develop the core competencies required and have the opportunity to work in a range of service settings. Entry-level positions will commence with smaller caseloads, which will be progressively increased over time and under close supervision.

Supervision, training and leadership are core functions of senior positions. To support senior professionals to undertake their roles, we will consider providing training in supervision, management and leadership, and reduced client caseloads.

We will encourage retiring or retired professionals to maintain links with mental health services to retain their knowledge and experience through, for example, consultancy roles that involve teaching and/or mentoring less experienced or new staff, and opportunities to participate in research.

### **Distribute and organise the workforce**

As well as having sufficient numbers of mental health professionals in the Victorian workforce, it is important that they are located where they are needed. Traditionally there has been an undersupply of mental health workers in rural, regional and outer metropolitan localities, a pattern shared by the broader health workforce.

In response to this, mental health workforce needs will be incorporated within broader health and community workforce initiatives that seek to improve the distribution of health and community professionals across the state.

In the short-term, we will build on current service provider initiatives that encourage rural students to study and work locally. This effort will be supported by improving linkages between services, educational bodies, registration and accreditation bodies on how best to increase the number of skilled mental health workers in rural localities.

We will also explore the feasibility of diversifying the roles of workers in rural areas to deliver new service models, such as nurse practitioner-led clinics. Technology will be utilised more effectively to support rural mental health services to access specialist supervision and expertise.

Over the medium to longer term, combinations of public and private, and rural and metropolitan employment will be explored to address local workforce shortages.

We will consider appropriate opportunities for placement of clinicians in PDRSS to facilitate continuity and integration of care. We will also consider the placement of specialist mental health workers in other agencies – such as alcohol and drug treatment, homelessness, community health and mainstream residential aged care. This will include strategies to ensure workers receive adequate professional supervision and access to ongoing training.

### **Create good working environments**

Continued high demand for services by people with complex needs challenge staff to continually provide high quality, therapeutic interventions. In addition, staff need to feel safe in their workplaces, be treated with dignity and respect by consumers, and supported to provide quality care.

Victorian mental health service providers that have demonstrated a positive contribution to consumer wellbeing and recovery will be identified, the reasons for their success analysed and the information disseminated to other service providers to assist in improving working environments.

We will explore ways to assist service providers to develop organisational cultures that facilitate recruitment and retention of staff. We will also explore models for leadership development in mental health services as part of a strategy to create and promote good working environments (see Goal 7.2).

The health and safety of staff and consumers is paramount. We will proactively identify and manage health and safety risks in line with WorkSafe guidelines. This may include improved physical working environments, better alignment between competencies and role functions, and manageable caseloads.

We will continue to support both aggression management training for all staff and to implement the *Creating safety* project to establish safer environments for mental health consumers and staff.

### **Support knowledge, skills and work practice development**

In consultation with key stakeholders (including unions, professional bodies, education providers, service providers, consumers and carers) we will develop a training and education agenda, underpinned by guidelines that facilitate practice development. The agenda will support the mental health workforce to continue to develop skills and competencies, based on best practice, and enable them to adapt to the evolving needs of consumers.

As a precursor to the development of the agenda we will, in consultation with key stakeholder groups, map specialist mental health roles and identify the core competencies needed to undertake them.

The core competency framework will inform the scope and nature of the training and education agenda, and will sit within national mental health and Victorian health workforce competency frameworks. This action will also:

- facilitate articulation of professional career paths
- provide both staff and organisations with a clear understanding of what knowledge, skills and experience are required to undertake various mental health roles
- guide the professional development of entry and mid-level workers
- be used as the basis for discussion with educational bodies regarding better alignment between training courses and mental health service provider needs

- include mental health consumer and carer roles, both consultancy and peer specialist, and Aboriginal mental health worker roles.

The competency framework will be supported by processes that facilitate curriculum change with professional, education and training bodies to achieve continued relevancy to mental health service delivery and government policy directions. Strengthening mental health content in relevant undergraduate courses will be a priority.

We will work towards strengthening training for the PDRSS workforce, focusing on the development of flexible, tailored training. Furthermore, we will explore in collaboration with relevant educational and professional bodies, and consumers and carers, the development of a psychosocial rehabilitation course for this workforce.

We will also look to develop more specialty roles in mental health care and support such as eating disorders, co-existing disability, personality disorder, trauma and forensic rehabilitation in area mental health and PDRS services. Any training developed would be available to mental health workers from all sectors.

In addition, skills associated with caring and supporting people with comorbid mental health problems and problematic substance use, and identification of physical health needs of clients, will become part of the core competency of specialist mental health workers.

To facilitate a comprehensive and coordinated approach to the development of the specialist mental health workforce we will explore the potential to establish an Institute of Mental Health Workforce Development and Innovation. The Institute will drive the implementation of mental health reform from a workforce perspective.

This statewide collaborative body would support mental health workforce development, coordinate mental health workforce training and provide an integrated, focused response to mental health workforce issues. It would also consolidate the work of the various mental health centres of excellence and facilitate the identification and uptake of best practice mental health care and support.

#### **Support adaptation and innovation**

The core functions identified in the competency framework will inform the development of new mental health roles and/or will expand and potentially redesign existing roles.

We will support job and service redesign that allows mental health workers to develop other specialist skills and creates more formalised long-term opportunities for staff with these skills to work in different service settings such as alcohol and drug treatment services and mainstream residential aged care services.

Advanced practice and consumer and carer peer worker roles may also be developed as part of the delivery of existing and new service models. Further areas of potential further development include Division 2 nursing and Psychiatric Support Officer roles.

We may explore the co-location of MBS-funded workers in public mental health community-based services with provision for the overheads to be absorbed in full, or part, by the public sector, on the proviso that these staff work at least part time in the public system.

### Goal 7.2 Develop work practices and cultures in mental health services that support high quality, effective, consumer-focused and carer-inclusive care

The transformation of the mental health service system needs to be underpinned by an assertive program of cultural change to improve the responsiveness of mental health services to the needs and expectations of consumers and carers.

We will identify national and international evidence of recovery-oriented services and develop a framework for implementation of recovery principles for the Victorian mental health workforce.

The framework will include the development and articulation of Victorian practice standards, based on the National Practice Standards for the Mental Health Workforce and focus on meaningful consumer engagement and recovery, family/carer inclusive practice, and cultural sensitivity. Standards will be developed for area mental health and PDRS services workforces, with implementation overseen by experienced staff skilled in work practice leadership.

We will assist in developing a learning culture in mental health services. Structures will be developed to identify, document and disseminate best work practice, and encourage and support benchmarking among service providers. We are also committed to the delivery of quality services, monitoring and continuously improving service delivery through input from consumers, their families and carers, and staff.

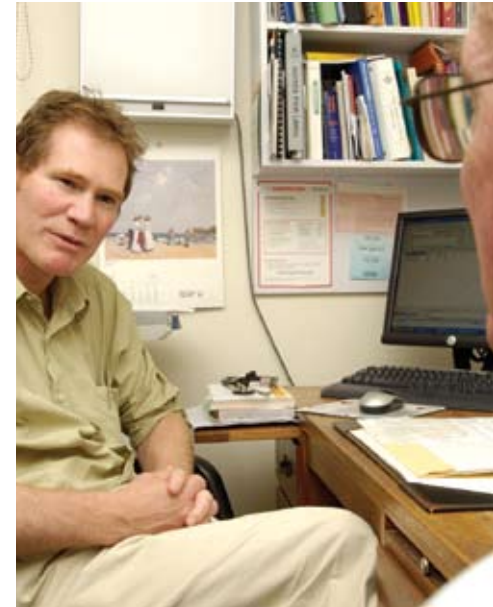
Staff need to ensure that their skills and knowledge are current, that they critically reflect on their work with consumers, their families and carers, and adjust their work practices accordingly. We will discuss with professional and credentialing bodies how best to ensure that mental health workers keep their skills up-to-date and pursue life-long learning.

Organisations need to ensure that their staff have access to ongoing training and development opportunities to further their professional and organisational skills in supervision, management and leadership. We will look at facilitating this through better use of e-learning opportunities, especially for rural staff.

Emerging leaders would be identified within service providers and professions, and additional opportunities provided to develop their skills.

Training and supervision are core functions of senior positions. These functions could be strengthened by identifying a set of core competencies for supervisors and managers, and opportunities for education and training at Vocational Education and Training (VET) and university levels to achieve those competencies. This could be usefully complemented by mentoring and coaching provided by identified mental health service leaders.

Senior managers and professionals, area mental health services and PDRSS, would also benefit from professional development in representing mental health interests at the executive level of auspicing agencies. This skill will be important to the success of any integrated governance platforms arising from the mental health reform process (see Reform Area 8).



Currently, the composition of the public mental health workforce does not adequately reflect population diversity. As part of our overarching mental health workforce strategy we will seek to increase participation of Aboriginal people and those with culturally and linguistically diverse backgrounds in the mental health workforce.

As indicated in Reform Area 6, in collaboration with VACCHO and other key stakeholders, we will work to develop an Aboriginal mental health workforce strategy to address supply and retention issues in this workforce.

### **Goal 7.3 Systematically improve the mental health competency of the other key workforces in the community**

A key theme of this strategy is the enhanced capacity of sectors beyond the specialist mental health services. This requires a systematic targeted effort to improve workers' skills in a range of health, welfare, justice and community services settings.

Staff working in services such as maternal and child health, aged care and community health, child protection, education, youth and adult justice, disability, housing and homelessness, employment, drug and alcohol services increasingly encounter clients with behavioural problems or mental illness.

It is critical that these key workforces increase their mental health competency to better engage people with mental health problems. They also need to work collaboratively with specialist mental health workers to facilitate a coordinated response to people with mental health needs.

Apart from facilitating the recovery of people with mental illness, these workers, with appropriate training, can assist in identifying people at risk of mental illness, or who are becoming unwell, thus facilitating prevention and early intervention.

Working across government, we will coordinate an ongoing program of mental health training for staff working in key sectors, building on existing training structures wherever possible. We envisage there would be two levels of training:

- Training for frontline staff could cover basic information on mental illness, such as mental health literacy, identifying and managing risk, understanding the service system, and working with people with challenging behaviour.
- The second level of training for more specialist staff could include early intervention for less complex forms of mental health problems, and collaborative practice and care coordination with primary and specialist mental health care providers.

Both frontline and more specialist program staff would be supported by mental health professionals through secondary consultation and advice.

In the short-term, priority would be given to training staff in youth justice, adult corrections, housing and homelessness, ambulance services and education. In the longer term, training would be made available for staff in the following programs:

- child protection
- disability
- maternal and child health
- aged care
- community health
- employment.

## Goal 7.4 Create an organised statewide research and knowledge management capacity to provide a robust evidence base on mental health care

### Strengthen the evidence base

Victoria has some world-renowned researchers and research units in mental health. Many innovative mental health programs have won awards at the national and international level.

The Victorian Government, while not the primary funder of research, will continue to support the diverse research effort currently delivered through research institutions and bodies, centres of mental health excellence, mental health research fellowships and jointly funded academic positions.

While biomedical research is a critical area of mental health investment in Victoria, this strategy focuses specifically on applied research to inform best practice in prevention, assessments, treatment and psychosocial rehabilitation interventions.

There is broad alignment between state funding for research initiatives and state and national mental health priorities, however, this has not been pursued within a systematic framework. We also generally lack systems and processes to effectively translate research into work practice, service models and policy.

We will develop an applied mental health research and evaluation agenda and work towards implementing strategies to disseminate and translate this knowledge into work practice and service models. Our existing practice research investment will be progressively aligned with the priorities identified in this research agenda.

The proposed Institute of Mental Health Workforce Development and Innovation (see Goal 7.2) would provide a mechanism to link the research activity of academic positions and bodies, disseminate this knowledge and facilitate its application into work practice.

Consumers and carers will play a key role in the development and implementation of the applied research agenda and will be supported to take an active role in research and evaluation projects.

As part of the idea of the Institute, we will explore the potential to bring together a collaborative Centre of Excellence for Consumers and Carers. This collaboration would actively promote and support consumer and carer-led research and the dissemination of this research knowledge; provide education and training to consumers and carers interested in participating in research and evaluation projects; and support consumers and carers to provide qualitative input into education, training and service quality initiatives.

The evidence base needed for mental health promotion and population mental health will be addressed in collaboration with VicHealth and the Centre for Mental Health Promotion and Community Wellbeing and in joint initiatives developed with the Commonwealth, such as the *beyondblue* national depression initiative (see Reform Area 1).



### **Improve information management**

Information and communication technology (ICT) can be better used in mental health to disseminate research and best practice information, serve as a platform for staff education and training, and improve continuity of client care across service sectors.

Consistent with the other aspects of the strategy promoting better integration of area mental health and PDRS services, we are keen to see increased data sharing between these sectors. The aim would be to facilitate improved continuity of care, shared planning at the client and service level and streamlined data reporting.

Options for achieving this will be investigated as part of collaborative governance arrangements (see Reform Area 8) and wider government ICT strategies.

In the longer term, we will consider how mental health services will connect electronically with other key sectors to improve continuity of client care and care coordination.

The mental health client data that are currently collected will be better used in aggregated or appropriately de-identified form to inform work practice and service delivery. Key indicators will be developed and used to benchmark services, as well as measure changes associated with mental health reform (see Reform Area 8).

### **Key strategy proposals**

Action to be considered over the life of the strategy includes:

- Pursuing a sustained recruitment and retention program that attracts students and re-entry workers, targets rural students and international mental health workers, supports postgraduate studies, and facilitates joint academic/service appointments, public/private employment arrangements and re-engagement of retirees to teach and mentor less experienced staff.
- Initiating a program of mental health workforce redesign, based on an assessment of core competencies required to deliver best practice mental health care and better align existing roles and skills with overall reform directions.
- Exploring the creation of an Institute for Mental Health Workforce Development and Innovation to drive workforce development and cultural change. This body would consolidate the work of separate specialist centres of excellence, define core competencies and training needs, facilitate training rotations across sectors and lead adoption of evidence-based practice.
- Considering, as part of the above Institute, the development of a collaborative Centre of Excellence for Consumers and Carers as a focus for consumer and carer-led research and workforce development.
- Bringing together a coordinated rolling program of training for staff in health, justice, education, housing, homelessness and other community service sectors to improve mental health literacy and effective early identification, referral and follow-up.







## Reform Area 8: Partnerships and accountability

### Strengthening planning, governance and shared responsibility

<b>Goal 8.1</b>	Develop a broad-based local area planning and coordination capacity embracing the diverse elements of a community response to mental health
<b>Goal 8.2</b>	Strengthen mental health service governance to deliver a more connected and holistic response for consumers
<b>Goal 8.3</b>	Embed accountability into funding and reporting systems across all relevant programs, under a common mental health outcomes framework
<b>Goal 8.4</b>	Drive strategic policy coordination, monitoring and evaluation of reform efforts at statewide level

#### Key outcomes:

- collaboration between services and agencies at all levels
- balance between health, social and other community outcomes
- matching of effort to identified needs in different sections of the population
- integration of different elements of care and support for clients with complex needs
- quality improvement in service delivery

#### Towards 2019

Improvements in service and system governance, closely linked to accountability and area-based planning, will be an important foundation for translating reform aspirations into better outcomes for Victorians.

As we move into the next decade, the mental health system should not be constrained by existing structures. Rather, organisational arrangements should be adapted to meet the reform goals.

We want to have in place a consistent set of area-based planning structures at local and regional level that provide a clear focal point for mental health issues across services and sectors.

These structures should be well integrated with other health and social planning processes and provide robust advice on the policy, program and service changes needed to achieve optimal mental health outcomes for local populations.

Partnerships spanning specialist mental health care, general health and a range of social support agencies should be consolidated as the key to a well networked system that shares common values and service development objectives. Good service coordination between agencies will set the foundation for effective care coordination for individuals.

Inclusive service delivery will also benefit from some change to governance arrangements for specialist mental health services. New arrangements will involve structures that knit together specialist clinical, psychosocial recovery and primary health components, with age-based service streams aligned across common catchments of similar size.

Creating more transparent and collaborative governance structures for mental health within health services will be a key step towards a mental health system that has at its heart a more integrated community-oriented delivery approach.

Underpinning all this must be a commitment to a common outcomes framework that embraces key determinants of mental health including social, cultural and behavioural, as well as service adequacy factors, and common service and client outcomes monitoring tools.

Finally, active coordination of mental health policy across government is critical to sustain effort and to make this strategy a reality. The leadership of the Minister for Mental Health, supported by the Mental Health and Drugs Division of the Department of Human Services, will be central to this task.

To drive action across all relevant agencies, a statewide Council for Mental Health Reform, bringing together major government and non-government stakeholders, is proposed to guide and report on change.

### New directions

The strategy recognises that a more networked service system that utilises a number of different service platforms to address mental health requires a shared commitment to participate in various joint structures and processes. In pursuing this, it is important to maintain distinctions between clinical governance, service governance, partnerships and system governance.

Discussion with stakeholders indicates a readiness for more decisive progress on these issues, building on local initiatives undertaken over recent years. Changes in governance and accountability must be based on clear identification of the benefits for consumers and carers and not pursued simply for the sake of administrative efficiency.

A staged change process guided by consultation with all stakeholders is required given the significant capacity, workforce, industrial, leadership and organisational issues involved.

### Goal 8.1 Develop a broad-based local area population and service planning capacity embracing the diverse elements of a community response to mental health

While area mental health services have reached out to many other services over recent years, and various alliances have been formed, there remains no genuine common ground on which all those with roles in responding to mental health across a given area come together.

This gap has been widely remarked upon. Where a genuine, broad-based collaboration has occurred (such as the Loddon-Mallee Community Mental Health Planning Group) it has been a highly-valued and effective driver of wider partnerships and shared goals.

A consistent and sustainable approach is now needed in order to achieve wide commitment to common outcomes and to coordinate improvement activity.

The most important functions for this effort are:

- outcomes monitoring and identification of emerging challenges
- service planning across the continuum of care, including attention to the needs of particular population groups
- service coordination at an agency-to-agency level.

Care coordination and brokerage of solutions for individuals is best seen as a task for operational service alliances (see Goal 8.2 below).

The focus of area-based partnerships should be to ensure that people with mental health problems are cared for in a well connected and comprehensive way and do not fall between gaps in service systems.

Local partnerships also have a major role to play in promoting the reform focus on prevention, early intervention and social inclusion and garnering the support of other sectors in order to achieve better mental health outcomes for local populations.

The reform directions of this strategy argue for a better integration of inpatient and community-based services. For this reason, the strategy proposes that the government's *Care in your community* planning framework be applied to mental health. This is consistent with the strong emphasis in this framework on continuity of care and prevention of hospital admission.

Community Mental Health Plans would be a focus in the early stages of this activity. These should be based on a wide systems analysis of local mental health related services. A local version of the mental health outcomes framework would be developed as a basis for this work.

Membership of the partnerships would be expected to include: Department of Human Services regional offices, area mental health services, PDRSS agencies, GP Divisions, community health, ambulance, aged care, police, early childhood services, housing and homelessness services, school welfare programs and local government.

These groups would be expected to draw on other local partnerships where these are most appropriate to pursuing particular actions. For example, Primary Care Partnerships are well placed to address primary health care and service coordination issues, and mental health promotion, and could form the basis for a wider mental health focus. Early childhood mental health issues, however, might be managed by a Best Start local partnership.

Department of Human Services regional offices will play an important role in facilitating this networked partnership approach.

### **Goal 8.2 Strengthen mental health service governance to deliver a more connected and holistic response for consumers**

Some important changes to governance arrangements for specialist mental health services will be necessary to deliver the reforms outlined in this strategy. While current structures have served Victoria well for over a decade, the logic underlying aspects of these arrangements is no longer as relevant as it originally was. There are many opportunities for improved service delivery that are difficult to achieve without structural change.

The current auspicing of public mental health services is particularly complex and confusing for many.

Child and adolescent, adult and aged components of our system are often managed by different health services and subject to different boundaries. This creates barriers to continuity of care for consumers and makes it more difficult for other service systems to collaborate efficiently with mental health services.

At the heart of this issue is the need to strengthen the capacity of health services to lead a wider networked mental health response. Ideally, change would deliver:

- functional integration of key aspects of area mental health services, PDRSS and primary health care activities
- improved transitions for clients across age-related components of area mental health services
- capacity to easily escalate clients to more highly specialised care where this is not available in every area mental health service
- effective working relationships between specialist mental health and wider health and community services.

A staged and multi-tiered approach to addressing these issues is needed.



In the first instance, action will be taken to bring child and youth (allowing for the new configuration outlined in Reform Area 2), adult and aged area mental health services under common health service management, and aligned along common boundaries as far as possible.

A process involving an independent panel and stakeholder consultation is proposed to be undertaken to resolve catchment and auspicing issues. Where choices about catchments need to be made, the preference would be for larger rather than smaller areas, up to around 500,000 population. These should be aligned with general government and health regions/sub-regions. The cross-regional roles of large specialist services will also need to be considered in this process.

In parallel with this, steps will be taken to create Mental Health Boards or Committees under the broader governance structures of those health services auspicing the newly aligned area mental health services.

These boards would be chaired by a Health Service Board member with particular mental health interests, and have additional representation from PDRSS and Primary Care Partnership and/or GP Divisions, and consumer and carer representatives. The directors of each age component of the mental health service and PDRSS would attend as appropriate.

These new Mental Health Boards would constitute formal structures for joint decision-making on a defined range of client services and related functions, with delegated authority from Health Service Boards. They would adopt aspects of the Integrated Cancer Services Model operating in Victoria, working across a range of services in the interests of local populations.

In particular, they would facilitate the joint management of rehabilitation and other intermediate care services (see Reform Area 4) and reach agreement on the operation of care coordination arrangements (see Reform Area 5).

More broadly, they would oversee joint initiatives on clinical/care governance, joint workforce development and deployment, discharge planning, information systems including client outcome measurement, and consumer and carer participation.

It is anticipated a 12–18 month process will be required to define the arrangements for these boards and the necessary change management process. Depending on the complexity of issues involved, it may be desirable to trial the new arrangements in a couple of areas.

During this period, work will be undertaken with the PDRSS sector to examine options for streamlining management of psychosocial recovery service delivery. Preferred options for achieving this involve formation of consortia of PDRSS providers around the new area based public mental health structures. Nomination of a lead PDRSS provider will assist in creating the boards outlined above and planning an adequate and comprehensive set of services for each area.

The expectation is that such changes will increase the profile and status of mental health within health services, while encouraging mainstreaming within both acute and community based elements of healthcare. At the same time, they would support a more collaborative and holistic response to mental health care.

Proposed changes will be reinforced in the short term by a new commitment to using the annual Statement of Priorities for each health service as a priority setting and accountability tool for mental health service development and delivery.



Creating more transparent and collaborative governance structures for mental health within health services is seen as a key step towards the long-term goal of a mental health system that has at its centre an integrated community-oriented service planning and delivery approach.

### **Goal 8.3 Embed accountability into funding and reporting systems across all relevant programs, under a common mental health outcomes framework**

As stated in Part One, mental health reform needs to be driven by a set of agreed outcomes, regular monitoring of progress, and an accountability structure responsible for achieving the outcomes.

A mental health outcomes framework, consistent with the national health performance framework, is outlined and its three levels described. An initial set of outcomes is proposed for Level 1 (Health and community outcomes) and level 2 (Determinants of mental health).

Level 3 (Performance of the service system) pertains to local services and programs and will include indicators on how well they are performing individually and collectively to deliver improved outcomes for clients. This level should also capture important dimensions of the culture of service delivery and consumer experience.

It is at this service system level that progress can be routinely monitored and reported, and direct action taken if the expected outcomes are not achieved.

The following table (p 142) lists the nine dimensions of Level 3. It is important to note that:

- Each dimension can apply at the individual, agency and population levels, depending on the point of interest for monitoring, reporting and accountability.
- The framework applies broadly across sectors such as the specialist mental health, primary health and social support, although not all indicators will apply in all cases.
- The indicators under these dimensions will reflect the results of capacity building efforts (such as training or standards development) as well as the impact of delivery to clients.





Mental Health Outcomes Framework	
Level 3: Service system performance	
Domain	Proposed outcomes
Effective	<ul style="list-style-type: none"> <li>Achieves desired outcome for clients</li> </ul> <p>For example, achievement of client's recovery goals, increased mental health literacy for key population groups</p>
Appropriate	<ul style="list-style-type: none"> <li>Is relevant to the client's needs and based on established standards</li> </ul> <p>For example, clients receive age-specific care, interventions are based on documented best practice</p>
Efficient	<ul style="list-style-type: none"> <li>Achieves the desired result with the most effective use of resources</li> </ul> <p>For example, outputs are consistent with current industry benchmarks</p>
Client-focused and carer-inclusive	<ul style="list-style-type: none"> <li>Meets acceptable standards with regard to rights, respect, participation and responsiveness</li> </ul> <p>For example, services comply with the <i>Charter of Human Rights</i>, reduction in consumer complaints</p>
Accessible	<ul style="list-style-type: none"> <li>People can obtain treatment/support/care at the right time and right place irrespective of income, geography or cultural background</li> </ul> <p>For example, service access for rural clients</p>
Safe	<ul style="list-style-type: none"> <li>Identifies potential risks of an intervention/action or environment and either avoids or minimises them</li> </ul> <p>For example, risk management plans in place</p>
Continuous	<ul style="list-style-type: none"> <li>Provides uninterrupted, coordinated care/support/services across programs, practitioners, organisations and levels over time</li> </ul> <p>For example, discharge practices, protocols between programs</p>
Capable	<ul style="list-style-type: none"> <li>Provides services based on skills and knowledge</li> </ul> <p>For example, mental health skill level for GPs and school health and welfare staff, agency accreditation</p>
Sustainable	<ul style="list-style-type: none"> <li>Has the capacity to provide sustainable infrastructure, such as workforce, facilities and equipment; is innovative, and responds to emerging needs</li> </ul> <p>For example, projected life of equipment and building fabric, number of undergraduate training places</p>

The purpose of the mental health outcomes framework is ultimately to drive strategic action to improve client outcomes. Such improvement may be measured using client outcome scores where the scores measure quality of life, are inclusive of physical health, and consistent across funding bodies. This will build on ongoing work at national and state level to increase uptake of client outcome measures and systems.

Particular effort will be made to work with area mental health and PDRSS agencies to enhance their capacity to measure client outcomes, using consistent tools that effectively capture key psychosocial recovery and participation factors. This will be facilitated by sharing of data systems and protocols agreed through the governance arrangements outlined in Goal 8.2.

At a statewide level, accountability and transparency in the delivery of specialist public mental health services will be achieved through the publication of a regular report, similar to the *Your hospitals* report, providing essential data on the performance of services across the state.

Initially this report will report on clinical mental health care, using the RAPID data system, and will be progressively expanded to include PDRSS and private/MBS mental health care information. It will also incorporate data pertaining to mental health care collected by general health services to document service usage by people with mental health problems beyond the specialist mental health service system.

Key outcomes for all three levels of the mental health outcomes framework will be combined to form a scorecard suitable for benchmarking across services and localities.

The proposed local mental health governance and planning structures will be accountable for delivering on outcomes on the scorecard, while a statewide mental health outcomes function in the Department of Human Services will oversee progress on achieving the scorecard outcomes across all areas and transparently identifying where improvement is required.

The proposed mental health outcomes framework will be developed further in collaboration with key stakeholders such as consumers, carers, General Practice Victoria, professional groups, peak bodies and service providers.

#### **Goal 8.4 Drive strategic policy coordination, monitoring and evaluation of reform efforts at statewide level**

The leadership role of Victoria's Minister for Mental Health and the Mental Health and Drugs Division of the Department of Human Services will be critical in driving reform forward and ensuring that government and its key partners and funded agencies remain accountable for progress.

While a number of advisory and consultative structures exist in mental health, there is no overarching body at present that can perform this broader whole-of-system reform oversight task. Consultation has confirmed that there is considerable enthusiasm on the part of a wide range of stakeholders to collaborate with each other and the government in driving real change.

To meet these needs, the government proposes to establish a statewide Mental Health Reform Council. This will be a time-limited body set up for five years to bring together all the key sectors that are central to progressing reform, including relevant peak bodies and professional groups, service providers, consumer and carer perspectives and key government agencies.

The inclusion of Commonwealth Government agencies on the council would reflect the joint commitment of both levels of government to positioning mental health as a key area for collaboration, building on early progress made through the Victorian COAG Mental Health Group.

The council will seek to identify priorities, agree roles and responsibilities, foster collaboration, and monitor and evaluate achievements. The council will report through the Minister for Mental Health to the government and the community and will produce an annual reform activity report, a three-year progress report and a five-year outcomes report.

This body will not replace the role of the Ministerial Advisory Committee on Mental Health, which will refocus its efforts on providing expert (including carer and consumer) advice on specific aspects of mental health treatment and care.

In addition to the Council, Partnership Groups bringing together government and non-government stakeholders will be responsible for more detailed implementation and further policy development work on particular reform priorities. Each group would be resourced by a lead government department and may be either purpose-specific groups or build on suitable existing bodies.

Initial groups may focus on:

- social inclusion and mental health (including housing and homelessness)
- children, young people and families
- the health service system
- mental health promotion and prevention
- justice issues.

## Key Strategy Proposals

Action to be considered over the life of the strategy includes:

- Using broad based local mental health partnerships and the Care in your Community framework, to undertake population needs assessment, service planning and outcomes monitoring. This would draw on the capacity of Primary Care Partnerships and other local collaborations for particular functions.
- Bringing Child and Youth, Adult and Aged specialist mental health services under common governance arrangements and boundaries aligned with general health service areas.
- Working towards the establishment of Mental Health Boards or Committees to sit under Health Service Boards. These would bring together clinical, psychosocial and primary health services, with consumer and carer representation, for joint oversight of a defined range of services and functions.
- Developing new monitoring and accountability arrangements based on a shared whole of system outcomes framework incorporating health and social indicators that reflect broader individual and community goals.
- Establishing a statewide Mental Health Reform Council to bring together all sectors that are central to progressing reform, including relevant peak bodies, professional groups and government agencies. Implementation and further work on particular reform priorities would be supported by a number of Partnership Groups bringing together government and non-government stakeholders.

## 6. Appendices

### Appendix 1 Submissions to consultation paper

The consultation period on the green paper *Because mental health matters* began in mid-May 2008, and ran until mid-August. Around 1,200 people attended a consultation event, which included:

- 9 public forums held across Victoria
- 19 policy roundtables led by the Hon. John Brumby MP, Premier of Victoria or the Hon. Lisa Neville MP, Minister for Mental Health, Department of Human Services or senior officers of the Department of Human Services
- 20 focus sessions held with a variety of professional bodies

Over 240 written submissions were received from a wide variety of stakeholders including:

- 15 academic institutions and research organisations
- 4 carer consultants
- 9 consumer consultants
- 12 State Government departments and offices
- 20 health and social service providers
- 15 individual carers
- 7 individual consumers
- 20 other individuals
- 5 Local Government Authorities
- 40 mental health service providers
- 5 other unclassified organisations
- 15 mental health peak bodies
- 23 non-mental health peak bodies
- 10 professional bodies or unions
- 42 other non-government organisations.

All the organisations, agencies, professional bodies and individuals who made written submissions and attended consultation sessions are sincerely thanked for their contribution to this Mental Health Reform Strategy.



## Appendix 2 Victorian policy contexts

Policy	Mental health context
<b>Social inclusion</b>	
<i>A Fairer Victoria</i> (Department of Planning and Community Development; 2005)	<p>Victoria's overarching social policy strategy <i>A Fairer Victoria</i> reflects the Victorian Government's commitment to creating opportunities to improve the lives of disadvantaged Victorians.</p> <p><i>A Fairer Victoria</i> combines emphasis on the provision of accessible and universal services for all Victorians, by targeting services to those in greatest need, including those with mental health problems.</p>
<b>Justice and Police</b>	
Victorian Charter of Human Rights and Responsibilities (Department of Justice; 2007)	<i>The Victorian Charter of Human Rights and Responsibilities</i> protects the rights of all Victorians and guides policy development, new legislation and service delivery. It requires all public authorities and their employees to act in accordance with the rights protected in the Charter. The rights come under four categories: freedom, respect, equality and dignity.
Justice Mental Health Strategy (Department of Justice; forthcoming)	<p>The objective of the <i>Justice Mental Health Strategy</i> is to provide a framework that will make the justice system more responsive and accessible to individuals with mental impairment, including people with mental illness.</p> <p>The strategy will cover a range of justice interventions that address not only the needs of offenders with mental impairment but also victims and witnesses.</p>
Victoria Police Mental Health Strategy (Victoria Police; April 2007)	<p>The <i>Victoria Police Mental Health Strategy</i>, contains directions for improving policy and practice in three broad areas of improving knowledge and information; strengthening internal and external partnerships and updating police training.</p> <p>These directions align with and support the strategic priorities of the <i>Mental Health Reform Strategy</i> by fostering integrated service responses to the range of mental health needs that present, at the earliest opportunity.</p>
<b>Health, Disability and Housing</b>	
Care in Your Community (Department of Human Services; 2006)	<p>Utilising partnerships among government and private health care services and creating a flexible multi-skilled workforce to deliver care in a variety of community and home-based settings, <i>Care in your community</i> aims to maximise access, quality and continuity of care, service flexibility and optimal use of scarce resources.</p> <p><i>Care in your community</i> also places emphasis on the social determinants of health and prioritises health promotion and illness prevention.</p>

Policy	Mental health context
<p>Primary Care Partnerships (Department of Human Services; 2000)</p>	<p>The <i>Primary Care Partnerships Strategy</i> strengthens, improves and unites primary health care providers in Victoria by utilising a partnership focus that support integrated, multidisciplinary approaches to practice.</p> <p>Primary Care Partnerships (PCPs) provide a platform to deliver state and Commonwealth Government priorities related to hospital demand, integration between general practice and other primary health care providers, multidisciplinary approaches to the management of disease and population health.</p>
<p>Rural directions for a better state of health (Department of Human Services; 2005)</p>	<p>The <i>Rural directions for a better state of health</i> outlines key directions that will position the health system to better meet the needs of rural and regional Victorian communities now and into the future.</p> <p>The plan focuses on illness prevention in a rural context and emphasises the importance of partnerships between health services. Additionally, the plan strengthens and sustains health services in rural Victoria by strategies that grow and retain a skilled health workforce.</p>
<p>Victorian Alcohol Action Plan (Department of Human Services; 2008)</p>	<p>The <i>Victorian Alcohol Action Plan</i> (VAAP) details the Victorian Government's actions to prevent and reduce harm associated with alcohol misuse. The VAAP identifies people with a mental illness as an 'at risk' group for alcohol misuse and aligns with the <i>Mental Health Reform Strategy</i> by taking an early intervention focus and strengthening primary health responses to address the problems of alcohol misuse.</p>
<p>Blueprint for alcohol and other drug treatment services 2009 – 2013 (Department of Human Services; 2008)</p>	<p>The new blueprint for the alcohol and other drug treatment sector establishes directions and key priorities for the delivery of funded services for the next few years.</p> <p>The blueprint will seek to reduce the incidence and harms from alcohol and other drug use and promote more integrated service responses for clients. Prevention, early intervention, client access, and opportunities to enhance responses for young people and families will be explored through this initiative.</p> <p>The blueprint provides an opportunity to update the treatment system to better respond to emerging and current alcohol and other drug use concerns. It will also provide an opportunity to promote linkages to deliver sustained behaviour change through support for client recovery and re-integration into the community.</p>
<p>Alcohol and Drug Abuse Prevention Strategy (Department of Human Services; forthcoming)</p>	<p>The Victorian Governments' <i>Alcohol and Drug Abuse Prevention Strategy</i> and overarching framework, forms one part of the government's overall response to the prevention of harmful alcohol use and to the abuse of illicit substances. The first phase of the strategy is the development of the framework.</p> <p>The framework will include a description of the evidence base; the principles underpinning the government's alcohol and drug prevention response; the broader government policy context and its relationship to alcohol and drug prevention; and case studies of effective alcohol and drug prevention responses.</p>



Policy	Mental health context
Victorian Drug Strategy 2006–09 (Department of Human Services; 2006)	The <i>Victorian Drug Strategy</i> provides a co-ordinated, integrated approach across government and the community to address drug use. It improves access to appropriate services integrated with other service and support systems, to provide better access to those with complex needs, including those with mental illness. The strategy also strengthens protective factors across different life stages, improves treatment outcomes and reduces the disease caused by drugs.
Victorian Homelessness Strategy and Youth Homelessness Action Plan Stages 1 & 2 (Department of Human Services; 2004)	The <i>Victorian Homelessness Strategy</i> emphasises the need for improved connectedness and integration between services and across government to achieve better long term outcomes for people experiencing homelessness. The strategy encourages has particular focus on women experiencing family violence, people with a mental illness and, through, people with a mental illness.  Through the <i>Youth Homelessness Action Plan</i> , young people experiencing homelessness will have better access to services and more intensive support for young people with complex needs.
Victorian State Disability Plan 2002–12 (Department of Human Services; 2002)	The <i>Victorian State Disability Plan 2002–12</i> ensures people with a disability, including those people with concurrent mental health issues, can pursue their own lifestyle choice and participate fully in the community through a strengthened support system
Autism State Plan (Department of Human Services; forthcoming)	The development of an <i>Autism State Plan</i> aims to build new and better approaches across government to meet the growing and complex needs of people with an ASD. Disability Services will continue to be involved with other government departments to ensure the continued development of a whole of government approach to support people with an ASD and their families.
Employment	
Workforce Participation Strategy and Disability Employment Strategy (Department of Innovation, Industry and Regional Development; forthcoming)	The <i>Workforce Participation Strategy</i> provides a strategic framework for Victorian Government actions to maintain our current and future supply of skilled labour by increasing levels of workforce participation including those of people with significant barriers to employment, such as people who have mental health problems.  The <i>Victorian Disability Employment Strategy</i> sets priorities for further action by the Victorian Government in its efforts to improve employment outcomes for people with a disability including those with a mental illness.
Securing Jobs for Your Future – Skills for Victoria (Department of Innovation, Industry and Regional Development; 2008)	<i>Securing Jobs for Your Future</i> provides directions to reform Victoria's skills systems. This will create new training places, upgraded TAFE facilities and greater flexibility for individuals, employers and training providers.  For individuals, the new skills system will offer more places, more opportunities for training throughout adult life and more flexible fee arrangements; for training providers, new opportunities to respond to market demand and contest for funding; and for businesses, a more responsive system that provides greater assistance with workforce development.

Policy	Mental health context
<b>Children and young people</b>	
<p>Vulnerable Youth Framework (Department of Human Services, Department of Planning and Community Development, Department of Education and Early Childhood Development; forthcoming)</p>	<p>The <i>Vulnerable Youth Framework</i> is a forthcoming government framework that will underpin all policy and program development related to Victoria’s vulnerable young people. It will continue to strengthen action across state and local government and communities, including schools, to better respond to the needs of vulnerable young people and their families.</p> <p>The framework is the Government’s commitment to ensuring that policies, services and systems for vulnerable young Victorians support and assist them to achieve their full potential.</p>
<p>Blueprint for Education and Early Childhood Development (Department of Education and Early Childhood Development; 2007)</p>	<p>The <i>Blueprint for Education and Early Childhood Development</i> sets out the Government’s five-year agenda for learning and development from birth to adulthood.</p> <p>The blueprint encourages collaboration between families, schools early childhood services and the broader community to achieve optimal health and wellbeing of all Victorian children and improves transitions between early childhood services and schools.</p>
<p>Wannik (Learning together – journey to our future): Education Strategy for Koorie Students in Victoria (Department of Education and Early Childhood Development; 2008)</p>	<p>Ensuring every Koorie child has the opportunities that a high-quality school education can deliver requires a whole new approach. <i>Wannik</i> provides such an approach. It represents a renewed level of commitment from the Victorian Government to ensure that every Koorie child receives a first class education in Victoria’s government schools</p> <p>The strategy recognises that an increased level of commitment and action is required from both within and outside the education sector. It sets out in detail the steps the Victorian Government will take to improve educational outcomes for Koorie children, in conjunction with Koorie parents and the Koorie community.</p>
<p>Every Child, Every Chance and Victoria’s Plan to Improve Outcomes in Early Childhood (Department of Human Services; 2007)</p>	<p>The <i>Every Child, Every Chance</i> policy reforms the child protection sector to enable earlier intervention, reduce neglect and abuse, provide better support to children and families and work together more closely with other service providers</p> <p>Victoria’s plan to improve outcomes in early childhood improves antenatal and postnatal support for parents suffering from mental health problems and supports the early intervention focus of the <i>Mental Health Reform Strategy</i> through the provision of comprehensive early intervention services underpinned by family-centred practices.</p>

Policy	Mental health context
<p>Future Directions: An Action Agenda for Young Victorians (Department of Planning and Community Development; 2006)</p>	<p><i>Future Directions</i> is the Victorian Government's Youth policy, providing a broad outcomes and policy framework in which to undertake redevelopment of youth specific mental health services.</p> <p><i>Future Directions</i> utilises principles of collaborative, integrated approaches underpinned by prevention and early intervention strategies.</p>
<p>Population frameworks</p>	
<p>Victorian Indigenous Affairs Framework (Department of Planning and Community Development; 2006)</p>	<p>The <i>Victorian Indigenous Affairs Framework</i> is a whole of government framework to improve responsiveness of services to Indigenous Victorians. The framework builds protective factors to reduce trauma and risk experienced in Indigenous communities, particularly children and adolescents and invests in the development of culturally appropriate and evidence-based prevention resources.</p> <p>The framework has a particular focus on improving maternal and early childhood health and development, preventing family violence and reducing substance use and misuse in Indigenous communities.</p>
<p>Victorian Multicultural Strategy (Department of Planning and Community Development; forthcoming)</p>	<p>The <i>Victorian Multicultural Strategy</i> will build on the existing policy framework <i>Valuing Cultural Diversity in Victoria</i> and provide a high-level declaration of the Victorian government's position on multiculturalism. The proposed policy will be underpinned by themes of valuing diversity; reducing inequality; encouraging participation; and promoting the social, cultural and economic benefits of cultural diversity to all Victorians.</p>
<p>Ageing in Victoria Policy Framework (Department of Planning and Community Development; forthcoming)</p>	<p>The <i>Ageing in Victoria Policy Framework</i> is a whole-of-government framework to position Victoria to respond effectively to the challenges and opportunities of an ageing population. The framework supports and strengthens social and economic participation by older Victorians, and encourages older people to lead healthier lives through the provision of community support and care when needed.</p>
<p>Refugee Health and Wellbeing Action Plan 2008 – 2010 (DHS, 2008)</p>	<p>The <i>Refugee Health and Wellbeing Action Plan 2008 – 2010</i> assists the Department of Human Services and its funded sectors to better respond to the health and wellbeing needs of refugees.</p>
<p>Victorian Women's Health and Wellbeing Strategy (Department of Human Services; 2002)</p>	<p>The <i>Victorian Women's Health and Wellbeing Strategy</i> is a key plank in the Victorian Women's policy framework (with new whole-of-government policy in development). Mental health and wellbeing is a key priority area, in recognition of the impact that mental health has on women's life chances and sense of wellbeing.</p>
<p>Victorian Men's Health and Wellbeing Strategy (Department of Human Services; forthcoming)</p>	<p>This strategy will be developed for 2009, with a clear statement that the health and wellbeing of men matters, and it will provide a framework for improved responses to identified men's health and wellbeing needs across DHS and its funded sectors.</p>



## Appendix 3 The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders

The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders was developed out of the 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders held in Melbourne in September 2008 (65).

The Charter is an enduring statement which will function to consolidate international focus on mental health promotion and prevention activity. It is an international foundation document to support future developments in mental health promotion and prevention activity.

### The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders

#### Preamble

The Melbourne Charter asserts that mental health and wellbeing is:

- an indivisible part of general health
- essential for the wellbeing and optimal functioning of individuals, families, communities and societies
- a fundamental right of every human being, without discrimination.

The Melbourne Charter affirms that mental health and wellbeing is:

- of universal relevance
- most threatened by poor and unequal living conditions, conflict and violence
- a key indicator of a nation's social and economic development.

The Melbourne Charter believes that mental health and wellbeing is:

- everybody's concern and responsibility
- best achieved in equitable, just and non-violent societies
- advanced through respectful, participatory means where culture and cultural heritage and diversity is acknowledged and valued.

#### Scope

The Melbourne Charter identifies principles and actions that governments, communities, organisations and individuals can take to influence the interconnecting social, economic, cultural, environmental and personal factors that influence mental health and wellbeing.

#### Mental health

Mental health is a state of complete physical, mental, spiritual and social wellbeing in which each person is able to realise one's own abilities, can cope with the normal stresses of life, and is able to make a unique contribution to one's community.

Mental illnesses such as anxiety disorders, depression and schizophrenia disorders are real and potentially disabling conditions, affecting over 450 million individuals, families and carers worldwide.

Poor mental health, loss of wellbeing, and illness have economic and social consequences for societies, communities, families and individuals. Mental health promotion is a strategic and sustainable approach to eliminating or minimising those factors which give rise to distress and loss of wellbeing and introducing and maximising those which create the circumstances in which all can flourish.

## The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders

### Principles for promoting mental health and preventing mental illness

Mental health and wellbeing are determined by multiple and interacting social, environmental, psychological and biological factors, just as health and illness in general are determined.

The critical social, environmental and economic determinants of mental wellbeing and of mental illness are common across nations. Individual and family-related and community protective and risk factors can be biological, emotional, cognitive, cultural, behavioural, interpersonal and environmental. The presence of multiple risk factors, the lack of protective factors and the interplay of these culminate in greater likelihood of poor mental health and wellbeing and the development of mental illness.

Mental health promotion aims to improve social, spiritual and emotional wellbeing by creating supportive living conditions and environments that foster connectedness between people, strength in recovery from illness, and competence and resilience in individuals and communities. Prevention strategies are a core component of mental health promotion.

Population-based approaches for promoting mental health and wellbeing and preventing mental illness work by:

- utilising principles of public participation, engagement and empowerment
  - redressing inequities and discriminatory practices that exclude the most socially disadvantaged or people at risk such as Indigenous people, people with mental illness, children and young people, people with disabilities and elderly people
  - action in everyday contexts such as in schools, workplaces, sports clubs, community-based activities, government services and the natural environment
  - providing access to quality care and recovery-focussed services for those who are experiencing poor mental health or mental illness
  - combining advocacy, communication, policy and legislation, together with community participation and evidence-building strategies
  - joining up policies and practices across sectors, including education, housing, employment and industry, transport, urban planning and justice
  - person-centered responses to mental distress and loss of wellbeing which foster hope, offer choices, support people to lead their own recoveries and ensure a quick return to active citizenship.
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## The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders

### Actions

#### Decision-makers

The Melbourne Charter calls national governments to:

- acknowledge the factors that influence their people's mental health and wellbeing
  - take responsibility for ensuring that those factors that protect mental health and wellbeing are accessible to all and those that place people at risk of poor health or illness are reduced or eliminated
  - actively engage with those who are most adversely affected and socially excluded, such as people experiencing mental illness, people with disabilities, young people, people forcibly displaced, and women subject to violence
  - protect Indigenous cultures
  - promote equal opportunity and freedom from discrimination
  - ensure policy is informed by best available and appropriate evidence and adequately funded
  - invest in training personnel in publicly funded agencies to promote mental health
  - facilitate partnerships across public agencies that impact mental health
  - adequately fund and deliver accessible, high quality and recovery-focused mental health services
  - ensure the private sector complies with local national and international regulations and agreements that promote and protect mental health.
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### The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders

#### People working to promote mental health and wellbeing

The Melbourne Charter calls on those working to improve the mental health and wellbeing of populations to:

- advocate for human rights, ensuring the protection of all and in particular:
    - Indigenous people and their cultures
    - people affected by mental illness
    - people forcibly displaced from their homeland
    - children, young people and older people
  - act to eliminate stigma, discrimination and inequities
  - engage, partner and build alliances with public, private, nongovernmental, community-based and international organisations to create sustainable initiatives
  - build greater community understanding of mental health and mental distress and loss of wellbeing
  - empower and mobilise communities and individuals, particularly the most socially excluded, by supporting their rights and providing resources and opportunities for them to shape and initiate their own actions to promote wellbeing
  - support engagement with and leadership by people with lived experience
  - use evidence to inform programs and ensure appropriate research and evaluation methods are used to increase the knowledge base
  - encourage the corporate sector to share responsibility by ensuring health and safety in the workplace, and to promote the health and wellbeing of employees, their families and communities.
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## Appendix 4 Glossary of terms

### **Acquired Brain Injury (ABI)**

A permanent brain injury that results in impairment to an individual's physical, cognitive, behavioural and/or emotional functioning. The injury may be caused by accident, assault, infection, disease, overuse of alcohol, stroke, brain tumour or other medical illnesses. Acquired Brain Injury is not in itself a mental illness, however, people with Acquired Brain Injury can also suffer from a mental illness.

### **Anxiety disorder**

A common mental illness characterised by feelings of unease, tension and distress with an exaggerated fear of possible danger or misfortune and often associated with significant disruption to a person's life, such as inability to hold down a job or use public transport. Examples of such disorders may include phobias, panic attacks and obsessive compulsive disorder.

### **Area mental health service**

The network of public mental health services managed by a general health service that operates within a defined geographical area and provides clinical mental health services.

### **Autism Spectrum Disorder**

Autism Spectrum Disorders are a range of neurological disorders that most markedly involve some degree of difficulty with communication and interpersonal relationships, as well as obsessions and repetitive behaviours. Those at the lower-functioning end of the spectrum may be profoundly unable to break out of their own world. Those at the higher-functioning end, sometimes diagnosed as Asperger Syndrome, may be able to lead independent lives but still be awkward in their social interactions.

### **Bi-polar disorder**

A mental illness in which the significant symptoms involve fluctuating states of mood characterised by marked depressive and/or manic episodes.

### **Borderline personality disorder**

A specific type of personality disorder which is characterised by a lifelong pattern of behaviour which may include unclear and disturbed self-image, brief psychotic episodes, involvement in intense unstable relationships, repeated emotional crises, fear of abandonment and a series of suicidal threats or acts of self harm without apparent cause. See also personality disorder.

### **Carer**

The term carer is used to describe someone who is actively caring for a person with a mental illness with whom they have an ongoing relationship. The carer need not necessarily live with the person with a mental illness. A carer may be a family member, friend or other person who has a significant role in the life of the person with a mental illness. Carers are at higher risk of developing physical and mental health problems themselves as a result of their caring role.

### **Carer consultant**

Carer consultants are persons employed in mental health services on a part-time or full-time paid basis to represent the interests of carers and provide systemic advocacy. Carer consultants: ensure the carer perspective is represented in service planning, evaluation and policy development; assist families to access appropriate services; and educate mental health staff and students regarding the carer perspective.

### **Co-existing disability**

In the context of the strategy, this term is used for the co-existence in an individual of a mental health problem and a mental impairment resulting from intellectual disability, Acquired Brain Injury or Autism Spectrum Disorder.

### **Community Treatment Order (CTO)**

Community Treatment Orders can be issued under the *Mental Health Act 1986*. They enable involuntary patients to receive treatment for their mental illness in the community. CTOs are made by an authorised psychiatrist and offer a less restrictive treatment option than involuntary admission to a psychiatric inpatient service.

### **Consultation and liaison**

Provision of consultation and support by specialist mental health practitioners to clinicians treating people with physical illnesses in general hospital settings, for example acute wards or emergency departments.

### **Consumer**

A term chiefly used to describe a person who is a client of specialist mental health services. However, the designation 'consumer' has been adopted by some people with a mental health problem whether or not they are current clients of the mental health system, and is used in the context of a 'consumer movement' and 'consumer advocacy'.

### **Consumer consultant**

Consumer consultants are people employed on a part-time or full-time paid basis to represent the interests of consumers and provide systemic advocacy. Consumer consultants: ensure the consumer perspective is represented in service planning, evaluation and policy development; assist consumers to access appropriate services; and educate mental health staff and students regarding the consumer perspective.

### **Continuity of care**

Provision of mental health services to a client in a way that ensures care is continued when there is a change of service. An example is when a person leaves a psychiatric inpatient service and their care is transferred to the community mental health centre or a psychosocial rehabilitation service, or where the client moves to a new area.

### **Criminal justice system**

Criminal justice is the system of practices and organisations used by governments, directed at ensuring public safety, deterring and controlling crime, and sanctioning those who violate laws with criminal penalties. The criminal justice system consists of public safety and law enforcement (police), courts and corrections (prisons and community corrections).

### **Culturally and linguistically diverse (CALD) communities**

Cultural and linguistic diversity describes the diversity of society in terms of cultural identity, nationality, ethnicity, language, and increasingly faith. Individuals from a CALD background are those who identify as having a specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, language(s) spoken at home, or because of their parents' identification on a similar basis. CALD does not refer to an homogenous group of people, but rather to a range of cultural and language group communities.

**Dementia**

A group of brain disorders that most commonly occur in old age, although sometimes develop earlier. They are the result of brain tissue deterioration. Common features include decline in the ability to recall recent and past events, decline in mental functioning (for example, the ability to make simple calculations or organise a routine task) and the person behaving in ways considered out of character.

**Depression**

A lowering of mood which includes feelings of sadness, despair and discouragement, which range from mild to severe and is sustained over a period of time. Mild depression is an emotional state that many people experience during their life. Severe depression is a severe mental illness producing symptoms such as slowness of movement, loss of interest or pleasure in most activities, sleep and appetite changes, and agitation. People experiencing severe depression will have intense feelings of worthlessness and may experience delusions; for example, a person may believe they are the cause of the world's problems. Severe depression can lead to suicidal ideas and actual suicidal actions.

**Drug induced psychosis**

A mental illness involving distorted or imaginary sensations caused by the one-off or repeated use of a drug (such as marijuana or amphetamines) or the use of a drug over a long period of time. The symptoms of a drug induced psychosis will usually appear quickly and can last for up to four weeks until the effects of the drug wear off.

**Dual diagnosis**

The co-occurrence of mental health problems and drug and alcohol misuse problems.

**GLBTI communities**

An overarching term that describes communities based on sexual and/or gender identities, including people who primarily identify as gay or lesbian, bisexual people, transgender people and intersex people.

**Homeless support services**

Services that provide accommodation and support services aiming to assist people who are homeless or at imminent risk of becoming homeless including women and children escaping family violence to transition to more stable living arrangements and active participation in the community.

**Inpatient services**

Bed-based publicly funded hospital psychiatric services that require either a voluntary or involuntary hospital admission for the treatment and management of a person who has a severe mental illness.

**In-reach services**

Clinical mental health services provided in a non-mental health service setting, for example in an aged care facility.

**Intellectual disability**

People with intellectual disabilities have learning difficulties and develop at a slower rate than normal. The condition is usually identified at birth or in early childhood. Intellectual disability is not a mental illness and requires very different specialist skills from those offered by mental health services. However, people with intellectual disabilities can also suffer from mental illness. Mental illness can be more difficult to identify in people with intellectual disability.

### **Involuntary admission**

Admission, without the person's consent, to a psychiatric inpatient service for the treatment of a severe mental illness. For an involuntary admission to a psychiatric inpatient service, a person must meet all of the criteria set out in the *Mental Health Act 1986* (section 8) and be admitted under the procedures set out in the act.

### **Mental Health Act 1986**

The Victorian *Mental Health Act 1986* provides a legislative framework for the care, treatment and protection of people with mental illness in Victoria. The act establishes procedures for initiating involuntary treatment, making involuntary treatment orders and independent review by the Mental Health Review Board.

Key features of the *Mental Health Act* are its emphasis on rights and the requirement that treatment should be provided in the least possible restrictive environment and in the least possible intrusive manner. The act states that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances.

### **Mental health promotion**

Any action taken to maximise mental health and wellbeing among populations and individuals by addressing potentially modifiable determinants of mental health. This encompasses:

- actions that strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain mental health
- influencing the social and economic factors that determine mental health, such as income, social status, education, employment, working conditions, access to appropriate health services and the physical environment.

### **Mental Health Review Board**

The Mental Health Review Board is an independent tribunal established the *Mental Health Act 1986*. Its purpose is to hear appeals and regularly review all involuntary admissions, community treatment orders and restricted community treatment orders.

### **Moderate mental illness**

This term is used in the strategy document to describe conditions such as moderate depression and anxiety which can have a significant impact on a person's ability to function normally, but do not require intensive and ongoing treatment and support from the specialist mental health system.

### **Multidisciplinary team**

Professionals drawn from different disciplines – such as psychiatry, psychosocial support, primary care and alcohol and drug services – who work together to provide integrated treatment and care for people with mental illness.

### **Outreach services**

Refers to the delivery of support to individual clients outside of formal service settings, for example in people's homes, or to homeless people on the streets or in transitional accommodation.

### **Personality disorder**

A group of disorders characterised by patterns of disruptive and dysfunctional behaviour, well established by early adulthood and continuing through out a person's life. The person with a personality disorder typically has marked problems and frequent crises in personal and social relationships including threatened or actual self injury. People with this disorder often have a history of inadequate or abusive parenting. See also borderline personality disorder.

**Primary health services**

A term used to describe services that are usually the first point or level of contact with the health system for individuals, the family and community. Primary health services bring health care as close as possible to where people live and work, and constitute the first element of a continuing health care process. In the context of this strategy 'primary health services' refers mainly to general practice and community health services.

**Problematic substance use**

Problematic substance use may be used to refer to any pattern or type of drug use (including alcohol, legal and illegal drugs) that impacts negatively on an individual, their family or the community more generally. Problems experienced may be social, financial, psychological, physical and/or legal.

**Protective factors**

Protective factors reduce the likelihood that a particular individual or identifiable group of people will develop an illness or problem.

**Psychiatric crisis**

Psychiatric crisis describes the situation where a person with a mental illness or severe mental disorder experiences thoughts, feelings or behaviours which cause severe distress to themselves or those around them, requiring immediate psychiatric treatment to assess and manage risk and alleviate distress. This may be the person's first experience of mental illness, a repeat episode or the worsening of symptoms of an often continuing mental illness.

**Psychiatric disability**

The effects of a mental illness, which to varying degrees impair functioning in different aspects of a person's life such as the ability to live independently, maintain friendships or maintain employment.

**Psychiatric Disability Rehabilitation and Support Services (PDRSS)**

The Psychiatric Disability Rehabilitation and Support Services sector is a core component of specialist mental health services, complementing clinical mental health services. PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness. They work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community.

**Psychosocial support**

Support provided to people with mental illness and psychiatric disability. Such services include housing support, day programs, prevocational training, residential services and respite care, aimed at improving a person's abilities to live independently, their domestic and social functioning, and that assists in improving a client's personal, domestic and social functioning, so that they can live independently in the community.

### **Restraint**

The physical restriction of a client's ability to move when, due to a deterioration in mental state, the client may harm him or herself or others. Section 9 of the *Mental Health Act 1986* and the Regulations contain the requirements for the use of restraint and its recording and reporting when transporting recommended patients.

### **Risk factors**

Risk factors increase the likelihood that a particular individual or identifiable group of people will develop an illness or problem.

### **Schizophrenia/schizophrenic disorder/psychotic illness**

A group of mental illnesses where the essential and most obvious features are the presence of psychotic symptoms such as hallucinations, delusions, thought disorder, or lack of insight during the active phase of the illness. There may also be a loss in the person's ability to perform some life tasks, such as relating to others, maintaining employment and domestic duties.

### **Screening**

Screening is a strategy used in a population to detect an illness or condition in individuals without signs or symptoms of that disease. Universal screening involves screening of all individuals in a certain category (for example, all people with severe mental illness) for a particular condition (for example, diabetes).

### **Seclusion**

Seclusion is an extremely restrictive intervention that is subject to minimum statutory requirements defined and prescribed by the *Mental Health Act 1986*. Seclusion means the confinement of a person alone in any room or space within a building, the exit of which cannot be opened by the person from the inside. The term applies even if the patient agrees to or requests such confinement, such that any confinement of a person, which meets the above definition, must be described as seclusion and not by such terms as 'time out' or 'isolation', and must meet the legal and clinical requirements described in this guideline.

### **Secondary consultation**

The provision by specialists of advice and support to professionals in a more generic service. For example, secondary consultation provided by primary mental health teams to GPs, by eating disorder specialists to staff in area mental health services, or by area mental health services to homelessness services.

### **Section 10 (s10)**

The section of the *Mental Health Act* which gives the police powers to apprehend a person who appears to be suffering from a mental health problem, if the member of the police force has reasonable grounds for believing that:

- the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or
- the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.

The member of the police must then arrange for an examination of the person by a registered medical practitioner or an assessment by a mental health practitioner.



**Severe mental illness**

A mental illness in which a person's ability to think, communicate and behave appropriately is so impaired that it interferes with the person's ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be significant impairment, disability and/or disadvantage. Typically includes people with schizophrenia or psychosis, bipolar disorder, or severe depression.

**Social Housing**

Social housing means housing which is owned or regulated by the government to assist people on low incomes.

**Social support services**

This term is used broadly in the strategy to encompass those services, such as housing, homelessness, employment, that, while not directly providing care, can significantly contribute to reinforcing the protective factors and reducing the risk factors for mental health.

**Student welfare**

A term for the range of services aimed at improving student welfare in schools, comprising Student Support Services Officers (SSSOs), Primary Welfare Officers, Student Wellbeing Coordinators and School Nurses.



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