July
2019

Monash Health Submission

Royal Commission into Victorian Mental Health Services

Monash Health

MonashHealth

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5 July 2019

Ms Penny Armytage
Chair, Royal Commission into Victoria's Mental Health System

Dear Ms Armytage

Thank you for the opportunity to contribute to, and participate in, the improvement of the treatment and care of some of Victoria's most vulnerable people.

Given the significance and importance of this work, our board and leadership group have made this work a priority. Over the past few months we have consulted with our employees and consumers to develop the enclosed submission.

Our submission shares our analysis and learnings on how the current system is experienced by our community, our clinicians and our organisation. We also believe there is value in hearing individual voices as a way to improve the care people receive and the Mental Health System. To this end, we have included in the submission the unedited views of our employees who have participated in employee forums conducted throughout Monash Health.

We have also included information from our consumers reflecting their experience and also their views on the changes we have made to the way we work.

Monash Health would welcome further opportunity to contribute to the Commission's important work. We acknowledge there is still much work to do and hope that we can continue to assist the Commission.

For further information, please contact either Andrew Stripp at andrew.stripp@monashhealth.org or Melissa Casey at melissa.casey1@monashhealth.org.

Yours sincerely

Dipak Sanghvi
Board Chair

Andrew Stripp
Chief Executive

‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people

We have reported data as coded using the International Classification of Diseases (ICD) 10 classification system during the document [1].

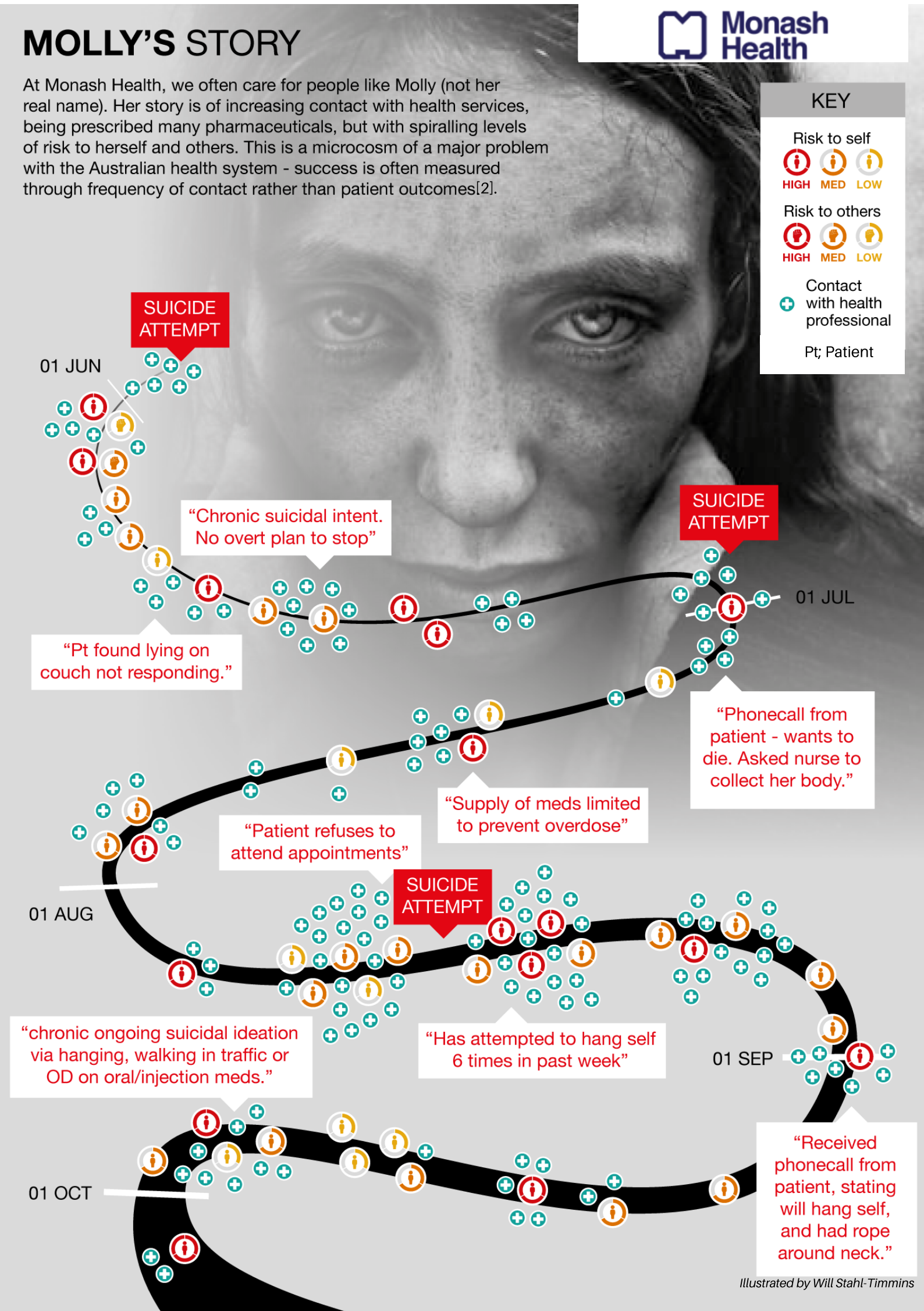
RECOMMENDATIONS

1. Increase funding to improve access to services and quality of delivery; review funding models and catchment areas
2. Adopt a biopsychosocial model of treatment for mental health patients and cease the current preoccupation with risk management
3. Apply design methodology, data analytics and user feedback to develop a value based community model of care, e.g. Monash's agile Psychological Medicine (aPM)
4. Invest in infrastructure, with a focus on community-based clinics
5. Ensure State and Commonwealth mental health services are complementary
6. Prioritise cultural reform, to aid development and retention of State's mental health workforce
7. Reform the governance of mental health services
8. Create a mental health co-design and leadership institute
9. Increase investment in research
10. Incorporate social determinants of mental health
11. Re-focus data system management towards clinical care and better utilise available technology and digital health solutions

MOLLY'S STORY

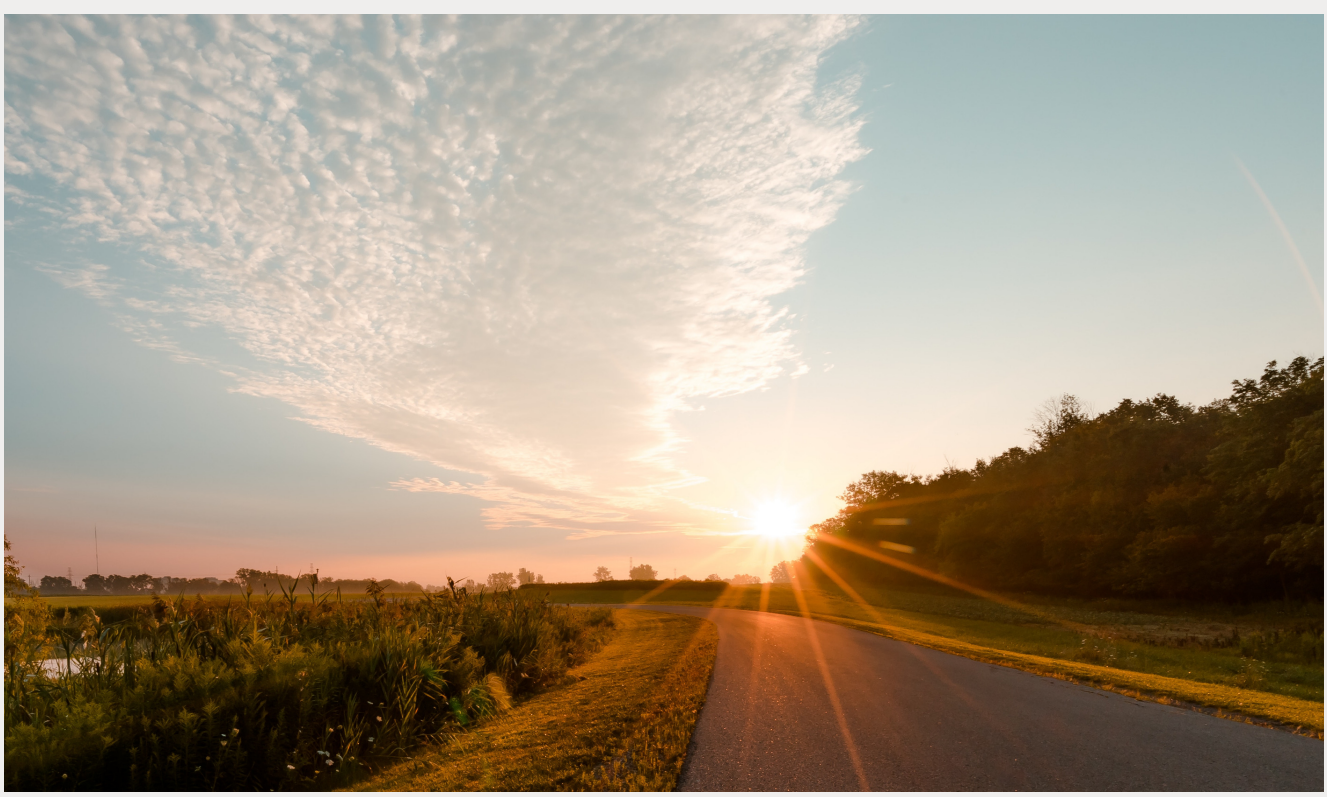
Monash Health

At Monash Health, we often care for people like Molly (not her real name). Her story is of increasing contact with health services, being prescribed many pharmaceuticals, but with spiralling levels of risk to herself and others. This is a microcosm of a major problem with the Australian health system - success is often measured through frequency of contact rather than patient outcomes[2].



Illustrated by Will Stahl-Timmins

> ***A journey towards a more evidence-based mental health care model that improves patient outcomes through continual feedback, innovation and agile service delivery***
>
> Casey [2]



EXECUTIVE SUMMARY

Monash Heath is the largest mental health service provider in Victoria, providing comprehensive services in both hospital and community settings.

Until five years ago, our program of mental health services broadly followed what was recommended in Victoria after de-institutionalisation in the 1990s. Our services comprised crisis assessment and treatment, mobile treatment and general adult community mental health services.

In 2013, we commenced a journey of self-reflection. We observed that as the only access point for tertiary mental health services that guaranteed same-day consultation with a clinician, Monash Health's Emergency Department presentations had been rising over the previous decade. This trend was consistent with what was occurring around Australia and is still occurring today [3].

Australians are accessing mental health services more than ever [4,5]. Prescriptions for anti-depressant medications have also risen significantly* and despite service increases, epidemiological and national surveys show no improvement in adult mental health [8]. The number of Australians experiencing a mental or behavioural condition is on the rise, largely due to a higher rate of anxiety and depression-related conditions [9]. Our country is experiencing higher treatment rates but less mental health [3].

Increased suffering has been accompanied by increased costs. In 2017-2018, 10.2% of the Australian population received Medicare-subsidised mental health-specific services, almost doubling from 5.7% in 2008-2009 [10].

Our analysis of why the mental health system was not delivering value to patients led us to develop a series of systems, and evidence-based interventions that have since yielded significantly improved patient outcomes. This analysis, at both the systems and individual patient level, showed many patients experienced multiple episodes of care within the system but rarely an evidence-based intervention, and that they often deteriorated rather than improved across the trajectory of care [3].

Our journey towards a new model of care for effective mental health services is the focus of this submission but we have also leveraged our analysis of the system holistically to make 11 key recommendations for the Commission's consideration that span the entire system, from funding to processes. We believe the proposed changes would enable the necessary authorisations, competencies and resources to deliver a stronger value-based mental health system for Victorians.

**Australia is now the second highest prescriber of anti-depressants in our band of OECD countries at 104.2 daily doses per 1000 people per day, behind only Iceland [6]. The national suicide rate is also climbing. In 2017, 3128 Australians died from intentional self-harm, an increase of 9.1% from 2866 in 2016 [7].*

MONASH HEALTH RECOMMENDATIONS

1 Increase funding to improve access to services and quality of delivery; review funding models and catchment areas

- Review strategic planning infrastructure and value to community of services
- Increase funding for services

2 Adopt a biopsychosocial model of treatment for mental health patients and cease the current preoccupation with risk management

- Need to move from crisis and risk management to biopsychosocial model of care
- Existing KPI's do not measure value of care to community
- Engage community in co-design of services and their treatment
- Systems design and change in the mental health should be informed by complexity science

3 Apply design methodology, data analytics and user feedback to develop a value based community model of care, e.g., Monash's agile Psychological Medicine (aPM)

- Learn from complexity science as to how to change and redesign a complex system
- Proof of concept aPM
- Feedback informed treatment and agile service delivery does provide clinical value to our community

4 Invest in infrastructure, with a focus on community-based clinics

- Invest in community based clinics including partnership care models
- Build a Mental Health Precinct at MMC
- Rebuild ward to increase inpatient beds at Casey
- Advocate for 12 bed Eating Disorders Residential House Glen Iris

5 Ensure State and Commonwealth mental health Services are complementary

- One mental health system of care for Australia
- Service delivery needs to be organised around its interrelations, each service delivering unique value
- Care transitions should be treated as relational transitions

6 Prioritise cultural reform, to aid development and retention of the State's mental health workforce

- Culture reform
- Reduce inequities between craft groups and between clinician and patient
- More graduate training opportunities
- Increase staff numbers, especially allied health

7 Reform the governance of mental health services

- Design one system
- Clear funding delineation
- Simpler model of monitoring and review
- Clear role delineation

8 Create a mental health co-design and leadership institute

- Service centric design is no longer acceptable to our community
- Train staff to be competent in design and change methodologies informed by complexity science
- Co-design with our community on two levels, their treatment and services
- Co-design can lead to hypothesis testing with outcomes; this is translational clinical science

9 Increase investment in research

- Increase research funding in mental health in Victoria
- Invest in translation clinical science

10 Incorporate social determinants of mental health

- Medication can diminish a person's agency
- Treatment designed to build a person's coping mechanisms and agency takes longer than medication
- People seek out people when in distress; if they are socially isolated or disadvantaged, they look for this social support in their community health service
- More education is needed
- Wrap-around services for asylum seekers and refugees

11 Re-focus data system management towards clinical care and better utilise available technology and digital health solutions

- A new statewide management system is required
- A new web-based portal required for Victorian community to increase fundability of mental health services

Recommendation 1

Increase funding to improve access to services and quality of delivery; review funding models and catchment areas

- The current Victorian Mental Health System has little by way of strategic planning, measurement of outcomes relative to purpose, or co-ordination with federal funding initiatives
- The resource distribution formula should be revised, to better estimate where services should be developed, aligned to population need
- Funding models should incorporate a mixture of output, input, block and outcome funding
- There is a particular need for more funding focused on inpatient beds, ambulatory services, and community mental health treatment

Recommendation 1: Increase funding to improve access to services and quality of delivery; review funding models and catchment areas

In the 1990s, Victoria migrated from institutional to community care of people with Severe Mental Illness (SMI). Large institutions were replaced with smaller hospital units, built on the sites of general hospitals and coupled with a range of novel community services. The design of the new mental health system was described in detailed documentation and the roll-out was managed by the Health Department.

Key descriptors of the change were 'mainstream' (meaning with general health) and 'integration' (meaning hospital with community). The values and intentions were largely viewed as positive by the community. At that time Victoria was proud to have one of the highest levels of investment in mental health services and was looked to for innovation and design. Today, however, the system falls well short of what could be achieved with the right funding and continued investment in services development, innovation and research. Victorians deserve much better.

It is our assessment that the serious problems being experienced by the mental health system in Victoria arise from a reduction in real terms of funding over decades. This chronic lack of resources has contributed to impoverished care and a mindset of scarcity that has meant that current resources are not being optimally used. There is little by way of strategic planning, measurement of outcomes relative to purpose, or co-ordination with federal funding initiatives.

This can be demonstrated by a variety of benchmarks (e.g., Victorian funding of mental health services compared to funding in other states) and has resulted in a poverty of action to develop and implement better care or adequately plan for population growth and associated infrastructure.

This issue was well documented in the recent Victorian Auditor-General's Office (VAGO) report, which noted that 45% of Victorians will experience mental illness in their lifetime, yet "DHHS [Department of Health and Human Services] has done too little to address the imbalance between demand for, and supply of, mental health services..." [11]. The Report concluded that "the mental health system in Victoria lags significantly behind other jurisdictions in the available funding and infrastructure, and the percentage of the population supported" [11].

In January 2019, the Federal Government announced $1.45 billion over the next three years for Primary Health Networks (PHN) to distribute to various providers such as Headspace and others, who provide community mental health nurses, psychological therapies and peer support. However, this system has no structure or experience appropriate to running mental health services and does not have a solid evidence base or operate in an integrated way with Victoria's clinical mental health system. There has been little, if any, meaningful engagement with the PHN.

Increased funding needs to be allocated to mental health in Victoria to improve the quality and safety of existing services and enhance service availability.

Further, an increase in the number of **inpatient beds** (see Appendix A) is required that allows for:

1. Different areas, with segregation on the basis of age, sex, acuity, disorder, high/low security. This could include open wards, closed wards, medium secure forensic units and Psychiatric Intensive Care Units (PICU) – each with appropriate staffing and model of care
2. The reintroduction of day programs to allow safe discharge and integration of patients on a journey of supported recovery, and a change in the staffing profile and model of care that will enable more therapeutic engagement and less emphasis on biomedical care

An increase in funding for **community mental health** especially to facilitate:

1. Redesigning community mental health informed by complexity science and using co-design methodologies
2. Investing in capacity building of our leaders in improvement science so they can lead point of care redesign and change
3. Improving access to acute treatment for acute distressed people (agile care)
4. Placing specialist treatment at the front-end
5. Transform Crisis Assessment and Treatment Team (CATT) and Psychiatric Triage Service (PTS) from risk management to engaging people in treatment
6. Improving access for people with chronic SMI
7. Increasing specialist treatment that facilitates recovery for people with chronic SMI
8. Integrate with community sector (PHN, single fund holder)
9. Offer choice - therefore abandonment of case management as the only model - for example agile Psychological Medicine (aPM)
10. Review multidisciplinary team member roles ensuring each craft group member contributes their unique value add
11. Increased ambulatory services with 24/7 operations

1.1 Catchment areas and activity-based funding

The VAGO report from March 2019 highlights multiple problems with catchment areas, including misalignment between service levels and types within a catchment, as well as accommodating population growth and demographic changes in that area [11].

In the 1990s, a critical component of the successful structural deinstitutionalisation reform process was an area-based formula for distributing funding to developing community services [12]. This included a needs-based population funding adjustment for socio-economic disadvantage and demographic properties of areas, among other elements. It was based on knowledge at the time of distribution of disorders. The evidence base around contribution of social determinants to occurrence and severity of mental disorders has only accumulated since that time [13,14].

Attention to these factors has not been maintained. There is no transparent and agreed method for distributing resources between areas based on population and no review of service boundaries and yet these are entirely feasible, as the successful implementation of the 1990s purchasing framework illustrates.

In particular, the characteristics of Australian cities have changed dramatically since the funding adjustments were made, with over a million extra people added in this decade alone. Socioeconomically, many inner-city areas – which in the 1990s were typically impoverished – have gentrified, with property and rental prices that prohibit residence by anyone on typical incomes. At the same time, the social housing stock has not expanded to adequately compensate.

Sprawling outer-suburbs, often relatively poor and constituting growth corridors present further challenges. We know that Commonwealth funded psychological services are distributed in very inequitable ways [15] which makes it imperative that State funded services are targeted to where and who needs them most.

There is a pressing need for two pieces of work:

(a) A revision and update of a rational resource distribution formula to guide our best estimate of where services should be developed, proportionate to population need. This is technically a simpler task than developing Activity Based Funding, and with a clearer evidence base, but it has received much less attention
(b) Attention to how such a formula can be connected with the diversity of funding structures proposed to respond to community needs. This includes integration with the 2017 commissioned review's recommendation of a mixture of output, input, block and outcome funding [11]

The VAGO report highlights other problems with catchment areas, including misalignment with other administrative boundaries. Attempts to realign catchment areas better with such structural imperatives have often foundered because there is no agreed or determined funding mechanism to accompany transfer of responsibilities between services [11].

Addressing these two points may be a necessary first step before other reforms in this important area have any prospect of success.

Recommendation 2

Adopt a biopsychosocial model of treatment for mental health patients and cease the current preoccupation with risk management

- The current system is too focused on risk mitigation, at the expense of client recovery. Existing measurement tools and performance indicators do not accurately track results for clients
- To encourage support for more trial-and-error learning, we recommend that the community be included in the design of new models of mental health care, introducing evidence-based methodologies to change a complex system
- Methodologies should be informed by improvement science, to design a new biopsychosocial model of care for community mental health

Recommendation 2: Adopt a biopsychosocial model of treatment for mental health patients and cease the current preoccupation with risk management

> *I have for many years held the view that the greater or lesser capacity of the ego to bear anxiety is a constitutional factor that strongly influences the development of defences*
>
> *Klein [16]*

2.1 Current system of care: risk mitigation

Models of mental health care have not kept pace with changing 21st century demographics and values. Our current model largely driven by severe resource constraints, is one of risk mitigation, along with crisis and biomedical management. Specialist and evidence-based treatment can be found within pockets of the system of care but it is by no means commonplace [2].

In the 1990s, a case management model was introduced whereby every person seen in the clinical mental health system was assigned a case manager; someone who would carry out a structured clinical assessment and then coordinate care.

In the years since, case managers have often been non-medical clinicians, mostly nurses. There has been a strong emphasis on 'risk assessment', and decisions about the type of care (e.g., admission to hospital) have been based on perceived levels of risk. In this environment, the nature of the problem – and the most appropriate treatment – has not always been the main consideration. Instead, risk mitigation has dominated community mental health management.

For their part, generic mental health clinicians acting as case managers have lost the therapeutic skills learned in their years of training, and many so-called consultations (welfare checks) are by phone.

There are few psychologists and allied health clinicians working in tertiary care. Day programs and groups, helping people to develop social and living skills, are a thing of the past. Community mental health services have limited hours of operation and limited capacity to respond urgently. Consequently, emergency departments are being used as a place of last resort by many people to receive help [3].

Concurrently, there has been enormous change in the provision of support for psychiatric disability. This is related to the introduction of the National Disability Insurance Scheme (NDIS) and the associated wind-down of Mental Health Community Support Services (MHCSS). Psychiatric disability services have been rationalised and recommissioned, leading to a virtual collapse of this important sector.

The injection of funding to respond to this situation has focused on the PHNs and Headspace, which has essentially created a "missing middle". Services required by people not eligible for NDIS can be difficult to navigate and require more clinical care than offered through PHNs or Headspace.

2.2 Challenging the belief that we can predict suicide from risk factors

> ***We cannot predict suicide from risk factors***
>
> Casey [2]

Contemporary research studies on the efficacy of a risk assessment approach to keeping a person safe have shown five things [2]:

1. The risk factors for suicide remain consistently reported; self-harm, depression, suicide intent, physical health problems and male gender [17]
2. Suicide, although too frequent, is statistically a rare event and we are not able to reliably predict a risk of suicide using our risk factors and measures. Indeed, evidence suggests the contrary [17,18]. The National Confidential Inquiry into Suicide and Homicide (UK) has 20 years of data on 120,000 people who committed suicide [19]. Appleby et al. [20] analysed five years of this data and found that 86% of people who suicide came from low-risk groups. Meta-analysis by Large et al. [21] concluded the means of distinguishing patients with a high risk of actual suicide remains elusive. Recent meta-analysis indicated 60% of people who die by suicide have not disclosed their suicidal ideation previously [22]
3. Why do we focus so much attention on assessing risk of suicide? Our current preoccupation with risk prediction over understanding the individual is potentially harmful to patients, staff and organisations [17]
4. Australia has prioritised significant resources for managing suicide risk on the premise that we can prevent suicides by assessing risk. The evidence does not support this belief
5. Using risk assessments has fertilised the erroneous belief that we can control who commits suicide; this heightens anxiety in mental health professionals and has fuelled a blame culture

2.3 A new approach to risk and recovery

The consequences of managing risk are currently held at the point of care. In a much documented culture of blame and accountability, clinicians have experienced and reported high levels of anxiety working with people with suicidal ideation, for fear of an adverse event and the consequences to them [2].

Flewett [23] notes that this high level of anxiety in clinicians negatively influences clinical work and is detrimental to the therapeutic alliance. Gutheil et al. [24] describes this defensive practice as a protective mechanism against blame and an undesirable outcome; from the clinician's perspective this would be an investigation or a registration issue [2].

We cannot underestimate the impact of clinician fear and anxiety on resulting patient outcomes and quality of care. The Berwick Review [25] of the National Health Service (NHS) found that fear is toxic to both safety and improvement. Fear and anxiety reduce the clinicians' ability to engage at work. A NHS study showed that low staff engagement is directly related to poor quality outcomes including patient morality rates [2,26].

When we examine the behaviour of our system at our access points; our emergency departments and our phone triage service, we also see a system responding defensively, providing risk and biomedical management not biopsychosocial care (see Figure 1)[2].

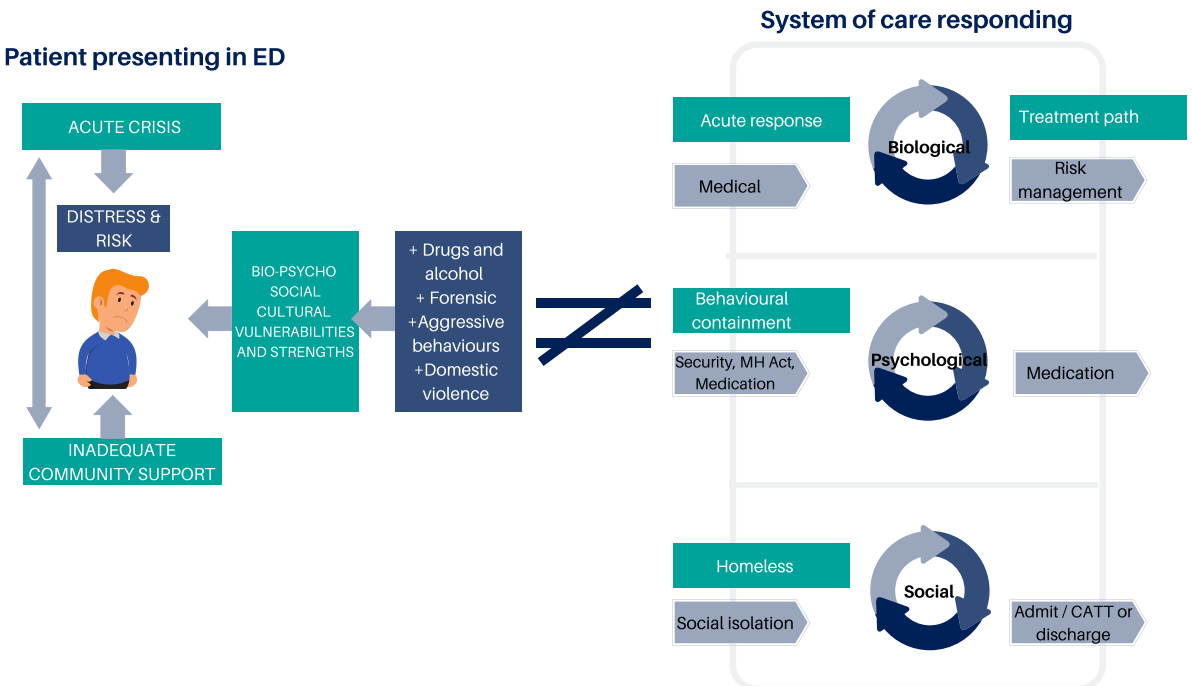


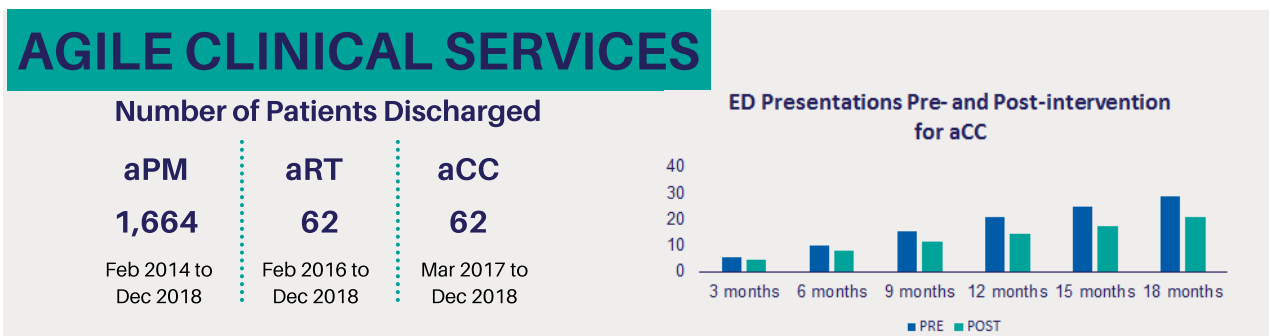
Figure 1: A system of care that is not fit for the purpose of treating biopsychosocial distress.

> ***The way we currently manage suicide risk in the mental health system is a systemic failure (by definition), as there is a disconnect between the purpose of the system and the human interface that delivers it***
>
> ***Casey [2]; Reason [27]***

Clinicians and the public at large need to be educated about getting people who are at risk of suicide into treatment. The current practice of using safety plans that address risk of suicide are necessary but not sufficient to keep people safe [2].

Monash Health has been working on the hypothesis that a greater focus on recovery will lower the risk of suicide. The data we have collected from our agile clinical services [2,3,28-31] support this hypothesis as seen in Figure 2.

Sixty percent of clients who have received treatment in the agile clinical services have suicidal ideas and there has been one patient death in this time. Comparative analysis of Health of the Nation Outcome Scale (HoNOS) scores comparing the relative acuity of agile clients compared to CATT patients showed agile were treating less well patients over this time (data available on request). aPM sees acutely distressed people for treatment, usually within three days of the ED presentation. Using the Patient Reported Outcome Measures (PROMs) after treatment, patients reported improvements ranging from 31% to 57% [2]. More is said about the aPM clinics in Recommendation 3.



Clinician & Patient Reported Outcome Measures

Measures	IMPROVEMENT aPM	aRT
HoNOS	31%	42%
BASIS-32	42%	40%
BDI-II	43%	48%
Demoralisation Scale	33%	-
PCL-5	-	57%
ORS	-	21%

For the aCC service, ED presentations reduced by 29% *12 months post-commencement of intervention, compared with 12 months pre-intervention*

Patient Satisfaction*

aPM	aRT	aCC
97%	98%	97%

Figure 2: agile clinical services clinician and patient reported outcomes data.

aRT; agile Recovery from Trauma; aCC; agile Comprehensive Care; BASIS-32; Behavioural and Symptom Identification Scale; BDI-II; Beck Depression Inventory 2nd Edition; PCL-5; Post-traumatic Stress Disorder (PTSD) Checklist for DSM-5; ORS; Outcome Rating Scale; SRS; Session Rating Scale; ED; Emergency Department

**Patient satisfaction was calculated using the average total rating on the Session Rating Scale (SRS) [32].*

2.4 Activity doesn't equate to outcomes

Using current key performance indicators, financial management indicators and quality metrics – and reviewing the traffic-light data provided in Table 1 below – Monash Health's five-year statewide performance has been in the middle of the range. This is in conflict with feedback we have received from our community. As long as services are driven by activity data they will not be motivated to achieve what is needed; good clinical outcomes for our community.

Monash Health recognised some time ago the need to go beyond existing assessments of the system's efficacy. As demand increased, it was initially hypothesised that more presentations were a result of the increasing population in Melbourne's Casey/Cardinia growth corridor.

Subsequent analysis showed that the percentage of new patients was inversely related to increasing presentations. That is, patients were re-presenting at a higher rate over time and the fact that half of all admissions occurred from ED explained the pressure on inpatient beds [3].

Ranking of Monash Health against other metropolitan Adult health services for mental health quarterly indicators

Monash Health is ranked against 8 health services in metropolitan Melbourne

1 being the lowest value and 8 the highest, colour formatting depending if high or low is a better result

Adult Mental Health	2013/14		2014/15		2015/16		2016/17		2017/18	
INPATIENT	Ranking	Avg (Metro)	Ranking	Avg (Metro)	Ranking	Avg (Metro)	Ranking	Avg (Metro)	Ranking	Avg (Metro)
Local access	5	79%	2	77%	1	76%	2	82%	2	72%
Bed Occupancy	8	92%	8	94%	7	96%	6	95%	8	95%
Trimmed ALOS <=35 days	5	10.3	4	10.3	4	10.1	3	9.8	4	9.3
Long Stay Bed Occupancy (>35 days)	5	11%	6	12%	3	10%	3	10%	3	11%
28 day readmit rate	2	15%	1	14%	4	15%	4	14%	3	14%
Seclusion per 1000 beddays	4	10.8	5	9.8	4	11.4	3	10.7	5	9.8
% Multiple seclusion	4	3%	4	3%	3	3%	2	2%	3	2%
Pre-admit contact rate, in area clients	1	62%	1	64%	1	62%	1	57%	2	62%
Pre-admit contact rate, in area ongoing	4	85%	2	88%	2	84%	4	79%	3	84%
Post-discharge follow up rate	5	87%	8	89%	6	88%	7	84%	8	89%
% Valid HoNOS Compliant	6	79%	6	66%	4	62%	5	58%	5	67%
% from ED to MH bed within 8 hours	3	67%	4	62%	4	56%	3	53%	1	49%
COMMUNITY										
New case rate	5	36%	5	35%	5	32%	4	35%	4	36%
Case re-referral rate	6	27%	8	26%	7	26%	4	27%	1	27%
Avg length of case	3	276.5	4	186.8	4	188.7	5	167.4	3	175.7
Avg treatment days	4	9.5	4	9.6	4	9.1	5	5.9	2	8.2
% Comm cases with client on CTO	6	26%	7	19%	7	17%	7	17%	7	18%
% Valid HoNOS Compliant	5	73%	4	69%	6	68%	6	59%	6	65%
Mean HoNOS at comm. case start	5	12.7	5	12.9	3	12.9	1	0.13	3	13.2
% clients with sig.improv. case end	6	51%	5	50%	3	49%	5	51%	5	49%
% self rating measures completed	1	2%	3	4%	1	3%	2	3%	7	4%
Change in mean # of clin signif. HoNOS items	8	1.4	8	1.3	8	1.3	8	1.4	8	1%

Table 1: Quarterly ranking of Monash Health against other Adult Mental Health Services (AMHS).

2.5 The need for new performance measures

When we reviewed the clinical value that our mental health teams were providing to the community, and where our clinical services re-presentations were highest, we concluded that existing measurement tools and performance indicators for quality improvement were not conducive to accurately tracking our results for patients. It became evident through model-of-care planning workshops over several years, that the Mental Health Program understood its supply determinants, but that 50% of the story was missing, i.e., patient characteristics that make up the demand [2].

For example, in the model-of-care workshops, data had not been used to describe:

- how patients (by clinical category) accessed the service
- how patients flowed through the system
- why many patients were not able to access the system
- why patients re-presented
- the patients' experience in the service

At this point, the mental health team at Monash Health set out to experiment with a system of care that would be truly designed around the needs, experiences and outcomes of our adult mental health patients [2].

2.6 From crisis management to recovery

The journey to recovery is the experience that our mental health system and services should provide to our community. Recovery as a goal is foremost in the World Health Organization's Mental Health Action Plan for 2013-2020 and there is much international agreement on this [33]. However, operationalising this into a functional and value-based mental health system of care has been elusive all around the globe [2].

The principles of recovery clearly challenge the prevailing paradigm of activity, risk mitigation and containment characteristic of our current system of care in mental health.

The principles of recovery are [34]:

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all'.
- The helping relationship between clinicians and patients moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be "on tap, not on top".
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

2.7 Improving patient recovery through a new relationship with risk, understanding complexity and using design

A leading expert on safety in complex systems, Perrow [35], is of the view that society does not allow a trial and error approach to risk-taking. The evidence about how a complex system learns and changes identifies trial and error learning as a foundation for emergence that leads to improvement and evolution. Therefore, if we accept the premise that our current system is designed to only manage risk, we are unlikely to be given permission by society to change that system through trial-and-error learning [2].

Our answer is to include the community in this process of co-design, introducing evidence-based methodologies to change a complex system. Further, to achieve the elusive mental health care "phoenix", Monash Health believes we need methodologies informed by improvement science to design with our community a new biopsychosocial model of care for community mental health [2].

This co-design methodology focuses on four key elements: **the know-what, know-how, know-why and know-who.** As we explain below, such an approach avoids an over-emphasis on strategy and top-down processes that have failed to deliver on purpose to date [2].

The **know-how** to design and change the mental health system is key. Existing reductionist and top-down methodologies have not led to the delivery of a mental health system that Victorians require to stay well. Complexity science, also known as Improvement science, provides the evidence base for how to design and change our complex system, as intended. The **know-what** draws upon the clinical evidence base and from local systems behavioural data and patient activity data and analytics. The **know-why** creates the human will and energy required for clinicians to open up to feedback, learn, and change and the **know-who** focuses on including the right people in the design and change process. We need a human ethical redesign of the mental health system delivery patient value. We should not underestimate the level of authorisation and capacity building required to effect this systems change [2].

> ***"The master's tools will never dismantle the master's house"***
>
> ***Lorde [36]***

2.8 The voices of clinical co-design

At the most abstract level, there are three voices of design that need to be involved in any redesign of the mental health system [2]:

(a) **The voice of intent**; a redesign needs to be in line with strategic purpose and authorised by the current systems holder who has authority and accountability for the current systems deliverables. At present, the tightly regulated mental health care system has an emphasis on compliance with rules and procedures. Innovations by definition, challenge and change existing rules, and will not prosper unless there is an authorising environment that sponsors and governs the safe prototyping of new and improved ways of delivering mental health care that meets the needs of the community. This safety needs to include clinical care for patients and psychological safety for staff. Unless this paradox is resolved at the highest level, and an authorising environment that governs innovation is established, a redesign of community mental health that meets purpose will not be delivered. This authorisation will enable the risk associated with change to be managed at the appropriate level and free frontline leaders to provide a psychologically enriched environment needed to enable innovation to prosper. At present the people who currently lead frontline innovations, carry all the risk factors associated with leading an innovation. Innovation in a complex adaptive system requires a new relationship with risk management, as the usual safeguards for staff don't exist (which is compliance with existing rules and procedures).

(b) The **voice of design** enables the evidence base relating to redesign and change in a complex adaptive system to inform the process. Currently and most commonly, the redesign of the mental health system has been left to clinicians to lead, with much disquiet from the community. Our patients are wanting their voice heard and there is much community support for co-design or co-production. Indeed, it is best practice to have users involved in any design process whether in health or any industry.

(c) As clinicians we do have expertise in providing specialist clinical care but we are not polymaths, so we don't know how to design a complex adaptive system unless we have specialist competencies in complexity science. Our patients are experts in what it is like to receive that care – therefore together, clinicians and patients are the **voice of experience**, 50/50.

Recommendation 3

Apply design methodology, data analytics and user feedback to develop a value-based community model of care, e.g., Monash's agile Psychological Medicine

- Monash Health believes a greater focus on client recovery will lower the rate of suicide (rather than an emphasis on traditional risk factors) and our data supports this hypothesis
- Since 2014, Specialist Psychological Services at Monash Health has continuously measured and analysed what clinical services our clients need to stay well
- By incorporating regular client feedback, we have generated significant insights that have guided the development of a model we call agile Psychological Medicine (aPM). This innovative model is delivering value-based mental health care, as defined by improved client outcomes and experience

Recommendation 3: Apply design methodology, data analytics and user feedback to develop a value-based community model of care, e.g., Monash's agile Psychological Medicine

We sought to create a mental health system of care that was truly designed around the needs, experiences and outcomes of our adult mental health clients. The design of the system is important as it is 90% responsible for how humans behave [2,37,38].

> ***We knew that redesigning at a systems level would enable significant downstream benefits to be realised by influencing how the human delivery system behaves***
>
> ***Casey[2]***

The purpose of our design framework was to deliver excellence in care through a true therapeutic partnership. Our redesign process is informed by complexity science and implemented using psychologically informed change principles from cognitive, behavioural and emotional domains [39].

In order to achieve this we needed to understand how our patients were currently experiencing the service. We commenced the analysis by understanding our patients' demand for service by looking at our access points; our three emergency departments and our phone triage service.

3.1 Access: Emergency Department

We set out to understand why presentations to our three emergency departments had increased ten-fold over a decade. Applying systems behavioural analytics told us that the increase of patients was related to increasing re-presentations i.e., the percentage of new patients went down (see Figure 3) [2].

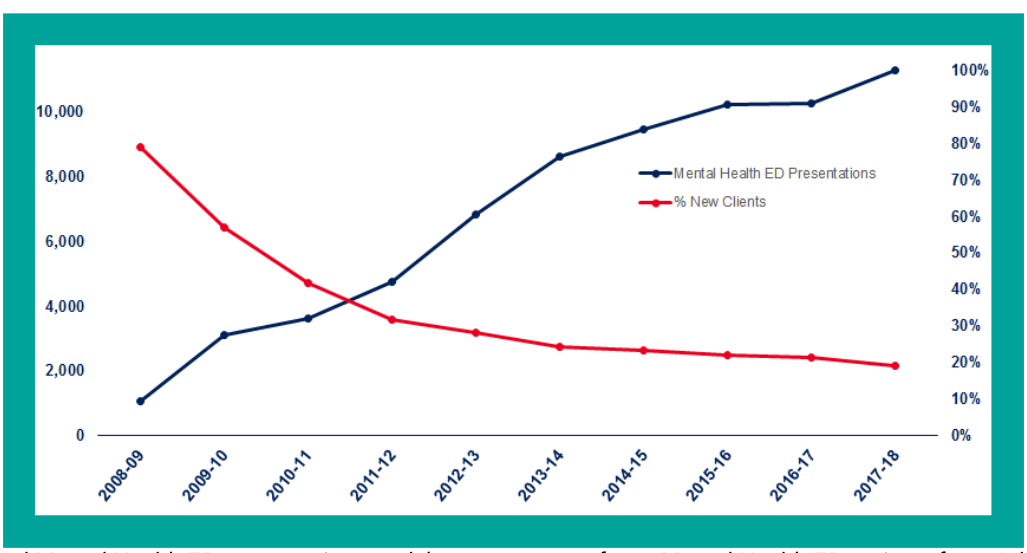


Figure 3: Total Mental Health ED presentations and the percentage of new Mental Health ED patients from July 2008 to June 2018.

That is, more of our patients were returning over time. Given that typically half our emergency presentations were admitted, the pressure on our inpatient beds was not a surprise. We also found our top two diagnosis were depression and suicide risk, this has remained consistent over the last five years (see Figure 4) [2].

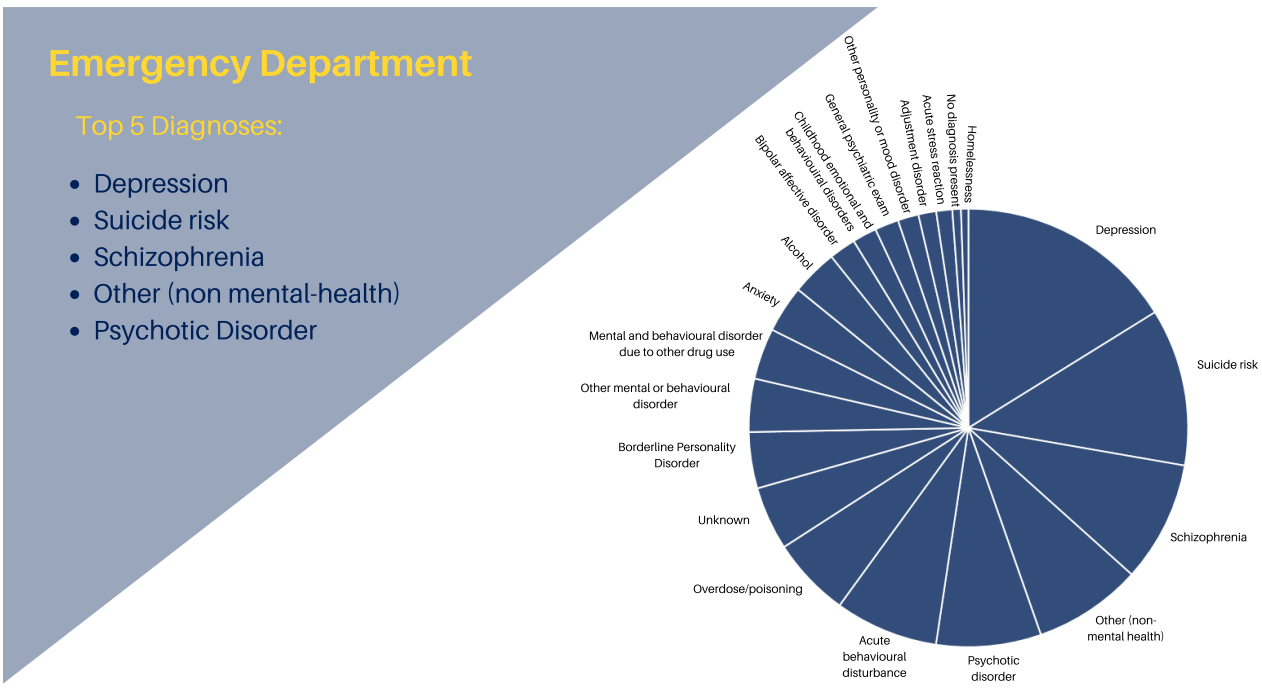


Figure 4: Top Mental Health ED primary diagnoses for 2018.

Figure 5 shows the average time it takes for a person to see a mental health clinician whilst waiting in the ED and Figure 6 shows the increasing time people spend waiting in our ED.

Figure 5: ED average waiting times in minutes, from presentation to referral and from referral to assessment.

MH; Mental Health

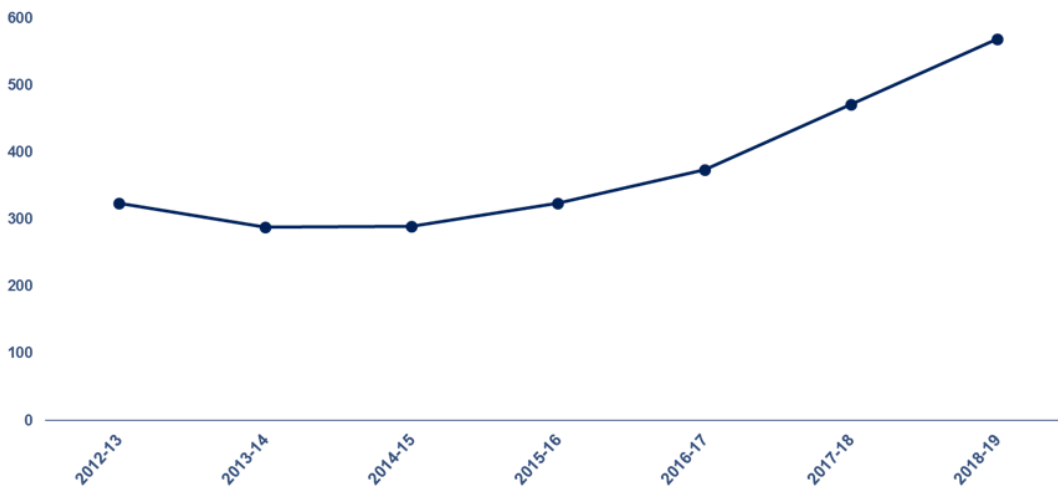


Figure 6: ED average waiting time in minutes, from arrival to departure.

3.1.1 Top 200 ED Presenters

Using the Pareto principle, we looked at our top 200 presenters to ED to better understand the drivers behind our increasing ED presentations. The analysis is presented in Table 2. We have approximately 5,000 unique presenters per year. Our top 200 presenters represent approximately 20% of all ED presentations, approximately 50% are concurrently being managed in our community mental health service, and around 70% re-present within 28 days of their prior ED presentation [40]. They also account for a significant percentage of our overall mental health budget [40]. Over the last five years our top 200 presenters cost the service just over $69 million.

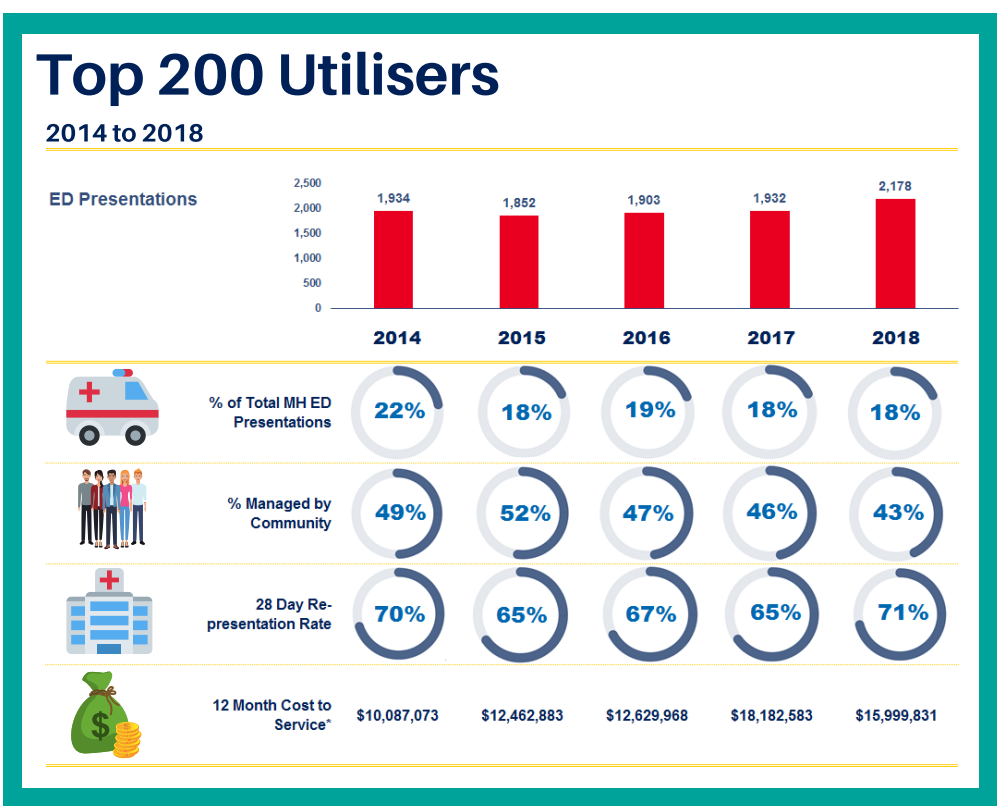


Table 2: Top 200 ED presenters by year, and their corresponding 28 day re-presentation rate, community management, percentage (%) of total Mental Health ED presentations, and cost to Monash Health services.

*Cost to service includes ED , inpatient and outpatient costs throughout all of Monash Health catchment.

3.1.2 Psychiatric Triage Services

We also looked at our other access points including PTS and noted the number of people who are not able to access services via this entry point.

In 2013, 84% of people were not able to access treatment from our phone triage point of access. This number has remained relatively stable over the last five years until 2018 where the number of callers has nearly halved. Please see the next two figures as an illustration (Figures 7 and 8).

Of significance, 95% of the people who rang PTS in 2018 had suicidal risk – that is 12,427 people seeking treatment with suicidal risk. Figure 7 indicates only 16% of people who rang seeking access to treatment in 2013 were mobilised into the mental health service. In Figure 8 below, 35% of people who rang seeking access to treatment in 2018 were mobilised into the mental health service. However, it should be noted the number of callers between 2013 and 2018, had reduced by nearly 50% [2].

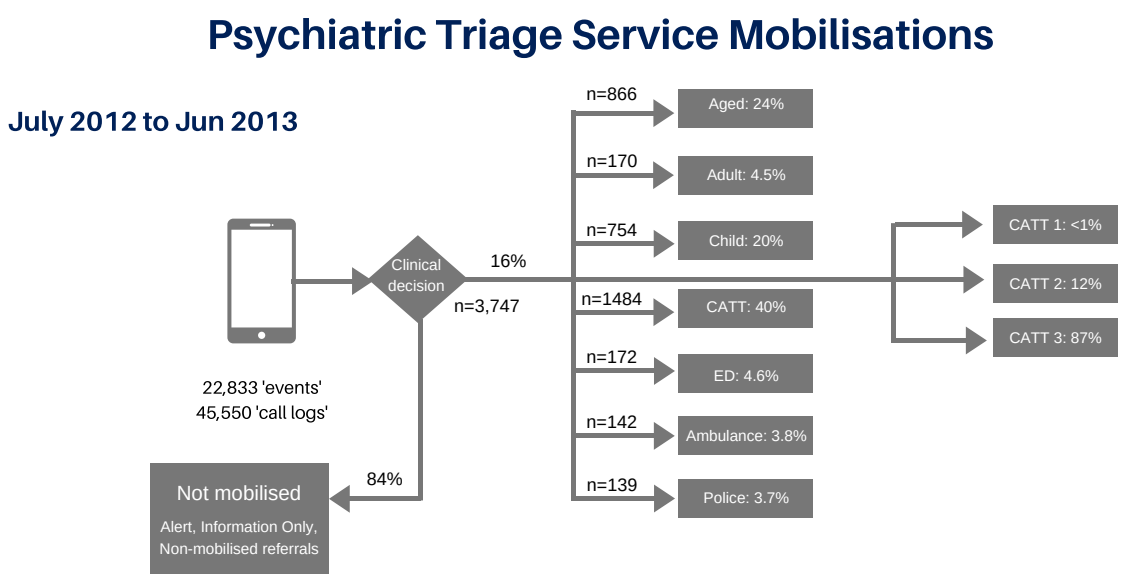


Figure 7: 2013 phone triage service mobilisations.

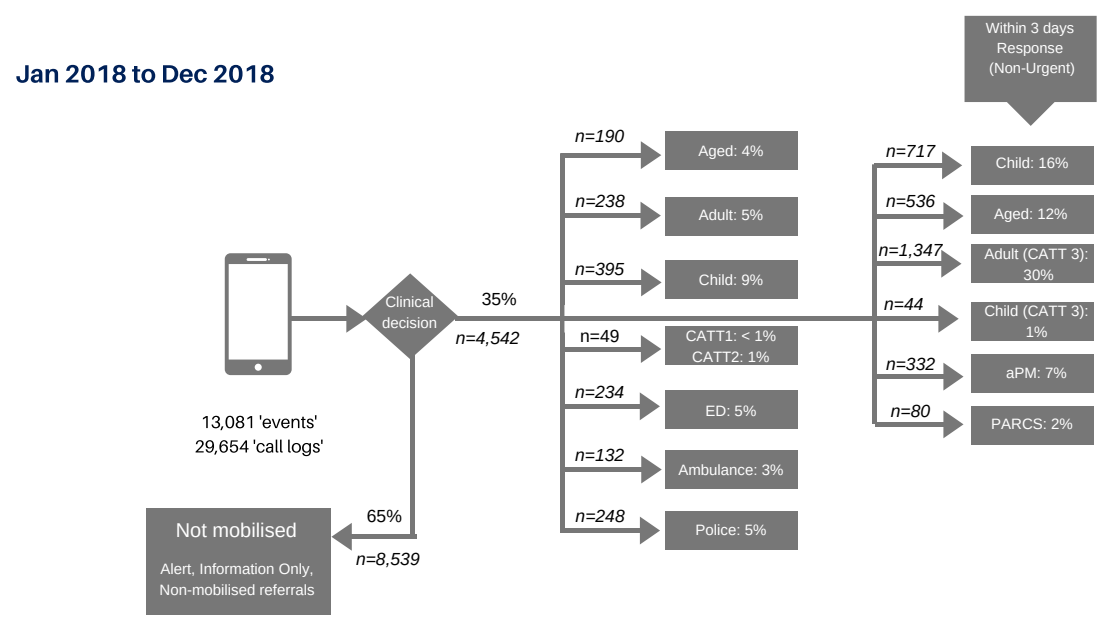


Figure 8: 2018 phone triage service mobilisations.

3.1.3 Beyond Access

We wanted to examine where the people went after being mobilised past our access points of PTS or ED. The patient pathways with quantitative data from 2013 and 2018 are shown in Figures 9 and 10 below.

We could see that adults particularly were mobilised into a CATT service, inpatient admission or discharged. That means that the majority of adults who gain access receive biomedical and risk management; not psychological treatment that is a key evidence-based intervention for high prevalence disorders [28].

In 2013 when we examined the quantity of people referred to CATT from PTS, 87% were triaged as a CATT 3 (see Figure 7); meaning they needed to be seen within 72 hours. In the context of a mental health crisis this did not fit. Our crisis workforce was largely dealing with non-crisis community referrals. We asked where our crisis referrals were being seen and PTS explained they mobilised these people into ED [28].

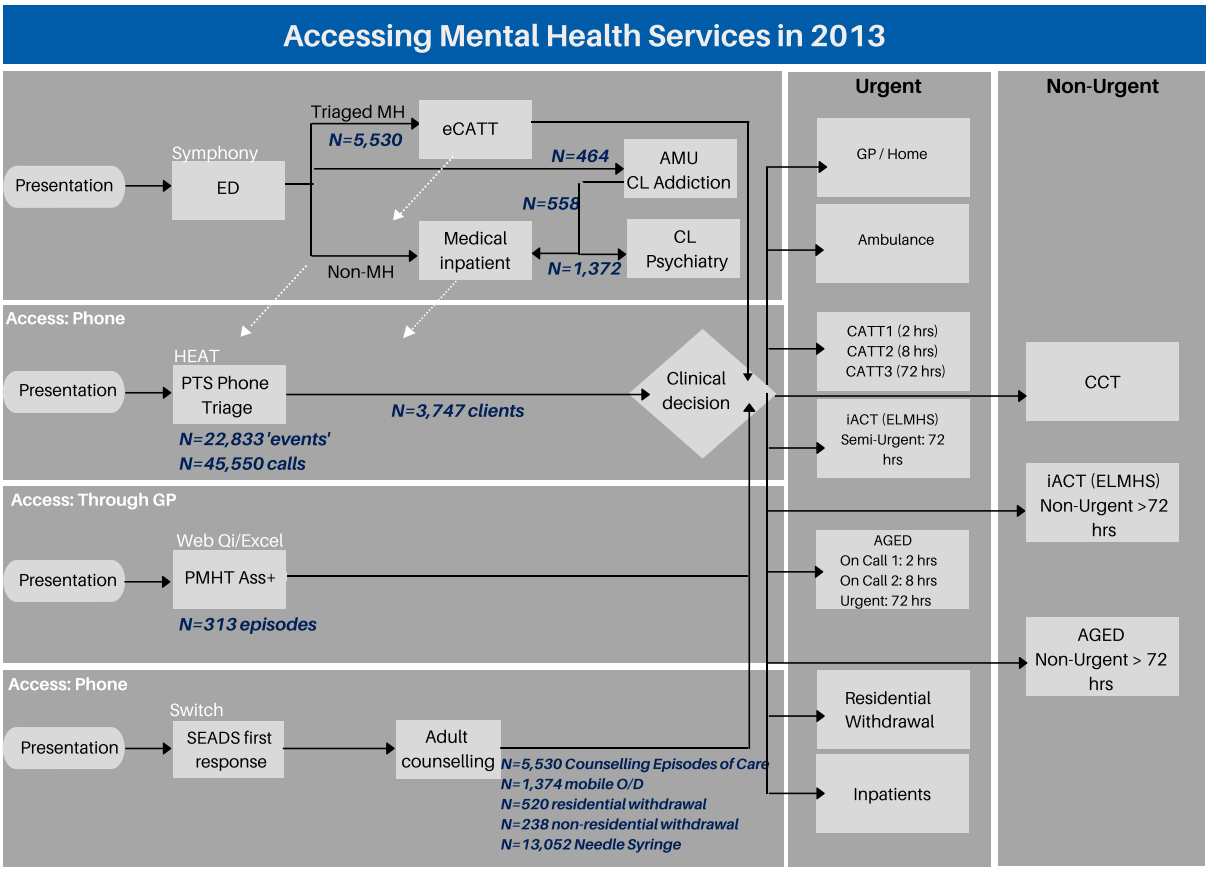


Figure 9: Mental Health access pathways 2013.

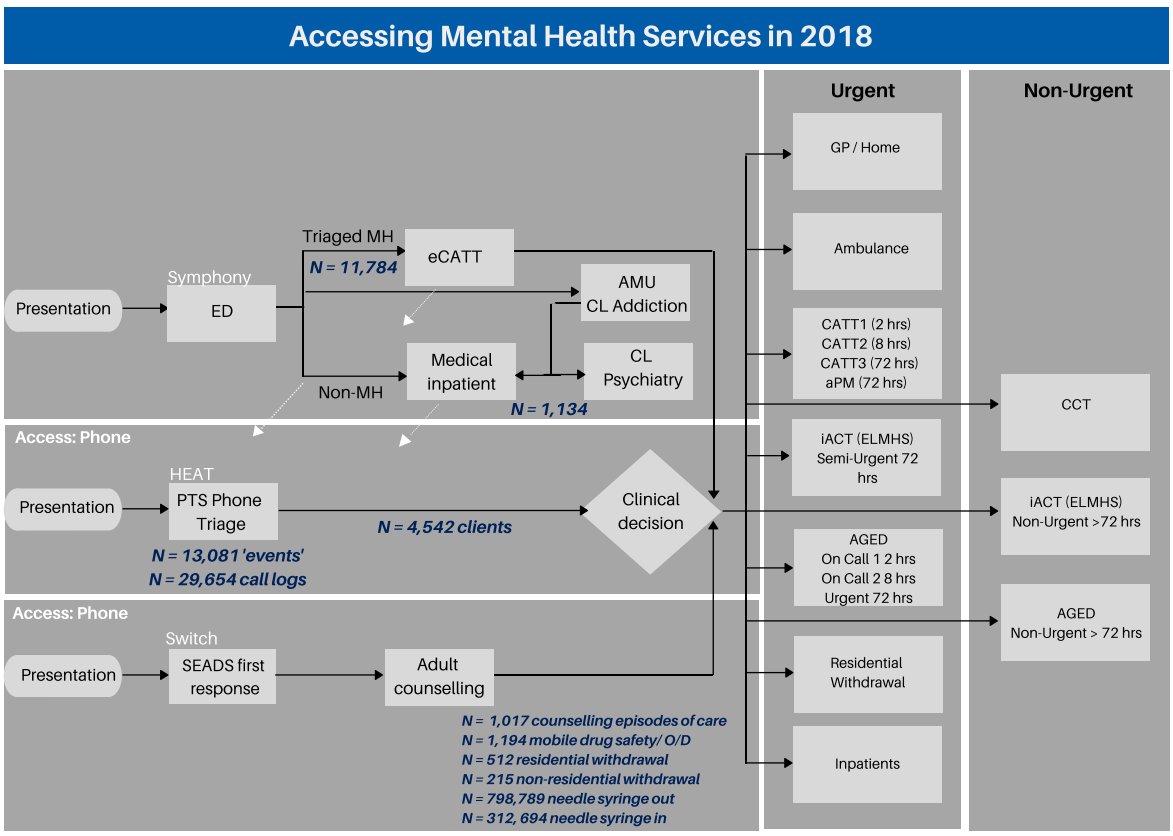


Figure 10: Mental Health access pathways 2018.

eCATT; emergency Crisis Assessment and Treatment Team; AMU; Addiction Medicine Unit; CL; Consultation Liaison; GP; General Practitioner; iACT; intake, Assessment, Consultation and Brief Treatment; ELMHS; Early in Life Mental Health Service; CCT; Continuing Care Team; SEADS; South East Alcohol and Drug Service; O/D; Overdose.

3.1.4 Access: Opportunity for redesign

As indicated in the data above and illustrated in Figure 11 below, we have a significant group of people presenting with depression and suicidal ideation at our access points, yet a large proportion are not able to access treatment and care.

Of significance in 2018, in our emergency department 1,885 people presented with depression, 589 with suicidal ideation and a further 707 with suicidal risk (defined as suicidal ideation plus history of self harm). All of these people could and should receive treatment in something like an aPM clinic - if they were able to get past the front-end access points (aPM is further explained in 3.1.6).

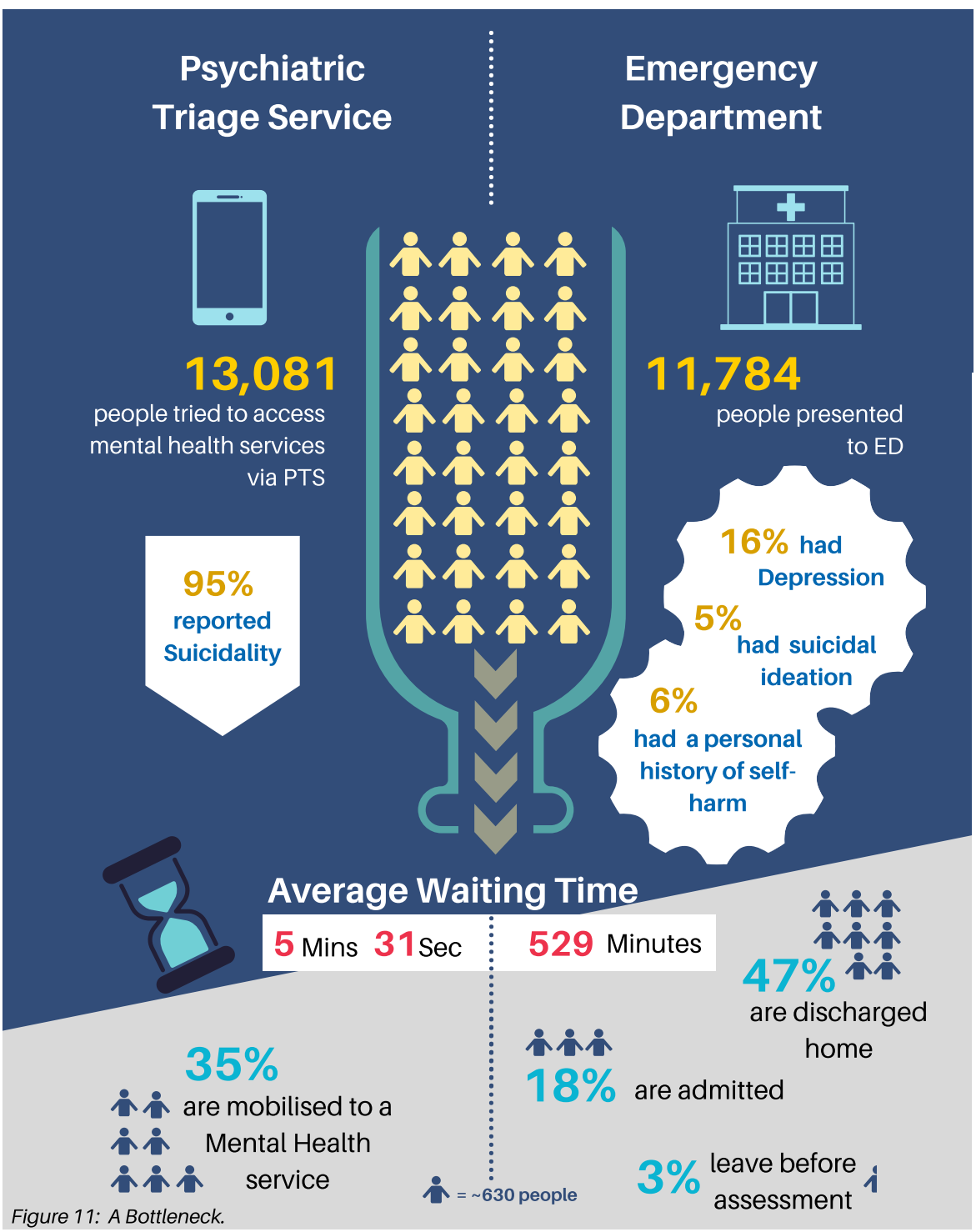


Figure 11: A Bottleneck.

3.1.5 Community Outpatients

We wanted to understand the value of care being delivered through our community teams as 50% of people presenting to ED are being managed in the community (see Table 2). We used the Service Unit Value (SUV) tool to generate insights as to why patients re-presented after receiving an episode of care. The SUV tool provides a relative value of the clinical service based on patient outcomes and service cost over time [3]. We asked ourselves if the re-presentation was due to the nature of a patient's severe and enduring mental health condition, or a failure to deliver the care that the patient needed for recovery.

Data provided by the SUV tool enabled us to dig deeper and see the community services were not sufficiently meeting patient needs. We examined what happened to people who had received a community episode of care during 2012. We knew from our earlier ED analysis that people we treat on average, represent for further treatment, so we compared three years of presenting behaviour (2013-2016) after their community episode of care to three years of presenting behaviour before their episode of care. The rationale behind this approach was if a person had received an intensive community episode of care and then discharged you would expect to see a reduction in their representations post discharge.

What the analysis showed was: people that were discharged from a community episode of care had on average deteriorated, and their patterns of re-presenting are shown in Table 3.
Whilst the CATT results show an improvement on discharge, their re-presentation rate was the highest. This research was accompanied by activity analytics to understand the patient experience (see Tom's story in Appendix C).

Community Outpatients Present More and Stay Longer after Treatment
April 2011 - April 2012

Service Type		CCT	MST	CATT
	N	490	48	452
	HoNOS valid	52% 6.6% deterioration	69% 21.2% deterioration	48% 33.6% improvement
	Mental Health ED presentations	2%	83%	52%
	PTS calls	40%	22%	17%
	Admissions	11.5%	21%	37.5%
	Admissions length of stay	7%	10.9%	26.8%
	CCT	30%	13.3%	55%
	CCT length of stay	39%	20.8%	50%
	CATT	35%	54%	26%
	CATT length of stay	57%	77%	0.03%
	Community	148%	20%	166%
	Community length of stay*	86%	54%	83%

Table 3: 36 months pre- and post- service utilisation for CATT, CCT, and Mobile Support (MST) episodes of care closed between April 2011 and April 2012.
** Community length of stay includes all community episodes, including; CCT, MST and CATT.*

This work gave us ***eight key insights*** as to where we could improve care for mental health patients [2]:

1. The system emphasises biomedical and risk management, not biopsychosocial treatment
2. There were many handoffs and transactional activities but too little evidence-based care
3. The medicalisation of mental health for high prevalence disorders has unintended consequences such as reducing the emphasis on self-help behaviours, personal efficacy and agency
4. Some patients were being discharged in a worse state than when they were admitted
5. Clinicians experienced episodes; patients experienced the system of care
6. Visualising the patient journey changed our perspective from clinician to patient and from clinical activity to patient outcome
7. Our existing measurement tools and performance indicators for quality improvement were not delivering clinical value to patients
8. We learned most of how we could improve clinical care from our re-presenting patients

Reflecting on our key insights led us to conclude that redesigning the system around patient pathways would meet our patients needs (see Figure 12).

> ***Redesign the mental health system around patient pathways***
>
> ***Casey*** *[2]*

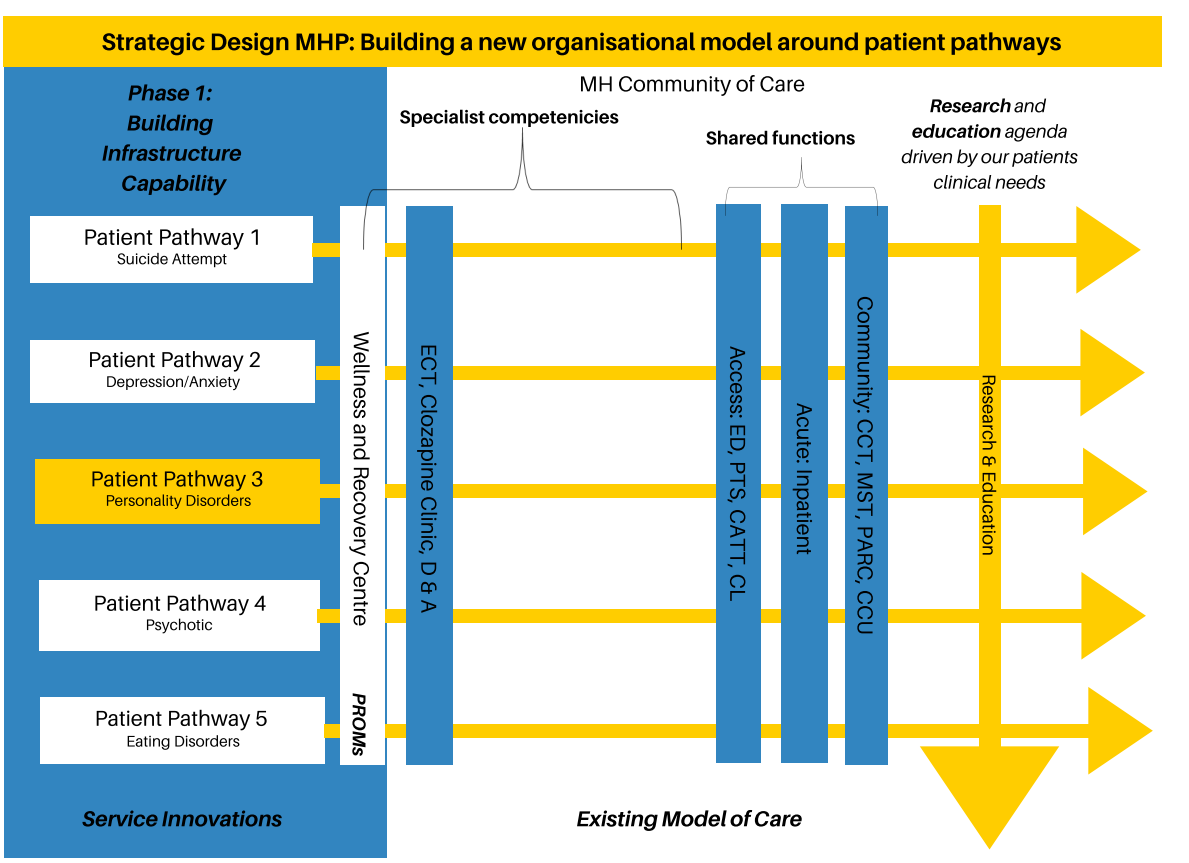


Figure 12: Strategic redesign using patient pathways.

ECT; Electroconvulsive Therapy; D & A; Drug and Alcohol; PARCS; Prevention and Recovery Services; CCU; Community Care Unit.

3.1.6 Agile Psychological Medicine: co-designed treatment pathways

It is widely acknowledged that healthcare is the most complex of adaptive systems. As a result of this complexity, and the way programs are funded, many agencies offer discrete services that result in little coordination for the patient between workers, within and across programs, sectors and the system [2].

The mental healthcare system should not be considered in the context of its component parts (like clinics, inpatient services, community clinical services, and related services like housing, social and occupational support services). This is not how patients and their families are best served. Rather, service delivery should be organised in terms of its interrelations, which would ensure client needs are met through a series of connected and value-adding services [2].

Since 2014, Specialist Psychological Services at Monash Health has continuously analysed, hypothesised, prototyped, listened to, measured, learned and iterated what clinical services our clients need to stay well. By understanding why our clients re-presented, we have been able to generate significant insights that were not immediately apparent when we embarked on this work.

We have developed a value proposition to implement a co-design treatment program (**agile Psychological Medicine, aPM**) with clients *in situ*, so that they:

(a) have an opportunity to co-design the treatment they experience whilst in treatment (measured by Patient Reported Experience Measures (PREMs))
(b) leave treatment better than when they presented on issues that matter to them (measured by PROMs)

The PROMs and PREMs demonstrate that when clients receive early access to feedback-informed treatment in aPM it leads to improved clinical outcomes and experiences.

On the occasions that clients do re-present, we prototype new clinical services for those clients and measure again for purpose, outcomes and experience. Figure 13 shows the new patient pathways. Our Specialist Psychological Services team has broadly termed this as agile clinical services and we believe the model is translational clinical science in action.

The aPM design experience video [41]:

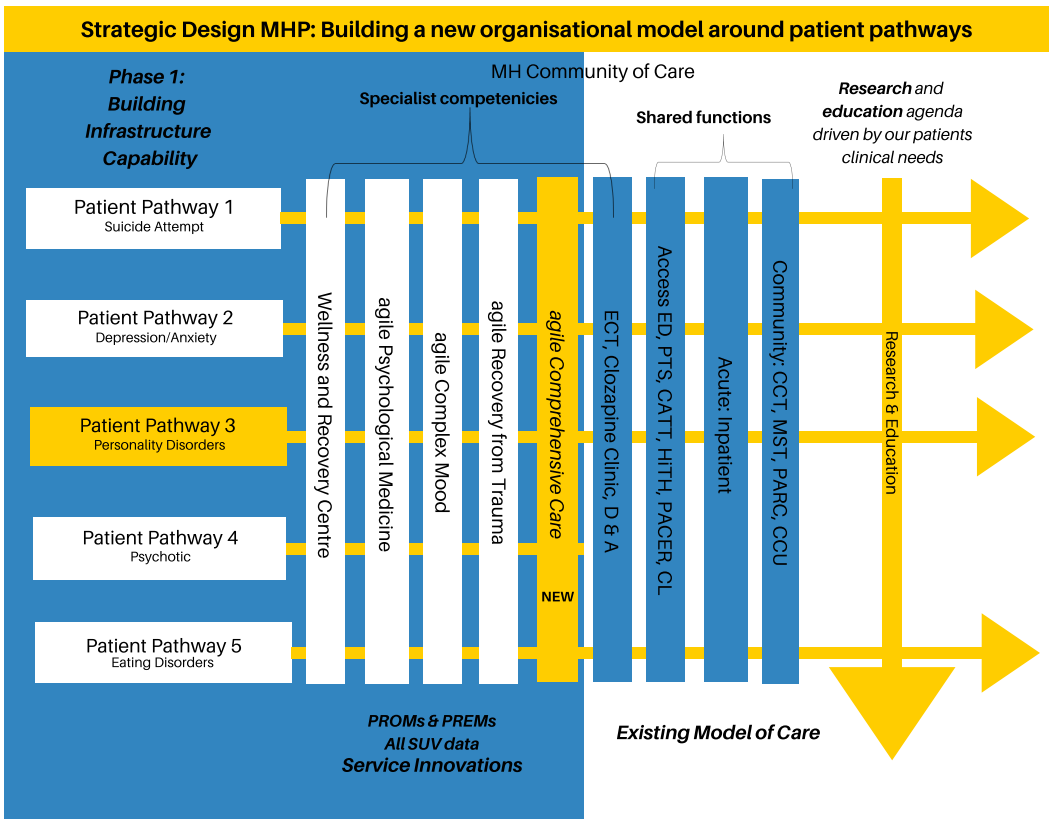


Figure 13: Strategic Design MHP: Building a new organisational model around patient pathways.
PACER; Police, Ambulance and Clinical Early Response.

As a result of the aPM work, we have expanded our clinical services to provide specialist evidence-based treatment for mood disorders, trauma and PTSD, as well as for our top 20 frequent presenters (in some cases presenting over 100 times a year). The outcomes data for aPM is shown in Figure 14 and improvements in service utilisation are presented in Table 4. Outcomes data for all the agile clinical services can be found on Page 14, Figure 2.

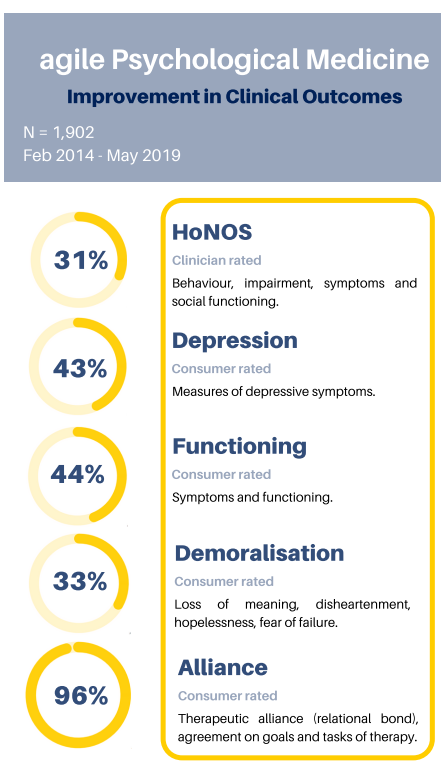


Figure 14: Improvement in clinical outcomes for aPM clients [29] discharged between February 2014 and May 2019 .

aPM Clients Present Less after Treatment

Feb 2014 to April 2018

N = 1,472

IMPROVEMENT

Service Type	2014	2015	2016	2017	2018
ED Mental Health presentations	51%	67%	79%	63%	38%
PTS calls	43%	60%	56%	47%	54%
Admissions length of stay	42%	65%	84%	84%	5%
CATT length of stay	67%	81%	89%	84%	81%
CCT length of stay	0%	50%	37%	81%	NA
Community length of stay*	100%	86%	-42%	-38%	89%

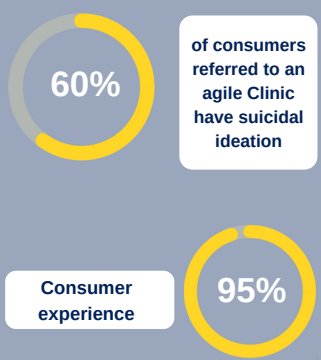


Table 4: 12 months pre- and post- service utilisation for aPM episodes of care closed between February 2014 and April 2018.

** Community length of stay includes all community episodes, including; CCT, MST and CATT.*

Every client who receives a treatment in an agile clinical service is followed up to see if they return into any part of the mental health service for treatment. We do this so we can learn and improve the long term effectiveness of our clinical interventions.

Table 4 shows that after an aPM episode of care, patients present less to all parts of the mental health service at Monash Health [29] (with the exception of 2016/17) where we had longer community length of stay. We learnt from this and provided longer treatment within agile in 2018/19 for those who we profiled as requiring it based on the evidence.

Over the past five years, the process of innovation by Monash Health has delivered ongoing value-based mental health care, as defined by improved client outcomes and experience, and measured by client feedback. To understand how the system is behaving, systems behavioural and patient activity analytics have also been used.

The SUV tool describes data in a manner that enhances continuous learning and delivers clinical value in keeping with community needs [2].

3.1.7 [redacted] story

Whether we have met purpose in this redesign exercise is best illustrated by one of our clients (see [redacted] story in Appendix C) [30].

For many years, [redacted] voice was not heard. He had been subject to abuse and neglect since childhood and as an adult was treated for eight years with antipsychotics. When seeking treatment for that trauma, [redacted] was told he had schizophrenia. He had also been diagnosed with gender identity disorder on another occasion, as well as six additional mental health diagnoses (gender dysphoria, depression, anxiety, Borderline Personality Disorder [BPD], PTSD, Obsessive Compulsive Disorder [OCD], and schizoaffective disorder with bipolar).

[redacted] experience is not uncommon. As a society we are becoming aware of the impact of untreated trauma amongst victims of family violence, war veterans, refugees, police and emergency services. However, trauma is often the undiscussable. Clinicians hear and write down awful incidents as a diagnostic component of medical records, then focus on treating the secondary physical or psychiatric symptoms. The fact is, symptoms of trauma often present as something else – back pain, depression, physical illness, anxiety or dissociations.

Recommendation 4

Invest in infrastructure, with a focus on community-based clinics

- Victoria needs greater investment in community infrastructure (buildings) so we can meet the clinical mental health needs of Victorians in their local communities
- Potential programs include clinics co-located in general practitioner surgeries (as with the aPM clinics) or community health centres
- Co-locating mental health services with general practice, community health, dental, and drug and alcohol services has great benefit for clients, particularly those who find it difficult to negotiate the complex health system

Recommendation 4: Invest in infrastructure, with a focus on community-based clinics

A program of work is required to develop appropriate buildings in the community to accommodate community clinic work. Some of this work could be co-located in general practitioner surgeries (as with the aPM clinics) or community health centres. Co-locating mental health services with general practice, community health, dental, and drug and alcohol services has great benefit for clients, particularly those who find it difficult to negotiate the complex health system.

There needs to be an investment made in our community infrastructure (buildings) so that we are able to meet the clinical mental health needs of our community in their community.

The details of the infrastructure required now and projected for 2026 are shown in Appendix B.

4.1 Inpatient wards

4.1.1 P Block

A complete rebuild of our Adult Inpatient Unit, P Block, is also required to meet Australian and International Standards.

The features of the new mental health precinct at Monash Medical Centre would include:

- 2 wards; one male, one female
- Sensory modulation suites
- Break out spaces
- Interview spaces to include families
- Occupational Therapy Spaces: including kitchen, rehabilitation spaces, activity and exercise spaces
- Separate wing for families to be accommodated
- Individual rooms with ensuites
- Bedrooms with natural light and windows
- Deescalation spaces
- Many little courtyards
- Office spaces for staff
- Research floor, conference and teaching rooms for students and interns.

The new inpatient units would have a new name and P Block as a name, would be retired. The estimated cost for the P Block redevelopment is $100 million.

4.1.2 E Ward

To increase our inpatient capacity at Casey, we require another ward. In order for this to be accommodated in the short term we recommend converting a current medical inpatient ward to a contemporary mental health ward. The cost would be as follows:

- Ward reconfiguration at an estimated cost of $13 million
- High Dependence Unit configuration at an estimated cost of $4.5 million

4.1.3 Early in Life Mental Health Service (ELMHS)

ELMHS was the first service to be redesigned in our Mental Health Program to meet patient needs based on systems data analytics and informed by the Choice and Partnerships Model [42]. ELMHS is comprised of 2 inpatient wards, Stepping Stones and the Perinatal and Infant ward; a neurodevelopmental ward, OASIS, and a number of specialist community teams. The iACT team provides centralised community access for parents and infants, children and adolescents and their families. The iACT team has senior clinicians who are also able to provide brief therapy. Should a longer intervention be indicated, the iACT team co-ordinate a transition in care to another ELMHS community specialist service. We would be happy to assist the Commission with further information about ELMHS.

4.1.4 Indigenous Health

Aboriginal Victorians residing in the rapidly expanding growth corridor of Melbourne's south east, Monash Health finds itself at a crucial juncture in the State government's Koolin Balit and Balit Murrup health strategies. The number of Aboriginal mental health related presentations to Victorian Hospital Emergency departments increased by 55% between 2012-13 and 2015-16 [43] and our models of care can be enhanced to embrace the Aboriginal experiences of trauma together with the concepts of social and emotional wellbeing, healing and resilience. Fresh Tracks, an initiative developed by Geelong-based Wathaurong Aboriginal Cooperative uses an assertive outreach model of care to enhance community contact and reduce the risk of treatment disengagement. With appropriate funding, a similar model that also includes inreach to acute services could be employed by Monash Health with special focal points during transitions of care between acute, sub-acute and primary health care services. Improving these pathways would undoubtedly enrich the patient experience and provided a greater continuity of care throughout the overall health care journey.

4.1.5 Youth and Aged Mental Health Services

Monash Health operates a youth (18-25) and aged (64+) mental health services. We would be happy to assist the Commission with further information about these services

4.1.6 Statewide Eating Disorder Service

Monash Health currently operates a statewide specialist eating disorders service including the Butterfly day Program, a four bed inpatient ward, and an outpatient service.

The Federal Government recently announced funding for six Residential Centres for people with eating disorders, one of which is to be located in Glen Iris, very close to our Butterfly Day Program in Chadstone.

We have currently been limited in changing our model of care to reflect International best practice based on our limited beds, hence using the inpatient beds for medical resuscitation admissions only. If we had access to 12 residential beds, this would enable us to change our model of care to include a more intensive psychological treatment early in the life cycle of the disorder. This would be an example of early intervention in action and our hypothesis is that this residential capacity with a psychological model of care would significantly reduce the average time of the illness (average time presently is approximately seven years to recovery).

The Commonwealth Government has committed this money for community mental health and a decision will be made to stream this into the primary health networks or through the tertiary hospitals.

Our recommendation is to advocate for this money to be given to Monash Health as we have delivered specialist care to this cohort of our community for the last 10 years and have produced excellent outcomes [44], see Figure 15.

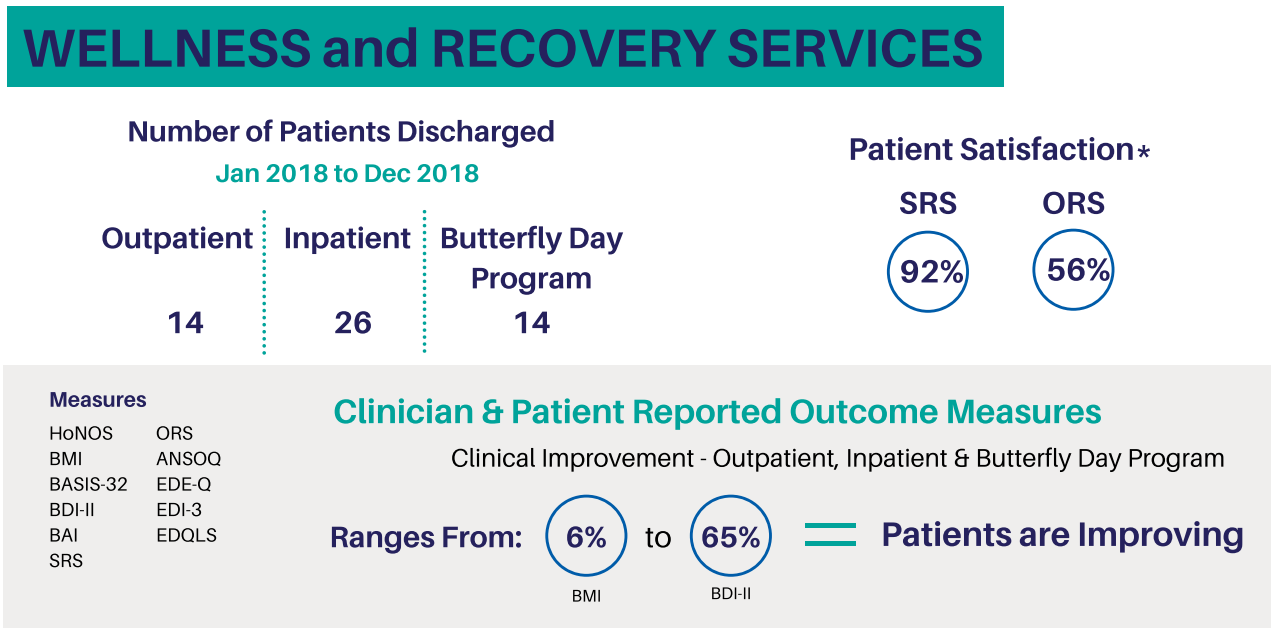


Figure 15: Wellness and Recovery Services clinician and patient reported outcomes data for patients discharged in 2018.

BMI; Body Mass Index; Beck Anxiety Inventory; ANSOQ; Anorexia Nervosa Stages of Change Questionnaire; EDEQ; The Eating Disorder Examinations Questionnaire; EDI-3; Eating Disorder Inventory-3; EDQLS; Eating Disorders Quality of Life Scale; ORS; Outcome Rating Scale

*Patient satisfaction was measured using the average total rating of two psychometric scales; SRS [32] and ORS [45].

4.2 Emergency Departments: a complete redesign for people presenting with mental health issues

We need separate spaces for children and adolescents, people affected by drugs and/or alcohol, and people with a forensic issue or being managed through the Justice System.

One crisis hub is being constructed at Monash Medical Centre and this includes a redesign of our emergency department for mental health.

Similar redevelopment is needed for both our other sites, Casey and Dandenong. At one of the community forums a psychiatric registrar who works in Casey ED said " there is no safe treatment for people with severe mental health issues in ED".

We also need a further strengthening of our PACER service. This is the service where a mental health clinician goes out with the police and they respond to calls for assistance when mental health issues are indicated. The outcomes of this service have demonstrated its effectiveness (data available on request). Further funding would allow a greater collaboration between police and mental health clinicians and more people being treated within their community rather than having to be brought into our emergency departments for containment.

Two days in the life of a Paediatric Emergency Physician:

Day 1: *We had three adolescents from overnight (one on an infusion after paracetamol overdose, one who had been physically and chemically restrained after being brought in by police, and another awaiting psychiatric inpatient admission), and I encountered a primary school child with a complex trauma history who had been given IM ketamine pre-hospital for severe agitation, and another suicidal teen referred by Headspace.*

Day 2: *I worked an evening shift. We received the same primary school child mentioned in Day 1 and this time she had been transferred from Dandenong ED for admission to Oasis Ward by ambulance. Unfortunately, the bed was not ready when she arrived (7:30pm), so she had to stay in our emergency department.*

Predictably, although settled on arrival, she had multiple "code greys" called during the two hours it took for her bed to become available. On one occasion, her DHS-appointed carers were sitting on her to keep her calm, and on another occasion she was settled with ice-cream (in the presence of 4 security guards).... At the same time that the first code grey had been called on the 7 year-old, I received a notification from triage about a 12 year-old boy with suicidal ideation who had been assessed as a triage category 2 (urgent, needing to be seen within 10 minutes), as well as a 16 year-old girl brought in by police and ambulance with concerns for her mental health (who was pretty agitated, but settled with oral medication). However, I also had the challenge of looking after three children (aged 2, 4 and 6 years) who had been unrestrained in a vehicle driven by their pregnant mother who was suspected of using illicit drugs, as well as a whole raft of "routine" emergency patients...

We have daily examples of children and adolescents who "fall through the cracks" of the health system. These include children in foster care with a background of complex trauma who move from house to house (in different mental health catchment areas), children with autism and/or intellectual disability who "don't quite fit" a simple model of mental health but have severe behavioural disturbance, children with serious socio-economic challenges due to parental abuse/parental drug & alcohol use/mental illness, and so on.

Recommendation 5

Ensure State and Commonwealth Mental Health Services are complementary

- The Australian mental health system should be conceptualised as one system of care, where State and Commonwealth roles and contributions are complementary

- The State system should not be considered in the context of its component parts (e.g., clinics, inpatient services, community clinical services, and related services like housing and occupational support). Service delivery organised around inter-relations would ensure client needs are better met through connected and value-add services

- The unique value-add of each contributor to the greater system of care should be clear and care transitions should be co-ordinated. Solutions include mapping patient care pathways across sectors (care transitions) so that service providers at the boundaries of care transitions can establish quality processes that ensure smooth transitions

Recommendation 5: Ensure State and Commonwealth Mental Health Services are complementary

5.1 Addressing disconnects between the Commonwealth and states

In recent years, increases in mental health funding, Australia-wide, have been given directly to PHNs to provide a range of recovery, rehabilitation and primary care services. However, these are not integrated to provide the 'wrap-around' services necessary for the care of people with SMI and enduring disability. The move to the NDIS has further disintegrated the system.

In particular, patient care transitions are a known risk factor in the journey for patients with multiple morbidities and/or accessing many parts of the system of mental healthcare. This includes transitioning from tertiary health care (State funded) to primary care (Commonwealth funded). Monash Health's patient activity analytics also indicate care transitions within a service can be numerous – even within one team given the shift changes – and frequently many care teams and care settings are involved in delivering one patient's care across the system.

Care transitions present an increased opportunity for risk that may result in patient harm and is recognised by WHO [46], the Joint Commission [47] and the Australian Commission on Quality and Safety in Health Care [48] as a key cause of preventable morbidity.

Primary care physicians are not satisfied with communication at transitions points between ambulatory and inpatient care and believe the content omissions lead to real harm [49].

Using our patient activity analytics we have an illustration of the human impact of care transitions; we concluded these care transitions led to an adverse outcome in [redacted] story (see his story Appendix C).

5.2 Our proposed solutions

Firstly, the mental healthcare system should not be considered in the context of its component parts (like clinics, inpatient services, community clinical services, and related services like housing, social and occupational support services), as this is not how patients and their families are best served. Rather, service delivery should be organised in terms of its interrelations, which ensure patient needs are met through a series of connected and value-adding services.

Monash Health's proposal is that the Australian mental health system should be conceptualised as one system of care, where State and Commonwealth roles and contributions are complementary. The unique value-add of each contributor to the greater system of care should be clear and care transitions should be coordinated.

Solutions in the literature include mapping patient care pathways across sectors (care transitions) so that service providers at the boundaries of care transitions can establish quality processes that ensure smooth transitions [50].

Secondly, the role of PHNs and federal funding needs to be reviewed. One option is to make a single fund-holder (designated mental health services) responsible for providing the range of care to people with SMI. Another alternative is for clinical mental health services to give up the case management role and hand it to the community sector, with clinical mental health services providing the specialist therapeutic input.

5.3 Case study: Monash Health

In 2013, we undertook patient analytics to review how patients flowed through the multiple clinical units within Monash Health's Mental Health Program. It became clear that the organising principle behind our care transition process was to optimise service efficiency and flow at a quantitative and transactional level, rather than facilitating each patient's successful care transition.

Figure 16: Service recovery value for clients in mental health.

These insights led to the strategic design depicted in Figure 16 below. We knew we needed to be clear about what unique value we could provide our clients as a tertiary health service. To do this we developed a strategic direction that was clear in identifying our unique value propositions given our role in the broader mental health system of care.

My Care Pathway

Whilst it was clear what our value propositions were we also recognised we needed to help our patients transition into a primary care relationship in this community.

The care transition was conceptualised as relational - not a transactional discharge. That is, the patient needed to be connected to a relationship established in primary care and then embedded, so the relationship transitioned smoothly.

The model provides for a dedicated senior nurse who manages the patient's care pathway across the multiple sectors involved. This paradigm-changing view of managing care transition – which we call the **My Care Pathway** and which is used in agile Comprehensive Care is outlined in Figure 17.

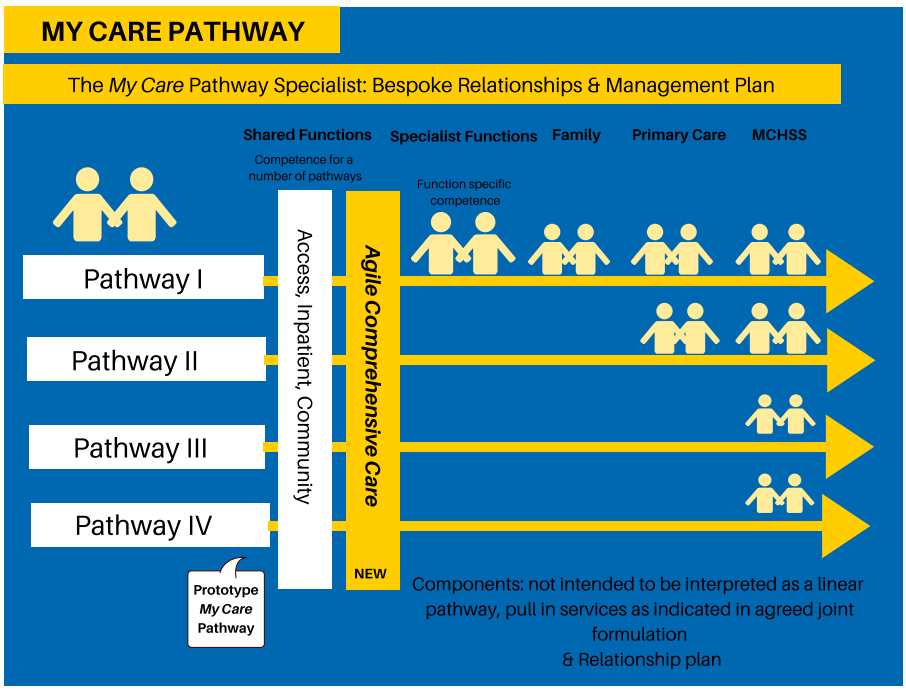


Figure 17: My Care Pathway facilitating connections across sectors to wrap care around the patient.

It is difficult for clinicians to find services for patients in our own catchment, so we can emphasise the difficulty for patients to navigate the system. As Figure 18 shows, there are a number of services in our catchment outside of Monash Health services who provide psychosocial support for people with SMI. Yet we find it hard to connect people to these services. Therefore, we finish up with the same function of psychosocial support being provided in multiple sectors but from our patients' experiences, none are doing it well.

Figure 18: Commonwealth LHN, Headspace and State funded tertiary care.

LHN; Local Hospital Network; EACH; Eastern Access Community Health; MMC; Monash Medical Centre .

Recommendation 6

Prioritise culture reform, to aid development and retention of the State's mental health workforce

- Studies show the Victorian mental health workforce is hampered by procedural inefficiencies, practices that discourage innovation and psychological distress from instances of patient abuse or bullying

- Allied health professionals play a key role in psychosocial care beyond biomedical management but numbers have been eroded to the extent that clients needing a specialist therapeutic intervention may not receive treatment

- Mechanisms to attract and retain more staff include: more training and development; limiting psychological exposure to risk and trauma; employee forums; giving managers more authority to facilitate greater problem-solving and team cohesion through shared purpose and increases in staff numbers, particularly allied health

Recommendation 6: Prioritise culture reform, to aid development and retention of the State's mental health workforce

Attracting, training and retaining a sufficient and appropriately skilled mental health workforce, and making mental health services safe places to work, is a major challenge for health services and DHHS.

The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) review of workforce issues [51], publicly reported in 2018, noted a shortage of Victorian Child and Adolescent Psychiatrists (CAP). Victoria has 31 CAP training positions, of which two are in regional areas. RANZCP says Victoria urgently needs 12 additional CAP training positions.

A 2016 study by the University of Melbourne and the Health and Community Services Union, published in the International Journal of Mental Health Nursing by Tonso et al. [52], found that 83% of 411 surveyed staff in Victoria's mental health workforce had experienced violence in the prior 12 months, mostly verbal abuse (80%) followed by physical violence (34%) and bullying (30%). One in three victims of violence rated themselves as being in psychological distress and 54% reported being in severe psychological distress.

Comparable data is not available for allied health staff working within tertiary mental health. As mental health is a biopsychosocial phenomenon, allied health professionals have a key role in providing psychosocial care and treatment beyond biomedical management. This part of the workforce has been eroded to such an extent in tertiary care that people who require a specialist therapeutic intervention – and are considered too complex to be treated within a primary care context – are left without treatment.

The lived experience workforce, clients, carers and peer support workers have a critical role in the redesigned mental health system. The roles and responsibilities, scope of practice, professional development and support of this workforce need to be re-imagined in the context of value-based healthcare, where each part of the workforce adds unique value to the patient's care journey. Therefore, significant issues need to be addressed if we are to have a sustainable workforce.

6.1 What needs to be addressed

The major issues that require a policy and system intervention include:

(a) cultural reform
(b) leading in Complexity Competencies
(c) an authorising environment for leaders to provide a psychologically enriched environment that enables innovation and growth in staff
(d) increases in staff numbers, particularly allied health
(e) training and development
(f) supervision and support
(g) limiting workforce psychological exposure to risk and trauma
(h) staff voices (employee forums)

Our proposals for how to resolve each of these elements are provided below:

(a) Undertake cultural reform

Thought leaders have suggested healthcare is in crisis [53] and adverse events outlining a catastrophic system failure to detect and act on risk have been widely reported. Two examples are the Mid Staffordshire review in the UK, [54] and more recently Djerriwarrh in Victoria [55]. It is also useful to note Wootton [56], who chronicles the history of medicine since Hippocrates and highlights the protracted lag between significant medical discoveries and resulting changes. Wootton asserts that historically common treatments (e.g. bloodletting, purging and emetics) acted in a negative way for patients yet existed for hundreds of years: "The barriers to progress were psychological and cultural not intellectual" [56]. These reviews and others highlight that healthcare workers don't necessarily change procedures and protocols in the face of seemingly overwhelming evidence that it is not good for the patient. Under these cultural conditions neglectful and abusive behaviour can arise [2].

Why do healthcare workers do this?

When there are strong workplace systems (i.e. formal practices and local culture reinforcing the *status quo*), even if an individual feels it is not the right thing to do and is fundamentally caring, dissonance is created, causing that person to find consonance [57,58]. This phenomenon is compounded in groups [59]. Therefore, perverse practices can emerge in the workforce. Without the consistent evidence that staff in health feel unable to speak up when they see unsafe practices, it seems an unimaginable and unbelievable phenomenon. This clearly demonstrates the power of culture [60]. While trialing service innovations to deliver evidence-based psychological care, we gained valuable learnings about the power of the *status quo*. A number of forces emerged in response to our agile prototypes [2].

> **"You cannot understand a system until you try and change it and when you do try to change it, only then will underlying mechanisms maintaining the *status quo* emerge"**
>
> **Casey [2]; Schein [61]**

To help us deal with the emergence when introducing new systems changes, an organisational formulation was developed (see Figure 19) that named the forces we were dealing with at the local level. This formulation was effective in informing the multi-tiered interventions required to sustain agile innovations at the people, process and systems levels. We learned that data proving value to the client was not sufficient to change existing perceptions and the forces maintaining the *status quo* [2].

Our experience also illuminated to us why the mental health system has been so difficult to change over the last 20 years.

(b) Recognise that leaders require Complexity Competencies

Our research identified that middle-management is the key intervention point when fostering innovation and quality improvement. However, this group needs more authority and professional competencies to lead change in a complex system that supports the *status quo* [3].

Executives need to provide more psychologically enriched environments for middle managers and staff that facilitate greater problem-solving and team cohesion through shared purpose. Additionally, an element of resilience is required to open up on what we do to feedback from clients, but the Monash Health experience is that such environments enable staff to become the best versions of themselves and, by extension, deliver high-quality evidence-based clinical interventions with clients [3].

(c) An authorising environment for leaders to provide a psychologically enriched environment that enables innovation and growth in staff

We would be happy to assist the Commission with further information.

(d) Increase staff numbers, particularly in Allied Health and peer support workers

We would be happy to assist the Commission with further information.

(e) Enhance training and development

We would be happy to assist the Commission with further information.

(f) Expand supervision and support

Professional supervision is only provided currently within certain craft groups. As it is written in Enterprise Bargaining Agreement (EBA) for psychologists, staff from other craft groups (particularly nursing) have previously requested access to supervision. Research has shown supervision mitigates burn out in nursing staff working in mental health [62].

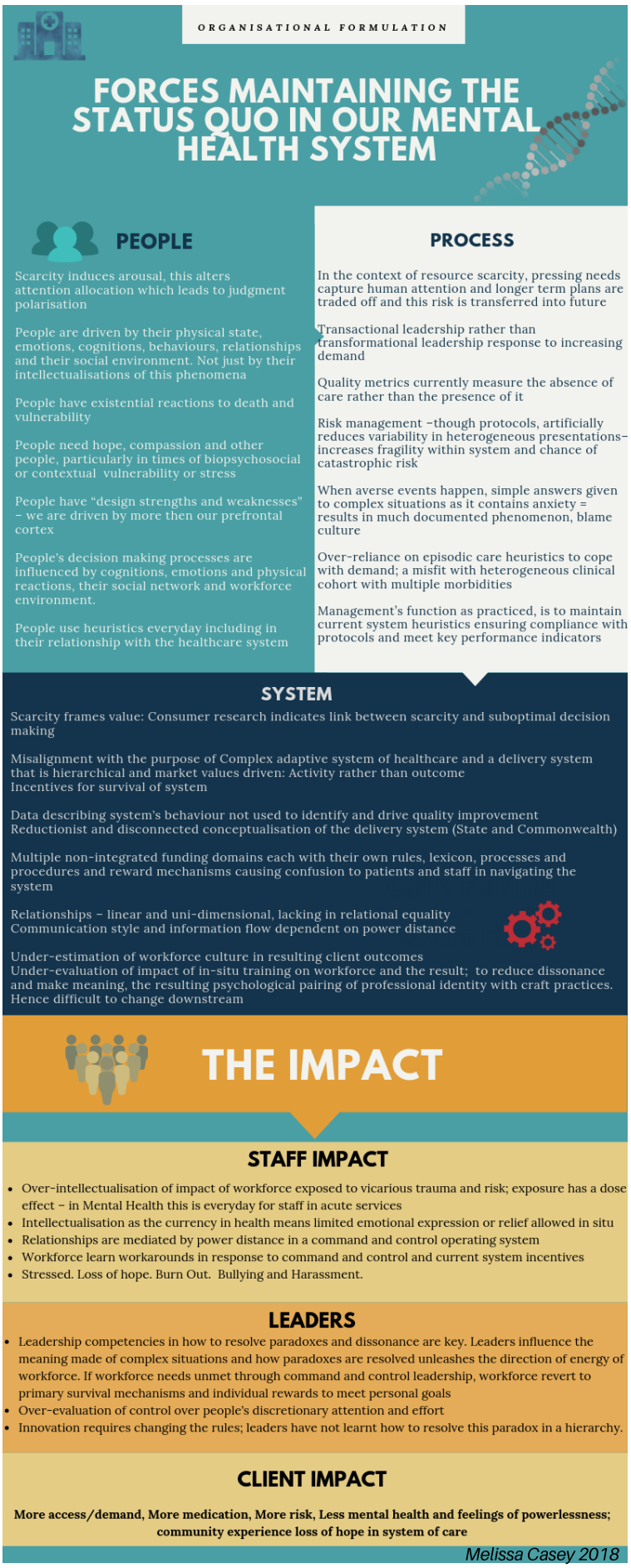


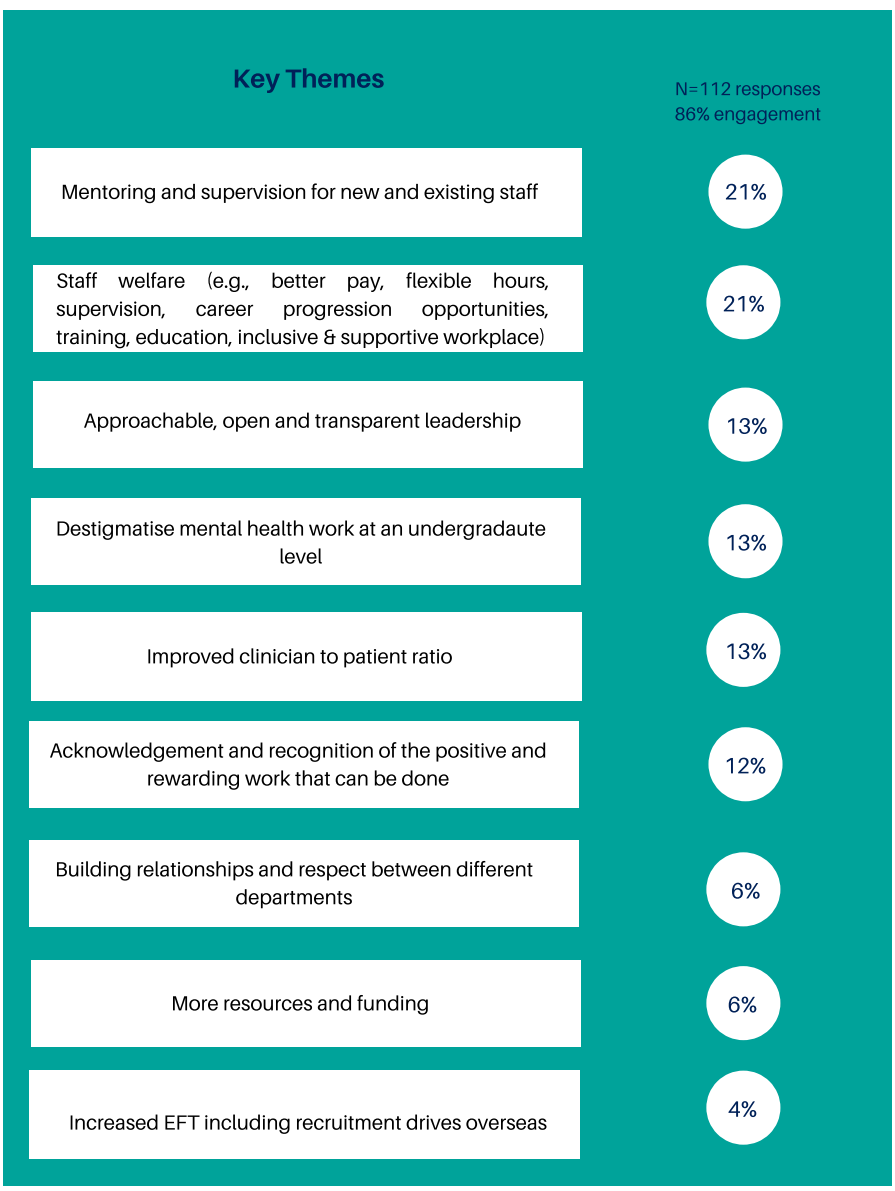
Figure 19: Organisational Formulation: forces maintaining the status quo in our mental health system [2].

(g) Limit workforce to fixed periods of psychological exposure to risk and trauma

The impact on staff of prolonged exposure to risk, trauma and Occupational Violence and Aggression (OVA) has a significant effect on staff in crisis and acute services. It also contributes significantly to the culture we have in these services and why it is so hard to introduce any qualitative change that would improve the mental health outcomes of our patients. As the Defence Force grades posts based on exposure to physical and psychological risk, so too should the mental health system [2].

(h) Staff Voices

Monash Health staff were asked through employee forums "What can be done to attract, retain and better support the mental health workforce, including peer-support workers?". Results are summarised into the key themes in the box below:



The eleven questions posed by the Royal Commission were asked in these employee forums. The voices of staff were heard and recorded, these are attached in Appendix D.

6.2 Case study: Resolving the paradox in mental health systems design

Since de-institutionalisation in the 1990s, more Monash Health mental health patients have needed more services more frequently. Until five years ago when we commenced agile services, patient satisfaction was in decline.

Whilst there had been longstanding agreement that change was required, and many attempts to find a solution since 2008, a subsequent biopsychosocial organisational analysis and formulation revealed there were seven major factors that created systems paralysis at the local level:

1. The enormity of the scope of change required in AMHS

2. An operating and management system in mental healthcare that focused on daily operational pressures of dealing with increasing demand for acute and crisis mental health services. Staff directed their energies to the following existing (and extensive) protocols and procedures

3. No evidence that health organisations adopting a structural change towards integrated teams had improved outcomes for patients (and indeed, it was accompanied by significant industrial action)

4. A public system that did not include analytics on patient demand factors; specifically, existing models of care took no account of the complex nature of chronic (and at times acute and crisis) mental healthcare or the social determinants of the health needs of our patients over time

5. A system that didn't account for the unique characteristics of the healthcare workforce (e.g., a mix of intensive academic knowledge training combined with an apprenticeship model and also the accumulative psychological impact on staff working in acute mental health over time)

6. A need for design and change activities appropriate for a complex adaptive system, i.e., requiring specialist competencies and authorisation from the existing hierarchy to prototype a service system with new operating rules

7. A means of accommodating many competing voices; everyone's lived experience (staff, patients and carers) was different and valid, so each had different views of how to identify a design that satisfied all stakeholder needs

Staff need hope that the system of care in mental health will improve. In many hospitals, staff have been involved in developing a new model of care for years, with very little change resulting. They have many ideas at the point of care as to how to improve care but the pressure to maintain the *status quo* is strong. An authorising environment and leadership that provide a psychologically enriched atmosphere will enable the workforce to grow and develop, reconnecting with a sense of purpose that unleashes new energies.

Recommendation 7

Reform the governance of mental health services

- Combine Federal and State mental health funding, with DHHS developing a clearer understanding of the funder-provider split, and its role in policy and contemporary regulatory practice
- Develop a simple model of monitoring and accountability; at present this is multiple and complex, and therefore not clear or efficient
- Integrate the funding and regulatory role for mental health into Safer Care Victoria, the health service commissioner and DHHS more generally. This will streamline and improve accountability and delivery by health services

Recommendation 7: Reform the governance of mental health services

The Governance of mental health services in Victoria needs to be examined, with particular attention to:

- combining Federal and State funding of mental health
- DHHS developing a clear understanding of concepts of funder-provider split, and its role in policy, funding and contemporary regulatory practice and not service provision
- a simple model of monitoring and accountability needs to be developed; at present this is multiple and complex, and therefore not clear or efficient

Integration of the funding and regulatory role for mental health into Safer Care Victoria, the health service commissioner and DHHS more generally needs to occur if we are to streamline, simplify and improve accountability and delivery by health services. This would also apply to Alcohol and Drug services.

We would be happy to assist the Commission with further information.

Recommendation 8

Create a mental health co-design and leadership institute

- Service-centric redesign is no longer acceptable to our community and client/carer wishes must be given a greater voice

- Patients and their families' experiences can provide valuable perspectives on the functioning of our healthcare system. Without drawing on their experiences, healthcare service deliverers will never truly understand the interrelations in our system

- We recommend the development of a planning, innovation and design function to provide leadership and a creative space for innovative and contemporary models of care that can be trialled across Victoria to drive reform in the sector

- Our vision is for design methodology, translational research, co-design and co-production; this will enable knowledge transfer to the community on mental health literacy

Recommendation 8: Create a mental health co-design and leadership institute

We recommend the development of a planning, innovation and design function to provide leadership and deliver a creative space for innovative and contemporary models of care that can be trialled across Victoria to drive reform in the sector.

This unit would provide advice to the DHHS about preferred models of care, and foster expertise in the treatment of people with SMI. Our vision is for design methodology, translational research, co-design and co-production; this will enable knowledge transfer to the community on mental health literacy.

In model-of-care processes in mental health, there have been many competing perspectives about what the mental health service system should deliver. While much of what has been said is right based on the context of the person expressing a view, the models of care end up full of paradoxes.

For example, how do we deliver both client autonomy and privacy while having carers included in the care? Both requirements are important but how do we operationalise this system of care if there is conflict?

Whilst many people have ideas as to how systems could be better, operationalising change has been less fruitful. At the point of implementation, any unresolved paradoxes come to the fore.

In a complex adaptive system, the role of leaders is to resolve paradoxes, that is balance competition and co-operation, calibrate clinical autonomy at the point of care, balance diversity with unity of purpose, bring top-down strategy to life by bottom-up innovation and work within a hierarchical authorising system.

It is a significant risk if leaders do not have the competencies required to resolve these paradoxes in a way that mobilises positive and purposeful action of the workforce.

We are transitioning from a time where service-centric redesign is no longer acceptable to our community and client/carer wishes are being heard. In 1997, Steve Jobs [63] also recognised technician led design was not producing meaningful advances. He revolutionised the computer industry; this triggered a large movement incorporating user experience into design processes that had been adopted in most industries.

8.1 Integrated mental health service delivery remains elusive

> ***One of the hardest things when you are trying to effect change is that people...are right in some areas...the hardest thing is, how does that fit into a cohesive larger vision?...you've got to start with the customer experience and work backwards... not start with the engineers and work out some technology that's awesome, let's work out how we can deliver benefits to the customer***
>
> ***Steve Jobs [63]***

[Steve Jobs in 1997 explaining an approach to change that ultimately revolutionised the computer industry]

The need for integrated mental healthcare services for the most vulnerable members of our community has long been recognised. A Google search of "redesign in healthcare" returned over five million results, as the topic has generated much activity. Yet it could be proffered that the redesign toolkits and overarching approach we have been using have only delivered incremental improvements to patients with service delivery through silos.

The "Holy Grail" – integration of multiple services as experienced by the patient, their family and their community – eludes us.

From a systems perspective, it is well acknowledged that healthcare is the most complex of adaptive systems, with many interdependencies [64]. As a result of this complexity and the way programs are funded, the core outputs of many agencies are offered as discrete services, resulting in little co-ordination for the patient between workers, within and across programs, sectors and the system [65].

The mental healthcare system in Victoria needs to be considered not in the context of its component parts (like clinics, inpatient services, community clinical services, and related services like housing, social and occupational support services), as this is not how patients and their family needs are best met.

Rather, we need to organise service delivery in terms of their interrelations so that patient needs are met through a series of connected and value-adding services. Examining and changing these interrelations holds the key to discovering how the patient and their family will most benefit and recover in the most optimal way.

The patient and their family are not external beneficiaries of the system but an essential part of it. Patients play five different roles in the healthcare system:

- As patients, with specific needs requiring care
- As clients, with expectations about the way in which they will be treated
- As taxpayers and therefore as the ultimate source of financing
- As citizens who may demand access to care as a right; and most importantly
- As co-producers of health through care seeking, compliance with prescriptions, and behaviours that may promote or harm one's own health or the health of others [66]

Patients and their families' experiences can provide broader valuable perspectives on the nature and functioning of the interrelations of our healthcare system. Without drawing on their experiences within a design-oriented framework, healthcare service deliverers will never truly understand the interrelations in our system.

8.2 Co-Design Institute

Healthcare services that create partnerships with client and carer representatives (i.e., the Mental Health Consumer Partnership approach) have been a significant step forward in healthcare service provision in Victoria. Monash Health has been at the forefront, operating a Consumer and Carer Directorate over the last decade. The time is right to build on this solid platform and evolve to the next phase.

Our concept is for a Co-Design Institute (CDI) that would lay a solid foundation for delivery of integrated services and encourage innovation. More patients could **sleep safely in their bed of choice** and **live, socialise and work in their community**.

So how are design activities carried out in the CDI?

The methodology is different in three ways:

1. It focuses on *Who* is involved in the design conversations and activities; *the patient is at the heart of everything we do*
2. The domain of design enquiry shifts from *problem in service* to *"person and place" [67] in the context of their family and community*
3. The design activities are different from traditional problem solving and reductionist redesign (such activities have their place downstream ONCE a desired service delivery configuration is tested through prototyping)

Co-Design Institute Methodology goals are:

- understanding human needs (patients and staff)
- a focus on the human experience to identify needs
- design services that build connections so care needs are met
- mechanisms for bringing people together in new ways to have new conversations and develop new insights
- innovate care delivery
- accessibility
- value-driven

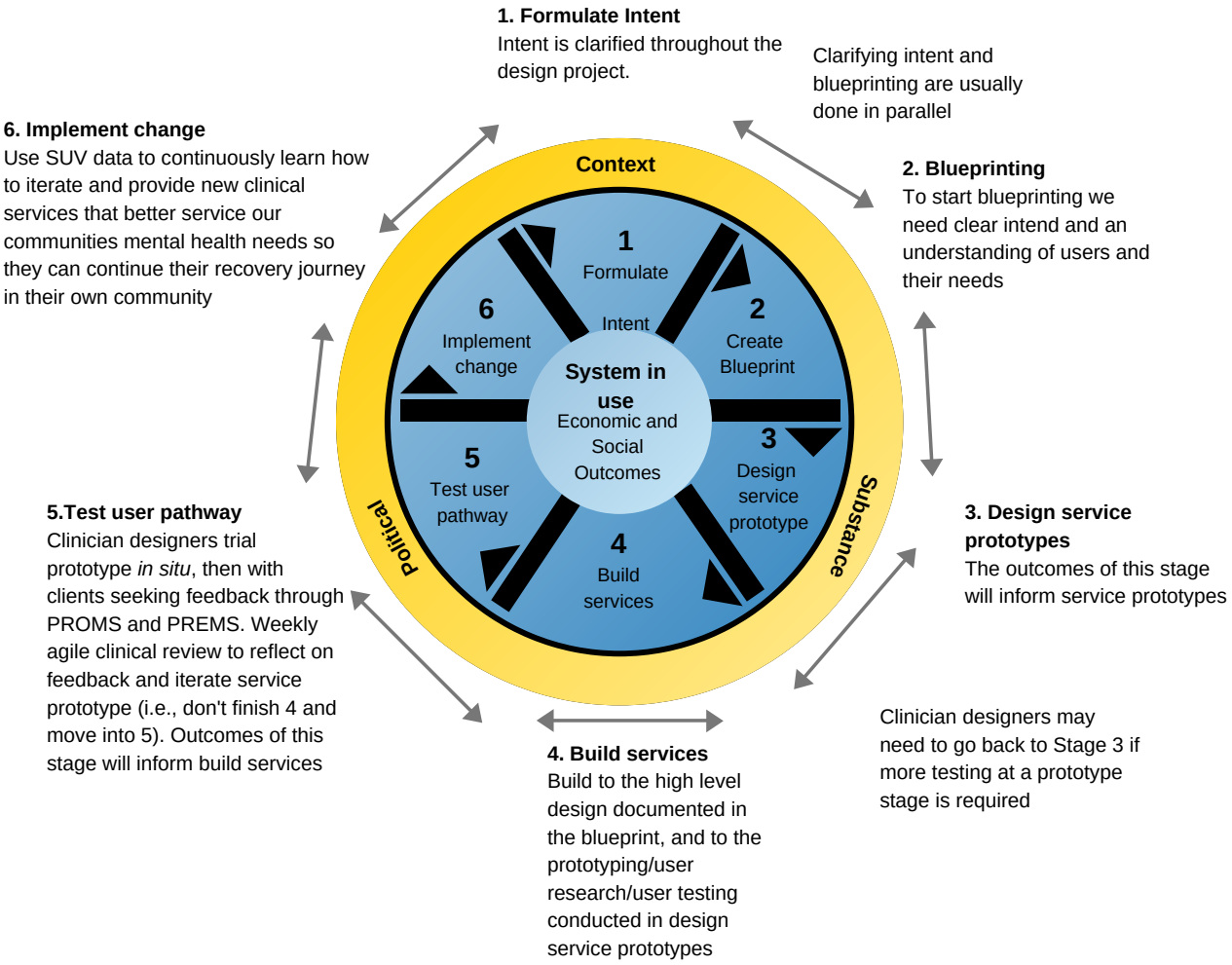


*Figure 20: The co-design process.**
**As adapted from the Integrated Administrative/Tax Design Wheel [68].*

8.3 The three voices

Three voices – intent, experience and design – must always be represented in a collaborative process as demonstrated in Figure 21. This brings together patients and suppliers of services (clinicians, managers, related support workers). Suppliers are guided by a vision and supported by specialist design expertise.

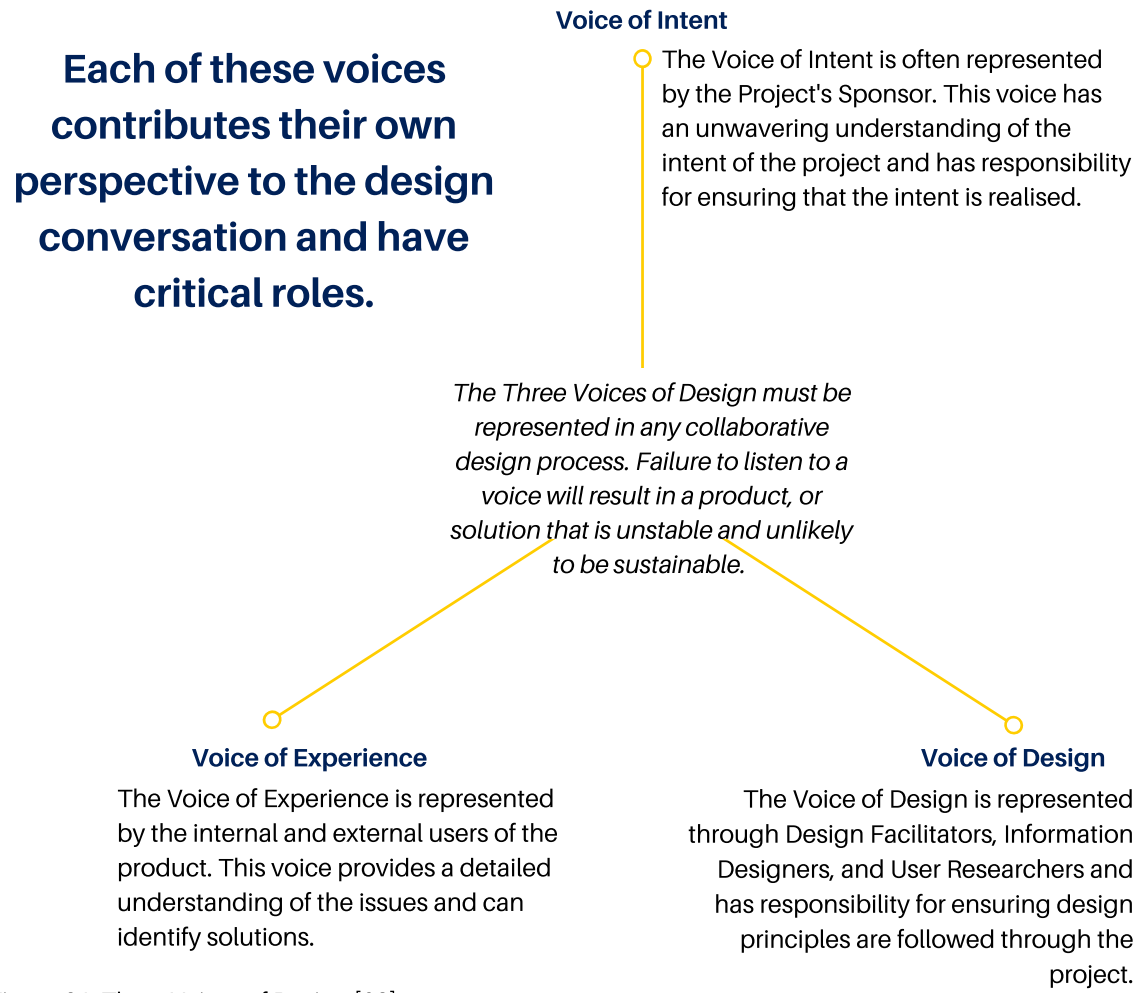


Figure 21: Three Voices of Design [68].

(a) Voice of Intent

- Government policy and management of programs provide visionary and governance expertise

(b) Voice of Experience

- Patients and their families contribute value expertise, they can direct change (this means actually involving consenting patients and their families in the process of design *in addition to* the groups' consumer and carer representatives)
- Clinicians contribute adaptive expertise, they can react to changing patient requirements if given the scope to do so

(c) Voice of Design

Designers contribute evolutionary expertise in five ways:

- Understanding connections and links in systems relationships (functional assemblies) by bringing patients and service providers together in design activities
- Bringing the "three voices" together in design conversations; as a result, new emergent insights are born
- Translating these insights into clear service propositions (ready to prototype)
- Conducting rapid prototyping experiences with all users of the service, patients and clinicians and related other service providers
- Proving a real-time feedback loop, incorporating learnings from rapid prototyping *in situ* with users

Real-time feedback is especially important from users of the clinical service. Firstly, it provides feedback that informs their treatment path whilst they are in treatment; secondly, it is important for sustainability and long-term healthcare systems improvement. As these prototyping sessions are *in situ*, they provide people with know-how to design change, as well as skills, knowledge and empowerment to recognise and explore innovative solutions when opportunities arise.

The added benefit of rapid prototyping is all users are learning the new ways of relating (providing and receiving services) so the "change" is already being rehearsed and acted out. Bugs can be ironed out in a safe environment.

8.4 Domain of Enquiry

Often the starting point for change is a problem. Within the context of design, considerable thought is given to the context in which this problem has surfaced and made visible the invisible elements that are an active part of the system – that is, the relationships, connections, environment (universals), context (the particulars), milieu (history and norms), and its meta system.

A solution to a problem, by definition, will produce an incremental improvement. A change guided by intent and orchestrated through design processes has the scope for transformational improvements.

Figure 22 highlights the important difference in identifying the domain of your design enquiry.

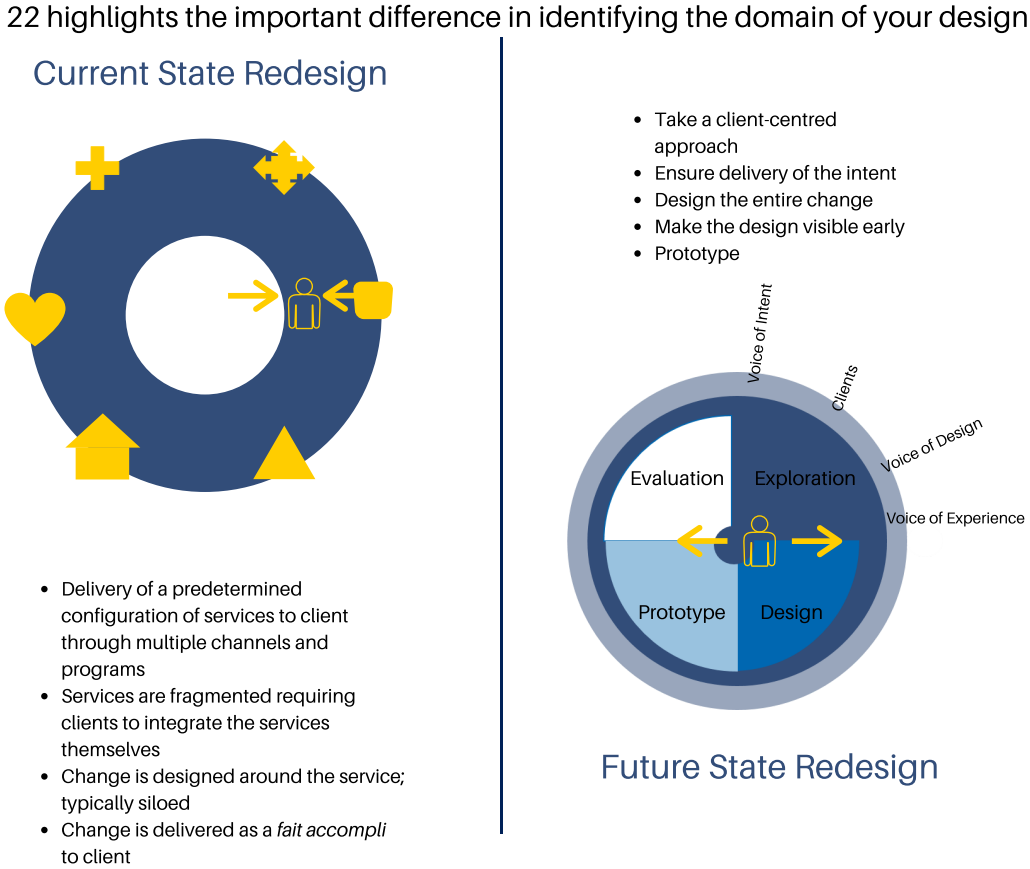


Figure 22: Highlights the important difference in identifying the domain of your design enquiry.

8.5 Design Activities

Service design activities are carried out by a multi-disciplinary group who include data analysts, user experience designers, strategists, psychologists, ethnographers, information architects, graphic designers and project managers [69].

The activities include:

- walkthroughs (of current service delivery)
- user observations
- user clinics
- insight workshops
- visual system mapping
- mapping the domain and inter-relationships
- developing service blueprints
- rapid prototyping design experiences
- developing success criteria and measurement frameworks
- knowledge transfer; building design know – how capabilities
- showcasing designs and reflective practice
- understanding patients stories

8.6 Addressing client, family, and community needs

The design process brings client and service providers together through design activities so that the health and quality of life outcomes for the client and their family improve as a result of enhanced service(s) configuration and connections.

This begs the question, how we will know "design activities" achieve this?

Our experience is that the design process needs to provide a return on investment measured in terms of a combination of:

- **improved client and family experience**
- **improved health and quality of life outcomes**
- **financial implications**
- **value created to society**
- **reduced drain on the environment.**

At the start of each design activity in the CDI, performance indicators will be determined with the project sponsor; this activity will be a mini design process in itself, as what is measured often plays a significant factor in shaping how service delivery is configured. The principle of determining what is measured should be driven by what is most likely to create a shared culture of improvement. This is what creates valuable, long-term interrelationships and enables sustainability [69].

All design activities will incorporate into proposed service delivery models a comprehensive client experience measurement system (measured at different times over their journey) and developed with the service providers.

For illustrative services only, the SERVQUAL [70] model could be used to measure gaps between client and family expectations and experience in five domains:

(a) **Reliability:** the organisation's ability to perform the service dependable and accurately
(b) **Assurance:** staff knowledge and ability to inspire trust and confidence
(c) **Tangibles:** appearance of physical facilities, equipment, personnel and communication channels
(d) **Empathy:** understanding of client needs and acknowledging them
(e) **Responsiveness:** willingness to help clients, provide prompt responses to requests and solve problems

8.7 Alignment with Government Policy

The overarching Victorian policy is to connect services for the client, their family and the community. This interpretation is schematically depicted in Figure 23.

The activities of the CDI could constructively contribute to the know-how identified in Part 8 of the Human Services: The case for change [71] that would design a better system together.

The CDI sees collaboration with **Consumer and Carer Representation** as core, due to the involvement of clients and their families in the activities.

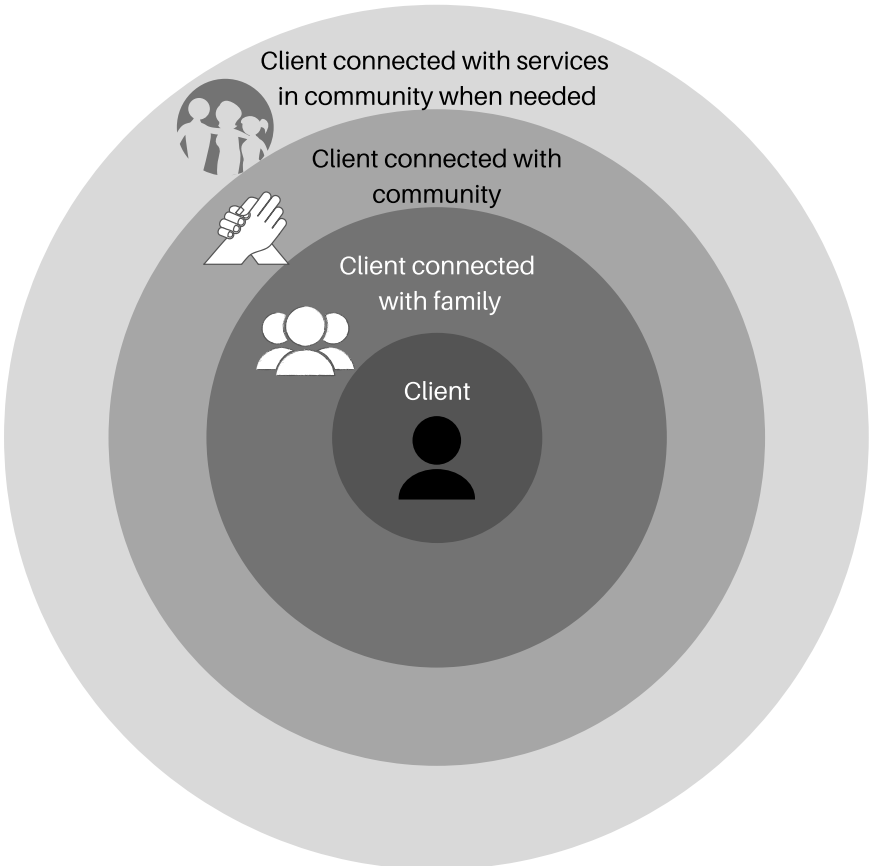


Figure 23: Services Connected with the client at the heart of what we do.

The Commonwealth NDIS has impacted substantially on services currently provided by the Victorian Services. The CDI design methodology could flesh out how acute health and the primary and secondary care sectors would work together with the client.

8.8 Alignment Government Policy: Victorian Design Initiatives

Design-driven innovation is at the forefront of many leading international economies and the stories illustrating true innovative solutions are becoming prominent. The Victorian Government has recognised the value of design in both product and service delivery innovation and is supporting both projects and capability building in this area. The Victorian Government is increasing its commitment to integrate world-class design practices and processes in Victorian firms. Firms that understand and use design as a core business capability can better "enhance their efficiency" [72].

Therefore, the CDI design activities are aligned with the Victorian Government's Policy on Mental Health Consumer and Carer representation and cross sector Policy on Design and Innovation in Services.

8.9 The Need for Dedicated Design Space

Designers need a flexible space that supports a variety of collaborative design activities. The CDI would be the first design laboratory in Australia integrated into Victoria's biggest public health clinical network of hospitals and community centres. It would be a purpose-built fit out, supporting design activities.

The design space would welcome people from a variety of perspectives to develop new insights, offer new ideas and have the opportunity to explore those ideas within a "humidicrib" or "incubator" until an idea develops some maturity and depth, ready for testing (via prototyping, workshops, simulation modelling or clinical pathway walkthroughs).

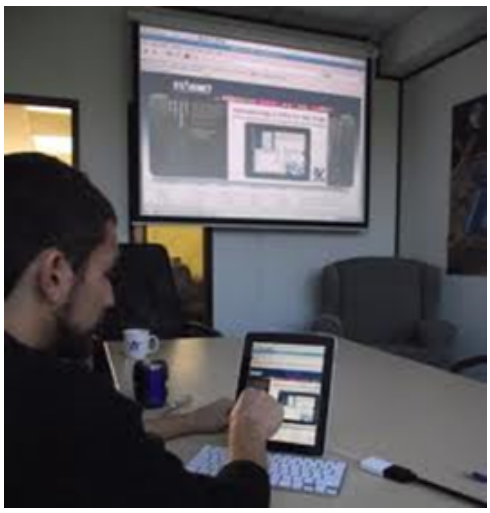
(a) Room 1: Design Central, our Design Showcase

The living room, largest of the rooms, where the large group design activities will be conducted. People will have access to raw materials to encourage journey mapping or prototyping for example, they will also have access to technology, iPads linked to a large screen in the room so they can comment or produce drawings live. Some people have a preference for talking about their experiences, others find it easier to write or draw, the CDI will cater to individual preferences of expression and all content will be visually consolidated by the designers.

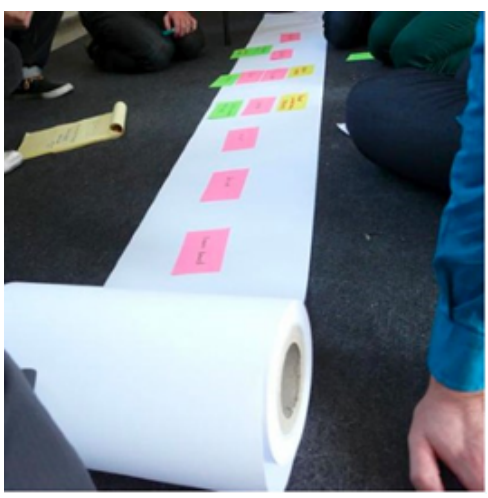
Designers will respect the input of every person participating in design activities and all material generated will be recorded by hand or technology via iPads, cameras (both still and moving images). All participants will be asked to consent to the process of recording ideas before entering the building.

Design central room will also have an observation mirror where design know-how and new insights can be observed and learned.

This is an example of what a dedicated design space could look like.



Journey Mapping: Today/Tomorrow/Next Week/Next Month/in Six months/Next Year for identified mental health cohort of clients (i.e., Schizophrenia with Drug and Alcohol issues; frequent presenters at ED).



Clinicians from different parts of the services mapping a mental health patient's pathway.

(b) Room 2: Designing in focus

Data is a good input into understanding trends and themes.

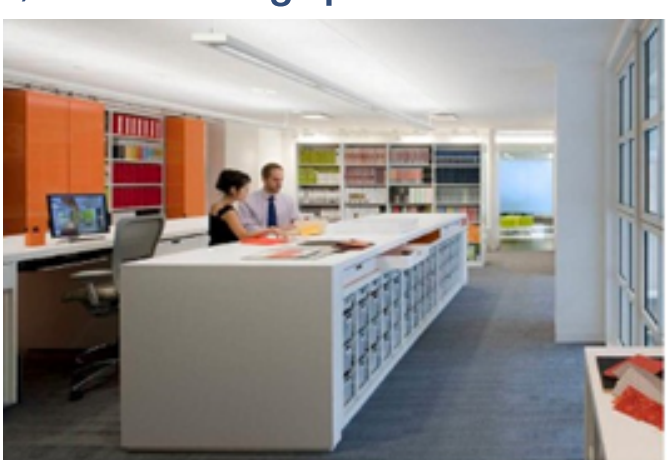
(c) Room 3: Designing: a personal approach

Understanding the broader context in patients' lives: the days before a good day/bad day.

Storage is required for Props to be used during design activities.

(d) Room 4: Multi-sensory Designing: Café workshops

(e) Room 5: Design production room



Print room capabilities, so designs can be produced within minutes of being created.

Recommendation 9

Increase investment in research

- Mental health receives less than 10% of National Health and Medical Research Council (NHMRC) funding, and the NHMRC typically funds less than 15% of submitted grants
- Victorian funded services should be informed by translational research to establish how to scale up what works to reach the people who need it. Funding opportunities for this are presently inadequate
- The Victorian Medical Research Acceleration Fund (VMRAF) is well structured but offers only $3 million each year across the whole of health and with no evident reserved quota for mental health grants
- Our proposal is for a return to the level of mental health research investment that characterised the years of the Victorian Centre of Excellence (VCoE) and the Mental Illness Research Fund (MIRF), i.e., about $2 million per annum, alternating between small to medium grants and major translation grants. Grants should be aligned with current service policy and delivery

Recommendation 9: Increase investment in research

Integrating academics within health services to support advances in mental health treatment, academic excellence and further systems reform.

Mental health care needs research to advance understanding of what works. Particularly State funded services should be informed by translational research to establish how to effectively scale up what works to reach the people who need it. Funding opportunities for this are presently inadequate.

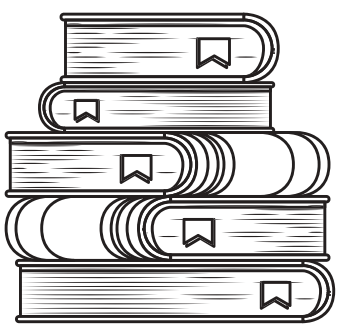
Despite mental health constituting 12% of the burden of disease it receives less than 10% of NHMRC funding, and the NHMRC typically funds less than 15% of submitted grants, 40-50% of which are viewed as adequate quality to be funded. The Victorian Government used to contribute to the VCoE in depressive disorders funded through Beyond Blue but withdrew from this nearly a decade ago now. MIRF was a good example of a funding approach for larger grants and requiring alignment with Victorian mental health priorities. Locally this led to the only study internationally to date demonstrating impact of staff training on consumer rated recovery outcomes, published in a top international journal [73].

This illustrates that the important studies to do in this area are expensive (here $2.3 million) and need funds directed to these specific translational and policy aligned purposes. But MIRF funding ran out in 2017. Nothing has replaced it. The VMRAF has a good structure but only $3 million each year across the whole of health and no evident reserved quota for mental health grants.

The Commonwealth Medical Research Futures Fund (MRFF) will not effectively come to the rescue here. For instance the Million Minds initiative sounds good but has only $5 million each year across the whole of Australia.

So this is a fairly simple proposal: Return to the level of mental health investment in research that characterised the years of the VCoE and and MIRF. That is to say about $2 million a year. Allocate those funds through the VMRAF alternating between years funding 5-10 small to medium grants and years funding 1-2 major translation grants. Clearly require that the grants are aligned with current service policy and delivery priorities. Each year run a day conference supporting dissemination of findings from the grant program along the lines for instance that the very effective Commonwealth General Practice Evaluation program used to run.

For most of the last ten years, as reviewed by the Productivity Commission [74], Victoria has had the dubious distinction of having the lowest *per capita* expenditure on mental health of any Australian State or Territory, and sometimes lagging 50% behind the leading State. This situation will need substantial correction with overall increased funding if Victoria is going to return to leading mental health service delivery. Some of this should be spent on translational research and this is a concrete proposal for how to go about that.



Recommendation 10

Incorporate social determinants of mental health

- The emphasis on medication for high prevalence disorders diminishes the agency of the individual. New evidence-based treatments (e.g., Transference Focused Psychotherapy) insist as part of pre-treatment that patients engage in meaningful paid or volunteer work, or studies

- Increase the focus on public housing, drug and alcohol treatment, and better access to Centrelink payments for acute phases of mental illness

- Facilitate more links to community networks, so patients can share experiences, learn problem solving strategies from peers, mitigate loneliness and normalise experience through the recovery journey

- Invest in better education in the community about mental health and where to seek help (starting at school)

- Create wrap-around limited out-reach specialist mental health case management services that are able to longitudinally therapeutically engage and follow asylum seekers, new refugees and temporary protection visa holders. These services should be sited in regions of high asylum seeker and new refugee numbers, in particular the south-east and north of Melbourne. They should be able to provide State-wide primary and secondary consultation to other health service providers including utilising telemedicine to regional and rural areas

Recommendation 10: Incorporate social determinants of mental health

Mental health is a biopsychosocial phenomenon and should not be treated as a biomedical and risk management phenomenon. The emphasis on medication for high prevalence disorders increases consumerism in a manner that de-emphases the autonomy and agency of the individual [2,75]. Conversely, new evidence-based treatments such as Transference Focused Psychotherapy for people with personality disorders (BPD, Narcissistic Personality Disorder) insist as part of the pre-treatment contracting phase that patients engage in meaningful paid or volunteer work, or studies [76].

Our employee forums gathered consistent voices emphasising that the social determinants of mental health were critical in redesigning a mental health system of care. Maslow's hierarchy of needs was often raised citing all the elements people need for good mental health as in Figure 24. Therefore, while people with a mental illness are on their recovery journey they may require:

- increased public housing
- drug and alcohol treatment
- involvement in groups with additional needs
- better access to self-help and developing individual coping mechanisms so their sense of mastery and agency increases
- better access to Centrelink payments for acute phases of mental illness
- assistance to find meaningful employment
- links to join a community network, to share experiences, learn problem solving strategies from peers, connect at a human level to mitigate loneliness and isolation and normalise experience through the recovery journey

There is also a need for better education in the community about mental health and where to seek help (starting at school).

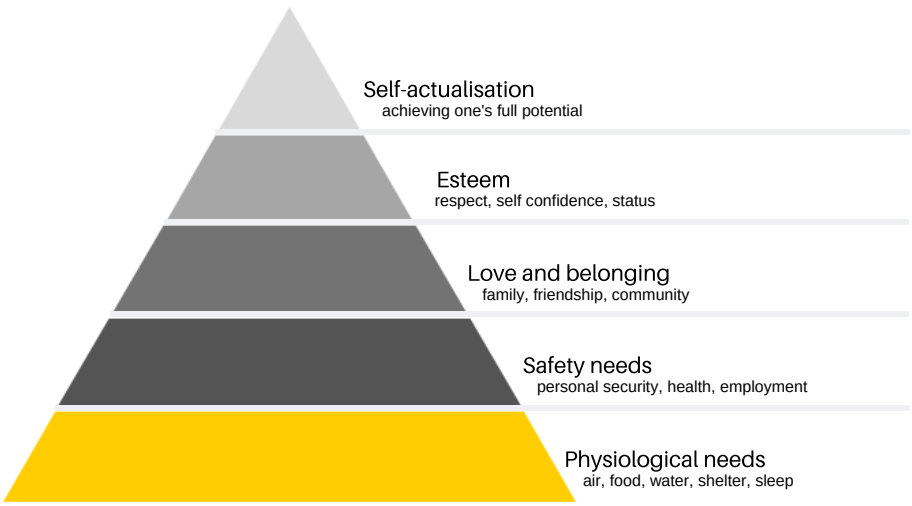


Figure 24: Maslow's Hierarchy of Needs [77].

10.1 Groups with additional needs

10.1.1 People experiencing homelessness

People experiencing homelessness has become a particular challenge for Melbourne. Approximately 6,300 people in the Monash Health catchment areas were estimated to be experiencing homelessness in 2016. The highest proportion of these people were located within the Dandenong catchment, with approximately 30% located in Greater Dandenong and around 20% in Casey.

These people fall into a number of categories, ranging from those living in supported accommodation and people staying in rooming houses through to people 'sleeping rough' [78].

Mental health and homelessness interplay is commonly considered to operate on three levels:

- poor physical or mental health that can reduce a person's ability to find employment or earn an adequate income
- some health problems that are consequences of homelessness. These include depression, poor nutrition, poor dental health, substance abuse and other mental health problems
- health issues for which treatment is complicated by homelessness. Homeless people have significantly less access to health services than the broader population. Reasons for this may include financial hardship, lack of transportation to medical facilities, lack of identification or Medicare Card, and difficulty maintaining appointments or treatment regimes

We have included a case of one of our adult inpatient wards, P Block, to provide an illustration of the extent of our homelessness issue. As earlier paragraphs indicate, P Block at Clayton, is not even in an area where homelessness is of greatest prevalence.

People experiencing homelessness: Case Study P Block

The following data provides a 100-day snapshot from one of our inpatient units, P Block. It clearly illustrates the extent of homelessness as an issue.

Overview:

- 47 homeless clients (or risk of homelessness) admitted within 100 days in P Block
- 80% of these homeless clients are on a low income, have limited family/friends support and have substance abuse issues

Group 1:

- 10 complex clients with six or more outstanding needs, averaging 24 days of hospital stay
- Vulnerable children at risk with DHHS involvement
- Urgent legal and court issues
- 90% have income issues (low income and can only afford $120 per week rent)
- Complex physical health concerns
- Asylum Seekers (AS) with limited support services available
- Visa issues requiring Immigration involvement
- English as second language
- No family or friends' support available as they live overseas
- Require urgent and intensive housing support

Group 2:

- 37 other clients have 3-5 outstanding needs, averaging 14 days of hospital stay. Typically, these clients have presented at multiple hospitals in the area
- 90% have low income 80% with drug and alcohol issues
- 75% family conflicts and limited support
- 75% history of aggression
- 70% with income issues
- 100% clients require housing support

Housing is one of the primary barriers to discharge for our clients because:

- Housing stock options are extremely limited and not appropriate for people with mental illness or complex psychosocial needs
- Where accommodation with family or friends is not feasible, the most realistic housing options for our clients are rooming houses, caravan parks and emergency housing due to their low income
- As noted above, most can only afford $120 per week in rent. Clients must have reached imminent discharge before these options can be acted upon
- Emergency housing and rooming houses will only confirm vacancies available on the day that the client presents. Vacancies cannot be booked in advance. Vacancy that is available must be claimed immediately because demand outstrips supply. Clients must be discharged immediately to take up a vacancy

- Shared housing requires that clients have the capacity to attend interviews with landlords. Once accepted, rent must be paid immediately to secure the accommodation and assistance to pay 2 weeks' rent in advance and security bonds is essential
- Supported Residential Service (SRS) accommodation is only suitable for vulnerable clients not at risk of substance abuse and who can manage their aggression. Partially funded SRS accommodation is offered for short periods to allow housing workers time to source suitable housing

The following information summarises their discharge paths:

DISCHARGE PATH	COUNT
In hospital - still pending	12
Family or friend	11
Own home	6
Emergency Housing Services - no address	5
SRS - Partial funding	5
PARCS	3
SRS - DSP	2
Safe Steps - no address	1
Transferred	1
Unsure	1
GRAND TOTAL	47

10.1.2 Refugees and Asylum Seekers

Prevalence and type of mental disorders in asylum seekers and new refugees

The prevalence of mental disorders in forced migrants (including refugees and AS) is manifestly higher than mainstream host populations. A large global meta-analysis of 81,866 forced migrants demonstrated prevalences of 30.6% for PTSD and 30.8% for Major Depressive Disorder (MDD) [79]. There was marked variation in these rates depending upon the type and location of the populations studied. Studies in Victoria demonstrated, in a cohort of new refugees and AS (n=131) with minimal detention experience and who were not reporting and were not recognised to have mental symptoms, that 61% and 52% met diagnostic criteria for MDD and PTSD, respectively [80].

The only prevalence study of MDD and PTSD in those subjected to Australian off-shore detention policies demonstrated even higher rates of 88.4% and 79.1%, respectively [81] and over 90% for either one or both disorders in a convenience sample of 181 detainees [82]. A considerable proportion of these cohorts are likely to reside in Victoria. The most recent published Victorian data, in a combined sample of n=313 AS, demonstrated PTSD and/or MDD in 32% of the sample [83].

This study, similar to the previous Victorian study, showed that rates of other mental disorders were low and analogous to that found in the mainstream population, albeit thorough epidemiological data is lacking. Additionally, in these studies, AS nor non-health professionals with whom they interacted did not recognise that they were experiencing mental disorder. Together, these data indicate the strikingly higher prevalence of MDD and PTSD in the new refugee and AS population globally, nationally and in Victoria; the additional deleterious impact of immigration detention on mental health; and the failure to identify mental disorder in these cohorts. Extrapolated to an adult population of 6000 in Victoria would equate to approximately 1800-2000 AS alone with clinically relevant MDD and/or PTSD with this a likely underestimate as increased transfer of detained populations occur.

Prevalence studies of mental disorders in child refugees and AS are more limited and methodologically fraught yielding widely variable rates depending on populations studied [84]. However, given that exposure to traumatic events are similar rates [85] are likely to be comparable or greater but with added impacts on education and psychosocial development [8].

Impact of mental disorders in asylum seekers on mental health services in Victoria

This burden would equate to approximately 80 individuals per area mental health service if they were evenly distributed throughout Victoria. However, even regions of Melbourne with high concentrations of new refugees and AS (north-western and south-eastern) which would expect to have more than 100 have less than 10 AS registered currently (personal communications with clinical directors).

Even factoring intermittent engagement and severity threshold criteria, it is evident that the vast majority of new refugees and AS are not receiving mental health treatment through area mental health services resulting in a very considerable unmet need. The reasons for this relate to low help seeking behaviour and limited ability and capacity of mainstream area mental health services.

Low help seeking behaviour is attributable to: the above issues of unrecognised mental symptoms by the individual, family and friends and non-health workers due to poor mental health literacy in these cohorts; stigma associated with mental disorders; low prioritisation for mental symptoms; and cultural shaping of mental symptoms. In addition, barriers to access include: poor English literacy; insufficient knowledge of services and accessing them; poverty impairing access; and shame. However, mainstream area mental health services predominantly treat people with enduring relapsing psychotic disorders such as schizophrenia, bipolar disorder and drug-induced psychoses; or chronic complex high intensity service use disorders such as borderline personality disorder.

The vast majority of clinicians in these services have limited experience of refugee related trauma, post-traumatic stress disorder and the cultural shaping of major depressive disorder; as well as the implications and impacts of the refugee determination process. The dispersion of new refugees and AS through-out Victoria makes it inefficient and costly to broadly train clinicians in these domains and the infrequent interaction will result in rapid dissipation of skill. Moreover, the complex and broad psychosocial needs of these cohorts across legal, welfare, housing, material aid and physical health needs requires in depth knowledge of the sector and demands a level of service provision that is generally not achievable within mainstream area mental health services. When new refugees and AS do access area mental health services it is usually in crisis settings through the crisis assessment treatment team, emergency departments and acute inpatient units. These are usually brief crisis containing interventions with clearly very few individuals accessing on going case management.

Consequences of untreated mental disorders in new refugees and asylum seekers

The impacts of unrecognised and untreated mental disorders are extensively described in the literature and include negative economic, social, family and individual effects including unemployment, poverty, homelessness, forensic and criminal involvement, family and intimate partner violence, increased substance use, impaired educational performance and suicide [86,87].
Of additional concern is the behaviour of at-risk individuals who may express their extreme distress and despair through actions that place others and the broader community in danger, such as self-immolation and other public displays.

Specialist mental health service model for new refugees and asylum seekers

The following salient points from above can inform a preferred model to address the mental health needs of new refugees and AS:

- Victoria is, nationally, over-represented with AS and new refugees. These cohorts are aggregated in specific regions of Melbourne (for example the south-east and north-west) and regional Victoria and are not evenly dispersed
- These cohorts have very high rates of mental disorder compared to mainstream populations, in particular, MDD and PTSD
- There is low recognition of these disorders and very poor engagement with treatment services resulting in considerable unmet need
- Mainstream mental health service providers and private providers are ill-equipped to address this need

A preferred model would incorporate an early screening process that allowed non-health workers such as case workers and lawyers, and non-mental health clinicians to rapidly screen for mental disorders and to refer early to appropriate clinical services.

Secondly, there would be nodes of expertise that could manage the complex mental health and psychosocial needs of these cohorts across the paediatric and adult spectrum. These nodes would respond to the cultural and linguistic needs of patients; be out-reach focused and responsive to the unstable accommodation status of these cohorts; be aware of legal complexity and provide medico-legal reports as needed; provide a State-wide primary and secondary consultation service.

There are two major current providers of psychiatric services for refugees and AS: Monash Health Refugee Health Service in the south-east of Melbourne; and the Cabrini Asylum Seeker and Refugee Health Hub (CASRHH) in the inner north. Additional mental health services are provided by Foundation House and the Asylum Seeker Resource Centre. Both these services have staff with clinical expertise to manage this patient population. In addition, they have network connections with psychosocial service providers to engage the additional supports these cohorts require such as financial, legal and accommodation. The preferred model would enhance these functions to provide a wrap-around case management approach where continuity of care and therapeutic engagement are privileged over multiple transfers of care due to homelessness, transient accommodation and frequent disengagement.

In addition to providing direct specialist care, an additional component will be secondary consultation to primary care providers, mainstream mental health services and other specialist providers. This is necessary given the sub-speciality nature of the work and the infrequency that any particular mainstream provider or service will encounter such patients. This would be provided both directly and remotely. Of relevance is the movement of AS, new refugees and temporary protection visa holders to move to regional centres and adjacent rural areas to find work and the associated itinerancy. Hence, specialist AS and refugee health services must be able to provide telemedicine services. These services would be teleconferencing to clinicians and teams to review cases and provide specialist opinions; and direct assessment and management of more complex cases.

There are however, considerable capacity constraints on both services with very limited funded clinical time. This restricts direct service provision, does not permit a flexible out-reach model, and does not allow more extensive primary and secondary consultation services across the State. Nevertheless, in geographical locations close to large clusters of AS and new refugee positions, these services should be developed into specialist nodes.

In summary:

- Prevalence of mental disorders in AS, especially PTSD and MDD, is manifestly higher than the mainstream Australian population and equates to more than approximately 2,000 adults and children in Victoria. This will increase with the likely transfer of previously detained cohorts to Victoria

- These mental disorders are under-recognised and under-treated in AS due to poor mental health literacy and de-prioritisation of mental distress, stigma, shame, poor knowledge and access to services and inadequate awareness by welfare and other non-health workers. This requires a brief and sensitive screening tool for mental disorders in this cohort [82]

- Currently, area mental health services are not managing many AS due to a lack of expertise and knowledge about mental disorders in AS; a lack of knowledge of the implications and impacts of the refugee determination process; a lack of awareness of the sector-wide issues and resources; a general reluctance to case manage people who do not have the typical disorders and needs with which they are familiar; challenges in working across cultural and linguistic variations; and an inability to commit to longitudinally engaging with a homeless or itinerant patient

- The unmet need has well-known adverse consequences on psychosocial functioning, economic and community costs and the risks of catastrophic outcomes as has been previously seen in this cohort

- A wrap-around limited outreach specialist mental health case management service model that is able to longitudinally therapeutically engage and follow patients will be effective in assessing and treating AS living in the Victorian community. This model should be sited in regions of high AS and new refugee numbers. It should be able to provide statewide primary and secondary consultation to other health service providers

10.1.3. Family Violence

We have identified a risk to victims of family violence that we believe could be mitigated through policy reform.

The circumstance is best illustrated as follows:

In the case of a male and female living together used in this example, the male will be implicitly referred to as the perpetrator, the woman, the victim. We acknowledge that the roles could be reversed, however for communication purposes in this example we will define the roles in this way.

If a woman discloses in a health service allegations of violence, the health services have access under the Family Violence Sharing Scheme (FVISS) to request a history from police about the male. At the moment, it is recorded in the male's file that such a search was conducted. Under Freedom of Information (FOI) and if the male goes to the Mental Health Tribunal, he would be able to access his records that indicate a police history search has been conducted on him.

The risk identified by our team who work in this space is the unintended consequences of the male getting access to the information provided by the wife and the possible consequences of him having this knowledge.

We are happy to assist the Commission with further information.

10.1.4 Alcohol and Other Drugs (AOD)

The following issues outline the need for the AOD workforce to be reviewed in the context of mental health:

- High burden of AOD issues in mental health patients across the catchment
- High burden of AOD issues in the psychosocially disadvantage community surrounding us - with youth preponderance and high growth rate
- High burden of alcohol and gambling venues in the catchment
- Neglect of early intervention opportunities for parents with AOD problems having children
- Poor funding for in-hospital and tertiary AOD services in the catchment including workforce development (particularly nurse practitioners, GP and Specialists)
- Tertiary Education of Mental Health nurses has neglected the mainstreaming of AOD treatment
- Inequitable financial and physical burden on patients with mental illness for smoking, substance and gambling related problems
- Model of mental health community care has placed Dual Diagnosis (Mental illness and AOD) patients at unacceptably high risk in Supported Residential Services and unregulated rooming houses
- Homelessness has particularly disadvantaged the mentally ill and drug dependent

We are happy to assist the Commission with further information.

Recommendation 11

Re-focus data system management towards clinical care and better utilise available technology and digital health solutions

- The current Victorian data system, Client Management Interface (CMI), fundamentally restricts clinical care and should be retired. It is highly prescriptive, encourages silos in the way it opens and closes cases, and increases the likelihood of people falling through the cracks

- Technology needs to allow flexibility in clinical work and services design. A new data system should be designed from the bottom up, to assist clinicians. Any top-down monitoring should minimise dashboard items to only those that are meaningful for mental health

- Low cost and early intervention telehealth solutions could be facilitated between consumer and clinician through a telehealth platform, as a way to mitigate relapse

Recommendation 11: Re-focus data system management towards clinical care and better utilise available technology and digital health solutions

11.1 Data Management System

The current data system for Victoria, CMI, fundamentally restricts clinical care. It is a legacy system and should be retired so that best practice clinical care is facilitated by, not dictated by, the data system. Technology needs to assist the clinical process and allow flexibility in the clinical work as well as in the design of services. We need to move on from CMI to something much simpler and flexible.

Currently, CMI is highly prescriptive, encourages silos in the way it opens and closes cases, and increases likelihood of people falling through the cracks rather than decreasing the likelihood which was intended. It should be designed from the bottom up to assist clinicians. Any top-down monitoring purpose should be simple, with few dashboard items that are meaningful for mental health.

Modern agile organisations always have and require effective information technology. Information needs to be available to the user/providers. At present, CMI services the clinicians very poorly. In the age of telehealth, low cost and early intervention solutions, could be facilitated through a digital platform. Similarly after an episode of care, human connection could be facilitated between consumer and clinician through telehealth as a way to mitigate relapse.

11.2 Intranet and Mental Health Services

Currently, we don't have a one-stop-shop where consumers and carers can locate services in their area, whether from tertiary, secondary or primary care. This would enable people to help navigate the system and the answer to the findability of services question. All content relating to services would be integrated in a push/pull interface where the user keys in what they are looking for (keyword search). This technology is readily used in other industries and would facilitate the navigation process considerably.

Appendix A: Inpatient beds required now and projected for 2026

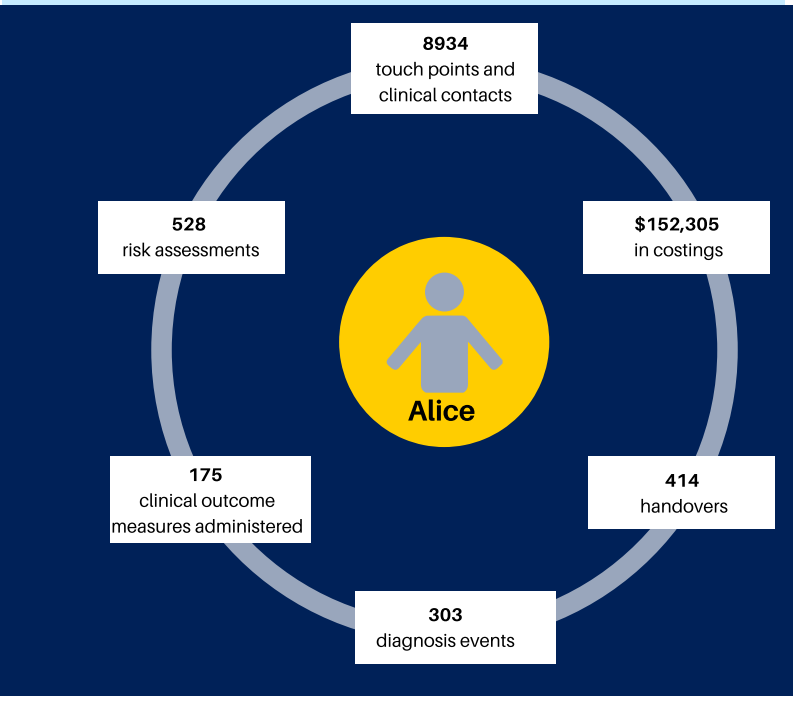
Site	Current	2026
Acute beds		
Monash Medical Centre	· Adult Inclient Unit – *31* · Perinatal and Infant Unit – *6* · Stepping Stones – *20* · Neurodevelopmental Unit @ MCH – *8*	· Adult inclient 2 x 24: replace existing facility with contemporary amenity beds, *with capacity for additional expansion.* · Perinatal and Infant Unit – replace existing *6 beds* with contemporary facilities · Stepping Stones – *20 beds* · Neurodevelopmental Unit @ MCH – *8 beds* · Acute eating disorder beds relocated from Dandenong Hospital - *4 beds*
Dandenong Hospital	· Unit 1 acute adult - *25* · Unit 2 acute youth - *25* · Unit 3 acute aged - *25* · Unit 4 SECU - *50* · Acute eating disorders on West 4 - *4*	· Unit 1 acute adult – *25 beds* · Unit 2 acute youth – *25 beds* · Unit 3 acute aged - *25 beds* · Unit 4 SECU - *50 beds. Additional SECU capacity to be considered in conjunction with other Health Services.*
Casey Hospital	· Ward E acute adult - *25*	· Ward E acute adult – *25 beds* · Additional acute adult 24 beds, *with capacity for* additional expansion.
Kingston Centre	· Biala acute aged - *20*	· Biala acute aged – *20*
Subacute (all standalone sites)		
Bentleigh East*	· CCU adult - *20*	· CCU adult – *20* · Refurbish or replace facility for contemporary amenity
Doveton*	· CCU adult - *20*	· CCU adult – *20* · Refurbish or replace facility for contemporary amenity
Clayton*	· PARC adult - *10*	· PARC adult - *10*
Springvale*	· PARC adult women - *10*	· PARC adult women – *10* · Replace with purpose built facility
Narre Warren*	· PARC adult general and extended - *20*	· PARC adult general and extended - *20*
Dandenong*	· Y-PARC youth - *10*	· Y-PARC youth - *10*

Appendix B: Community infrastructure required now and projected for 2026

Site	Current	2026
Middle South		
Clayton precinct	• 270 Clayton Road, Clayton, 3168 • 352 South Road, Hampton East, 3188	• Consolidate on single Clayton site
Dandenong		
Dandenong Hospital precinct	• 102-104 Cleeland Street, Dandenong, 3175 • 43 Oswald Street, Dandenong, 3175 • 145-151 Cleeland Street, Dandenong, 3175 • 7 Garside Street, Dandenong 3175	• Replace facilities and consolidate on single (or fewer sites)
Drug and alcohol	• TBA	• Replace facility with contemporary central Dandenong amenity
	• 122 - 138 Thomas Street, Dandenong	• Continue in collocation with community health
Casey and Cardinia		
Casey Hospital	• CATT team	• Consider expansion opportunities to meet the growing Cranbourne East demand • Relocate CATT to community location in Berwick • Expand CCT in this location to service western part of Casey LGA
Endeavour Hills	• 1 Raymond McMahon Boulevard, Endeavour Hills, 3802	• Close and relocate services to Berwick
Pakenham CHC	• CCT	• Improve public transport access for consumer access
Cranbourne ICC	• CCT	• Consider expansion opportunities to meet the growing Cranbourne East demand
Berwick	• Existing ELMHS site	• Establish site for Adult CCT
Peninsula	• 4/454-472 Nepean Highway, Frankston, 3199	• Continue in location • No growth strategy

Appendix C: Summaries of Patient Journeys

For links to full patient journey videos, refer to Supplement



Kalen's Story

For 14 years Kalen received "band-aid" treatment

- **13** different diagnoses
- **3** misdiagnoses
- **15** different medications prescribed
- **8** years on antipsychotics
- **4** different psychiatrist referrals
- **1** neurological admission

Kalen was then referred to aPM

12 CPT sessions twice weekly with **1** psychologist
All PROMS and PREMS showed improvement
Kalen no longer meets criteria for PTSD and depression

In 77 days Tom had...

- **3** contacts with Mental Health clinicians (in person)
- **13** case managers, touched 70 times
- **18** hand offs
- **5** IT systems
- **15** paper records and lots of different updates

COREY'S STORY

Episode 1 - iACT (Community)	Episode 2 - Inpatient	Episode 3 - iACT Youth (Community)
3 iACT sessions	**8** days admitted	**13** iACT psychology sessions by 1 psychologist
2 Psychiatrists	**21** risk assessments by 15 different RNs	**5** iACT psychiatric reviews by 2 psychiatrists
1 Case Manager	**4** Psychiatric reviews by 3 psychiatrists	**0** Case Managers
2 Handoffs	**1** Handoff	**0** Handoffs

AMY'S STORY

- **21** aPM psychology session by 1 clinical psychologist
- **2** aPM psychiatric reviews by 1 psychiatrists
- **0** case managers
- **1** hand off

In 19 days Rob had...

- **6** phone contacts with clinicians
- **10** face-to-face encounters (with 11 different people)
- **14** Handoffs
- **14** Clinicians involved:
  - 11 Registered Nurses
  - 1 Social Worker
  - 1 Consultant
  - 1 HMO

...26 days later Rob died by suicide

*All patient names have been changed

Appendix D: Employee Forums

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

More proactive education. Access to information to families using the service for a family member	Greater focus on adolescent awareness and social media, skills for employers to support staff	Increase advocacy for mental health consumers and carers, so perhaps develop a non-clinical workforce in this space.
Education, reducing media stigma, communication	Address the power imbalances	Awareness programs
Community to be given education about types of mental illness and where to get treatment for various illnesses and issues associated with mental health in the community/outpatients as emergency departments and psychiatric wards are not the only solution.		
More education/ openness the mental illness	Impact of illicit drug use and mental health impact	Education and especially around early intervention
Provide the community more information and understanding of the MH act and how it applies to the community	Education of healthcare staff around terminology and appropriate language to avoid stigma	Education - knowledge transfer about mental health and recovery to the community
Having more education about mental illness, have peer worker going out and discuss this in schools, work place and in medical wards	Funding for education programs about mental illness (e.g. in schools, documentaries) especially about serious illness and ECT.	I think that schools need to acknowledge that mental health issues are prevalent in our society and teachers should be encouraged to pick up warning signs with children and youth
Provide education on mental illness in schools	Greater alignment of education and health	Educate the educators/teachers
More funding for education to schools on understanding mental health and the supports available	Orientation to mental health for students and parents in schools.	Providing education about mental illness and mental health through the education system
Education programs	I meant fund mental health as well as physical health funding	Enlist celebrity to discuss their experiences with mental illness
That mental health has a lot to do with what has happened to someone. This confronts the just world hypothesis.	Improve supports and education programs for carers and family members	Education of healthcare staff around frequent attendees, that this is part of what we do and how we can support them
For the stigma against people with mental health, I think there should be campaigns to raise awareness in the public about not just anxiety and depression, but also schizophrenia, bipolar, and other mental health conditions.	Mental health as an organic illness the same as having a heart attack with causative factors that are genetic, environmental and not to do with choice or how you are raised	Health promotion campaigns, safe and secure housing so people with serious mental illness are able to make inroads to their recovery, more AOD facilities with qualified dual diagnosis staff
Partnerships between health services, education providers and other community organisations	Greater profile of public leaders and figures who live with mental health e.g. AFL players	Celebrities and people that they know and already have an opinion on telling their stories of mental health
Funding of psychosocial support NGO services for consumers of mental illness which previously there was access to but have now been decommissioned with NDIS	Rid the negative connotations and the stereotypes of how mental health presents through positive reinforcement and education	Public awareness media campaign re: psychosis, personality disorders, etc similar to what's been done with depression and anxiety to challenge negative stereotypes portrayed in media
More politicians and public figures being transparent about their mental health issues	Open discourse about mental illness with a much stronger voice to lived experiences.	Promote that mental health has just as much important as physical health
Fund mental health as well as physical health.	Have access to inpatient beds when needed	Treating mental health as equally important as Physical health
They should be treated for all range of illnesses and not just mental health concern.	That the Royal Children hospital appeal doesn't just have physically sick children	Improve access to services so that there isn't the postcode lottery which currently exists
Reduce barriers to accessing services	Improving visibility and access to peer support cafes	Improving ward conditions in mental health units
better community counselling to avoid escalation and admissions	Increased peer support workforce - both consumers and carers.	More funding to go to mental health services in the community and support programs for people suffering with mental illness
More peer support workers	RUOK days on the media	Education campaigns (e.g. television and social media)
The role of mass media e.g. TV, radio, newspaper, and destigmatise mental illness public, such as explaining that MH issues are common, can be treated and prevented, like other illness such as hypertension, diabetes, cancers. Social media such as FB, twitter and IG will be a good platform for all age groups. And it should be compulsory to have at least a part time psychologist or mental health clinician in both primary and high schools.		
More TV shows throughout the year like the ones made for mental health week	Ongoing education and discussion. Possibly we also need to further consider publication of suicidal acts in media	More TV shows with characters with mental illness who can be empathised with
Provide education in school age children about everyone's mental health, focus on looking after yourself and less focus on disease. Education about how to help someone who is struggling, support services and what to do if you suspect or know that somebody is at risk of suicide.		
Media/television campaign with examples of real mental health conditions (like TAC) to increase awareness	Improved media requirements around use of terms and language	More PARC and other transitional services, between acute and community
Make more activities available for patients in wards	More consumer consultants	Increase amount of PARC facilities
Regular Orientation (individual and group) to mental health treatment for families and carers.	Reasonable caseloads for case managers, so they have time to educate and support families and carers as well as patients.	Open and transparent reporting of data - how common is it? What types are there? What are the outcomes?
Patient stories with real people	Lived Experience Recognition as a vehicle for change	Pts to be safe from sexual and physical abuse

Client centred practice that looks beyond the presenting issue and education to clients family and friends on understanding the mental health diagnosis	All new parents should be given education in child development and training in mental health promotion for their children with specific knowledge given prior to key stages of their children's development up to 18 -25	
Statistics on mortality and morbidity of mental health	Think beyond the metro areas	Targeted education for culturally diverse populations
Public education programs around acceptance of target groups with mental illness, e.g. young men, adolescents	Personal stories and experiences shared - we are all part of the community	Often media can portray positively High prevalence disorders but Low prevalence are often portrayed negatively.
Openness and transparency regarding prevalence of MH issues	Increased focus on patient centred care.	Improve vocational rehabilitation services
I believe that this need to begin within our own service, public mental health services need to be valued, improved, appreciated as an integral part of the organisation. Other departments often receive the funding for resources, infrastructure, etc however mental health departments are over stretched without the appropriate facilities.		
Leading culture change in modelling non-discrimination from mainstream health service sector	Giving the community opportunity to see how mental illness can be really affecting and how treatment can improve the illness	Education that mental illness is just another illness that requires treatment
Media exposure	More consumer input	More education
Education in schools and community groups about mental health	health promotion campaigns with emphasis on prevention	Increase education to the community
Greater education in the community	Greater Education and understanding	Community education
Increased integration of mental health services into other services	More community mental health access outside business hours	Health promotion via social media.
Education of the general public	Highlight it more in positive ways on the media	More education in schools.
Make sure mental health subjects/ units are part of all education programs	More data/stats in advertising to the community highlighting the prevalence of MH and suicide e.g. TV adds community programs	More awareness via using electronic mode of communication such as TV, radio and Bill boards.
Health promotion investment with emphasis on prevention.	Have more 24 hour services so that people can access out of hours	Education programs
Focus on real integration of care - not co location	Education and training	Run a public health campaign led by our peak bodies
Develop high profile, public faces of serious mental illness beyond depression	patients to be able to access any services they want, not to be limited to area mental health services	Education of media outlets regarding appropriate language and not sensationalising any event. Education to start at schools
Education in the broader community	GP compulsory training programs	more education /training
Spent as much per capita on mental health funding as we do on acute care	Continue, but increase the community education programs around mental health being a clinical treatable issue which affects many	For staff to go out and reconnect with the community in schools, workplaces, GP clinics, etc
More awareness raising campaigns across all forms of media	Share accommodation with non-mental health services	A balanced approach supporting tolerance while encouraging resilience.
We need politicians and high public profile people to role model best practice understanding and challenge bias and stigma. Change starts with public personas and State leaders.		Mental health and well-being promotion & awareness. Public campaign and combining general & mental health services into shared spaces
Community education	Encouraging OCP to challenge publicly poor media reporting	Open honest discussions in the community and through media
Trauma informed and empowering language within health services.	Integrate more	Better integration with general health and community services

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

What can be done better? Help navigating "the system" and timely access to care.	Improvement: Ability for teachers to directly refer at risk students to psychology and family therapy services	Counselling response phone services attached rather than triage service try to provide triage and phone support
Improvement: Clear single point of access to the system	Quick & easy access to Services / Agile clinic	Increased access to psychology that is not restricted by funding
Agile psychology clinics in ALL catchments	Alternative options to "go to emergency"	Fund community mental health to reduce the need for hospitalisations
More funding to community teams to assist in caseloads. The ratio of patients to case managers are about 40ish: 1 respectively. And there would hardly be any capability for the worker to perform therapeutic work		
Increase in governmental funding to facilities such as PARCS, EPARCS, YPARCs and CCUs as those facilities are rehab focused and emphasize on upskilling patients back to living independently in the community.	More Mental Health Staff in Community Mental Health Clinics to manage the excessive Case Loads that prevent Clients receiving better treatment and support.	What can be done better; more funding provided to increases community services coverage to support people with mental illness in the community
Community programs and AOD programs all exist and simply need increased awareness, access and linkage with hospitals	Working well are our fabulous staff butcher need more 24/7 in community and ED and partnerships with other agencies e.g. police an example is fire brigade now do advanced life support as first responders to all emergencies in Geelong	
More availability of f/u Services in the Public sector.	Disability training for staff	Getting indications of mental illness picked up and treated earlier
Comprehensive discharge planning where partnering with carers where possible	Recognition and activation of intervention seems to happening earlier, especially by GPs and schooling systems	Growth of focus on early intervention and treatment rather than just management is a positive step.
Needs to be a better system-wide focus on early intervention and prevention programmes i.e. whole model of care needs to be revised to be less crisis driven. Including increased access to Medicare funded services in the community such as psychology, drug and alcohol services etc to address issues before they get to crisis point.		
Early intervention for AOD	More early interventions team initiatives	Greater focus on early intervention and not only acute
Prevention is always better than treatment. Hence more funding allocated to early prevention services	Early intervention services which are holistic and provide integrated care involving all stakeholders	More overall governance for non-government services rather than menu services providing the same role and changing names frequently
Increased education to general public about how to talk about mental illness would help with prevention and early intervention.	Early intervention is crucial. Education in schools around mental illness and self-care, self-soothing strategies. A public mental health pathway for people who are not yet in crisis but needing support would be good, often we don't see them until they are in crisis	
What can be done better; early prevention and identification of at risk groups. More supports and services ought to be organised for them. I.e. buddy systems with positive role models	Increased recognition of the role of developmental early in life trauma as major risk factor for mental health challenges later in life, and addressing this earlier	Step down services PARCs/ CCU great opportunities for support prior to going home. However more work needs to be done with engaging with carers to work alongside and validate their experiences
Obviously there needs to be a strong ongoing focus on community models of care. But we still desperately need more inpatient beds.	Stop the fragmentation particularly federal funding cutting across state funding without coordination i.e. headspaces, PHNs etc	What can be done better is to ensure mental health funding does not get swallowed up by acute services. In other words ensure tied funding
Good practitioners well skilled and trained	Outreach psychiatrist in the community esp. country areas	MHCPs are good but not enough sessions
G.P.s need additional training and support to identify mental illness early on. Incorporation of mental health professionals within general practices to support those with mental illness and initiate/update/activate aspects of mental health care plans as needed.		Improved awareness in the community and curiosity. Need more psychiatrist GP's can talk to.
Improved access for services for those in psychosocial crisis before getting to the point of mental health crisis	Working well: GP being first port of call and providing a centralized point of referral	Increased attention to social drivers of mental illness such as homelessness and poverty
Increased services aimed at early intervention rather than focus only on risk	The 10 Medicare funded sessions through a GP are great, but there needs the ability for additional sessions to be granted on an on needs basis. This should extend to covering trauma specialist consultations when appropriate.	
Increased access to MH professionals for GPs.	Less medication focus on treatments , crisis band aid	Linkages to homelessness services and emergency funding
increased services providing support for those with both AOD and mental health issues	Needs improvement: Expansion of psychology funding, availability of publically funded group therapy (e.g. DBT)	Increase the number of Medicare-rebates sessions for psychology services
Mental health EDs. Triaged and treated by MH not general ED staff	Current work on mental health hubs for EDs	More and Better housing / Family peer workers
More funding for counselling and psychology treatments	We can always do with better funded programs	MORE PSYCHOLOGY IN PUBLIC HEALTH!!!
PARC Services work really well and this needs to be rolled out statewide and made more accessible	Having the Community mental health supports such as Phams ongoing, introducing peer workers to wards etc.	More funding for mental health practitioners and social workers in the wards to assist in supportive discharge planning
Increase in peer workforce is good start. Teams that have smaller caseloads works better.	professional learning opportunities for teachers around mental health and neurodevelopmental difficulties	Increased MH in kinder/childcare set up to identify early needs. Quicker access to services which requires more staff and more funding
Education for people working with children to recognise warning signs and provide early intervention, education and therapy services	There needs to be improved referral processes for patients post-discharge	More of a Multidisciplinary approach in schools - education and health personnel
Programs in schools / Team work but need more staff.	More funding and accessibility to Psych triage services.	Recruitment campaign for psychiatric nursing
Improvement to Support at GP level for referral processes, what services could be bolstered in the GP clinics to support first presentation or early presentation at GP's	The whole acute mental health system including CAT teams, inpatient wards, emergency departments are under extreme duress. The headspace centres and other secondary organisations are not able to contain or manage patients properly and they refer the patient to emergency departments and acute services rather than managing the patient, no consistency and management plans.	
More social workers on the in-patient Units to manage the increasing incidence of homelessness of people with a Mental Illness and in crisis.	Secondary consults and able to facilitate quick consults with treatment teams	Step down services between inpatient and home - fully supported by all disciplines (PARC have no psychology or social work)
Soft handover to community teams before discharge.	What can be done better, other treatment options post discharge.	Integrate with kids in out of home care / DHS...
Triage- point of contact for all services: for client, family and professionals. Could also be expanded to other media forms, e.g. web chat.	Increase the availability of talking treatments and use data analysis that incorporates then use of the patients experience to improve service design and delivery	Use the Wellways "Snapshot" program for supporting families and carers as a model of best practice and have this type of program attached to all Mental Health Services across the state
What can be done better; upskilling NDIS service providers through professional development	We need a better working model that includes drug and alcohol, Intellectual, and mental health services.	Independence's of services ability to screen as required based on expertise in the service
Challenges with drug and alcohol, autism, intellectual disability....	Housing stock / Starting young / Peer worker cafes	More holistic approach to treatment
Allied health should be valued more in inpatient units - more reasonable clinician to patient ratio is needed	Improved support for families who support those with mental health problems	Working in collaboration with AOD and medical. Many mixed presentations and co morbidities
Both government and each MH services aware that to focus more on community and emergency MH, yet funding still an issues. From years to years, there is a surge of MH presentation, due to more acknowledgement but also illicit substances, need more pragmatic approach to tackle this	Improved access to treatment, not just focusing on management of illness. Development of more specialised services to treat mental illness	More consumer rights in choice of service and treatment considered esp. advanced statement included in treatment.
Need greater access of resources for schools esp. primary schools where there is little support beyond units such as Oasis - bridging supports from inpatient to being back at school	Develop an equivalent of the Tavistock institute in the NHS to promote the use of talking treatments and continuously skill up the workforce to rely less on crisis assessments.	What is working well is that there has been increased funding over the last 10 years and there is a very committed if somewhat fatigued workforce
Destigmatising mental illness will encourage people to seek help sooner	Wrap education around 3 major phases - treatment, recovery and reintegration	Focus on the social determinants of mental illness including access to housing and good jobs with income security
Patient need more occupational therapy support as well	Stop watching children spiral down until hospital admission is required	What can be done better; more mental health trained workers
A true "no wrong door" approach rather than the constant turning away and re-referring of patients based on cumbersome bureaucratic processes, catchment areas, box ticking etc	Understanding the intersection between mental health and a range of other factors in people's lives and for mental health practitioners to collaborate with other services in supporting consumers	Case manager's services are working better than without them but they need more support in their role. Patients need more input into their treatment plan.
Trauma informed care within mental health services but not neglecting client participation in their care	Need personality disorder treatments (like Orygen) in all catchments, not just one	Good work being done around mental health links with family violence victims, but more to be done
Stop the to and fro in the foster system - adopt a 2 year max of DHS care similar to other states	Increase access to neuropsychology services given high rates of affective distress in the brain injured population	Gender specific mental health services i.e. Women's only or Men's only tailored services
Drastically redesign inpatient units	Better service alignment between AOD and MH for people	More work with CALD populations
Increased support in community and mapping of services	When people get into therapeutic treatment	... intellectual disability trainings to be more responsive
The health promotion and illness prevention work of naturopathic and lifestyle medicine practitioners who focus on targeted nutritional interventions to support and reverse mental illness is working well. Support for this approach would greatly improve recovery and patient adherence to treatments.		
Increased support for those who are unwell but not unwell enough for public mental health services; make it easier for families to get support earlier in the illness rather than having to wait until it is 'bad enough'	Increased length of stay, increased violence/aggression and increased safety risk to staff and other patients especially children in emergency departments. Suggestion: Purpose built behavioural assessment hubs within all EDs or co-located; with specialised mental health medical, nursing and allied health staffing.	
Standardised risk assessment for better communication across services	provide more ECATT support within emergency departments to assist	Improved care coordination across services
Less work in silos and more understanding of the trajectory if adequate early treatment is not provided.	Lower the threshold of severity or levels of risk required for referral from Psych triage to CATT or Continuing Care Teams.	Access through mental health care plan and medication review by psychiatrist
better screening tools to determine acute psychiatric risk when presenting to ED	We have a medical model for a bio psychosocial phenomenon- this needs changing	More funding and education towards drug and alcohol services to reduce the potential presentations of drug related psychosis etc
Sensitive response and care coordination for youth by headspace	A more compassionate workforce.	Preventative interventions and better carer involvement.
Some areas of community support work well. CATT teams however need a total overhaul, more allied health staff required to support and manage complex psychosocial matters. All mental health staff need basic qualifications in addiction/family violence and intellectual		Support for carers and understand both the reality of FaPMI and Carer burnout.
Early prevention focus is done well. Increase awareness that these systems are in place. Roll out partnerships with the health system in all levels to increase awareness.	Mental health plan is helpful but doesn't suit everyone - still large gap payment and 10 sessions does. It should be flexible to suit everyone. Greater access to different types of therapy e.g. online, phone call, and text check ins particularly in regional areas. Make checking on mental health a greater role of GPs and other primary contact practitioners and education provided as to how to link clients to services.	
There needs to be better access points after hours and more ages	Case managers should be able to arrange a direct admission.	Start education about mental health in primary schools.
Emergency departments are now recognized in developed countries as an initial point of entry to service focus on mental health pathways, demand placed on ED and pt experience needs further support and improvement to aid not just patients and family but staff		Educate on early warning signs of mental illness particularly GPs and not just refer to the ED
The return of mental health nurses in GP surgeries.	Employment and spread of the peer support workforce	Education about mental health v's substance effected behaviours.
Mental health practitioner in schools	Increase Recognition of early warning signs.	Healthier communication between service providers

GPs and private clinicians need more support to manage patients in the community rather than always defaulting to the overworked public system, but they need to know how to assess risk better than they do now						Again education for all is key- early identification leads to early assessment, treatment and support		
Clear pathways to access help.	Focus on early intervention		When patients have care plans with GPs			Education and self-awareness could be done better from early stage.		
Schools early action programs	Education and assistance		Assessment or help provide by drop in clinics not always via ED.			Treatment programs with demonstrated outcomes		
Mental health issues are on the rise so I question what is working well in the community. More resources are needed for the community. Most families have no idea where to go/who to contact (other than lifeline) when their loved one is unwell. Education around this should be increased but services to support it need an increase (nursing and medical particularly)								
Early intervention in the home and community			Education around early warning signs of relapse			More Medicare subsidies around programs and treatments		
You can't fix the social- financial - education disadvantage that can impact on a person's mental health in isolation from clinical/ support services - if you want do make a difference in this area focus on early - youth - perinatal Mental Health supports and interventions						Not much at all in the prevention space and early intervention is hit and miss		
Cymhs services	COPMI	Not much	Mainstreaming of major depression and its treatment.			Better education and understanding		
It's early intervention that is the key - have mental health specialist in kinder - early childhood education and primary school - the early detection and intervention is the key to changing life trajectory			Committed and expert workforce, we do have hospitals, PARCs, community services etc, school intervention programs, multiple funding sources,			We have Quick responses at present to identified risks but we may need more disciplines (e.g. school teachers, scout leaders, sports coaches) to be able to identify the need for referral.		
Community services into schools			Overall it is not working well.			schools liaison/high profile of headspace		
Hospital based interventions working well			School counsellor/psychologist programs			School mental health programs	More bulk billed service	
Different points of access. Not one size fits all			The Families where a Parent has a Mental Illness program			Antenatal care	Easier access	It isn't working well
Monash Health Stepping Stones and Oasis - we need more of these services across the State.			More welcoming services that are easy to access and respond in a helpful manner to individuals and families			Improve survey questions to avoid composite items that are intrinsically unreliable.		
Easy access to facilities and funding			Direct access for GPS to advice			Easy access with no barriers	More community services	
More focus on providing services that offer this treatment and shift focus away from only assisting in crisis points			Better sense of community, upskilling of staff, more timely and effective access			More services into primary health - e.g. psychological services in community health		
Mental health nurses in GP clinics and community centres			Increase mental health peer workforce			Clients being empowered in their treatment		
Early identification of family dysfunction and adequate pregnancy and perinatal interventions.			Help parents, help schools, help workplaces to help people be mentally well.			Easier access to services, no wrong door actually meaning no wrong door		
Easy access, less fragmentation of services			Ease of access to services instead of blocking assessments			Holistic approach not just focussing on mental illness		
Less waiting times	After hours, assertive outreach.		More investment in perinatal and infant mental health services			Improved communication between all services		
Increased funding for mental health services to provide health promotion services			Increased support for infant, child, adolescent, and family mental health			More frontline staff. Don't forget psychosocial dimensions such as housing.		
24/7/365 Mental Health Services - not 9 to 5 Monday to Friday.			Reduction in wait time to cases being taken on for therapy			Engagement with families and carers. Education at school		
The ability for services to be able to provide support and treatment before a person is in mental health crisis			Have scope for people to remain in hospital until they are well- not discharging early			Low stigma drug and alcohol services		
						More awareness of tier 1 & 2 services		
First episode psychosis services	Stepping Stones and oasis		Access to services outside of business hours			increased support for GPS	GP mental health care plans	
Services to be no more than 7-10 mins away from each person, better presence in schools; improved interventions in work environments a free MH check like a free vaccine etc								

3. What is already working well and what can be done better to prevent suicide?

Access to community services not just for youth but more targeting on high risk groups such as socially isolated people in their 50s	Agile psychological medicine provides short term treatment for people at high risk for suicide or have attempted it	RRRR program in schools is raising the concepts of inclusivity, identity and belonging	
Working well - Monash Agile psychology clinics	It would be good for all ASSIT training to be free and accessible	Promotion and increased awareness of the community to seek help	
Greater support post-discharge, particularly for those patients who are directly discharged home from ED.	Working well: availability of suicide crisis support services. Done better: police need to be less heavy handed with patients threatening self-harm. Expansion of the PACER service or implementing a Mental Health Ambulance service would help		
The beyond blue suicide prevention app is a useful tool for adolescents and younger adults.	Reduce caseloads in the community/CAT teams by increasing numbers of case managers	Education, early intervention, family support, people knowing where to go and what to do, reducing the ongoing stigma, communication	
To prevent suicide. Stop the ongoing of stigma behind this as just BPD but a more situational circumstances. There are groups such as Roses in the Ocean that support people and families. More on education.	Education to help break down the fear around telling people - community programs like are you OK are great and can be followed up with how to help when someone says they aren't ok	What can be done better: more education to the community especially you people on the importance of seeking support around mental health and hence reducing the stigma on this.	
Early intervention strategies as described previously to try and prevent people from reaching suicidal crisis point in the first place.	Awareness campaign for the public around what are signs to look for and seek help if you are concerned about someone	Increased public awareness on how to help someone experiencing suicidal thoughts, things to say, who to call etc	
To be done better: destigmatise suicidal by informing the community to reach out, help out and its okay to discuss this. It is not taboo to talk about it. Again role of media and wide knowledge			
Frequent discussion of suicide to reduce stigma. Comprehensive suicide risk assessment training for all mental health staff.	Early intervention and targeted treatment. But need more accessible resources	General public awareness is increasing and therefore better early intervention	
Increased community awareness of services. Deceased waiting times and length of stay in emergency departments to prevent patients leaving without treatment.	Being able to discharge from ED to quick review with active intervention without having to go through a full lengthy assessment in the ED	More ECATT support to have capacity to complete assessments. Having both ECATT and psych reg/consultant support will assist with assessment and acknowledging acute suicidal risk with the ED	
Early intervention, easy access to Service providers.	More awareness of ED staff to existing good services and programs	Providing education towards police re: section 351	
Begin the work of education and support early in young families with targeted training at key life stages	The importance of education for families to acknowledge the signs of suicidal risk and easy steps to take to seek help	Prevention measures to be incorporated into school curriculum to prevent suicide ideas forming at all.	
Education in schools needs to be increased	Improved funding for alternative therapies such as art & pet therapy	HITH is making a difference. We need more	
More funding more develop 24hr suicide prevention helplines and funding to raise awareness on those services available	Expansion of access hours to support services. Crisis does not occur only in the hours of Monday to Friday.	Better connection and communication between existing services. Increase resources and accessibility to teams such as HITH.	
Enhanced capacity for cross sector communication and co-operation to have a more cohesive approach e.g. between primary care, mental health services, AOD services, social services esp. housing, forensic services etc. As all these things combine to increase suicide risk and shouldn't be addressed in isolation.		Publically funded campaigns helpful. More support services for individuals in Crisis who need immediate assistance. Develop improved CAT communication systems	
Time for increased outreach support - you find out more about how people are going in their space than you can in a clinic based service	Improved awareness from care providers around how their interactions can also send negative messages	Shared communication/medical info systems within different hospital catchment systems	
Increased access to trauma-based services/therapies	There needs to be more clinicians on the PTS hotline	More lived experience workers in the community	
Partnerships in the community, for example health promotion activity with Metro trains and secondary schools	One psychosocial suicide prevention (currently have 2 in same area, Hope and The wayback)	Better funding of NGO psychosocial support programmes to address social isolation as a risk factor. Same has been subsumed by NDIS.	
I have found my interactions with psychiatric triage positive	More police education and training on mental health	We need more clinicians who are trauma specialists	
Hmmm doing best we can with what we have suggest prevention focus on more monitoring and counselling in community to avoid deterioration and admission	I was on hold for PTS - Psychiatric triage (emergency hotline) for an hour the other day with no clinician attending to my call. If I were a suicidal patient I would have killed myself by then.	Better referral processes between health services and other support services e.g.: Family Violence specialist services and homelessness services	
More safe housing for people leaving hospital	Support for hospitals for quick links to community psychology	[redacted]ait time is atrocious. We waited almost 2 hours this week	
Urgent access to intervention as needed, with dedicated (max 2-3) clinicians	Expand Psychiatric Triage Services to reduce waiting times for people trying to get help	Suicide hotlines, lifeline etc could refer directly to psychological/psychiatric services?	
We have brilliant suicide prevention trainings.	Resilience rights and respectful relationships curriculum	Support burnt out carers.	Good secondary consultation
Way back accepts referrals only after someone has attempted suicide. Would be beneficial to refer prior to attempt. MH HITH is working well. Increase pacer hours	Greater staffing to allow increased access for all. Better and more efficient communication between private and public to assist with collaborative support of clients	I think more resources for communities i.e. sporting, arts etc, to better support people i.e. training information, health and wellbeing position to link between community and services	
When somebody presents to hospital after a suicide attempt there is a lack of support for the patient and family on dc unless the patient is willing to seek support or admits that they are imminently at risk. There should be a requirement for education, links to services, safe discharge arrangements prior to the person being able to leave the hospital. All carers should be able to access information regarding their admission and what to do.			
Clinics are available but how quickly can pt get access and coming to clinic should be replaced with telemedicine	Well: early detection, risk stratification, clinician's skills in managing the risk and outcomes.	Earlier access to therapy, less episodic case management, better access to mental health services	
Developing useful treatment options for very high risk groups (e.g. men in the 50's) which are not just repeated risk assessments, but actually treating what is happening	Education in our schools targeting coping mechanisms.	Health Promotion on suicide awareness and prevention.	
	People get easy access to evidenced based treatment	Easy Access to Brief intervention clinics at first presentations	
Suicide rates increase in societies with increasing inequality. At a societal level increasing opportunities to be involved economically and socially is the number 1 initiative. The next best is to better work therapeutically with people who are suicidal including instilling hope and remaining connected and stop having multiple people asking them if they are suicidal and relying just on medications to reduce suicidality. A range of evidence informed approaches exist but our main approach is CATT and hospitalisations which are not so effective.			
More Tier 1 Health Promotion and work and Targeted early intervention work with vulnerable groups	Appropriate (not adequate) support services delivered by highly skilled teams.	Soppier consistent predictable responses for individuals accessing resources	
Apply nutritional psychiatry practices	Case management and CATT need overhauling.	Compassionate care.	Upskilling PTS clinicians.
Greater access to therapy/psychology in the community	Recognition of the fact that risk assessments are very flawed and looking for better tools to manage risk, rather than a tick-box approach		
Our children need to be able to be children, they need to play, fight, they need to be raised with more resilience, early interventions within families and schools- families need support from GPS, better health promotion, more drop in programs for all people- so to encourage and offer inclusion and connection, greater inclusion for our elderly- health promotion re these issues			
Providing measures to support ED staff and mitigate careers fatigue	Reverse methylation problems	Increase staffing and bed	Ensure access if preventing to services
More open discourse- a general willingness to engage with this difficult topic across the public space	There is a more care and understanding needs more of the same plus extra care and resources	Encourage stronger communities; decrease loneliness and increase people's ability to access meaningful occupations	
Education around asking difficult questions	Present the facts to the broader community	Strengthen CATT	Early intervention
Life line is discussed readily now in all media which is important however isn't enough. Mental health wards are difficult environments to be in for patients who are depressed and suicidal. More education around the areas which are worst e.g. young males		More focus on high risk individuals such as young males, Middle Aged men.	
Providing quick response. Minimizing risk. Improve staffing to minimize risk.	Suicide is the first reason for death in young people under 25, easy access to services outside a hospital, having young people be able to recognize it is ok to ask for help and to educate schools Uni rage and work places on how to support access is important		
Building a relationship with a primary clinician. Frequent changes of staff inhibit this developing and it can be highly protective whilst treatment goals and best pathways are negotiated	Risks could be reduced if we didn't expect families to use psychiatric terms to explain the need for help e.g. person is a risk to self and others	Having resources or collaboration with services to assist with the consumers stressors i.e. housing, family services, finances and timely access to quality services	
Stigma around suicide in the media, needs to be more open and transparent	Early intervention and removing the stigma allowing people to come forward and ask for help sooner	Recognising and responding to trauma in all parts and tiers of the health services system	
More 24 hours services	Raise the profile of the issue	Stepping Stones - need much more of this sort of service.	Empowering people to seek help early
Scheduled follow up appointments prior to discharge	Multiple community services working together	Family to recognise early warning signs	
Better integrated care, less handoffs	Greater community education	De-stigmatise suicide.	Done better- involving families at multiple points in treatment
Address homelessness situation and improve accommodation SRS supported accommodation and private provides have a rent cap	Peer support workforce EFT in EDs and community mental health services	Greater accessibility to clinical staff trained in this area — easy access - quick access	
Access to psychological treatments via ED and PTS	Responsive care, less wait time in ED	access to specialists and more funding	
We should cash out MBS resources and directly fund targeted equitable services.	Increase resources in the community and use of Telehealth where increase in resources is not possible	Give young Australian men better self-care and emotional management skills.	
Best practice crisis care, specific models of care for crises	More outreach. Don't believe suicide can always be prevented	Not waiting until someone is in crisis before we see them	
Better understand and address the broader psychosocial problems that often drive it.	Reduction of isolation and loneliness, supporting people to find motivation and implementing reasons to get up, job, housing, pets, support groups, make our list of pathways and choices exhaustive not limited		
Services to engage youth in community settings	Addressing psycho social areas of support	More outreach therapeutic services	
Addressing the social determinants of health/mental health	Providing access to specialists	Youth outreach is working well.	Community awareness in youth risks is working well
Fund public mental health services to provide 24/7 telephone peer support for consumers and carers	More front line service in schools - Mental Health clinical staff assigned to school	VPeR and PACER work well, but need to be better linked in / accessible by our triage services	
Planned leave phone calls and follow up and post discharge contacts	Adequate housing	Working well- Pacer.	Safety plans on paper and smartphones
Listen to families and address warning signs	Better engagement of families and carers	Assertive outreach for identified at-risk individuals is not working well.	

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Some services can only be accessed if you have funds and/or capacity to access referral based services		Lack of affordable housing. Improve access to housing for people experiencing mental illness		Currently a silo mentality hence cohesion is difficult across services this is so confusing for people	
Difficulty accessing services - location, traffic, long delays in ED/community teams. Limited beds. Pressures to discharge due to demand whilst Consumers still needing support. Not a smooth transition between teams as well as psychosocial supports. MH EDs, more community teams based where the demand is			We do not have a smooth continuum within our own service and between services, when are we all as services and states, going to stop saying we are better than another and start sharing the knowledge and best practice		
Access to services are a must. Having to travel for extended periods of time and multiple means of public transport should not be the norm for accessing MH appts in the Community. Housing availability is very poor. Model of 'housing association' owned homes that can homes, provide psychosocial intervention and access to MH and physical health services onsite will assist our community for those who have MH and AOD issues.					
Cost and waiting times	Cost of treatment/accessibility.	Services should link seamlessly with each other		Lack of central oversight to multiple services	
There needs to be better communication between services from hospital to the community		Disconnection of services means people need to re-tell their stories over and over - this compounds the trauma		Breakdown of families, community isolation and lack of safe supportive networks	
Homelessness and poverty contribute to not improving		Awareness and access	Loneliness and isolation.	Cost of treatment and medication	Bed pressure
Lack of housing, Social /community support		Language - must provide more resources in a variety of languages		Lack of personal follow up when discharged from hospital	
Making it easier for people to access us. At present the bar for someone to get through PTS is so high and hence people really escalate. Early intervention, good talking treatments and less hospital admissions would be good. If people need to be hospitalised they should be safe and can stay a bit longer to stabilise.			It can be improved by gaining a better understanding of the experience and expectations of patients / consumers that access or attempt to access our service		Services need a variety of strategies to engage - to be meaningful to the individual
Cost, Medicare funding, rigid inclusion/ exclusion criteria, not enough family /carer involvement, insufficient communication between private and public sector		Mental health bed access in hospitals is currently difficult. Hospitals should be getting smaller and just for the most unwell. Everyone else should be treated in community hubs.		Alternatives to ED for those with acute mental illness. The ED is highly stimulating, noisy, uncomfortable, and there are limits placed on movement (i.e. walking out of cubicle).	
Lack of funding impacts on the amount of skilled workers available to support consumers in the community		Drop-in centres could form hubs for connecting people to each other and to the right services		Economic, Social disadvantage , improved access to financial resources i.e. increase in new start	
Patients discharged not because they are ready, but because the hospital needs to meet KPIs		Public awareness campaign around what it looks like to be mentally healthy - with friendships, work life balance, etc. It's easy to know what a good diet is, e.g. 'five a day, but what does a good mental health diet look like?			
Financial support to access and attend appointment/services - bus passes, taxi vouchers, volunteer services		Lack of activities on wards. People are bored. That's why PARCs are such a great model of treatment		Bed pressures/ numbers game in the hospital makes it hard for consumers to receive proper care	
More Mental health training for ED staff		NDIS creates a huge gap in the system for mental health patients		Websites with out of date information	
Out of hours services	Stigma	Disparity of services available in regional and metropolitan areas		Time pressures and lack of ability to refer straight from ED	
Better connection with hospital and community services, communication with family and carers, listening to what consumers' needs are, non-judgement practices from psychiatrist and nurses, giving opportunities for self-determination and risk. Providing information that is without jargon. Use holistic approach to mental health, use all types of resources.					
Disconnection of service means that clients/carers/supporters are constantly needing to repeat what can be very painful and difficult experience and life stories		More ECATT support are need we need more psychiatric staff at the cold face both ECAT psych reg/consultants to facilitate plans and discharges		A care team approach would be great with lol services involved - this is a time sink so lower cases loads and increased funding would be needed	
There is an entrenched divide between community, inpatient and primary care. Information is lost at each transition requiring people to re-tell their story over and over. Accessibility is difficult, as there is no single point of entry to the system. Triage are crisis focused and unable to refer easily to services external to their service. The experience of mental health care, especially in the IPU is often traumatic and at times we permit violence to occur to our patients. This only re-traumatises them and impairs the therapeutic relationship. There is a one size fits all inpatient unit which fails at treating anything but the most severe illnesses. Lack of access to AOD services on a compulsory basis is a source of ongoing frustration for families					
Extra funding to support longer term engagement with people and to connect them to their communities is critical. Ensuring that we can more seamlessly connect people from hospital to the community.					
Lack of funding for enough staff, increased caseloads make comprehensive treatment impossible. Only 10 sessions for Medicare funded psychological support means people with complex needs can often only afford the 10 as they can't pay per session, yet they're are deemed not complex enough for public mental health support.				We are hyper connected digitally through social media - but disconnected socially at a human level. This can compound loneliness and sense of isolation	
Social issues e.g. homelessness, poverty, unemployment. Unaddressed trauma which becomes inter-generational and has massive wide-reaching impacts. Not enough AOD services. Limited options for public mental health care between GP/MHCP and crisis presentation to ED if you can't afford private. Not enough linkage and collaboration between sectors, everyone trying to 'pass the buck'.					
Inpatient unit experience has been the most terrible experience for most of people I know, including myself working there previously as a clinician/staff, due to the lack or organisation and lack of suitable environment. Why we in public sector have to have less favourable environment to be compared with private inpatient; has money been an issue? Don't the non-private insured patients in public inpatient don't deserve better treatment? Also, high stress level for clinicians. Clinician's own MH issue has been undervalued, under statistic, and need to be more appreciated.					
Lack of culturally diverse services that cater to different cultural needs of people especially around language		Local physicians and emergency staff should be trained to better identify patients seeking help		The lengthy and challenging NDIS process is actually one of the barriers to consumers assessing support in the community	
NDIS is difficult for Clients to access if they have a Mental Illness. This needs to change.		They don't access services readily, need outreach and care co-ordination		Difficult or lack of referral pathways which can be often leave consumers without any support	
Lack of connectedness to individuals families and social networks		Stress, depression. Lack of support network around them.		Waiting times for consumers and families for services	
The current mental health system was designed in 1990 to service the most acute unwell patients. The system needs to be more fluid more agile, more services 24/7 rather than 9-5 Monday to Friday. The data shows more presentations to ED and CAT teams after hours especially in younger patients				Services popping up in isolation for specific needs but not being broad enough for complex patients - those at highest risk fall between the gaps and get bounced from service to service	
Services often seem to work very hard to find a reason to refuse a referral, based on any criteria they can think of.		Not all general public knows how to refer mentally ill patients to the right mental health programme available		It's a hard system to navigate and not holistic. Lots of referring and would be better to have a one stop shop for pts	
Referral processes are long windy cumbersome, take a long time, delay treatment. Often treatment is refused based on an incorrectly completed form.		Refugee community and delay to formal processing therefore unable to work, access accommodation after a certain time period and many then become depressed, turn to drugs/alcohol		Difficulty experienced by people with mental health issues to maintain personal and family relationships. More services required to support healing relationships	
Most people prefer treatment outside hospital. But safe treatment options are at times limited outside hospital. Need this addressed.		Community teams to have safe caseload numbers to be able to provide care		Service linkage is often very poor and needs to move with consumers rather than be decided by service structures	
Early allocation of a single point of contact to help navigate "the system" for those discharged from ED		Agree there is still a stigma attached. Should services in secondary schools be improved?		There is still a stigma around accessing mental health services and identifying if you have a mental health issue	
What makes it hard fear, judgement, stigma, past trauma, side effects of medications, lack of compassion, lack of communication amongst services, hospital under staffed, the need for peers workers in ER and Wards		Within the ED: the environment is over stimulating and staff are limited to provide the appropriate management that is required due to the heavy constraints of the ED. Frequent presenters and highly violent and aggressive patients place a huge risk to staff therefore limitations to providing optimal care. It is important to have a specific space that has deviated psych trained nurses within the ED to manage the patients and what their emotional and clinical needs are.			
Everything	Put resources into CMI	What makes good sense of Mental Health		Stigma	AOD overlay to mental illness
The ongoing stigma of needing assistance and support and not seeking it. Feeling as though we need to always be ok, strong and capable. Not allowing ourselves to be vulnerable.		Stigma currently within our society makes it very difficult for people who experience mental health challenges. Cyclically it then becomes very difficult for people to pick up the phone and seek assistance/support and so the downward spiral continues. It may be a generational thing as younger people are better at speaking up about their challenges but this needs to apply to all age groups.			
Maslow's hierarchy: knows safe stable housing = everything else falls apart		The stigma around mental health and also poor experience from mental health services		There is a huge lack in qualified service providers in the mental health system under the NDIS	
The main reasons are lack of societal connection for people. We need to have neighbourhoods. We need to have functional friends and families.		People who happen to have a Personality Disorder mentioned anywhere on their file (whether it was warranted or not) are refused treatment, not taken seriously, and dismissed.		Employers still not treating employees who experience mental health issues with the same respect they would if they needed support with a physical health issue.	
The system is dysfunctional. People wait hours and hours in ED for a risk assessment, and then sometimes days waiting for a bed. Access to inpatient beds very important. Timely follow up for those sent home from ED is also needed - waiting weeks after visiting ED is unacceptable.				Campaign and education to reduce use of phones and tablets in the young especially at night	
Recovery phase - who is taking responsibility? Esp. for the young child		Break down of behavioural patients that demand treatment from staff		Improving resilience buffers you from mental health issues	
Adults feeling infantilised by staff when they are talked down to like they are children during a hospital admission		High levels of prolonged stress with little or no relief create poor mental health. Lack of social cohesion and support contribute to this. Poor diet of processed nutritionally-poor food intake exacerbate this			
Creating stronger communities, groups for isolated individual to attend that is not in hospitals. Creating safety for staff to work more with people in the community (i.e., 2 clinicians being able to attend homes) and not having KPI that are unrealistic therefore clinicians are left with doing solo visits.			'Good mental health' is not the focus of Mental Health Services. fragmented systems between commonwealth and state are an issue		
Housing stability; Lack of meaningful occupations; Lack of ability to access specialist allied health services when required		Having a medical/response to illness model rather than a holistic, working towards wellness model.		Not acknowledging, avoiding the subject. Needs to be talked to more and understand and to find closest avenues for help	
Poor access to [redacted] for the most vulnerable		Lack of community services for people in crisis		Better integration of physical and mental Health presentations	
'Episodic care' in the community is not fit for purpose for those with chronic enduring illnesses. Discharging people to their GP from community MHS prematurely or against patient's wishes is doing harm		The fast pace of modern life and an emphasis on consumerism and a "have-it-all now" mindset makes sitting with distress and making longer term changes to diet/lifestyle/health challenging.		If things are hard to access, then they may stop trying as they feel overwhelmed. Stop services "passing the buck" and help clients no matter what their needs.	
Mental health is a dynamic phenomenon - so we should view treatment services as a pathway - not an episode		All comes back to Maslow's hierarchy of needs- If a person doesn't have stable housing, sufficient income, and access to required services e.g. AOD, family violence etc, their mental health will suffer. All these service areas and more need improvement as they are all connected			
EDs are not good places for anyone with mental health issues, especially children		A focus on management rather than significant quality of life improvement throughout our mental health services is an issue, as is our reluctance to rely on data (including data from the voice of consumers) rather than conventions and beliefs.			
Our inpatient settings are dangerous. I would not want my friend or relative admitted. They are violent places. The community knows this and are scared to come to us. More facilities for drug users to work on these issues and their mental health- particularly trauma. Our prisons also need investment in mental health and AOD programs. The public are not accessing public mental health because they are fearful.					
It is difficult when people move between catchments and they get lost to follow up		Multiple systems in use which do not talk to each other, so you cannot see what other services within the organisation are doing.		Pain clinic at [redacted] has a 12 month wait list! This type of wait can cause severe deterioration in mental health	

Area mental health services have silo positioning	Again increasing profile on what is Mental Health is vital. GP	Review cost for patients for accessing services
Having to wait for appointments headspace currently has a 4 week wait	There is not enough adult community supports outside a tier 3 service to access	Allowing workplaces to have better work/life balance programs and have employers genuinely support this
People are more at risk if they are financially unstable, lack housing, employment, social supports. Not only do we need accessible mental health services we need our Centrelink and employment services to help those most at need and provide reasonable and supportive programs to help people return to a meaningful life. Every service needs to work together and recognition that a mental illness is similar to a physical illness in that it can prohibit people from working and therefore disability payments are reasonable to allow people to seek the help they need prior to having to deal with looking for work and all the other responsibilities of life.		
I feel a "one door entry" to support is easiest.	Previous experiences in Ed	Engage schools so that there can be more early intervention.
Often people feel invalidated by their experiences. GP visits are timed and brief; people are ha balled between services without anyone there to oversee and go through the journey with them	Wait times in ED, is like any other illness should be treated the same not just left to wait long periods before treatment started, definitely need more ECATT clinicians to cope with demand	Lack in a proper treatment plan and early intervention makes it hard. More awareness and continue support from peer support workers/ case manager could be provided.
Many services operate as silos. It is difficult in large organisations to build meaningful links both internally and externally to optimise patient care. Communication remains a challenge	Too Multifaceted to answer hence why MH issues are on the rise. Poor knowledge of resources available to families particularly after hours. Resources in ED don't support the levels needed	The stigma of mental health makes it difficult to have good mental health. It touches all aspects of their lives from family, friends and work etc.
There is greater room for both hospital and community pharmacy services to communicate to ensure continuity of care. Greater access to specialist mental health pharmacy services to provide education and support regarding treatment options to both patients and health professionals		Education in schools from an early age so awareness and knowledge about mental health and mental illness are instilled. Social media promotion about types of mental illnesses and locations of services.
AMHS - 100 different IT solutions that don't talk to each other	Recognising early warning signs Stigma	Review of management in ED to keep patients and staff safe
Having services only available in business hours makes it harder as people have to take time out of their jobs etc. to seek help	GP's are vital in improving how community sees Mental Health. They should spend time in understanding the patient.	Increase in mental health collaboration with police and ambulance to provide emergency responses to those in need.
Too much pressure on young people socially. We don't work on resilience for our children	Not enough residential beds that have different types of models and length of stays	Structural deficiencies (housing, employment, community networks) are driving poor mental health across generations and communities
Access to chronic pain services Social isolation.	Difficulties gaining admission to mental health facilities	Attention to social determinants. Effectively.
Easy access. Better treatment options	Stigmatisation from general health services and general public	support sites must be close to where people live
Health services are not geared to address the wider social problems that sometimes drive poor mental health	too many ideas diverting funds away from hospitals and further fragmenting the system making navigation and timely access harder	Public mental health services need to be focussed more on psychosocial recovery, currently too focussed on psychiatric treatment
Not having fit for purpose community facilities	Silo mental health services and mental health catchment areas	Less boundaries between Monash Health services
Lack of resilience building during a person's upbringing - education in schools and parental education. Also first impressions of access to services.		Public are unclear where to go to get good help or appropriate help
Waiting lists for co-related conditions	Accommodation issues. Poor housing options makes it extremely difficult for people to access services and maintain good mental health.	
Stigma, discrimination and shame make it hard for many people. The service system is complex, based on western medical model and it is fragmented.	People that need to be seen the same day, being told to come to a clinic-based appointment the following day. This often leads to an ED presentation.	Socio economic issues DV issues. Need more info in multiple languages. Need timely response and adequate follow up and engagement
Community mental health services need to be accessible 7 days extended hours in an inviting relaxed atmosphere	Moving away from a one size fits all treatment model to an individualised options of treatment where consumers can be offered options based on what they need to recover rather than the all or nothing model of mental health treatment	
The lack of timely access to clinical services- the bed demand pressures don't allow time to recover in a safe place- the fragmentation of Mental Health clinical service - the disconnection between clinical- and social support services		Integrate at the entry point, one service across Victoria as in Queensland
Promotion of alcohol and gambling	Waiting for appointments	Timely and useful discharge summaries to receiving services
Societal pressures are greater than in previous generations - at a systemic level we need to change the stressors that weigh on our population. This requires outstanding leadership at a Federal and State level!		
Focus on engagement and client experience, warm friendly manner	Social inequalities affect the capacity to access long term care	Better understanding of the available services
Community teams offer one model - case management. This is not suitable for all people. The severity, complexity and acuity that these teams see has been increasing over time. There are no more "straightforward" cases. The people with more complex and severe illness receive case management (useful, but not treatment), and a whole group miss out (or get 10 sessions privately)		

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Lack of safe housing	Drug and alcohol	Illicit drug use , social supports especially in rural areas,		Poor community supports	Lack of education
Accessibility to services, lack of transport. Creating a more community connection or village mentality to support those within our community. This could be in the form of volunteers and peer workers.		Lack of resources, distance, lack of public transport, and no outreach mental health services that includes psychiatrist, peer workers, social worker, psychologist, community mental health practitioners.		More sustainable housing. Increase Newstart rate as is not sufficient. Poverty is a huge issue. More staff needed to provide support both in inpatient and community	
Transportation issues, housing issues and access to supports. There are also increased levels of unemployment, substance use and violence.		Lack of access leads to lack of engagement leads to lack of review, lack of timely intervention, increased use of MHA2014.		Family violence , history of trauma - not enough services out there to even begin to address these	
Substance use, lack of opportunities for employment, healthcare availability, family breakdown, Greater service provision in lower socio economic areas i.e. regional locations often isolated with poor resources, Greater education around services				Communities where there is a higher prevalence of family violence will experience much poorer mental health outcomes	
Lack of or poorer availability of services		Lower SES, lack of education, AOD issues		Lack of education to young people	
Homelessness - no fixed address, access services across catchment areas, staff cannot follow up		A lot of consumers have histories of poor coping or learning at school that have never been addressed. Kids leaving the school system unable to read and feeling rubbish about themselves when evidence-based interventions in primary school could have made a huge difference.			
Asylum seeking and refugee population amongst communities		Lack of education about what constitutes good mental health		$$$$$	Homelessness
Lack of knowledge as to what and where services and treatments that are available. Wait lists. Select services are only available within business hours		Social issues such as homelessness and lack of infrastructure, which increased risk of substance use which then increases risk of mental illness.		Social inequalities mean unless an advocate can support our vulnerable communities it is simply too difficult to navigate how to get support and assistance for mental health problems.	
Language and access ability especially in rural areas		Education in primary schools	Domestic violence	Cultural and other minority groups	
Increased presence of aboriginal health workers in hospitals for patients and staff training		Some communities will also have higher proportions of refugees or indigenous people for example, and both populations are at significantly increased risk of mental illness for variety of complex socio-cultural reasons.			
Lack of or underutilisation of interpreters for assessments and ongoing communication		Cultural barriers as some community view mental health as a social taboo.		More outreach to certain communities concerning the importance of mental health.	
Language Accessibility of information in a variety of languages		Location of 'home' - where are the resources for rural and small towns		Lack of culturally diverse services	Cultural awareness and belonging
Fewer services in regional areas, too far to travel, too expensive		Geography e.g. no support for rural areas		Lack of safe homes for our homeless popular	
Lack of health and community infrastructure in growth areas		Refugee and overseas visitors access to care		Wealth inequality	
Refugee population - delay to processing, lack of health information in appropriate languages, lack of housing options, contact with family abroad and/or unrealistic view of being able to bring family to Australia					
Access to services!!!! In regional communities it's very difficult for consumers, carers and families to get support and assistance		Access to substances and limited local options for treatment and rehabilitation.		Addiction/ poverty/inter-generational trauma and dysfunction/patriarchy	
Poorer Social determinants of health		Socioeconomic disadvantage		Poor response to physical health matters	
Stigma about mental health		Refugees without Medicare cards cannot access many health services		Only getting a service when it's a crisis	
Lack of cultural training in the hospitals		Language barriers	Information in more languages	Lack of culturally appropriate services	
AOD use, financial difficulties, lack of services available, DV, homelessness. Re-align services with population demand		Economic, housing, education, unemployment, drug and alcohol issues...		Persistent social disadvantage perpetuates cycles of inter-generational trauma and risk of mental illness occurring across generations	
Alcohol and drugs. Poverty. Homelessness. Domestic violence.		Awareness of service availability	Violence against women	Stigma around mental health to stop people from getting help	
Geography or age based catchments		Energy dense nutritionally poor food choices		Lack of safety, being under constant threat of assault	
Insufficient access to alcohol and other drug services		Education system having difficulty to manage behaviours at school		Increase substance use	
Media	Social isolation	Isolation	Addressing this can help identify gaps and increase service access.	Resources	Poor socioeconomic status
Location and accessibility to services, poor referral process, and long wait to be seen. Consumer has to be their own advocate which sometimes they are not able to do.			Rapid expansion of the south east corridor has not kept pace with mental health investments. Rural and remote communities are much more likely to receive medication alone without psychological support. Our aged population are at an even higher risk of receiving only medication. There needs to be a greater focus on training psychologists in particular in managing older patients		
Refugees	Access to resources and education		Lack of resources provided to refugees and migrants	Homelessness [redacted] is in top 5	
Cultural diversity has been a major barrier in Australia, but also geographical issues e.g. Rural and remote. This will require outreach services or more MH services in those community, not just in urban area.					
Non English speaking back ground		Pervasive hopelessness that things can change		Poor housing	Lack of education, social isolation
Social and economic disadvantage is critical. The rise of inequality is the key driver. People having no job security, stable housing and educational opportunities are a critical dimension. I am a strong advocate of the social gradient theory. If people don't have opportunities they don't have hope. No hope leads to mental health difficulty even for those with more biological disorders.					
The first community amenity in a new estate... the local pokies venue		Not all employers provide their staff with access to an EAP program		Stigma; Dual disabilities or multiple disabilities	
More incentives for mental health staff to relocate		Being released from prison with no follow up, no place to go etc...		Better education of police members.	
No homeless team	Cultural	Money	Despondency	Poverty	Culture specific education	They don't have a voice
Stigma associated with mental illness and seeking help in regional areas. If you see a doctor or psychologist in the area it is someone who you know or may see at the supermarket and there's a fear the information may be spread. Particularly amongst men there's difficulty processing emotions effectively and beliefs that you should be able to deal with it internally amongst the pressure of providing for your family.					

Lack of training in our education systems- the social and emotional capabilities curriculum must be seen as core in all schools as well as RRRR			Violence against women
Long waiting times and poor access to child/adolescent experts, and children with ASD and ID often not really "fitting in" to the standard mental health models		Children in out of home care (DHS / foster care) get moved around. Therefore, they end up in different catchment areas with different mental health clinicians.	Development of new housing estates which are often cheap but lacks infrastructure/ essential services e.g. public transport, which can lead to isolation and lack of jobs for those who move there
Support is needed for CALD communities who don't have interpreters to assist.		Dysfunctional/ broken families, poor social supports, lack of education among families regarding long term effects of substances children.	Quite often going to a go for a mental health plan is one step too many for vulnerable youth
Inability to access services i.e. Through inability to access community. Or lack of resources like finances		The relentless drive for consumerism and ownership, drives people to work harder and longer, and still feel like they haven't arrived, and those who are left behind feel like they will never make it. How do we get the media to stop pushing this demand?	
All the determinants of health are absent coupled with undesirable place to live and work for professionals and unaffordable staffing and co-location of professionals as in adequate budget			
And each of us needs to stop pointing fingers, blaming each other's or certain communities e.g. drug addicts, homeless people, broken family. Not just the clinicians but also the government and politicians. Who to be blamed?			Minimal to no insight towards ADL's, management of money and nutrition
Density of illicit substance use	Cultural	Adequate resourcing of child protection so they can work well in supporting families and provide therapeutic trauma responses to children	
Patients that have pre-resisting medical conditions that affect their cognitive abilities to make safe and appropriate choices can influence poor diet, lack of exercise, poor relationships etc		Incorporating trauma education on all mainstream health education is medicine, nursing, allied health to ensure appropriate responses and engagement of people presenting with the impact of trauma	Persons experiencing persistent pain need to wait 2 years to access specialist medical services, during which time their condition becomes worse.
Distance, not enough trained staff etc. To address this we have to have a regular contact within the community.		Socioeconomic standing. Language barriers. Cultural barriers. Rural and remote locations. Increase funding and services.	Newly arrived migrants, socio economic class, where they live plays a big part.
Significant childhood trauma.	Trauma	Lack of good quality mental health staff in regional areas	More 24 hour services with interpreting services
Not enough MH services in remote areas - Provide outreach services to remote communities via Telehealth		Inequality in opportunities for education, health care, community services and employment. Additional support/funding for targeted services for single-parent, lower-income, refugee, aboriginal and other disadvantaged members of our community.	
Socioeconomic status	Poor access	The sociology of ill-health always impacts on mental Health outcomes	Access to health services, health literacy
Low socioeconomic background- poor understanding from some staff working with them but also difficult to change culture in these cohorts. More education to those communities.		Poverty, inequality and poor still social capital. Broader political agendas need to address these but mental health services should be targeted systematically to areas of greater need	Better community services of housing education And investment or funding for GPS for caring for MH clients. Establishment of innovation funding
Lower incomes, drug use, domestic violence		Newly developed growth corridors- health services playing catch up	socio economic variables
Come communities rely more heavily on community health. This is mental health and physical health. Slow response to both mental health and physical can compromise ones mental health. Areas that have more people accessing private health may do better.			Education at all levels. Preschool, school and extending this to parents which is being modelled in Endeavour Hills.
there is an over -representation of people who have speech language and communication needs in mental health that act as a barrier to access and effective treatment		Young people are experiencing greater social pressure than ever before and have less protection from adults around them due to the changes in communication (I.e. social media).	Lack of cultural understanding can result in patients not having an optimal treatment for their mental health conduction. Also lack of health literacy regarding medications
Many and complex. Improving educational attainment and social standing may help break cycle between generations.		Tyranny of distance and isolation due to poor public transport. Can be improved by better access to services in a local area	Government focus on areas that gives them popularity not areas of need
Societal inequity and bias. Address housing, education and employment needs of key affected communities. Stop playing political football with vulnerable communities.			
Increased in population in disproportion to services, addiction trauma, financial stress and homelessness. Poor community development planning		In [redacted] there is a lack of informal community support. People move there for the housing, but are removed from their neighbourhood	
Promotion of gambling, access to alcohol and junk food are substantial drivers of depression.		Financial issues, lack of housing options, loss of family and friends, loss of purpose and faith, stigma, lack of community	Low incomes, poor engagement in community including education, Drug use and trauma
The social stigma of males admitting frailty		Alcohol and Drug use, gambling, family violence.	lack of housing	Isolation
Low SES, hardship, lack of trust, fear		Lack of affordable accommodation	Access and locations of mental health services e.g. access to transport
build more housing included supported housing		Poor past experience	Psychosocial disadvantage	Language and cultural barriers. Socioeconomic issues

6. What are the needs of family members and carers and what can be done better to support them?

Better communication about "what's next" - how long they will be waiting, who they are going to see. Reducing waiting times (which can be hours and hours in the acute setting and weeks to months when not "in crisis"			
Quick reference guides who to call when- safety plans for family not just client		More staff employed, separate to treating teams, to liaise with and support them	Education, counselling, understanding of their social position regarding finances, culture, all aspects of care responsibilities
Education on how to understand mental health diagnosis		Give workforce time to work with carers as well as patients	Finances / Include in treatment planning
Include carers in treatment planning		Need to be valued as a vital relationship and involved in discussions.	More communication between health workers and families
In adolescents and children more support for parents regarding parenting skills. Educating families about early warning signs of relapse and means to access services. Role and need for treatment. Understanding and education about role of medications in treatment and need for psychological interventions		Knowledge about how to and where to seek assistance. What support services are there for carers? Assistance with escalation when the affected family member is deteriorating, how does the family /carer link in services when the person is resistive to seek their own assistance	Increased funding of and access to NGOs that can provide specific support services to families and carers. Increased acknowledgement/decreased stigma around the need for families and carers to be given this support to they can care effectively for their loved ones
Post discharge follow up and support		Access to support services!	Support, care, acknowledgement
Work needs to be done to build capacity to provide support before a crisis point is reached		Understanding of the impact of carer fatigue and referral pathways to support carers	Trained family therapists as part of all allied health teams (in addition, not instead of, psychologists and social workers and OTs)
3 words: funding, funding, funding		Being respectful between the consumers and their families/Carers.	System-based interventions. As in family system therapy
Improved access, quicker outcomes		Prioritising listening to not talking at carers	Providing a 'voice' for young people who are non-verbal
Families can often require just as much support as the patient. We need to increased family/Carer services to offer support, education, links to assistance.		More supports available - both those with lived experience and clinicians to listen, acknowledge the challenges especially where there are treatment gaps for clients declining treatment	More publicly available information around what is available for those families that feel it is their responsibility to manage very unwell family members on their own
One direct contact at school one direct contact in health		Respecting diversity in carer configurations	Respite relieve services would be welcomed
To be included / Agency		Respecting input and following up on concerns	Carer hubs in the ward / Education on how they can help
Strategies to cope rather than quick fix		Better communication pathways.	More centres like Bouverie
More supportive discharge planning that's inclusive of carers and family		Understand that family input and listening to what they say can greatly impact how things go post discharge. Educate and inform family of diagnosis, medications and long term effects of medications. Empathy and communication that is congruent.	
Less financial burden / Respite		Continue care. Provide more trained staff to continue liaise.	Lack of knowledge.
It's a mindset of the workforce. The practitioner who do this the most have had family members with a mental health problem and had to navigate the system. Once you have done that you are changed forever as a practitioner.			Increase options available to them to seek and receive service based on severity and need
They need to feel that it is not their fault and acknowledge that what they are doing is difficult		Adequate financial support for carers. Carers respite and NDIS funding and access to protect their mental health and wellbeing.	better access to family therapy and family support (we are not funded to offer this often but it is essential to peoples recovery)
Health literacy on how to support loved one including available access		Knowledge of resources available.	They need to be listened to.
To not be actively excluded from Mental Health Tribunal hearings when they have to deal with the decisions made by the Tribunal and the impact on the consumer between and during periods of hospital admissions			
Ongoing support in their role as a carer and not just in crisis. Better acknowledgment of the effect on their own mental health. Must be part of treatment planning		More support and listening to what they have to say as they know what has worked etc, counselling, material relief, peers support, psychiatrist not to be dismissive against families. Funding for respite.	To inform and advertise the family that, even though they have family members with MH issues, they still will be supported and also offered treatment if needed e.g., counselling, work, disability
Families need to be accepted better and less stigmatized when they bring their loved ones back again and again to ED's		Families and caters must be included and supported same needs as pt as they keep them well	Difficulties with consent for contacting relatives when patients arrive as patients are too unwell to give it. Can this be done as a pre-existing?
Emotional support for caters needs to be forefront		Carer burnout / Building caring communities	Emotional support for carers
Families and carers need to feel as though they are part of a team and not just receiving a service		Carers and families should be acknowledged more for their hard work supporting the people we see	More funded lived experience positions in public mental health services
Families or carers need a platform of respect, free from judgement, that is responsive and helps alleviate their burden. Not compounds it with complex systems and repetitive retelling of concerns		New South Wales have implemented the rights of the principal carer in their MHA. This requires services to involve carers and should be replicated here. Families are often in desperate need of respite from their loved ones illness. Our system is not designed to cope with this. Expansion of PARCS or an alternative model to include respite for carer burnout should be considered	
Understanding of psychosis, treatment and correlation b/w drugs and mental health. In adolescents and children more support for parents regarding parenting skills. Educating families about early warning signs of relapse and means to access services. Role and need for treatment. Understanding and education about role of medications in treatment and need for psychological interventions.			Because of strain on current services and models of care - patients are often discharged when they are still very unwell which can be really hard for families/carers
Improved communication with treating team and client		Access to support, services, medical care, and respite are only a few...	Empower input from family then listen
Funding for Medicare sessions for carer support that reduces cost. Increase staffing to support parents/carers, often this is all done by the same worker reducing the time allowed		Changing the culture: we need to consider that various cultures don't acknowledge that MH is an illness. Changing that stigma amongst the multicultural community will assist	Money...most of the time they don't have financial support (or they don't qualify) to be able to assist with caring for their loved ones that have mental health concerns that can debilitate them
More access to mental health sessions through GP care plans if family's have loved ones affected by mental health		More non for profit organisations that can assist with family stress, family respite	Support groups, crisis number for themselves not just the patient, family case managers not just for the patient
more specific interventions such as family therapy		Family sessions, active listening, trust	FaPMI / Respect
Increased access to respite. Targeted service response to assist with managing challenging behaviours. More transparency between families and service, collaborative and inclusive approach		Families are often scared and struggling. Compassion and reduction of judgment would help. Increase in services for families but also inclusion of families, where possible, in treatment process.	More support for their family member so that the responsibility isn't completely up to them, provide options if the person isn't safe to be alone.
Listen to their view / inclusion in treatment design		Family Carer consultants employed by peak bodies	Access to treatment for their loved ones.
Take their concerns seriously rather than pathologising their deeply held concerns and distress as a problem		The system needs to be more accessible and responsive to requests for help	Sometimes families also just need a break and to have the sense that someone else is carrying the burden of care for a while.
Knowledge about access to mental health services, especially when their family member doesn't have insight and isn't willing to seek help themselves		Carer fatigue can be a problem so family's need support to help them through the difficult times - we need to work together and listen to each other.	Education on recovery as mental health is not a quick fix. This is important for them to link with career support or even their own mental health support in community
System is too complicated at every level including services such as Centrelink and aged care services to accessories		Ease of access to services. Support and involvement in the care continuum. Easier process to be assigned NDIS funding.	Family dysfunction and mental illness is often cross generational so parents often need as much support as the kids
Access to help when they need it. They need coordinated services that talk to one another, not just in mental health services.		They need counselling also to see the progress need financial support and relieving them	Respite. Mentor support from other families with lived experiences. Encouragement to attend to their own self-care.
Often their experiences can be more traumatic than the patient themselves- particularly people who have a family member with a mental illness but also using drugs- chaos/ danger/family violence. We should have outreach teams that work solely with families and caregivers.			Often in respite is required where it is not available to the extent it is needed.
To be heard, helped, respected and included. Much more availability of family/carer peer support workers		Access to resources and support services, education around early warning signs.	They need information and support just as much as the consumer. They need to be HEARD
Understanding about how hard it is to cope when someone they love isn't taking the steps to help themselves, they need support, don't make assumptions that they are able to provide this sole support as it's not always possible. Also the client is often the one who is asked the questions about the person's mental health and the story to the carers is much different so getting both sides of the story.			
Information and support.		Clinicians need time to slow down and make the inquiry.	Honesty, compassion, clear information, listen.
Listen to the family as they know the patient best and are their support network		Systems where supports engage in family homes providing education/time modelling	Education about mental illness, early warning signs, what to do in a crisis, information is vital
Better understanding of carer the experience		easy access / increased financial support	Early childhood interventions
More family/Carer peer workers		Health staff need to Regard and respect and communicate	More access to Carer brokerage funding
Provide family in conjunction with client education about what would be helpful and strategies to assist. Supported with written information to takeaway			Increased community support, e.g. in home respite care, for family members of patients with dementia
They need good access themselves to high quality and capable primary mental health care.		Listen to them and not be judgemental and condescending when in crisis	Treatment education (including drug treatment) and de-escalation skills.
Lack of funding and availability of services		To be listened to and asked their opinion and observation	They need to be asked / system easy to navigate
Response service- caters need to be able to refer in and access services in a timely and easily navigated way		Supports to sustain their own wellbeing and prevent carer fatigue, information & to be heard and opinions valued.	Information and communication when loved ones are in need of MH advice and care and if and when they are in crisis.
To be included, to be heard, to be understood, to be cared for		They need to be heard	Funding for family/Carer consultants
A service that will listen to Carers and families.		Listening to them They are the expert in their family needs	Families and carers don't have a voice. Carer consultants are needed to support families /carer s in the community

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Have a model of care that enables guidance for service provision but also recognised the required resources needed to provide the care. Increased working spaces that meet OHS standards. Enable safe working practices.		Increase EFT for staff to work with students to give them the best experience possible.
Recognition of the positive and rewarding work that can be done.	Having a trauma focus on our mental health practice.	Mass recruitment drives overseas
Mentoring for new staff	More staff / Acknowledge efforts	Building relationships Between different departments
Provide more opportunities to medical students to do electives in psychiatry so that they do not make career decisions based on not really experiencing what this area has to offer	Have reasonable expectations of what staff can deliver; we can't be everything to everybody and not given sufficient resources and support to deliver - we do care!	Resources that allow staff to do the job in a way that is recovery focussed with family and client input rather than just maintenance and crisis management
Organisation to trust in their structures policies and work force.	better salary, manageable caseloads, supportive work environments	Adequate staffing levels
Respect to peer workers across all disciplines to the deeper impact they may have to the outcomes of consumers.	Dedicated time and support for our Acute services to access supervision and reflection	Expanded opportunity for psychotherapy clinic based practice for psychiatry registrars
Reduce unnecessary work and paperwork	Invest in recruitment campaigns for psychiatric nursing	Increasing pay / Respect between disciplines
Holding the whole health system to a standard of behaviour that stops stigmatising clients, the staff advocating for them and stops blaming staff for a lack of resources	Better pay, flexible hours, and train about peer work and the positive skills and knowledge they have. Have Psychiatrist and Mental Health staff see Peer workers as equally valued members.	Constant crisis-driven model of care doesn't enable reflective or recovery-based practise. This becomes demoralising and staff can become disillusioned and burnt out.
Improve workplace culture- difficult given the nature of the work. But needs to be done.	The staff face real physical danger every day, they need to debrief at regular intervals	Supervisions for all clinicians that required at least once a week, or every two weeks, for at least them to discuss issues, or also debriefing.
Service as a whole needs to be better resources for the huge population we are serving. Currently the whole system is so over-burdened and is running in constant crisis and this translates down to staff well-being		
Increased remuneration / Culture change	Include them in creating the answer to the problem	Open and transparent leadership
A comprehensive strategy that includes physical space design as much as all the other key elements of workforce attraction, dev and retention....	Training, education. Sufficient staff to allow for breaks! Career progression opportunities. Involvement in research, community education, outreach, advocacy rather than just day-to-day clinical work. However, current service pressures are so great that all people see is the "next task"	
Better workplace cultures / Increase supervision	Better clinician to patient ratio. Otherwise clinics leave due to burnout	Open and approachable leadership
Creating a work place that encourages shared ideas and skills. A work place is a family friendly and inclusive. More group building activities	The best fix for burnout is enough staffing to allow for people to do their job properly	No human can function in crisis mode full time without some downstream impact on their health and well-being
Upgrade of mental health facilities	Improved pay conditions	
Make the work rewarding and get the Bean counters to have less influence.	Provide education Qualification opportunities for teachers - financial support, time release etc	Increase funding for staff's individual professional development budgets
Good supervision includes access to regular non-judgemental time with an experienced practitioner with adequate time to reflect on cases. Admin requirements and the impact of the work on the person	Doctors in training require adequate staffing to ensure that they can function in their roles with a sense of wellness. Knowing that an expectation is for a period of on call for 24 hours is not a great advertisement. Junior staff often feel overwhelmed by the mountain of paperwork (I estimate 50-60% of my business hours work is paperwork) involved in psychiatric care and feel their time is wasted	
Strong leadership that respects the contribution of MH workers	Smaller more appropriate workload	Mental health (trained) in schools a part of a multi-disciplinary team
Acknowledgement of the direct and vicarious trauma we deal with on a daily basis and how hard this can be, and a culture of being able to vocalise this and seek support for same without feeling guilty or stigmatised	Organisational support, acknowledgement of work, peer review, supervision, continuous ongoing education and assistance for further studies/training. No knee jerk reactions from the senior management and no witch hunt to an adverse incident or accident.	Mental health nurses need Clinical supervision to better support their patients and not having this puts us at risk of burn out and will illness and then there will be no staff to care for the clients/ patients coming through our services so they get the best possible care.
Value and respect from psychiatrists towards all other disciplines please!	Acknowledge that peer workers may experience trauma in their work and pre plan to support, low threshold for leave if required	Supported when exposed to OVAs with active steps by organisations to minimise this risk
Smaller workloads / Respect diversity in skillsets	Place multidisciplinary teams in schools or across a few schools	More clinicians to spread out the workload
Shared responsibility with staff- they are not alone when dealing with tricky issues	Leading a culture of positiveness, building and leading a Team where staff want to come to work.	Ensure programs are funded with the right EFT to match presentations or case load.
Clinical supervision for all mental health nursing staff.	Increasing staffing levels to account for large caseloads	Make sure their work conditions support retention
Good management support allows and encourages brave and vulnerable work	Better pay, access to good affordable current training, good supervision and management support	Peer support workers to be incentivised by offering training that may count towards study and employment
Increasing efficiently by streamlining certain administrative tasks	View workers lived experience as valuable in the Mental Health space	Flatten the hierarchical structure - similar to plane crews in aviation
Replace staff who are on leave or resigned, so others don't have to pick up their workload	View workers as equals as part of the team rather than viewed as part of a hierarchical structure	Positive campaign to show the positive effects of what working in mental health can achieve
Improved staffing levels / Increase pay	More safety, more money, more help for all included	Mental health nursing needs to be endorsed as a specialty by AHPRA

Compulsory supervision no matter what your profession is. It is ludicrous that CATT and ECATT don't have regular or sometimes any supervision.	Redesign the nursing undergraduate training - UK model - 18 months general and 18 months mental health. Increase the clinical placement hours for mental health. Recently reduced from 4 weeks to 3 weeks.	The physical environments of many mental health settings are depressing for both the workforce and consumers. Creating better spaces would make a difference to both.
Better HR structure- unsupportive and uncaring. Health can be a scary workplace	Bigger workforce in ED. ECATT staff at burned out and need more staff within the department to maintain the patient load.	Having clear guidelines, pathways, secondary consultations and support to ensure they do not feel isolated in their decision making
Bring back the '12hr' shift on the MH unit	More social workers in community teams	Increased security presence in EDs
Need to ensure demand for our workforce matches supply. Also need to make sure the work is rewarding and we allow the bakers bake the break and not be caught up in process led services that forgets that the relationship is the heart of the work. Also need to have a postgraduate centre that continues to train people in the common factors, evidence based talking treatments		
Reduce redundant paperwork and processes to increase the time with patients / clients	More recourses and more staffing to reduce individual workloads and pressure	Mental health nurses need to be enabled to spend more time with patients rather than being used as security and admin in acute services
Demand on contacts and caseloads means staff often do not take time off, rarely use PD time. There is no funding for in services to staff. Providing more learning and professional development on site would increase satisfaction	Can government consider subsidise sessions for psychology for supportive counselling for those who works in mental health? If there is GP MH plans, why can they come up with such plans for "MH staffs psychology plan"...?	Within the ED: working as a team, better communication between both disciplines, provide educations amongst both disciplines about each speciality, using strategic planning to be able to provide optimal care for mental health clientele.
How do we make mental health sexy?	Vicarious trauma of the workforce	Care for the carers (workforce)
Stronger SW department- needs the structure and leadership similar to the psychology department	Increase in pay. More opportunities for training & professional development	Staff to patient ratios are just as important in the community as it is in hospital settings
Improve work environments- opportunities for team building, create more harmonious environments. Support from management to nurture employees mental health	Enough staff employed to cover caseloads and crisis work. LESS paperwork, which takes over from clinical work. One hour clinical time with a client equals about 3 hours paperwork time!	Better education, better recognition for the career, better workplace psychological support, better leadership of the Mental Health services and agenda.
Some recognition as to how traumatic this work can be	Maintain staffing level and experience	Scholarships for additional training
dedicated psych ED team 24/7 to assist with decision making and reducing departmental block and escalation of patient behaviour within the ED	Consultant psychiatrists 24/7 in Emergency departments, to ensure timely decision making and prevent aggression escalation and ensure safe safety	Creating well-supported work environments to prevent burn-out and cynicism. Creating an environment where new ideas are welcomed and responded to.
Helping create more fun/relaxing/ visually attractive places to work	Zero tolerance for violence 100%	Increasing $ / Consultant always in ED
more educations for ED nursing and medication staff to be able to work as a team	Need more staff to ensure workload is manageable. Often the impossible demand on clinicians is a huge cause of burnout	Better biopsychosocial infrastructure, career pathways, entry positions, safer working conditions
More remuneration and ongoing advance training will be really helpful.	Important to look at working conditions i.e. space to do work and see patients and airflow computers	Emotional support to frontline workers. A forum to be heard. No tolerance of verbal and physical abuse of frontline workers!
More consultant time / Debriefing and support	Increase ECATT staffing, more debriefing in the ED	Increasing work/life balance and acknowledgment of specialist skills.
Ensuring staffing levels for pharmacy services are in line with SHPA ratios, this will provide better care and reduced stress for staff	Work life balance, greater support from management. Keeping staff safe	Work with police on section 351 and appropriateness to ED environment
More family friendly shifts, staff not having to do night shift rotations onwards, more upkeep of buildings (Kingston), lower case lists for community workers. Community not having to "sell" the need for help to other services. All work together!		Prioritise recruitment of vacancies rather than carrying them to the detriment of those who take up the slack
Clinical supervision as part of the EBA	Keep them safe / Create workable caseloads	Pay a supplement for all ED shifts for all staff
Allowed time for supervision	Debrief and support following incidences of aggression	Zero tolerance for violence and aggression
Increase e-catt Staff numbers and all areas of MH to disperse workload. Difficult to get staff return when workload so high	Having sufficient staffing so that people are able to take a break and look after themselves, instead of burning out. Also so that meaningful work can be achieved rather than having too many patients and not enough time to see them thoroughly	
I represent pain services and have major concerns for my overworked team who do. It have opportunity to debrief, but are subject to hearing of people's trauma day in and day out.	We need a work force who is able to communicate one another and understand each other. ED clinician working with triage clinician, working with community clinician, having enough doctor coverage...	State wide or country wide framework on learning and development and a MH workforce strategy for the state which is signed off by all stakeholders incl tertiary institutions
Recognition and validation that the work is hard and takes a toll. Provision of debrief supports where needed that are attuned to the workforce. External consultants are often not aligned with the experience of tertiary and acute mental health services		Increased support from management about the significant risks for staff when dangerous patients are in the ED and injuries are sustained
More staff to deal with ED aggression	Supportive management - manageable work loads	Abuse of administrative teams is also an issue
Give staff days off together as much as possible in the roster	Recognition of demands on team due to workload and staffing issues	No break in day to recognise clinician stress
Zero tolerance for aggression	Enable graduate programs above numbers	Time to attend education and training
Ongoing professional development including tertiary. Career structure, reward more flexible work agreements	Reduce stigmatising mental health in University programs who actively deter nurses from applying to Grad years	Providing more funding for education and improving stay patient ratios
consider supporting 457 visa to attract overseas nurses	Training opportunities, supervision, mentoring, carpark	Facilities including location

Make mental health careers more desirable financially as a start and then in all other aspects	Increased support ,Supervision , conditions , and acknowledge clinical excellence	Support in ongoing relevant training/education with quarantined time allocated to keep up with evidence based training
Mental health clinicians involved in secondary schools career night	Reduce occupational violence	Improve AOD skills / Career pathways
More positions for students	Fund peer work discipline lead positions	Professional body and training for peer workers
Funding for nurse trainees to allow rotation into community	Destigmatise mental health work at undergraduate level	Compassionate manager
Reduce exposure to occupational violence and provide opportunities for growth. Meet employee practical needs - staff room, desk space & parking	Infrastructure - have enough space, offices, buildings, computers for the staff we have. Show that we respect staff with a respectfully looking workplace that they spend most of their time. Have equally appropriate treatment rooms for consumers undergoing therapy. Need to feel proud of where we work.	
Celebrate the successes and the importance of the work. Raise the profile of a career in mental health	Support at unit level such as space to debrief and reflect and kindness for others	Mental health clinicians treat Ching into universities and other teaching organisation
For peer support targeted specific funding	Better pay for peer workers	Improve facilities and environments including safety
Training framework / Pay More money	Destigmatise mental health	Make it safer to work in these roles.
Entry level training opportunities	Variety and opportunities - particularly in diverse tertiary services	Increase peer worker salary / Less OVA
Change expectations of teams, create passion and rewards apart from money.	Ensure universal supervision	Less box ticking, more engagement. Clients need to have a relationship with someone. The focus on procedures and forms interferes with this.
	Approve and improve e-recruits	
Scope to use the breadth of their skills	Support and respect for kindness in this workplace.	Encourage reflective practice and provide supervision for all
Our services are understaffed. The current system of linking funding of services to KPIs does not capture the complexity and additional hours of work completed by clinicians. More funding for permanent clinicians that allows them to take adequate leave to prevent burnout and to have comprehensive handover between shifts and extended breaks will allow us to retain hardworking, highly skilled staff who can then provide high quality care.		

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Education for employers will facilitate openness to considering people with mental illness as people with employable skills		The opportunities are not clear. We used to have social firms who organised work for people with mental ill health but they weren't supported by government (like they have in Italy where a percentage of government tenders must include people engaged for work through social firms.			
Increase support during transition, better acceptance and understanding of mental illness from businesses. More after hours mental health services to maintain wellness - not just acute		Increased access to services for treatment. To offer day programs to assist with psycho Ed to self-manage MH matters, provide links to further education and employment opportunities		Ongoing and enhanced cross-sector attention and response to the massive issue of domestic and family violence which disproportionately affects the female population.	
Earlier intervention and targeted treatment and follow up to support		Coordinating the NGOs and public services		Employment that is flexible and inclusive.	
Our goal should be that the opportunities for those with a mental illness are the same as those without		Housing. Employment incl. access to MH specific/informed employment agencies. AOD support. Psychosocial support.		A range of services that allow people to work in their own goals - work/parenting/social integration	
Access to stable affordable accommodation		More community housing for low to medium income earners.		Enhanced access to childcare services	
More community programs to be able to be accessed		Improve access to Centrelink DSP and Sickness Benefits.		Employ psychologists, OTs and social workers at PARCS	
First of all we need to recognise that this is an essential part of mental illness ensuring the biopsychosocial economic is adopted. People need love and work to either prevent or manage mental illness. We need to have real jobs not macjobs to place people in.				Opportunities for consumers to return to work through specific organisations	
More public housing	Return to work program	Increased upskilling of drug and alcohol workers		Stable housing and social support	Access to education is critical
Opportunity of being treated equally by others		More accessible group programs, psychological and recreational		Easier access to NDIS for people with MH issues	
More CCU and similar rehab & re-integration facilities		Better accommodation options needed for greater stability		Less stigma around MH issues and their capacity to work	
Need for governments to support social firms so employment can be part of the recovery journey for people		Community based programs - including social programmes in areas accessible by public transport		Continuation of therapeutic workers for clients, instead of constant turnover and getting to know new clinicians, case managers etc	
Cross sector partnerships to create employment opportunities		Support for consumers to live their best life on their terms		Support with return to work	Once again housing!!!
More OTs at rehab facilities	Improve EAP programs	Support for employers to better support employees		Management level to talk about their own mental illness	
Better supports for families and carers		More lived experience support workers to inform better practice		NDIS has set back Community Mental Health 30 years	
Peer work has given me the opportunity to participate to my social and economic development. Giving back to my community. My volunteer work in Frankston Coast Guards has done the same. Fairer tax system for low to medium income.				Increased CCU and PARC - rehab focused facilities would benefit the consumers	
Access to allied and psychotherapeutic services		A focus on strengths and potential of consumers		Innovative social enterprises targeting this area would be great.	
Education for NDIS workers around disability and mental health as a lot of workers are not trained in mental health		Not just PARCs, please focus and consider more crisis accommodation related to MH services... it's like pseudo-PARCs		Compulsory support for gradual re introduction to work for people with mental illness	
Opportunities and supports through services in the community to be able to find employment or activities based upon person's ability to maintain a life structure and given patients sense of empowerment					
Identify their skill set or train them in areas where they have aptitude for, and actually improve their skill sets as well as their self-esteem and job marketability		FOR NDIS STAFFS TO BE MORE TRAINED AND RELATED TO MENTAL ILLNESS, AFTER ALL NOT ALL OF THEM HAVE WORKED CLINICALLY ON MH SERVICES		We have too many young people disengaged from education - We need to reconnect them and need other options other than just mainstream schools	
We need social firms - that can facilitate workplace connections		Stigma limits social participation	Cross sector involvement	Better access to the NDIS for support and integration work	
Many non-government organisations provide great services - we don't always know about them to refer to. Mapping exercises may need to be done, partnership groups formed and relationships built.		Some support programs exist that work brilliantly. We need more individualised support that is flexible in their delivery so that they can be accessed easily		Connecting people socially within their community through groups or work - giving them skills to ensure they can participate and support to help problem solve when issues emerge	
Support services perhaps separate from Centrelink that provide financial and other assistance		Centrelink needs a cultural shift to providing support for people looking to re-enter the workforce		More social connections through specific agencies who work with mentally ill to integrate with / into mainstream activities	
Support groups. Faster Centrelink access.		Normalising mental health days and reducing stigma in workplaces		Funding supporting mental health job recruitment	
Stop defining people by their health condition		Consideration to employment opportunities for those recovering from mental illness like we do already with disability/minority groups e.g. ATSI			
More open more understanding one to one or group help more government help		NDIS supports which address the imbalances and promote re integration into the community		Opportunities for engagement with support workers through the NDIS for community engagement	
Organisations like Grow	More PARC facilities	Providing incentives for businesses to employ our consumers		Send staff to help complete NDIS applications as they are too complex	
Have an approach where education goes to the young person and not always stating that young people have to get to an education facility		Develop individual education plans for our young people Let us focus on their strengths and interests		Improved funding for community capacity building which is client centred	
At the moment those with the smallest voices are not heard		Create programs for them to do unpaid or low paid work		Upskilling of NDIS workers	Better trained support workers
Links to Centrelink and other associated financial services. More services on a social work capacity to assist with financial services in the community		A centralised Resources (app/website/phone number) that can be given to people that need assistance and they can access information to social services to assist		Hospital organisations to assist with food drives, clothes drives and other community drive events to provide every day supplies and needs to assist	

More specialised return to work services for people with mental health issues.		Changing social and cultural attitudes toward mental illness from a very young age will help reduce stigma		Improving access to Centrelink to make it easier for people with mental illness to receive payments	
More day programs and community support		NDIS is too complex	Supported employment.	My aged care is very hard to navigate.	
NDIS works if you have great advocacy skills		Increase in mental health work force.		Assistance for people navigating NDIS!	
Young disabled in SRS and nursing homes		More recreational based services to promote social engagement and connection. More supported pathways to return to employment or study.			
Inclusion policies. Skilled training workshops that have flexibility to allow for the needs of individuals with mental illness.		System is complex. Not simple. We really need to work on family friendly application to services.		Create voluntary positions where people can grow their skills and confidence	
education and security of work	More alcohol free social venues	A specific mental health focussed Employable Me program in the ABC		Supported work programmes	Sports inclusion programs
Multidisciplinary responses in community to support reintegration and independence including more community social workers and care coordination		Maybe some type of grant that can be distributed from various organisations such as St Vinnie's, the Salvation Army and other non for profit organisations to assist with food, rent, clothes etc		Minimal opportunities unfortunately. Activity based funding came in and many smaller, psychosocial programs had to close down. These programs did a lot to support clients.	
There are very little- dangerous and unaffordable "Housing" operated by unscrupulous amoral people, Centrelink is another broken system, no safe affordable and secure housing for anyone- particularly for women and children traumatised by poverty including family violence, drug addiction. These people are then shunned, marginalised, rejected.					
Social agencies more linked up with all agencies linked to MH		Better support for young people with school non-attendance		Carers groups and council support groups to take patients out	
Issues with homelessness and accommodation impact the ability for them to move forward with linkages		There needs to be easier access to services - psychosocial supports as well as more targeted psychological support		Thoroughly review the demoralizing circumstance of living in unregulated SRS's	
Isn't the NDIS addressing this?	Free TAFE	Increase vocational training	Work participation programs	Inclusion in local community gyms, basketball football etc	
Apprentice positions to skill them up		Include 'mental health' days in leave allowances		Employment, education, social involvement	
Complex system to work with NDIS which has impacted links to mental health support in community		It's not a straight forward process. Can be very overwhelming for patients and their families		Employer assist programs for consumers with MH should be introduced	
Respite for parents/carers	More funding	Question perhaps should be how can employers assist with.....		Inadequate supported job placements	
Social inclusion, meaningful employment, greater opportunities, drop in centres, day program, peer support		There needs to be greater opportunities in the work place / perhaps subsidise companies		There aren't many. People are stigmatised and disadvantaged with every wall of bureaucracy they come up against.	
Opportunity is limited due to the lack of psychosocial support. Poor access to housing. We need more than SRS's as a discharge options. We need greater supported accommodation with rehab focus and support					
Partner with employment and training agencies		Independent living mechanisms		there is lot of land and new development to build housing	
Opportunities for meaningful occupation needs to be part of therapeutic interventions		Better balance of generic and discipline specific roles to meet needs of clients e.g. OT assessment and support		Revise Victoria's approach to NDIS funding transfers and re-establish MHCSS services that were shut down in recommissioning.	
Very few opportunities for those with enduring illnesses. Don't wait for recovery before employment becomes an option		Employment advisors and education advisors e.g. Uni and tafe available in mental health facilities		Nothing currently. Options similar to drop in centres or day programs should be funded	
Can we have a careers/education worker?		Hit and miss, depending on connections either family , supports or luck			

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

MH triage on presentation to hospital should be quicker and preferably by a MH professional.		Simplified system without bureaucracy where clinicians can really provide high quality clinical care.		More satellite drop in centres in outlying areas so people don't have to travel so far before they can talk to someone.	
The missing middle (between GP and ED)		Variety of PARCS type services - one size does not fit all		Understanding of LGBTI	Paediatric facilities
MH EDs, better access to beds, increase group program on wards, 7 day community teams with the ability to increase contact with their consumers. Community services based closer to population - reduce travel time. Carer and Consumers need to be a part of the reform				Design of system of mental health care around patient needs and pathways	
Timely accessibility. Family/carer supports to reduce burn out.		Safe, accessible housing to reduce homelessness.		Appropriate places for respite, support, both for clients and carers	
Specialty units that treat AOD and mental illness		Stop disintegrated funding - fund based on integrated care knowing this means cooperation between a range of service providers in the system			
Sufficient inpatient beds for those in crisis		Increased capacity for admission for safety		Fill positions of resigned clinicians IMMEDIATELY	
Clinician : client ratio	More beds	Better supports and education for carers and family members		Let's develop wrap around services	
Offer more opportunities for patients to be engaged during their stay		Inpatient wards need complete rebuilding		Unlimited rebates for psychological services	
Resources both staffing and suitable for purpose spaces - offices, clinics, groups where people where they are in the community		Support outreach with afterhours access prior to crisis. Increased access to housing. Less delay for support and interventions		Connection for all Mental Health, AOD, ID services. Training, education.	
Funding for staffing levels	Agile, agile, agile!!!!	Increasing funding	Education, education, education	Improved patient nurse engagement	
Appreciation of the brain injured population and providing adequate supports to pts and their families		More funding in the acute settings to allow for innovative approaches to be trailed and run		Increasing funding to hospitals for increased staff profile on psychiatric wards	
Prioritisation of unique trauma-informed/based lingers-term services and models of care for those who have experienced developmental trauma and for whom crisis-driven acute medical models of care are proven to be counter-therapeutic and re-traumatising. Currently these clients have nowhere to turn to until they are in severe crisis, and what current services can provide is actually harmful and perpetuates their cycles of trauma. This leads to further distress and dysfunction for them, and burden on the already overburdened system.				To bring back the Community mental health supports such as Personal Helpers and Mentor Service with a recovery focus. More community drop in centres. Community buses. More respite support for those who need support while not in crisis but needing support for relapses.	
Support that can follow clients in unstable accommodation who move between service catchments		Attention to forensics, intellectual disability, autism, drug and alcohol, trauma, etc... All contribute!		Ongoing support for those who have MI yet are functioning in the community with few or without support.	
More supportive workplaces for practitioners		Money for mental health systems only		Holistic MH units which treat the whole person.	
24/7 secondary services like headspace centres. More resources, patient load, r/v by age appropriate workforce in the acute settings including inpatient wards, ED, CCT. More resources		Increased resourcing of community AND inpatient models of care. This includes short-term (acute wards) and long-term (SECU) as well as psychosocial rehab such as PARCS. Can't have one without the other. Also expansion of the better access scheme to improve psychology access in the community that is less time limited.			
Adequate staffing for ECATT and community services to avoid prolonged waits for care.		Community Capacity building, increased integrated service approach currently quite disjointed.		Tier 3 services valued and funded to do more research and long term therapy support in all fields particularly in child and adolescents	
Increase the 10 Medicare funded sessions		Upgrading physical psychiatric wards		Staffing levels	Access to services
Availability of publically funded group and 1-on-1 psychotherapy, increased funding for PARCS beds (as we too often have people waiting in IPU unnecessarily), increased public housing, the creation of independent living communities for people needing extra support (i.e. CCU level care but at a larger scale), the abolishment of seclusion practices in all but secure units				Access to MH from the point of first presentation at ED, through to early intervention, intensive support, ongoing community care and then Exiting public MH into community care services.	
More step down facilities and prompt OP follow up when discharged		Strengthen educational services in all our schools		NDIS is crap	Mental health bed access
Refer to recommendation 105 from the Royal Commission into Family Violence and place pressure on the Federal Government to implement this so that family violence survivors can access additional counselling sessions under its own independent Medicare item number				Strengthening services by upskilling and supporting staff through increasing professional development and increasing supervision	
More education on police response to mental health calls		Massive increase in mental health bed capacity in Victoria		The whole mental health sector, focusing on client centred care	
UPGRADE INPATIENT UNITS, AND ALSO BETTER STRUCTURE AND FUNDINGS FOR COMMUNITY, TO PREVENT FURTHER ADMISSION AND READMISSION. ALSO, ROLES OF MH SERVICES IN SCHOOL. START EARLY					
More acute beds so pts not in Ed awaiting assessment and admission more psychiatrists and other alternative worker models if not enough professionals greater community mutt support to pts and families					
Large scale advertising campaigns aiming to normalise mental illness. Reducing stigma is crucial to individuals accessing support in a timely way				Supervision for nurses	Finances specific to mental health
Early intervention to reduce social stigma and more focus rehabilitations programs to get them back on track.		Improved trauma informed care and an increase of trauma specialists being trained		All of it! And better communication between Police and Forensic services with Mental Health Services.	
More Peer support workers with lived experience.		Upgrading inpatient units	More beds	Nursing, Nursing, Nursing	Early prevention services
ED should not be the first point of contact pressure needs to be reduced. Pressure also needs to be reduced on the public health systems with beds in high demand and hospitals unable to meet the need. GP's need better education and refer to community rather than straight to ED.		The main priority is to increase funding, to ensure the funding can't be used by hospital networks for anything other than mental health services, that we use patient journey experiences to design our services, to use the evidence of the importance of talking treatments not just medication management and risk assessments and to focus on allowing people into our services before they are so unwell that we struggle to make them better. We also need more beds and a choice of placing in a bed i.e. women's only wards, and to allow a good step down process of stepped care. To have a skilled workforce that know how to establish a therapeutic relationship and to work with the person and the family.			

Early intervention - there needs to be significant rethink of the services for primary students who are dealing with mental health issues- currently extremely limited		Update mental health wards to make them more therapeutic and comfortable. Currently many MH wards are like old institutions and need a complete redesign		Separate MH ED in each hospital. Faster response time to clients. Increase funding in all areas. MH worker/psychologist to be a part of all medical teams to support any MH needs	
Community facilities and care for patients with intellectual disability and acquired brain injury		Address the regional/metropolitan service gap (or more like a Grand Canyon)		Incorporate carer hubs which validate and encourage positive carer input	
More compassionate, accessible, inclusive services. Lower caseloads in community, increased staff on wards. Sufficient access to safe housing and sufficient income.		Inclusive and safe. Female only wards and specialist teams. Holistic, multi specialist teams- mental health/ addiction- including gambling/ housing/ family violence etc...		Open all acute units and introduce a 'professorial unit' staffed with senior experienced staff to treat the acute patient intensively until able to be stepped	
Connecting existing services	More inpatient MH beds	ED care plans to be reflective across all sites of organisation		Long term services which put the client and family first	
Increased access to coordinated care in community		Compassionate and caring system		Expand Community teams to avoid premature discharge to GPs	
"In between" services established - between acute and community there is a huge gap		Focus on community care and increased recourses and lower caseloads to improve care for individuals		Infrastructure, more appropriate and expanded clinical spaces in the community	
Greater focus on community programs not only inpatient. Individuals do not recover in hospitals.		PTS needs to be better staffed and provide more options before an inpatient admission is needed		Increased housing availability and affordability. Better designed inpatients units, with increased space, and complimentary therapies.	
We need an in between service - when clients can't access MH plan or this isn't enough and before they need to access a hospital		More broad, more people involved, more care for customers and their families ,more empathy and understanding		ED nursing staff and medical staff need more MH attaining to provide better care and able to assess acute psychiatric risk	
CATT and case management need to be reformed.		Increase in staffing and access to staffing with shortfall and sick leave		More trained e-Catt staff in Ed to reduce workload	
More eating disorders bed and community based programs i.e. residential, day programs etc.		More clarification and education towards the police in relation to section. 351's and inappropriate transfers mental health VS criminal		Treat acutely unwell patients in their own environment with residential intensive 24hr care	
Standardize IT state wide	Much more allied supports	More clinical staff for mental health		Safescript May present more issues	
Research around iatrogenic factors of our system and appropriate response to thus research		Education regarding the impact and expression of trauma and trauma informed responses in all of health education		Session numbers to be determined by research and feedback from clients, not arbitrary lines in the sand.	
Permanent psych medical staff and more ECATT staff 24/7 in ED- reduces work load, drives early discharge planning and provides better outcomes for patients potential reduces the amount of patients on AO's etc					
Fund hospital beds proportional to population, to avoid discharging people while still acutely unwell to community teams.		More psychology services to deal with underlying issues associated with sexual abuse, childhood trauma etc.		Ensure appropriate pharmacist to patient ratios (i.e. at SHPA standard) to improve quality/effective use of medicines in mental health patients	
A standardised MH escalation pathway within the ED relating to inpatient admissions		Shift of focus from management to therapeutic interventions across all our settings		Implementation of ongoing consumer feedback informed treatment across our services	
Space need to see pts in ED	Refugee trauma services	More funding into specialised areas		Encourage use of PTS numbers to help direct pts appropriately	
Emergency department length of stay leading to violence and aggression. Purpose built behavioural assessment ED/hub with specialized mental health medical, nursing, allied health and security staffing.					
Improve access to services. Destigmatise Mental Health. Increase beds for patients who need admission rather than sending them home without support services.		Change the funding model for public health. Mental health teams need more support and respite to continue doing their work. Current staffing ratios lead to burnout and high staff turnover.		Where we can provide social, economic, physical resources on time to provide an early intervention in someone's mental health. The priority area will be in the community.	
Addressing why the high levels of anxiety at university level.		Reduce pain management waiting times.		Emergency departments should not be first port of call	
A focus on education of parents to support health child development at key stages of change		Trauma informed care- all staff to be trained in this- modelled on the Orange Doors in Victoria.		Better communication between CAT/PACER and ED to facilitate patient placement	
Major Ed's need consultants in every department. This would decrease wait times and improve flow for patients and organisations		Suitable accommodation for people who really can't cope in the community (not SRS)		Get MAS to adhere to the DHS Police protocol for mental health re Section 351	
ED staff to be trained in Aged Mental Health.		Greater numbers of mental health staff		Easier access	Family Carer support
Increased staffing and funding for hospital mental health services, including pharmacy services		More perinatal support integrated into other systems that already exist		Consider behavioural units as a priority in major ED's. Some areas Not appropriate for unwell or aggressive MH patients	
Greater focus on research of the ultimate cure for a mental illness		Infant, child, and adolescent mental health		Access - multiple points, integrated with other services	
More medical services in Aged mental health. No wrong door approach. More inpatient aged acute units for mental health OR a step down unit for those needing placement. For help to be available for struggling families, at home, managing family members with dementia.				Sufficient pharmacy services to cover both inpatient and community mental health services to ensure continuity of treatment.	
Stop [redacted]eing a barrier to change		Basic AOD capacity for new mental health workforce		Women's mental health	24/7 access to treatment
Inpatient mental health beds are reported to be at least 80 less than needed for this catchment area. This then increases readmission rates and demands on ED.		Legislation needs to change around what police can place substance effected people into police cells and charge them. Rather than bring them to the ED.		Section 351s aren't always proper 351s so education with police and proper use of the EDs. ZERO tolerance to violence and aggression, more security	
Arrange swiping out of ED people on AO's walk out then suicide much too often		Police need to be given the power to charge nuisance callers rather than utilising emergency services on a daily basis.		Improve relationship with Vic police. Currently 351's are an easy way for police to offload despite not always being mental health patients	

Acknowledge that some seriously unwell patients will continue to need core clinical services and stop dispersing money into 'soft' non-clinical programs for those who aren't really unwell	Establish pathways for clients to move through the system. Currently not even those in it are aware of what services do what in which area. Constant name changes and border lines with NGO's limit referrals made. Borders for areas of mental health and AOD do not always match which means a client can have one network provide mental health and another do the AOD resulting in a fragmented and inconsistent response.	
Specific mental health areas in EDs and greater ECATT staffing to deal with work loads	Enough funding for community outreach services to do more than acute and crisis work.	An improved mode of care for substance use as mental health seems to be the fall back for patients presenting to ED
housing and mental health hand in hand	Clear strategy from the department	Patient experience and outcomes
There needs to be a balance- deinstitutionalisation was not the answer and had led to many deaths, including one in my own family	Substance use doesn't always indicate mental illness, police need education	Patient flow away from ED and reduction of silo services to provide consistency of care
Services that promote mental wellbeing and all-inclusive services where a person can have needs met in 1 place, services that can be physically access 24hours/ 7 days outside of the ED	Make mental health inpatient units a safe place. Separation of those affected by amphetamines from those who need a place of refuge, and recovery	Community, community, community....we need to rebuild community mental health services to provide treatment in flexible and responsive ways that support people in their own social support networks
Change the funding model and distribution to include capital, population based investment and remove non sensible KPIs	Vastly increase in-patient bed numbers. Aim for highest per Capita ratio of any OECD nation!	Mental Health Emergency Departments immediately alongside existing EDs.
24/7 service inpatient and community	Joined up in community mental health services	Increase community support, mental health and other agencies
Future focus on care for adults but particularly intensive support for vulnerable parents and young families.	Easier access with emphasis on community support, therapeutic interventions.	Take Victoria back to the top of the state's funding ranking rather than the bottom.
Move away from input based funding	Funding model to be moved to a outcome based	More community based services including community based beds
Lived experience workforce Intensive perinatal support	Strategic Direction, Funding, Infrastructure	State centralised phone triage service
It should be accessible, well organised and well-funded.	Challenge union ability to influence innovative service design	Statewide patient management system is a start
Affordable secure housing in their community. Should not have to move away from social connections in order to find accommodation		Get people who are experiencing a mental health issue out of ED as a place of safety

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Employ staff to track that any new money is spent on mental health and not consolidated revenue for med/surg		Start designing a delivery system of care around demand determinants as well as supply provisions (resources) and preferences		Integrate the entire care pathway from start to finish so that it aligns with evidence, people's preference and resources	
As MCH School we need to play a larger role in the recovery phase when young people at home recovering and when the risk of disengagement and isolation is heightened		Staff resources. Plan for the future - think of infrastructure that will last in years to come rather than just short term. Behavioural units within EDs should be built		Increase staffing levels. Stop trying to run services on a shoestring budget with no commitment to ongoing and meaningful funding. Join up services.	
Quarantine mental health money for mental health services		Also focus on the people not just KPIs		Establish a MH model of care to guide service provision	
Create a vision and plan for mental health care		Governmental commitment to funding		Open more community drop in centre for adult mental health.	
Simplify access and movement within the services.		Improved expectations of all health staff in interactions		Adequate suitable spaces - offices	
Ensure that outcomes are measured in a way that is meaningful and useful to inform how we change the system		Reinvest in hospital based nursing training with some post grad components		More consumer input into their own mental health treatment and support.	
value the skill based in our current workforce		Increase in workforce in the frontline services		Increase bed capacity now	
Refine the use of resources by using population based planning and distribution		Ongoing work between public mental health and NGO's. Tier 3 services to provide greater support to Tier 1 and 2 services. Create a mental health program that is attractive for people to want to work for and to stay working for			
Be less hierarchical	More agile clinics	Improved and supportive working environments		Introduce more activities available to the patients on the wards	
OTs in all community mental health teams		Models to link existing services		Improve working conditions to retain skilled staff	
Promotion of trauma-informed care and practice across all services and sectors		All new mental health services established are set up to measure what matters to patient and carers in outcome and experience		An NDIS profile that does not miss those without someone to advocate for them	
Wider governance of services in an area rather than lots of small silos providing the same services multiple NGO's		Respect and empathy to mental health patients attending emergency departments.		Continue funding current Phams programs, support more peer consumers and family carers on to wards and in ER.	
Change of culture of hospital discharges		Recruit from overseas to bolster staffing levels in inpatient units		More rural beds	GET RID OF 24 hour ED KPI
Upskilling NDIS coordinators and service providers		Increased opportunities for secondments to upskill staff		More beds, and building timelines organised appropriately	
Different models of care to support regional rural care		Change of culture in the community to more therapeutic approaches		Be proactive and forthright when implementing change	
Streamline paperwork - know why a form is being filled out and make it useful		Funding for expanded long term family therapy services for those with mental		In emergency departments special child and adolescent team to r/v children 24/7 and provide specific care and treatment.	
Educate people about how the changes will be implemented		Rationalise funding to ensure it goes where it's really needed.		Medicare rebates for neuropsychology services	
Capital redevelopment of existing wards and more beds		Capacity building and education to practitioners on client centred care		Delegating appropriate funding for inpatient mental health services	
More psychologists in community, and also social workers specialising in MH.		Really listen and respond to the feedback provided and not just from a financial position.		Support the frontline staff in terms of funding and working conditions, increase social workers support as well as OT support.	
Education and awareness	Better aged services	More Geri-psych inpatient bed access		Preparations for aging population in mental health services	
Give staff opportunities to have secondments in other areas of the health service to increase their knowledge		To rethink our schools in hospital model and develop a more systematic approach across the state		More Psychologists to be employed in in-pt and Community Mental health services	
Consideration to facilities/funding to allow "hub" style programs in the community. Mental health would feature alongside other disciplines such as exercise physiologists, dieticians, social workers, youth workers and community health nurses. If look after people before they need an acute services it will free up ED and hospital beds		Move away from a generic clinician model of community treatment to MDTs that include people with therapeutic skills including family therapists, therapeutically trained clinicians. And use the evidence for treatment that doesn't rely on case and medication management approaches as our only intervention.		Find ways to retain mental health staff and ensure their safety. As well as staying in touch with those at ground level and listen to what is really going on. Management are sometimes too far removed from it and don't necessarily make decisions that meet the need of staff and patients	
Be open to change and not be stuck in the mindset of "but things have always been done this way!"		Plan for when you are going to build beds. Enough to support the community in the future not just now		Change KPIs to remove the motivation for discharges who are not ready	
Telehealth	Rid 24 hr KPI ED	Psychology and Social Work team collaborations		Research into staff burnout.	More forums like this
Psychiatrists at ED triage for timely decision making and care		Deal with the crazy employees		Increased funding into frontline resources	
Remove or reduce cumbersome bureaucratic procedures which slow down or impede treatment		The KPIs we have focused on activity need to change to outcomes and value based healthcare		We want to reflect on the Oasis unit experience and strengthen our return to school capacity	
Allocation of more beds in wards and rooms in community facilities		Forums like this one	Listen to the consumer	A Workforce strategy that cares for recruits for the long haul	
More collaboration between mental health and other services especially when discharge planning		Introduce a planned staggered implementation process targeting high priority areas.		Roll out of more community based treatments including for those who have high prevalence problems.	
Education of the general public and also emergency service personal.		Make mental health more attractive to work in, more staff		Better and more infrastructure around mental health.	
Even there is more beds projected for IPU, but if quality of care not improve what is the point. Remember, quality over quantity		Improve support for ward discharged with robust housing and follow up plans		Every clinical service should have a homelessness team (e.g. HOPS), and a suicide prevention team	

Collaborate with the work force, understand the gaps, and look at ways these can be addressed.		More funding, more inpatient beds, free mental health training, more accommodation for respite, less paperwork.		More forums like this with different areas to understand what's going in around the hospital	
Permission to think outside funding silos to deliver care with client truly at centre		Increase publicly funded direct trauma responses given the connection to many mental health conditions		Gather research around what works. Then invest more than enough money to deliver this	
More resources that can be accessed by aged care staff for Geri-psych residents (maybe similar to a PACER team) that attends to aged services.		Often money is distributed across the hospital in various ways and the MH program pool seems limited at times. In addition moment is taken from teams when contacts not met despite the efficiency of the time and the excellent service they provide. Consider teams across all areas of MH lifespan and catchments to be consistent. E.g. CATT team for child and adolescent.			
proper triage tool to acknowledge acute psychiatric risk in the Emergency department		Funding to all Victorian Emergency departments to implement behavioural assessment hubs.		We need to trial a targeted nutritional approach on acutely and chronically unwell patients to show efficacy in the hospital population	
Empower ED staff to ask risk questions to patients as a mental health assessment may not be required		There is a tendency to repeat and recycle initiatives. Business practices to reduce this redundancy would be helpful.		More community services to decrease admissions and treat people in their homes	
Look at the people who are inappropriately placed in mental health units because there is nowhere else safe to go- we need to collect data. Staff burnout and retention		Create services for people with severe mental illness but deemed not to have 'case management needs'. These people are usually unable to afford private psychiatrists/private health cover		Allocate a fair amount of funding to the area in budget. Train more clinicians in mental health, maybe back to hospital training and have students working for $$$	
Start training more clinical staff	Undergraduate training	Take risks and try new models and properly fund the trial		A royal commission	Unions to review EBA staffing
Forward planning	Workforce support	Invest in leadership development in mental health services		Investment in building infrastructure	
University's to include a significant amount of education and training about MH to medical and nursing staff.		Research in relation to ambulance and police passing closest hospital to attend Dandenong		Review of the increase in demands in ED presentations and mental health client contact	
Collect robust empirical evidence around clinical outcomes		Develop a rational approach to area based funding distribution.		Encourage increased professional education now	
Fixed rotational positions between units/teams, not just secondments as they come up		Improve staffing. Improve and increase care options. More mental health specific undergrad training and exposure		Strategy, Outcome focus, consumer focus and partnership, Adequate funding	
Create appropriate outcome measure		Weaken the ANMF power over State Labour government.		Educate and upskill the current workforce	
Change org structures that encourages less silo		Build and strengthen clinical capacity		Review university course components for all disciplines	
Mixed training program - hospital and university based training		Continue to roll out ED Crisis Hubs don't wait for current ones to prove their worth			
Greater mental health components in undergraduate training		Allied health graduate training program		Development of graduate workforce	
		Recruitment from overseas, Consumer and Carer consultation with model of care			
Recruitment and upskilling of all staff including staff in general sector in mental health		We don't need to wait until the end of the Commission to know we need more inpatient and PARCS beds in the Casey/Cardinia area. We should be investing in developing the peer workforce now to deliver the kinds of care we will have moving forward			

11. Is there anything else you would like us to share with the Royal Commission?

Stop making it such a lengthy and complicated experience for people to access treatment when they realise they are asking for help	Look at restrictive practises being used in ED due to long delays for beds.	Please demand AHPRA to improve process times for registering overseas Drs
	Strong nursing leadership in mental health like there is in physical health	
Beds, beds and more acute and PARCS beds needed	Focus on getting it right from the start - look at the EDs	No mental illness is safely treated in an Emergency Department
Please help us fill the gaps in service for our clients, carers and staff	Training in Disability for staff, or disability / mental health wards.	Technology that speaks to all databases and services
Better research is needed. What works? What doesn't work? What do we need to do differently?	Re-instation of funding and access to NGO psychosocial support programmes which have been neglected by NDIS	Help me to have the resources to treat patients adequately so that I don't need to discharge patients that I know will be back in a month
To establish ways to better hear the voices of the families who are the careers of those with mental health issues	I would like to find a way to bridge the gap that appear to exist between children and adolescent services and adult MH services	More beds, more facilities, more staff with an ongoing focus to rehabilitate consumers and encourage independent living
Without more money, nothing can be done.	Funded Medicare psychology consults beyond 10	More beds and staff / Mental health funding please
We need more beds, more staff, less pressure, more tome for therapy and greater cohesion between services.	Help to support the many victims of trauma to receive evidence based trauma support rather than just acknowledging their past	Increased access to long-term subsidised evidence-based psychotherapies in the community is a MUST
Include neuropsychology services in Medicare item numbers	Complete overhaul of the entire Mental Health Services in Victoria	More mental health specific funding allocated to hospitals please
Less talk more action / Just get it done	Role of social media and mass media on destigmatise of mental illness	Please listen and respond to feedback, lives are depending on it
We need to look at new ways of working in the psychiatric field that doesn't only rely on quick crisis interventions but a holistic approach to mental health.	Better ways to ensure the voice of children are heard in all aspects of mental health when they are the person identified or if they live in the family of others who identify	Culturally appropriate psychological services e.g. Psychologist who can speak Mandarin, Spanish, and French. Rather than using interpreter as third person
I strongly recommend that the Community Mental Health Programs such as Phams to be maintained and the funding is ongoing.	Allow for longer service engagement to maintain stability rather than discharge and wait for deterioration	Forgot to mention the mix of drugs alcohol and mental health someone needs to own it
More funding for Occupational therapists in mental health please	One neuropsychologist for all of Monash Health is a disgrace	Changing culture in mental health workplaces
More trauma informed and empowering language within health services	We hope that the royal commission takes the time to seek out feedback from professionals who are in the field	Hospitals cannot be the default for violent patients who are intoxicated.
GENDER DYSPHORIA! Focus on equally both for young people and adult		
How do you minimise the difference and quality of service you receive and allow for a smooth seamless transition between services	There is no point putting in place a whole lot of measures or interventions without deciding - up front - how you can tell if they are going to work... please make sure that we are measuring what matters to patients, carers and staff	
More counselling services in community	Please put to action our recommendations	Mental health clinicians deserve better!
I would like to see a particular focus on the unique social and MH challenges that women face in our society today. This includes the impact of domestic and family violence, homelessness, unemployment and inter-generational trauma. And how all this intersects also for refugee and indigenous women. How can we bring this into better focus and develop gender sensitive models of care.		
More services for Psych Geri patients	Robust training programs / Women's health- specialist teams	Better funding for AOD services including residential rehab services
Need to look at strengthening AOD sector- lots of mental health admissions due to substance use and there's no alternative bed for them	Lived Experience has currency in mental health and needs to be respected / Please look after the mental health and wellbeing of mental health staff	we need safe, secure and affordable housing, we need family violence experts within mental health in all emergency departments
Aged services- not a sexy subject- they are our forgotten people.	Indigenous mental health- specialist teams	Dealing with MH and drug relationship (ice epidemic)
Community needs education about different mental health illness, differences between psychotic illness, mood disorder, personality disorders and behavioural disorders. Also the difference in treatments and management for each illness. Community needs education about role of acute services, secondary services, psychological services and emergency departments and the limitations of the all the above services.		
Don't use leave beds on wards for admissions	Fill the vacancies / Please help / Don't forget AOD	EDs need more physical space to see mental health patients
Seamless transitions across age and lifespan	Its difficult environment for the people who work within mental health, more consideration needs to be given to how to manage before people need to access acute services. Skills and knowledge building in the community, outreach visits and checking in after discharge.	
I hope you can make real change / Housing / Thank you		
24/7 psych docs in ED / More ECATT staff in ED	We focus on containment and management not treatment.	More drug and alcohol workers in ED 24/7
Let's change the funding model from activity to outcomes. Let's focus on the central place of the therapeutic alliance in people's recovery. Let's focus on ensuring funding increases are not taken away by other parts of the health network and that we move to value based healthcare where we measure our outcomes and the patients/caregiver experience of our services change our services.		
Appropriate allocation of service for increase in demand	Hi a frontlines incentive to keep up the work!	Review of night staff ratios in ED
Engaging carers makes sense on all levels and traditionally they have been labelled and dismissed. It's time to understand their value in recovery and that they have a right to be supported through each admission		
To fix Mental Health Act. / More staff in Ed desperately	We need more drug and alcohol services to help too.	Better staffing for mental health especially doctors
The complicity around the family violence information sharing scheme and clients especially perpetrators right to their information under the freedom of information and mental health tribunal board. It would be beneficial for the commission to provide clarity as lack of clarity and uniform processes amongst health services can lead to safety issues for victims of family violence		Occupational violence is causing compassion fatigue and resignations. Hospitals can be the default for violence. Police need to take calls for code blacks seriously. Security specials should be routine.
More security staff in Ed appropriately trained	Even if I had resource to recruit, I probably couldn't find skilled staff	Make mental health a priority at a policy level
People who work in MH are really trying to make a difference. The workforce is made up of many dedicated people who are often largely unrecognised for the work they do.	Yes, I invite you all to visit, and buddy up, with outreach mental health clinicians to see what we do on the ground. If this happens, I guarantee we will see changes to funding immediately.	There needs to be change around what behaviours that frontline workers have to tolerate and get traumatised on a daily basis as they have no voice!

Numbers are increasing without an equal allocation of resources	Remember older persons mental health	Hold the Labor government to account
Since commencing work in public mental health the level of acuity and complexity has increased considerably. This means that those who would have recorded treatment a decade ago no longer get in the door.		
24 hour care / GPS need timely support	Community services need to be resourced better	Keep the infants and parents in mind
We are working with the Department of Education so we (schools in hospitals) can provide lived experience in working alongside families - MCHS, Avenues Education, Austin, Yarra Me and Travancore		
Support consistent standard of care response from GPS for people presenting with mental health conditions	Providing Mental Health Care is a challenging career path. It is crucial that we look after the people who look after others.	This should be Australia wide not just Victoria! We have a national issue not a state issue.
Adequate and ongoing funding support to MH in hospitals is a must	Ensure recommendations are doable achievable and can be funded	No more sky rail! / Give the ANMF some love.
Area mental health services creating their own IT platforms for mental health and ED that don't talk to each other hundreds of millions wasted and no state wide benefits	Most MH units should be unlocked to create a more supportive therapeutic environment and a specialised locked unit for temporary containment of acutely unwell patients for rapid intensive treatment	The system is broken at so many levels and it really needs help to be fixed to make it a better and safer situation for all patients, staff and family involved
Don't overload clinicians with too much admin just to prove KPI's- this takes away time from doing the real work with clients	Too often ideas are raised by people on the ground and not heard further up the line	Review HDU bed availability there is not enough in service to meet demands
Destigmatisation, often for the best, can however go too far and become over-medicalisation.	The service framework, funding models and clinical practice is way past its use by date and no longer fit for purpose.	Please also think of staffs wellbeing in this process in the process which will improve consumer experiences and outcomes
ED under the pump, patients do not get treatment started in the ED, breach 24 hours, behaviour escalates essentially get sedated as unable to contain in the environment we work in. More ECATT clinicians. More doctors in the ED.	Chronic pain management services are chronically under resourced. Whilst they don't sit in an official mental health space, most people presenting have had significant trauma. Delays accessing services are proven to reduce outcomes. Referrals triple by the year. Where we used to have most referrals coming from GPS and community, 50% now come from within the acute/sub-acute services as they attempt to get people out of beds and Ed.	
Trauma histories can be impacted in ED with police and restraints better areas for pt to decrease stimuli	People need longer in inpatient units but are required to leave because of the pressure for those waiting to come in	Please hear what we are saying and asking for, as one day it could be you or your family needing our services
We need to remember that some people need asylum. They and their families need for them to have a place of safety to get well. NOT discharged early, not medical valued case mix funding. We need qualified staff to support a person to get well and recover- no more band aid approach		Don't let the politicians' worm out of showing courage, owning the problem and making real change based on what our communities actually need!
Lack of respect and follow up from clinicians towards carers and family members		
It is not yet well accepted by the community that our patients don't choose to be unwell.	Kindness should be the core of our work not statistics, KPIs and funding concerns	Severely mentally disordered patient are getting lost within the system unless they are dangerous or high risk
There should be better education about and ability/access to care for those with dual disability (Mental illness + intellectual disability/substance abuse)	Realize that mental illness won't go away- build a system from EDs that span the lifetime and support the specific needs of different, diverse groups	System needs to be fixed. We have a system that gaps we can all see and we have the opportunity to listen to patients, families, and ground staff to identify the needs. Let's fix it!
The system is broken. Staff are exposed in aggression in ED so often. Inpatient units are also horrific to walk into. I wouldn't want a family member to end up there but private hospitals can't accommodate suicidal patients with plans. Volume is huge and getting worse. We want to see things improve for patients and staff		Good people work in mental health but they are impeded from doing the most effective job possible due to a lack of funding in the system and a system that is ad hoc and disconnected
I have worked in public and private mental health for more than 30 yrs. I have seen so much change from the days at Mont Park! Mostly good. I hope we can continue to keep reviewing practices often and adapt to the needs of our communities		Our patient and family group deserve the same level of funding and access to funded services as someone undergoing a liver transplant
Please look after the mental health and well-being of mental health staff. They can't keep propping up a failing system for ever.	Ensuring patients, carers and health professionals have access to specialist pharmacy services in order to ensure the safe, effective and economical use of medications. This can only be achieved with appropriate pharmacy staffing and this should be in line with SHPA ratios	
Mental health arrives need to respond to the clients and their needs. Rather than shifting clients around to fit into our system and refuse to treat the clients that present with distress but do not fit our system.	The potential implications of the Family Violence Information Sharing Scheme to place victim survivors at further risk when a patient's medical record is requested through FOI or the Mental Health Tribunal need to be addressed and the way health services document and store the information received from other Information Sharing Entities needs to be the same across the state.	
Consideration for increased sessions funded by Medicare as often there is also minimal discharge options for clients who enter public due to the cost. Consider clinics for specific complex diagnoses. E.g. eating disorder clinic that includes medical and mental health that provides effective treatment but also provides a consultancy role to upskill others.		Create services for people with severe mental illness but deemed not to have case management needs. These people usually cannot afford private psychiatrists or private health cover
We have lots of people who need help w mental health and it's growing yet improvement is very slow or not evident	If you undervalue an area such as mental health, this has a ripple effect to the community and the people we service. Value the program, show this through appropriate funding, resources, training, staffing, facilities and the rest flows onto the consumers.	
Patients with intellectual disability and acquired brain injuries should not come to hospitals because the community has failed at being able to provide a safe place. When not acutely unwell from a medical or psychiatric perspective we must be able to do better. We are not a default accommodation	The lack of bed access for mental health patients in ED's is having a massive impact on the staff when behaviours escalate and this is affecting staff mental health. Not only are the mental health patients being looked after for extended periods in an inappropriate environment, but it is really damaging our ED staff.	
The culture within psychiatry is still authoritative, dismissive of other disciplines and patients, extremely hierarchical, unreflective, and unaccountable. The Mental Health Act 2014 is still not followed within Monash Health. Until this changes, patients and their families will keep suffering.	At the moment, mental health patient cannot be treated for illnesses that are curable but because the cost of medications are prohibitive, they are denied treatment. / Mental health patients with other co-morbidities should be treated holistically	
I think there is a lot of short term thinking that occurs. For example, a client is well enough to see their GP. Then they are discharged to the GP. Ok, but the GP doesn't provide the same level of support so they relapse. Back to hospital, back to case management. Maybe instead, they could have stayed at a low level of care with the case manager (maybe monthly for an hour) with not the burden of 91 day reviews, just a person who the client knows. Maybe this prevents the relapse. Clinicians are not interchangeable. We are providing an interpersonal service. Clinicians need to be supported to stay in their positions.		

References

[1] World Health Organisation. ICD-10: international statistical classification of diseases and related health problems. Tenth revision, 2nd ed. Geneva: World Health Organisation; 2010.

[2] Casey M. Designing in Complexity; to a value-based Mental Health System [unpublished manuscript]. Melbourne: Monash Health; 2019.

[3] Casey M. From crisis management to recovery: healing clients and the public mental health system. InPsych. 2019 Jun;41(3):26-30.

[4] Australian Institute of Health and Welfare. Mental health services in Australia: Prevalence and policies [Internet]. Canberra ACT: Australian Institute of Health and Welfare; 2011 [updated 2019 May 3]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies.

[5] Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, Barendregt JJ, Hall WD. Estimating treatment rates for mental disorders in Australia. Aust Health Rev. 2014 Feb;38(1):80-5. doi: 10.1071/AH13142.

[6] OECD. Health at a Glance 2017 [Internet]. Paris: OECD Publishing; 2017. Available from: http://dx.doi.org/10.1787/health_glance-2017-en.

[7] Australian Bureau of Statistics. Causes of Death, Australia, 2017: Intentional self-harm, key characteristics [Internet]. Australia: Australian Bureau of Statistics; 2018 [updated 2018 September 26]. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3.

[8] Jorm AF, Reavley NJ. Changes in psychological distress in Australian adults between 1995 and 2011. Aust N Z J Psychiatry. 2012 Apr;46(4):352-6. doi: 10.1177/0004867411428017.

[9] Australian Bureau of Statistics. National Health Survey: First Results, 2018-18 [Internet]. Australia: Australian Bureau of Statistics; 2019 [updated 2019 May 27]. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70.

[10] Australian Institute of Health and Welfare. Mental health services in Australia: Medicare-subsidised mental health-specific services [Internet]. Australian Institute of Health and Welfare; 2011 [updated 2019 May 3]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/medicare-services.

[11] Victorian Auditor-General's Office. Access to Mental Health Services. Melbourne: Victorian Auditor-General's Office; 2019. 61 p. Report No.:16. Available from: https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf.

[12] Meadows G, Singh B. (2003). 'Victoria on the Move': Mental Health Services in a Decade of Transition 1992-2002. Australasian Psychiatry. 2003 Mar;11(1):62–67.

[13] Enticott JC, Meadows GN, Shawyer F, Inder B, Patten S. Mental disorders and distress: Associations with demographics, remoteness and socioeconomic deprivation of area of residence across Australia. Aust N Z J Psychiatry. 2016 Dec;50(12):1169–1179.

[14] Isaacs A, Enticott JC, Meadows G, Inder B. Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas. Front Psychiatry. 2018;9:536.

[15] Meadows G, Enticott J, Rosenberg S. Three charts on: why rates of mental illness aren't going down despite higher spending [Internet]. Australia: The Conversation AU; 2018. Available from: https://theconversation.com/three-charts-on-why-rates-of-mental-illness-arent-going-down-despite-higher-spending-97534.

References

[16] Klein M. Envy & Gratitude. Psyche. 1957;11(5):241-255.

[17] Chan M, Bhatti H, Meader N, Stockton S, Evans J, O'Connor R, et al. Predicting suicide following self-harm: systematic review of risk factors and risk scales. Br J Psychiatry. 2016 Oct;209(4):277-283.

[18] Mulder R, Newton-Howes G, Coid JW. The futility of risk prediction in psychiatry. Br J Psychiatry. 2016 Oct;209(4):271-272.

[19] Hunt I, Kapur N, Webb R, Robinson J, Burns J, Turnbull P, Shaw J, Appleby L. Suicide in current psychiatric in-patients: a case-control study The National Confidential Inquiry into Suicide and Homicide. Psychol Med. 2007 Jun;37(6):831-7.

[20] Appleby L, Shaw J, Kapur NN. Avoidable Deaths: Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Department of Health: Department of Health and Social Care, 2006.

[21] Large M, Sharma S, Cannon E, Ryan C, Nielssen O. Risk Factors for Suicide Within a Year of Discharge from Psychiatric Hospital: A Systematic Meta-Analysis. Aust N Z J Psychiatry. 2011 Aug;45(8):619-28. doi: 10.3109/00048674.2011.590465.

[22] McHugh C, Corderoy A, Ryan C, Hickie I, Large M. Association between suicidal ideation and suicide: meta-analyses of odds ratios, sensitivity, specificity and positive predictive value. BJPsych Open. 2019 Mar;5(2):e18. doi: 10.1192/bjo.2018.88.

[23] Flewett, T. Clinical Risk Management. An Introductory Text for Mental Health Clinicians. Australia: Churchill Livingstone, Australia; 2010. 238 p.

[24] Gutheil T, Bursztajn H, Brodsky A, Alexander V. Decision making in psychiatry and the law. Baltimore: Williams & Wilkins Co; 1991. 265 p.

[25] Berwick, D. Berwick review into patient safety. Department of Health: Department of Health and Social Care, 2013.

[26] West M, Dawson J. Employee engagement and NHS performance. London: The Kings Fund; 2012.

[27] Reason, J. Human error: models and management. BMJ. 2000 Mar 18;320(7237):768-770. doi: 10.1136/bmj.320.7237.768.

[28] Casey M, Perera D, Vo H, Waerea M, Miller C, Enticott J, Cubra S. The agile Psychological Medicine Clinic [unpublished manuscript]. Melbourne: Monash Health; 2019.

[29] Casey M, Perera D, Waerea M, Miller C, Yates K, Habib G. Scaling out agile Psychological Medicine [unpublished manuscript]. Melbourne: Monash Health; 2019.

[30] Casey M, Perera D, Yates K, Miller C, Tulchinsky M, Zheng A, Nixon R. agile Recovery from Trauma: Cognitive Processing Therapy in Public Health [unpublished manuscript]. Melbourne: Monash HEalth; 2019.

[31] Casey, M, Perera D, Tulchinsky M, De Silva L, Miller C, Clarke D, et al. The agile Comprehensive Care [unpublished manuscript]. Melbourne: Monash Health; 2019.

[32] Duncan BL, Miller SD, Sparks JA, Claud DA, Reynolds LR, Brown J et al. The Session Rating Scale: Preliminary Psychometric Properties of a "Working" Alliance Measure. JBT. 2003;3(1):3-12.

[33] The World Health Organization. Mental Health Action Plan 2013-2020. Geneva: The World Health Organization; 2013. 50 p. Available from: https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.%20pdf?sequence=1.

References

[34] Shepherd G, Boardman J, Slade M. Making Recovery a Reality. London: Sainsbury Centre for Mental Health; 2008. 20 p.

[35] Perrow, C. Normal Accidents: Living with High Risk Technologies. Princeton NJ: Princeton University Press; 1984. 464 p.

[36] Lorde A. The Master's Tools Will Never Dismantle the Master's House. 1984. Sister Outsider: Essays and Speeches. Ed. Berkeley, CA: Crossing Press; 110-114. 2007. Print.

[37] Reason J. Safety in the operating theatre – Part 2: Human error and organisational failure. BMJ. 2005;14:56-61.

[38] Reason JT, Carthey J, de Leval MR. Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management. Qual Health Care. 2001;10:ii21–5.

[39] Casey M. Agile psychologists designing and delivering change in adult public mental health. InPsych. 2015 April;37(2).

[40] Casey M, Perera D, Habib G, Vo H, Enticott J, Cubra S. Is our mental health care system iatrogenic for high utilisers of Emergency Departments? [unpublished manuscript]. Melbourne: Monash Health; 2019.

[41] Monash Health. Agile Psychological Medicine Clinic [web streaming video]. Melbourne: Monash Health; 2014. Available from: https://www.youtube.com/watch?v=fhAdHrDthMQ

[42] York A, Kingsbury S. The choice and partnership approach: A guide to CAPA. United Kingdom: Caric Press Ltd; 2009. 240 p.

[43] Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027. Victoria: Department of Health and Human Services; 2017. 54 p.

[44] Casey M, Perera D, Waerea M, Hurley A, Miller C. Wellness and Recovery Centre: Eating Disorders Specialist Services [unpublished manuscript]. Melbourne: Monash Health; 2019.

[45] Miller SD, Duncan BL, Brown J, Sparks JA, Claud DA. The Outcome Rating Scale: A preliminary study of the reliability, validity and feasibility of a brief visual analog measure. JBT. 2003;2(2):91-100.

[46] World Health Organization. Patient Safety: Action on Patient Safety: High 5s. Geneva: World Health Organisation; 2007. Available from: http://www.who.int/patientsafety/implementation/solutions/high5s/en/index.html.

[47] The Joint Commission Center for Transforming Healthcare. Hand-off communications [Internet]. Illinois, USA: Joint Commission; 2009 [updated 2014 Dec 22; cited 2012 Oct 11]. Available from: http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1 [Accessed 11 Oct. 2012].

[48] Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 6: Clinical Handover. Sydney: ACSQHC; 2012. 31 p.

[49] Arora V, Manjarrez E, Dressler D, Basaviah P, Halasyamani L, Kripalani S. Hospitalist handoffs: A systematic review and task force recommendations. J Hosp Med. 2009 Sep;4(7):433-40. doi: 10.1002/jhm.573.

[50] Snow V, Beck D, Budnitz T, Miller D, Potter J, Wears R, Weiss K, Williams M. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009 Aug;24(8):971-6. doi: 10.1007/s11606-009-0969-x.

References

[51] Victorian Auditor-General's Office. Child and Youth Mental Health. Melbourne: Victorian Auditor-General's Office; 2019. 132 p. Report No.:26. Available from: http://audit.vic.gov.au/sites/default/files/2019-06/050619-Youth-Mental-Health_0.pdf.

[52] Tonso M, Prematunga R, Norris S, Williams L, Sands N, Elsom S. Workplace Violence in Mental Health: A Victorian Mental Health Workforce Survey. Int J Ment Health Nurs. 2016 Oct;25(5):444-51. doi: 10.1111/inm.12232.

[53] Kaplan R, Porter M. How to solve the cost crisis in health care. Harvard Business Review. 2011 Sep;89(9):56-61.

[54] Francis R. Robert Francis inquiry report into Mid-Staffordshire NHS Foundation Trust. London: The Stationery Office; 2010. 434 p.

[55] Picone A, Pehm K. Review of the Department of Health and Human Services' management of a critical issue at Djerriwarrh Health Services. Melbourne: Australian Commission on Safety and Quality in Health Care; 2015. 17 p.

[56] Wootton D. Bad medicine: Doctors Doing Harm Since Hippocrates. Oxford: Oxford University Press; 2006. 336 p.

[57] Festinger L. Cognitive dissonance. Scientific American. 1962;207(4):93-107.

[58] Hinton A. Agents of Death: Explaining the Cambodian Genocide in Terms of Psychosocial Dissonance. American Anthropologist. 1996 Dec;98(4):818-831.

[59] Bion W. Experiences in groups and other papers. London: Tavistock; 1961. 200 p.

[60] Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based healthcare professionals: a literature review. BMC Health Serv Res. 2014 Feb 8;14:61. doi: 10.1186/1472-6963-14-61.

[61] Schein E. Kurt Lewin in the classroom, in the field and change theory: notes toward a model of managed learning. Systemic Review. 1996;9(1):27-47.

[62] Edwards D, Burnard P, Hannigan B, Cooper L, Adams J, Juggessur T, et al. Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. J Clin Nurs. 2006 Aug;15(8):1007-1015.

[63] Jobs S. Apple WWDC 1997 Closing Keynote – Steve Jobs Fireside chat [web streaming video]. California (USA): Apple WWDC Videos; 1997. Available from: https://www.youtube.com/watch?v=KWJ6rGiopvo&list=PLLvZWArDhEHRLAWRW5iAW1PnvA3VudJpC&index=19

[64] Mick S, Wyttenbach M. Advances in Health Care Organization Theory. Journal for Healthcare Quality. 2003 Nov;25(6):46.

[65] Department of Human Services. The case for change. Melbourne: Victorian Government Department of Human Services; 2011 Dec. p12. Available from: https://www.thelookout.org.au/sites/default/files/1_iwas_human_services_case_for_change_0412.pdf.

[66] Frenk J. The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress. PLoS Med. 2010 Jan;7(1). doi: 10.1371/journal.pmed.1000089.

[67] Department of Human Services. Human Services: the case for change. Melbourne: Victorian Government Department of Human Services; 2011 Dec. p4. Available from: https://www.thelookout.org.au/sites/default/files/1_iwas_human_services_case_for_change_0412.pdf.

[68] Vivian R. Elements of Good Government Collaboration: Future Challenges for E-Government. Canberra: Australian Government Information Management Office; 2004. p27-46. Available from: https://www.finance.gov.au/sites/default/files/Future-Challenges-for-Egovernment-Volume01.pdf.

References

[69] Polaine A, Reason B, Løvlie L. Service Design: From Insight to Implementation. Brooklyn, New York: Rosenfeld Media; 2013. 216 p.

[70] Valarie A, Zeithaml A, Parasuraman LL, Berry LL. Delivering Service Quality: Balancing Customer Perceptions and Expectations. New York: Free Press; 1990. 226 p.

[71] Department of Human Services. Human Services: the case for change. Melbourne: Victorian Government Department of Human Services; 2011 Dec. p30. Available from: https://www.thelookout.org.au/sites/default/files/1_iwas_human_services_case_for_change_0412.pdf.

[72] Wallis Market and Social Research. Victoria Design 2015: Victoria's Design Capabilities, Performance & Business Use of Design. Melbourne: Department of Economic Development, Jobs, Transport & Resources/Creative Victoria; 2015. 141 p.

[73] Meadows G, Brophy L, Shawyer F, Enticott JC, Fossey E, Thornton CD, et al. REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. Lancet Psychiatry. 2019 Feb;6(2):103-114.

[74] Productivity Commission. Report on Government Services 2019: Mental health management. Melbourne: Australian Government; 2019.

[75] Meadows GN, Prodan A, Patten S, Shawyer F, Francis S, Enticott J, et al. Resolving the paradox of increased mental health expenditure and stable prevalence. Aust N Z J Psychiatry. 2019 Jun 25:0004867419857821.

[76] Hersh RG, Caligor E, Yeomans FE. Fundamentals of Transference-Focused Psychotherapy: Applications in Psychiatric and Medical Settings. Switzerland: Springer International Publishing; 2017. 269 p.

[77] Maslow AH. A theory of human motivation. Psychological Review. 1943;50(4):370-396.

[78] Australian Bureau of Statistics. Census of Population and Housing: Estimating homelessness, 2016 [Internet]. Australia: Australian Bureau of Statistics; 2018 [updated 2018 April 16]. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/mf/2049.0.

[79] Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. JAMA. 2009 Aug 5;302(5):537-549.

[80] Hocking D, Kennedy G, Sundram S. Mental disorders in asylum seekers: the role of the refugee determination process and employment. J Nerv Ment Dis. 2015 Jan;203(1):28-32.

[81] UNHCR Regional Representation in Canberra. Submission by the Office of the United Nations High Commissioner for refugees on the inquiry into the serious allegations of abuse, self-harm and neglect of asylum-seekers in relation to the Nauru Regional Processing Centre, and any like allegations in relation to the Manus Regional Processing Centre referred to the Senate Legal and Constitutional Affairs Committee. Australia: UN High Commissioner for Refugees (UNHCR); 2016. 40 p. Report No.: 43. Available from: http://www.refworld.org/docid/591597934.html (Nov 12, 2016).

[82] Sundram S, Ventevogel P. The mental health of refugees and asylum seekers on Manus Island. Lancet. 2017 Dec 9;390(10112):2534-2536.

[83] Hocking D, Mancuso S, Sundram S. Development and validation of a mental health screening tool for asylum-seekers and refugees: the STAR-MH. BMC Psychiatry. 2018 Mar 16;18(1):69.

[84] Abubakar I, Aldridge RW, Devakumar D, Orcutt M, Burns R, Barreto M, et al. The UCL–Lancet Commission on Migration and Health: the health of a world on the move. Lancet. 2018 Dec 15;392(10164):2606-2654.

References

[85] Abbott A. The mental health crisis among migrants. Nature. 2016 Oct 13;538(7624):158-160.

[86] Ngui EM, Khasakhala L, Ndetei D, Weiss Roberts L. Mental disorders, health inequalities and ethics: A global perspective. Int Rev Psychiatry. 2010;22(3):235-244.

[87] Kessler RC, Berglund PA, Bruce ML, Koch JR, Laska EM, Leaf, PJ, et al. The prevalence and correlates of untreated serious mental illness. Health Serv Res. 2001 Dec;36(6):987-1007.