



ST VINCENT'S  
HEALTH AUSTRALIA

*Serving, Seeing, Striving for*  
something  
greater

## ST VINCENT'S HOSPITAL MELBOURNE

**SUBMISSION TO:**

## **ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM**

*Supporting vulnerable populations with mental health issues*

**JULY 2019**

---

## Contents

<b>1</b>	<b>EXECUTIVE SUMMARY</b>	<b>3</b>
<b>2</b>	<b>ST VINCENT'S MENTAL HEALTH</b>	<b>6</b>
<b>3</b>	<b>ST VINCENT'S MISSION AND ETHIC OF CARE</b>	<b>7</b>
<b>4</b>	<b>THE VULNERABLE POPULATIONS</b>	<b>8</b>
4.1	People with a dual disability	9
4.2	Prisoners	10
4.3	LGBTQI+	10
4.4	People with personality disorders	11
4.5	Aboriginal and Torres Strait Islander populations	12
4.6	People with substance use disorders	12
4.7	Aged Persons	13
<b>5</b>	<b>THE NEEDS OF OTHERS</b>	<b>14</b>
5.1	Family members and carers	14
5.2	Mental Health Workforce	15
<b>6</b>	<b>CHALLENGES TO GOOD MENTAL HEALTH</b>	<b>16</b>
6.1	Housing	16
6.2	Employment	17
6.3	Physical Health	17
6.4	Access to mental health in Primary Health Care	19
<b>7</b>	<b>EXAMPLES OF INNOVATIVE SERVICE DELIVERY AT ST VINCENT'S</b>	<b>21</b>
7.1	Early Intervention	21
7.2	Innovations	23
<b>8</b>	<b>RECOMMENDATIONS</b>	<b>26</b>
8.1	Models of Care	26
8.2	Integrated, linked up service systems	27
8.3	Review of Jurisdictions	27
8.4	Upgrade Infrastructure	28
8.5	Information and Communication Technology (ICT) solutions	28
8.6	Consultation Liaison Psychiatry (CLP)	28
8.7	PACER	29
8.8	Alignment with National Disability Insurance Scheme (NDIS)	29
<b>9</b>	<b>CLOSING REMARKS</b>	<b>30</b>
<b>10</b>	<b>GLOSSARY</b>	<b>31</b>
<b>11</b>	<b>LIST OF REFERENCE MATERIALS</b>	<b>33</b>

## 1 EXECUTIVE SUMMARY

St Vincent's Hospital Melbourne (St Vincent's) welcomes the establishment of the Royal Commission into Victoria's Mental Health System. We are eager to play our part in helping to provide the community with a clear and ambitious set of actions that will change Victoria's mental health system, to enable all Victorians to experience their best mental health. To begin our contribution, St Vincent's makes this formal submission to the Royal Commission.

While the key areas of focus highlighted by the Royal Commission in the Terms of Reference are used as the basis for this submission, we wish to highlight that, in line with the mission and values of St Vincent's, we give particular focus to the needs of the vulnerable populations with mental health issues that we serve.

St Vincent's mental health catchment includes populations which experience significant financial and social advantage and disadvantage. Melbourne's homeless population is centred within the catchment. Additionally, St Vincent's mental health service provides care to a number of correctional consumers. Across the period of 2007-2018, one in five people cared for at St Vincent's were living with at least one vulnerability, and many with multiple vulnerabilities.

Our mission to support the vulnerable and disadvantaged members of our society, together with the realities of the inner city population we care for, provides us with a unique perspective on the impact of today's mental health system on the more vulnerable groups. We have also been able to develop innovative approaches to improving the mental health outcomes of our consumers.

In particular, we have found the following:

- While treatment of the mental health condition is important, the provision of supported housing and employment are equally as crucial to ensuring a long term successful outcome. Consumers need a supportive community around them.
- Treatments should encompass the whole person, including a person's physical health, not just their mental health. The various health services need to provide an integrated approach which ensures continuity of care.
- For the more vulnerable members of our society, programs may benefit from a more flexible approach which allows services to be taken to the consumer, rather than requiring attendance at a clinic or other facility. It is also crucial, however, that the models of care reflect an evidence based approach that integrates the unique needs of vulnerable populations.

To enable Victorians to experience their best mental health, St Vincent's would welcome the following changes to Victoria's mental health system:

1. **Funding:** An increase in the funding to mental health programs and services across the state, but in particular to those areas where the funding today does not match the needs of the catchment population. Funding models should ensure stability and sustainability over time.
2. **Jurisdictional boundaries:** A state-wide approach to mental health services to ensure that consumers receive the appropriate level of care in the correct geographical locations via a co-ordinated approach, whilst also facilitating the sharing of resources and information.
3. **Integration of care:** Better integration and resourcing across tertiary health services and primary health services. This will address the current gap in service delivery between the two types of care, to ensure that people can access the right help and treatment quickly and easily, and ensure continuity of care.
4. **Investment in Information and Communication Technology (ICT) solutions:** Further investment in ICT will allow clinicians to have the right information, at the right time, which will improve care and support that can be offered to consumers and their loved ones. This investment will facilitate integration of care across jurisdictional boundaries.
5. **Specialist / tailored care:** The development of more specialist mental health services to provide integrated treatment and management of mental health needs alongside other health and social support needs.
6. **Community:** An increase in services being provided within the community, which acknowledges the difficulties that vulnerable populations have in accessing health services. In addition, further investment in support structures that help create a sense of community (for example, upgrading aging infrastructure to deliver an environment that promotes health and wellness for all by providing safe and therapeutic spaces).
7. **Early intervention:** Expansion of services known to support early intervention; such as the Police and Clinician Emergency Response (PACER) service, which places a mental health clinician with Victoria Police who are responding to people in the community with disturbed behaviour. Further consideration of how to support Ambulance Victoria in their early response to crisis situations should also be explored.

The needs of families and carers should not be forgotten and are also highlighted in this submission, including the need for more lived experience support roles and evidence based approaches to family support work. The lived experience workforce is acknowledged for the important role they play in recovery oriented mental health services. The need for improved organisational readiness and support structures, such as supervision, is required.

Please note that the following programs of St Vincent's Mental Health have been invited to provide testimony at the public hearings and are therefore not a significant focus of this submission:

- HOPE suicide prevention service
- Victorian Transcultural Mental Health (VTMH)
- PARC - Prevention and Recovery Care delivered in partnership with Wellways Australia

## **2 ST VINCENT'S MENTAL HEALTH**

St Vincent's Mental Health is a program of St Vincent's Hospital Melbourne which is in turn part of St Vincent's Health Australia (SVHA). SVHA is Australia's largest not-for-profit Catholic healthcare provider and the second largest health care provider overall, and operates under the direction of Mary Aikenhead Ministries.

St Vincent's Hospital Melbourne has 22 sites, including a major teaching, research and tertiary referral centre located in Fitzroy, subacute care at St George's Health in Kew, palliative care at Caritas Christi Hospice, as well as aged care, correctional health, pathology collection centres, general practice services and dialysis satellite centres.

St Vincent's Mental Health Service was established in September 1995 as part of the reforms documented in the National Mental Health Policy and Plan, 1992. Such reforms included:

- the mainstreaming of mental health services with the wider health system;
- the delivery of a seamless, integrated and balanced range of services which are community driven; and
- the provision of acute patient care within general hospital settings.

Today, St Vincent's Mental Health Service is a designated state-funded Area Mental Health Service (AMHS) providing adult and aged mental health services to the Boroondara and Yarra Local Government Areas, and operates Victoria's Indigenous adult inpatient beds.

Worryingly, over a 10 year period (2007-2018), the number of patients with mental health issues attending St Vincent's Melbourne's Emergency Department (ED) rose by 44%, while the number admitted as inpatients rose by 42%. Over the same period, the number of general patients rose by only 5% in the hospital's ED, and general patients admitted as inpatients rose by 13%.

St Vincent's Mental Health is a comprehensive adult mental health service for people aged between 16-64 years who live in the inner urban east area of Melbourne (Cities of Yarra and Boroondara). Underpinned by a recovery oriented approach, the service is aimed at people experiencing mental illness and associated disability, including acute and long-standing psychotic disorders, mood and anxiety disorders, or severe personality disorder. In addition, St Vincent's Mental Health manages specialist state-wide, regional and hospital services which focus on providing and improving services for groups with special needs.

St Vincent's Aged Mental Health also provides comprehensive inpatient, residential and community services including specialist clinics for people aged 65 years and older. It services residents of the municipalities of Boroondara, Yarra and part of the City of Darebin.

### 3 ST VINCENT'S MISSION AND ETHIC OF CARE

As the largest public hospital in the SVHA group, our mission is to support vulnerable and disadvantaged groups. Our mission and values are front and centre of our work every day and drive our ethic of care.

*As a Catholic health and aged care service our mission is to bring God's love to those in need through the healing ministry of Jesus. We are especially committed to people who are poor or vulnerable<sup>1</sup>. This mission shapes our culture of compassion and justice for people experiencing mental illness, and we are proud to be a part of the SVHA group.*

Our ethic of care draws on the talents of our people and collaboration with others who share our vision and values to continue the pioneering spirit of the Sisters of Charity in the service of the poor and most vulnerable. We are committed to providing compassionate and innovative care, enabling hope for those we serve.

St Vincent's ethic of care focuses on:

- recognising and responding to diversity;
- recognising the impact of discrimination on mental health and wellbeing;
- recognising cultural safety and cultural responsiveness as a human right for all Victorians; and
- recognising the role of families and communities in mental health recovery and care.

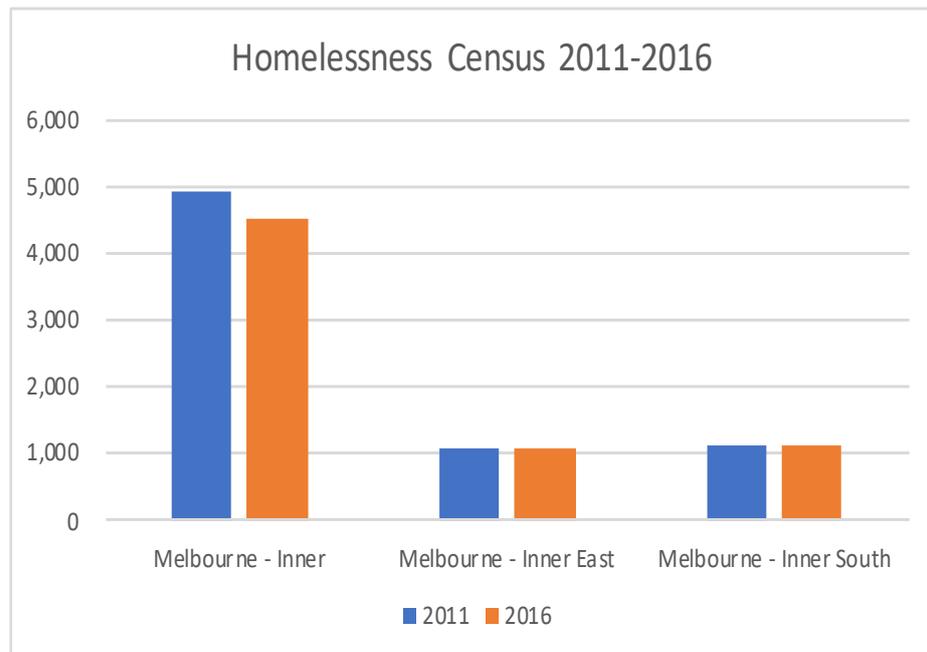
St Vincent's is committed to continuous improvement of the service and care we provide to mental health consumers, as well as the safety and wellbeing of our staff and volunteers.

---

<sup>1</sup> <https://www.svha.org.au/mission/mission-vision-and-values>

#### 4 THE VULNERABLE POPULATIONS

The St Vincent’s Mental Health catchment includes populations experiencing financial and social hardship and significant disadvantage. Melbourne’s homelessness population is centred within the catchment.



St Vincent’s Mental Health Service also delivers the Victorian Dual Disability Service (VDDS), the VTMH Service and, in partnership with Austin Health, the Body Image and Eating Disorders Treatment and Recovery Service (BeTRS).

Services are also delivered to a significant number of non-residents, including overseas visitors to the inner city and students.

St Vincent’s is in the catchment area of the Thomas Embling Hospital and is in the vicinity of Melbourne Assessment Prison (MAP) and the Melbourne Magistrates’ Court. As a result, St Vincent’s receives a high number of prisoners post release, who would greatly benefit from a more collaborative approach to their ongoing mental health care and treatment.

This is all demonstrated by the statistic that one in five people cared for at St Vincent’s are living with at least one vulnerability and many have multiple vulnerabilities. Between 2007-2018, we found that, of the vulnerable groups, 6% were Aboriginal and Torres Strait Islander consumers with a similar percentage being homeless, 13% were prisoners, 40% were people with drug and alcohol issues and over 70% were people with mental health issues. At least 40% of all vulnerable people were also members of at least one other vulnerable group.

As demonstrated below, people with comorbidities (such as intellectual disability, drug and alcohol problems and personality disorders) have difficulty accessing and engaging the health services they need. Other groups, including older persons, prisoners, people who identify as LGBTQI+, and those from culturally and linguistically diverse backgrounds also have unique needs that are not well met in the current public mental health system.

#### **4.1 People with a dual disability**

People with neurodevelopmental disorders (such as intellectual disability and autism) are known to have a higher rate of mental health illness than the rest of the population. Unfortunately they are often unable to access appropriate mental health services for a range of reasons, including:

- communications issues;
- problems being attributed to the disability itself;
- difficulties in assessment;
- lack of advocacy;
- dependency on others to access services;
- inappropriate treatment models;
- lack of resources; and
- unclear responsibility within a fragmented service system.

As a consequence, people with a neurodevelopmental disorder and mental health illness will often:

- not receive appropriate mental health care;
- have a poor quality of life;
- live in unsuitable accommodation;
- be overrepresented across the range of public services (including disability, emergency services, health, mental health, justice and housing); and
- experience premature mortality.

*What can be done better?*

Policy makers need to recognise that the mental health needs of people with neurodevelopmental disorders are different from those seen in the broader population. Meeting these needs will require:

- the development of a specialist mental health service that can provide specific treatment and management approaches integrated within a social care model so that mental health and disability needs can be attended to in a coordinated and seamless fashion;

- policy that acknowledges the difficulties people with neurodevelopmental disorders have in accessing day-to-day medical care and provides mechanisms to address this; and
- having access to a range of supported and appropriate accommodation options for the consumer and their family.

#### **4.2 Prisoners**

According to the Australian Institute of Health and Welfare, in 2019 a total of 2 in 5 (40%) of prison entrants reported being told they had a mental health condition at some stage in their life, one-quarter (26%) had a high or very high level of psychological distress score on the Kessler Psychological Distress scale, and almost one-quarter (23%) were taking medication for a mental health condition. Access to mental health care while in the prison system and upon release from prison remains challenging.

*What can be done better?*

St Vincent's would welcome opportunities for better collaboration and planning of mental health services prior to someone being released from prison. A more robust system of patient transfer and an improvement in communication would assist in engaging people in treatment and coordinating ongoing care.

Further, as suitable accommodation plays a crucial role in providing the stability required for treatment planning and facilitating access to care, St Vincent's would also welcome greater housing support for released prisoners who have a mental health condition.

#### **4.3 LGBTQI+**

Research shows that there is a gap in the service being provided by mental health providers pertaining to the unique needs of LGBTQI+ consumers and their families. Studies demonstrate that members of Lesbian, Gay, Bisexual, Transgender, Queer and Intersex communities have:

- reduced access to medical care;
- disproportionately poorer mental health outcomes;
- negative experiences with health workers; and
- higher rates of suicidal behaviour.

*What can be done better?*

Those who identify as LGBTQI+, and who are socially marginalised and disadvantaged as a result, need to receive more tailored support.

More targeted inclusiveness initiatives are required to ensure a respectful, equitable and culturally safe work environment for LGBTQI+ staff. Providers of mental health services have an opportunity to ensure best practice by focusing on the following (as outlined in the Rainbow Tick guideline):

- organisational capability for service improvement;
- workforce development;
- consumer participation;
- being welcoming and accessible;
- protocols on disclosure and documentation; and
- being a culturally safe and acceptable service for LGBTQI+ consumers and staff.

Achieving this would require:

- dedicated resourcing of program development staff;
- co-production with lived experience workers and consumers;
- training and professional development to build skills and knowledge;
- community and stakeholder collaboration; and
- mentoring and leadership.

#### **4.4 People with personality disorders**

People with personality disorders experience challenges in accessing mental health care and support due to a lack of awareness and understanding of those disorders. Accurate identification of personality disorder can be a challenge, with mental health services often ill equipped to assess and diagnose due to a lack of understanding and expertise. Attempts by individuals to access help are often met with rejection and judgement, where the person is often blamed and criticised for their situation. This has a significant impact on individuals and their families as they struggle to understand the disorder and get help.

In addition, access to evidence based therapeutic interventions is limited and often costly (i.e. service is provided in the private sector), leaving individuals few options to get the help they need, despite the evidence of efficacy and cost effectiveness of these services when provided.

*What can be done better?*

Specialist personality disorder services need to be embedded within the AMHS. Public mental health services need to be resourced to provide support and specialist evidenced based interventions to this group.

#### **4.5 Aboriginal and Torres Strait Islander populations**

Almost two-thirds (65%) of Aboriginal and Torres Strait Islander people have a long-term health condition, including 29% who reported a diagnosed mental health condition. In 2014–15, Aboriginal and Torres Strait Islander people with a mental health condition were more likely to have experienced problems accessing health services (23%) than were people with other long-term health conditions (13%) or no long-term health condition (10%) (Australian Bureau of Statistics).

St Vincent's have the state-wide adult inpatient Koori beds (five beds) and use a Social and Emotional Wellbeing model, which is an Aboriginal model that is a holistic and whole-of-life view of health.

Admission of Aboriginal and Torres Strait Islander consumers to St Vincent's is not bound by local area mental health service catchments, offering Aboriginal and Torres Strait Islander consumers choice in where they receive their treatment. There is a designated treating team for Aboriginal and Torres Strait Islander consumers, and a long term relationship with the Victorian Aboriginal Health Service (VAHS); with the consultant psychiatrist working at both the St Vincent's Inpatient Unit and VAHS, allowing for continuity of care. Two psychiatry registrars further support access to care while the training experience assists in further development of a specialist psychiatrist workforce experienced in this area. Further, to assist with access to services, there are flexible arrangements, for consumers who aren't case managed or are homeless, to access PARC.

*What can be done better?*

Cultural safety needs to be embedded within AMHS treatment, care and decision making. Aboriginal Mental Health Liaison Officers are needed as they have an essential role to play in providing cultural support and advocacy to consumers utilising mental health services.

#### **4.6 People with substance use disorders**

Inequities and structural barriers in the Victorian health system make it difficult for people with substance use disorders to find access to necessary treatment. The majority of these consumers are living with moderate mental health illnesses, however the public mental health system can only accept very severe, extremely unwell, very complex consumers with clear significant mental health illnesses given its limited resources. As a result, those living with moderate mental health illnesses often cannot access the treatment they need. Rigid requirements for entry into Alcohol and Other Drugs Treatment sector makes access difficult, even more so for those with significant mental illness.

*What can be done better?*

Peer support services for families and carers of people with substance use issues and further development of competencies in the mental health workforce to support people with dual substance and mental health disorders. Funding for research to support the best practice dual diagnosis treatment would also be beneficial.

Further integration of mental health and drug and alcohol workers and programs to ensure treatment can occur concurrently. For those living with moderate mental health illnesses and substance use disorders, there needs to be earlier intervention of integrated services that links people with support and treatment.

#### **4.7 Aged Persons**

The aged population experiences multiple medical co-morbidities and complexity of physical health and iatrogenic issues from pharmacological treatment.

*What can be done better?*

During the time of transition, aged persons need to be supported, as they are often experiencing major life disruptions, including loss of work role, loss of partner or family, loss of independence, or pain and ill health. There is a gap in the support offered to aged persons and their families during this time.

A model of integrated geriatrician support could reduce ED presentations by early intervention into medical care and treatment. Stronger links between primary mental health and working with GPs, in the aged sector, would be useful in assisting their capacity to manage complex patients and earlier intervention in relation to developing mental health issues.

## **5 THE NEEDS OF OTHERS**

### **5.1 Family members and carers**

St Vincent's recognises the important role of family and carers in the recovery and support of consumers. The involvement of family and carers within AMHS programs is vital, given the expertise, opinion and support they can provide to assist the decision making of clinicians. Accordingly, it is a priority of St Vincent's to ensure that families, children and carers are accurately identified and engaged within a family inclusive practice model.

Roles that support the children of people with mental illness (FaPMI) are particularly valued. The limited resourcing available for these type of roles does, however, result in only those children and families with very high needs receiving the necessary support.

There should also be more support and/or requirement for AMHS to provide evidence-based family support interventions, such as the Bouverie Centre Single Session Family Counselling model (which AMHS are encouraged to use). Unfortunately there is very limited resourcing available to ensure such models are firmly embedded, which means that such approaches are not routinely available for all families, even though they have been shown to be effective.

*What can be done better?*

The role of consumers, carers and parents needs to be recognised and supported as an opportunity to provide true early intervention and support for a vulnerable next generation.

This would be achieved through:

- investing in the implementation of evidence-based family support interventions;
- providing adequate resourcing to ensure that the children and families of all consumers could be seen at least once and offered time-limited or ongoing support, rather than only being available to a limited number of families;
- appropriate space being made available for carers and families when accessing services; and
- carer support roles, in particular carer peer support roles, being made available across services, to provide direct support to carers who are supporting consumers of public mental health services.

## 5.2 Mental Health Workforce

Consumer and carer lived experience peer worker roles are highly valued by services and the people that access services. They are an important element underpinning recovery orientated practice and the number of peer workers employed across services has steadily increased in the past 10 years. In order to fully support these roles, services are required to pay greater attention to structures supporting individuals in these roles, and the roles themselves as part of a significant emerging workforce group (much the same as has been done for clinical disciplines).

*What can be done better?*

Services need support to train clinical staff in how to work effectively alongside peer workers (organisational readiness training), while peer workers need consistent access to training including, but not limited to, Intentional Peer Support. Services must be supported to ensure there are adequate structures in place in relation to individual peer supervision, governance/management structures (e.g. a dedicated lived experience manager) and career advancement structures inclusive of senior roles.

## **6 CHALLENGES TO GOOD MENTAL HEALTH**

### **6.1 Housing**

Access to affordable and permanent housing continues to remain a significant challenge for people with mental illness, as safe and secure housing is not readily available for people with chronic and enduring mental illness. Yet, the ability to maintain good mental health and recover from acute mental illness is directly impacted by a lack of permanent safe accommodation options.

Insecure tenancy can exacerbate health and welfare issues for those involved, and have a negative effect on the safety and development of families and children. There is also a flow-on impact to the broader community services sector. Individuals and families facing mental health issues can be at higher risk of losing tenancy, given the significant challenges they face in terms of maintaining their homes, keeping up with rental payments, behavioural difficulties and sustaining a safe and stable household environment.

St Vincent's endeavours to ensure that consumers have a place to live following discharge from our medical services, particularly if they are being discharged from an acute inpatient unit. It should be noted, however, that this often takes the form of temporary crisis accommodation, such as a motel stay. These placements, while providing temporary shelter, do not address the long term need for permanent, affordable and safe accommodation.

#### *What are the challenges?*

Access to a range of supported accommodation is an issue for those living with a mental illness and also for those that have psychosocial disability. Consumers move from acute crisis accommodation to rooming houses to other unsuitable options, often ending up on the street or in homeless shelters away from their community. They are then unable to engage effectively with health services, are disconnected from their usual support systems and often experience a relapse or re-traumatisation (i.e. being evicted, assaulted). Without co-ordinated support, there is an increased risk of losing tenancy that can then result in lifestyle instability or homelessness.

#### *What can be done better?*

There is a need for planning and coordination of support for consumers to be able to successfully access suitable accommodation. For example, housing services could be embedded within the AMHS.

More accommodation options should be made available within the community. For example:

- low-income housing in inner metro areas, so that consumers can continue to live within their community which will enable continuity of their care and treatment;
- housing that has onsite mental health staffing; and
- supported, time-limited accommodation for consumers to stay following discharge from an acute mental health medical facility, which would allow for the planning and co-ordination that is required to find the consumer a more appropriate, long term housing solution.

## **6.2 Employment**

Access to employment remains challenging and an issue nationally. Meaningful recovery for a person with mental illness cannot be adequately addressed without access to meaningful occupation; be that employment, volunteering, study or community participation. There are limited support services in place for those with mental illness to gain access to meaningful activity or employment on full time or a part time basis. Having a role in the community and being able to contribute to society, however small, often brings with it meaningful and lasting recovery.

*What can be done better?*

Specialist mental health expertise embedded within employment services is required to support people with mental illness obtain employment.

Programs that utilise Individual Support Placement approaches have been shown to be effective in improving access to employment and sustaining that employment for people with mental illness, as well as subsequently improving mental health and recovery.

## **6.3 Physical Health**

Good mental health has clear links to good physical health. People with chronic and enduring mental illness have poorer physical health and poorer health outcomes. The greatest cause of premature death among Australians living with mental illness is poor physical health leading to preventable disease.

Recovery cannot be adequately addressed without access to healthy lifestyles and physical health programs tailored to this group. Physical wellbeing is intrinsically linked to mental health recovery.

For example, among those people with schizophrenia and related illnesses, the biggest cause of early death is cardiovascular disease caused by obesity, smoking and lack of exercise – not suicide. It's a problem that's exacerbated by the fact that some anti-psychotic medications can contribute to significant weight gain.

Evidence has also demonstrated the following:

- Among Australians experiencing psychosis, it is estimated that three quarters are overweight or obese, around half have high blood pressure, two thirds are smokers, and the overall level of physical activity level is very low.
- The rate of nicotine dependence among people with schizophrenia is between 75-90 per cent – three times that of the general population. Approximately half have substance use disorders.
- Mortality associated with cardiovascular disease among people experiencing psychosis is two to four times that of the general population.<sup>2</sup>

Premature deaths among Australians living with mental illness can be reduced significantly if our health system did a more effective and comprehensive job at screening, intervening and then monitoring the physical health of this patient group.

Traditional models where a person can access physical health supports or interventions externally to the mental health system have not worked and a medical model does not address the need for sustainable and sometimes lifelong interventions. People with significant psychosocial disability and mental illness require their mental health and physical health to be brought together to enable recovery.

*What can be done better?*

AMHS should be resourced to employ a range of allied health specialists with mental health experience (such as physiotherapy, exercise physiology, dietetics, diabetes education) to provide holistic, integrated mental and physical healthcare as part of the mental health team. Funding should support clinicians (including General Practitioners) to not only provide direct care but to collaboratively plan well integrated care.

---

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4175996/>

Physical health programs and services embedded and located within public mental health services are required so that interventions can be integrated into an individual's recovery plan.

#### **6.4 Access to mental health in Primary Health Care**

There remains a significant disconnect between primary health care and public mental health services where there is a gap in service delivery. Many people seek help from the AMHS when they are unable to access services in primary health care, often due to a lack of free or affordable services (including where there is a gap payment), or where interventions are time limited and of insufficient quantity. The AMHS are unable to assist as their capacity and focus of care do not align with the person's needs. This leads to dissatisfaction with the service and potentially poor outcomes for the person, with GPs struggling to provide effective treatment.

Availability of mental health interventions in the community (outside of the AMHS) such as psychological services, via GP referral, have improved and increased over the last 17 years, but does not meet the needs of a large proportion of the community who are unable to utilize these services due to a range of issues including accessibility, cost and mental health complexity. The introduction of Primary Mental Health Services (PMHS) into AMHS in 2001 enabled primary health care services, in particular GPs, to increase their capacity, quality and delivery of mental health treatment to those people not requiring the level of services of the AMHS. In addition, PMHS were able to provide brief tailored evidenced base interventions to people presenting with moderate to severe mental illness and worked alongside GPs to ensure continued specialist support and treatment was provided.

##### *What can be done better?*

A revisit and review of the role that PMHS provide would assist in identifying improved ways to address this significant gap in the community and to treat those individuals excluded from costly and limited therapeutic services in the community and Primary Health Care settings. Specialist support to GPs and an ability to provide interventions (specialist assessment and treatment), in conjunction with education, would be beneficial.

Clarity is needed regarding what services can be delivered in Area Mental Health Services and primary health care settings. Where they intersect, how they support each other and clearer referral pathways are needed. Services should be able to assist people to get the help they need at the time they need it. There should be a consideration in the resourcing of the AMHS in the provision of psychological

therapies to people with complex and enduring moderate mental health illnesses where they are unable to access this in Primary Health Care settings.

## **7 EXAMPLES OF INNOVATIVE SERVICE DELIVERY AT ST VINCENT'S**

### **7.1 Early Intervention**

Prevention of mental illness and strategies to encourage and support people to seek help is a whole of health and community responsibility. This relies on access to primary health care services, community support services, workplace mental health and school programs to name a few. Health promotion campaigns that address stigma are also key to supporting this. AMHS have a role in ensuring there are clear pathways to care and easy access in seeking interventions early in illness or early in episode, so that people can receive timely and effective support to minimize further deterioration and disability. This may take the form of access to specialist treatments and programs within the clinical mental health service, maximizing opportunities in identifying emerging mental illness or providing alternative ways of connecting with vulnerable groups and facilitating connection to appropriate supports.

St Vincent's highlights the following initiatives that support early identification of mental ill health in vulnerable populations as well as providing early intervention and services in a range of settings.

#### **(a) STAY**

In the absence of tailored coordinated supports, there is an increased risk of losing tenancy for those people living in Public Housing that can then result in lifestyle instability, eviction, or homelessness. Insecure tenancy can additionally exacerbate health and welfare issues for those involved, and have negative effects on the safety and development of families and children. The domino effect of unsteady housing arrangements also has substantial implications for the broader community service sector. Individuals and families facing mental health issues can be at higher risk of losing tenancy due to more significant challenges with maintaining their homes, keeping up with rental payments, behavioural difficulties, or sustaining safe and stable household environments. For this group of Victorians living in Office of Housing properties, there is an opportunity to provide a coordinated service response to prevent tenancy loss and subsequent homelessness and in doing so, improve outcomes for people in high-risk tenancies who experience mental health issues.

The Supporting Tenancy at Yarra (STAY) project is a unique, tailored partnership between St Vincent's, Department of Health and Human Services (DHHS) Mental Health Branch, DHHS and North East Melbourne Area Fitzroy Housing Service. The project has been developed to provide:

- mental health assessment, care coordination and referral for tenants;
- support to housing staff to build capacity in identification of emerging mental health issues and strategies to provide support and referral; and
- engage local health and support services to promote connections and ease of referral.

This is achieved by the co-location of two mental health clinicians within the Fitzroy Housing office team to support at-risk tenants. While the project is in its infancy, early indicators of success are positive.

Since commencing services in October 2018, STAY has had 79 referrals and completed 41 assessments. Additionally, 38 secondary consultations have been completed, 12 pop up events have been held in public housing common areas, and 27 training events have been conducted for housing staff. The mental health clinicians hold a daily huddle with housing staff to check in on any referrals and progress. An evaluation is currently underway, with tenants and housing staff providing feedback regarding their experience through surveys and focus groups.

(b) Early Psychosis Program

The Early Psychosis Program at St Vincent's is a clinical program utilising an integrated model of care and an expanded age range for whenever people experience a first episode of severe mental illness across the adult age range (16-65). The program offers evidence based ease of access, personalised psychoeducation, appropriate medications and psychosocial interventions, more intensive follow up and support, and family engagement. The inpatient and 5-session interdisciplinary evidence-based family psychoeducation is an internationally recognised and respected program, delivered now across 10 years, has been reported by families to reduce isolation, increase knowledge of diagnosis, resources and relapse prevention, and increase social support. The ability to provide a flexible, multi- faceted and responsive service to those people experiencing mental illness for the first time and their families at a time of increased stress and trauma, is key to this program's success.

Importantly access to this service is not limited by age in contrast to other early intervention programs which focus only on youth.

## **7.2 Innovations**

### **(a) Safe Haven Café**

Based on the successful UK model, the Safe Haven Café represents an alternative to attending the Emergency Department (ED) for those who may be experiencing difficulties, feel isolated or lonely. While there are a number of services available during business hours, few are available in the evenings or on weekends. Of those services that are available out of hours, none offer a safe, therapeutic, non-clinical space where practical support is available. This results in presentations to the ED when people are feeling unsafe or need to talk.

The St Vincent's Safe Haven Café is open 20 hours per week and has been a success with over 1,000 attendances in the 12 month trial period. The potential of the Café can be demonstrated through one particularly positive example. In January 2019, a consumer presented to our ED for physical medical reasons relating to leg pains and, after discharge, was taken by a Peer Worker to the Safe Haven Café. Since discovering the Safe Haven Café, the consumer has not presented to our ED, which is remarkable given that they had previously presented to the ED 19 times in a single month.

This model can be replicated across the state across a variety of care settings, including housing, and would increase non-clinical alternatives to mainstream treatment.

Linked to the Safe Haven Café model is the lived experience peer worker in the ED who is able to work with clinicians to identify and support those who are experiencing long delays in accessing appropriate care and able to introduce them to an alternative to ED which is the Safe Haven Café.

### **(b) Brief Psychological and Physical Health Interventions**

#### **(i) Psychological Interventions**

St Vincent's has implemented a program of brief, targeted psychological interventions for consumers of the mental health service. The outcomes of the pilot and first year of operation have been positive. The provision of psychological therapies such as Acceptance Commitment Therapy and Cognitive

Behavioural Therapy have traditionally been difficult for consumers of public mental health services to access except through the private sector which can be very costly, particularly for anyone who may require that intervention over a long period.

Since February 2017, there have been 203 referrals (33 consumers are receiving their treatment, 71 consumers have completed treatment, 18 are on a waitlist and 12 others received a secondary consultation). Interventions utilise Cognitive Behavioural Therapy, Acceptance Commitment Therapy and other generalised psychological interventions. Outcomes include a reduction in depression, anxiety and stress, as measured using Depression, Anxiety and Stress Scale – 21 items (DASS21 scale), and modest improvement in the consumers' self-report of their own recovery using the Questionnaire about the Process of Recovery (the QPR scale).

(ii) Physical Health Interventions

Physical health interventions are offered by a Dietitian and Community Health Nurse to provide 1:1 support to consumers to address areas such as poor diet, sleep problems, smoking and health lifestyles. Assessment of physical health and lifestyle is completed included metabolic screening and monitoring with 6 sessions scheduled for follow up and intervention. Since May 2018, there have been 58 referrals.

(c) Group Program

St Vincent's has also set up a comprehensive group program as part of its range of community mental health service options. A range of interventions is made available through the group program including therapeutic approaches like the Hearing Voices group (a peer led group supported by clinicians to reduce the distress associated with hearing voices and improve social connectedness), and options that address physical health such as Healthy Lifestyle or Smoking Cessation. The group program is staffed by various clinical staff as well as a strong peer workforce component for co-design and delivery of the programs. Consumers benefit from the content of the program as well as the opportunity to interact with peers through the group process itself. Programs like this should be supported and expanded where they are found to be effective.

The programs and initiatives are examples of ways that AMHS can support early intervention, engagement and the delivery of evidenced based interventions by being flexible and extending their reach beyond traditional models of care. Programs that in-reach to vulnerable groups, are flexible with referral criteria and support at risk and vulnerable groups can deliver effective interventions that can reduce further ill health and deterioration and promote meaningful recovery.

22 groups have been offered since July 2018, addressing psychological, social and physical health needs. A consumer's needs are identified by the consumer and staff assessments. There is a mix of one off sessions/workshops and weekly group programs which run between 3 – 10 weeks. Examples include: Introduction to Mindfulness (6 weeks); Healthy Eating & Weight Management (6 weeks); and Social Anxiety (6 weeks). Participants rate the programs highly, reporting that they have learnt life skills, feel more confident, are less anxious and are better equipped to rebuild their health.

## **8 RECOMMENDATIONS**

Throughout this submission we have endeavoured to set out how mental health services could be delivered differently to provide better outcomes for those more vulnerable groups within our society. More often than not, those experiencing mental health issues are also battling another illness. To add to this already challenging set of circumstances, a significant majority face the burden of falling within one or more marginalised or vulnerable communities within our population.

In recognising this, St Vincent's would welcome a greater integration of Victoria's health and social services and recommends the following:

- The development of more specialist mental health services to provide integrated treatment and management of mental health needs alongside other needs, whether that be for a neurodevelopmental disorder, personality disorder, or geriatric support. Embedding specialist services/workers into the mental health system (for example, specialists in substance use disorders working side by side with mental health clinicians) would also be highly beneficial.
- More tailored support being provided to those who identify as LGBTQI+, as well as those with culturally and linguistically diverse backgrounds, to ensure that their experience with health care workers is a more positive one, leading to better treatment outcomes.
- Policy change which acknowledges the difficulties that vulnerable populations have in accessing generic mental health services, which we hope would lead to improved rates of consumers seeking help early and thereby reducing the reliance on EDs and acute levels of care.
- Clearer referral pathways, as well as better collaboration and planning between services to ensure continuity and consistency of care and support, to help reduce the chances of an individual experiencing a gap in support during their time of need.

St Vincent's welcomes the opportunity to propose a range of more general recommendations, which are detailed below.

### **8.1 Models of Care**

Models of care should be evidenced based and should address the unique needs of vulnerable populations, including but not limited to those with dual diagnosis and dual disability.

When a person is admitted to an AMHS, while their physical health needs or drug and alcohol use may be assessed, there is often a lack of resources to intervene and treat on a long term, sustainable basis.

Dual diagnosis is one example. Models of care should reflect an evidenced based approach that integrates mental health, drug and alcohol and physical health as one.

Consideration needs to be given to the practical impact of models of care and systemic demands on the mental health workforce (which struggles with recruitment, retention, burnout and vulnerability to assault).

## **8.2 Integrated, linked up service systems**

Having integrated, linked-up service systems, which are reflected in specific policy and procedure frameworks, can help drive change and embed evidence based practices. The dual diagnosis key directions and associated action plans with relevant funding were a good example of government policy driving change to care delivery.

Adequate investment and prioritising of community and sub-acute services would relieve pressure on emergency departments and provide a more proactive/preventative, rather than the current reactive, approach.

Proactive follow-up should be expanded across many of the existing roles in mental health as dual diagnosis consumers need active engagement, rather than passive and crisis driven responses. The inclusion of special dual diagnosis service teams embedded in mental health may also be helpful for target groups with particular high dual diagnosis needs.

An integrated linked up service system ideally includes housing as a core component. Consumers will continue to cycle in and out of acute mental health care and homelessness unless this is attended to. Access to a range of housing options is desirable from supported accommodation options linked with mental health services to permanent low cost housing.

## **8.3 Review of Jurisdictions**

A disconnect currently exists between AMHS, which can result in less than optimal outcomes in terms of the transfer of information and consumers between catchment areas. More crucially, restricting services for consumers to whatever catchment they are located in at the time of their need for mental health services can lead to capacity issues for the providers, but also result in the consumer being treated some distance from their network of family and friends.

This is a particular challenge for an AMHS that has a prison or forensic hospital located within their catchment area, as consumers being discharged from those facilities will be transferred to the relevant AMHS within the facility's catchment area regardless of whether it is the most appropriate place for that consumer to attend (i.e. they may need access to a Secure Extended Care Unit (SECU) bed).

A state-wide approach to mental health services would assist with the above challenges, as a more co-ordinated process would help to ensure that a consumer receives the appropriate level of care (and security) needed, while also facilitating the sharing of resources and information.

#### **8.4 Upgrade Infrastructure**

Upgrading aging infrastructure is important to delivering safe spaces, modern facilities and an environment that promotes health and wellness. Unfortunately, there are many examples of acute inpatient service buildings that do not meet contemporary design standards (Australasian Health Facilities Guidelines – National Standards). Aging facilities are an impediment to consumer and carer engagement, and for many people do not feel therapeutic or safe.

Facilities have been designed to accommodate a large number of people with varying and complex needs, often with limited and cramped communal spaces and limited options for quiet space away from other people to relax. Physical infrastructure and consumer mix limits flexibility and the capacity for individualised care based on each person's needs (e.g. based on gender, age or mental health needs). It does not easily support trauma-informed care principles and there is often limited outdoor space for families or group programs.

Additionally, buildings that house the community mental health clinics have a range of similar issues that require significant upgrade to ensure they better deliver safe, therapeutic environments.

#### **8.5 Information and Communication Technology (ICT) Solutions**

Ensuring integrated ICT systems where information is readily accessible across AMHS is important. Solutions that clinicians can readily access, wherever they see the consumer, as well as technology that allows people to connect, would improve service delivery and efficiency.

#### **8.6 Consultation Liaison Psychiatry (CLP)**

With the growth in acute activity, there has been an increase in admissions to St Vincent's. Of these acute admissions, while 20% of inpatients have comorbid psychiatric illness, not all these inpatients are able to be seen by CLP

To ensure continuity of care, there needs to be the ability to review patients once they are discharged from non-mental health settings. Further, it would be beneficial for patients to have access to mental health support and assessment prior to a planned admission.

It is recommended that the level of service provided to patients in non-mental health settings be considered, with a view to recommending approaches that keep pace with this growing demand.

## **8.7 PACER**

The PACER model is a valuable, early intervention model that has improved linkages and relationships with Victoria Police. There is opportunity to expand this model to other emergency services, such as Ambulance Victoria. There is also the potential to explore Telehealth as an innovative model to enable people in the community, who are being attended to by emergency services, to be assessed by a mental health clinician who is located, for example, in the ED.

## **8.8 Alignment with National Disability Insurance Scheme (NDIS)**

It is imperative that work continues to ensure alignment of public mental health services with the NDIS, including the National Disability Insurance Agency, Local Area Coordinators and mental health service providers. The funded program lead positions have been helpful in this, but there is still more work to be done, therefore support roles should be expanded and extended for best outcome for consumers and their families.

Greater protection is needed to ensure adequate accreditation of service providers, to maximise the value and to prevent exploitation of consumers' limited NDIS resources.

## **9 CLOSING REMARKS**

The mental health sector is a vital component to the health of a large and increasing vulnerable population in our Victorian community. St Vincent's is committed to being an advocate for the more vulnerable members of society and welcomes the opportunity to have input into this important debate.

Our submission is focused on the needs of vulnerable populations with mental health issues that are cared for by St Vincent's and we trust that the information and proposed recommendations provided will assist the Commission in its enquiry. St Vincent's remains willing to provide any further information that the Commission may request.

## 10 GLOSSARY

**AMHS** Area Mental Health Services

**BeTRS** Body Image and Eating Disorders Treatment and Recovery Service

**Bouverie Centre** is a state-wide service which provides family therapy, training and consultation. Family therapy is provided to families affected by serious mental illness, serious trauma or acquired brain injury

**CLP** Consultation Liaison Psychiatry

**Comorbidities** is the co-occurrence of one or more disorders in the same person

**Depression, Anxiety and Stress Scale – 21 Items (DASS21)** is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress

**DHHS** Department of Health and Human Services

**ED** Emergency Department

**FaPMI** Families and Parents with a Mental Illness

**GP** General Practitioner

**ICT** Information and Communication Technology

**Kessler Psychological Distress scale (K10)** is a widely used, simple self-report measure of psychological distress which can be used to identify those in need of further assessment for anxiety and depression

**LGBTQI+** Lesbian, gay, bisexual, transgender, queer and intersex identifying people and community

**MAP (Melbourne Assessment Prison)** is an Australian remand and reception prison located in Spencer Street, West Melbourne, Victoria

**NDIS** National Disability Insurance Scheme

**Neurodevelopmental disorders** are impairments of the growth and development of the brain and central nervous system. Examples of neurodevelopmental disorders include intellectual disability, autism

**PACER** Police and Clinician Emergency Response

**PARC (Prevention and Recovery Care) services** are short-term, residential treatment services located in the community, which have a recovery focus. PARC services provide early intervention for consumers who are becoming unwell and for those in the early stages of

recovery from an acute psychiatric episode, to strengthen and consolidate gains from the inpatient setting.

**Mental Health Peer Worker** is someone employed on the basis of their personal lived experience of mental illness and recovery, or their experience of supporting family or friends with mental illness.

**PMHS** Primary Mental Health Services

**Primary health care** is generally the first contact a person has with Victoria's health system. It relates to the treatment of patients who are not admitted to hospital

**Questionnaire about the Process of Recovery (QPR)** is a 15 item measure developed from service users' accounts of recovery from psychosis in collaboration with local service users

**SECU** Secure Extended Care Unit

**STAY** Supporting Tenancy at Yarra

**St Vincent's** St Vincent's Hospital Melbourne

**SVHA** St Vincent's Health Australia group

**Thomas Embling Hospital** is a high-security forensic mental hospital located in Fairfield, Victoria

**VAHS** Victorian Aboriginal Health Service

**VDDS** Victorian Dual Disability Service

**VTMH** Victorian Transcultural Mental Health

## 11 LIST OF REFERENCE MATERIALS

- Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey, 2014-15
- Day, K., Starbuck, R., & Petrakis, M. (2017). Family group interventions in an early psychosis program: A re-evaluation of practice after 10 years of service delivery. *International Journal of Social Psychiatry*, 63(5), 433-438.
- Petrakis, M., Hamilton, B., Penno, S., Selvendra, A., Laxton, S., Doidge, G., Svenson, M. & Castle, D. (2010). Fidelity to clinical guidelines using a care pathway in the treatment of first episode psychosis. *Journal of Evaluation in Clinical Practice*, 17, 4, 722-728.
- Petrakis, M. & Laxton, S. (2017). Intervening Early with Family Members during First-Episode Psychosis: An Evaluation of Mental Health Nursing Psychoeducation within an Inpatient Unit. *Archives of Psychiatric Nursing*, 31(1), 48-54.
- Petrakis, M., Penno, S., Oxley, J., Bloom, H., & Castle, D. (2012). Early psychosis treatment in an integrated model within an adult mental health service. *European Psychiatry*, 27 (7), 483-488.
- Selvendra, A., Baetens, D., Trauer, T., Petrakis, M. & Castle, D. (2014). First episode psychosis in an adult area mental health service - a closer look at early and late onset first episode psychosis. *Australasian Psychiatry*, 22 (3), 235-241.
- Australian Institute of Health and Welfare.  
<https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/mental-health-of-prison-entrants>