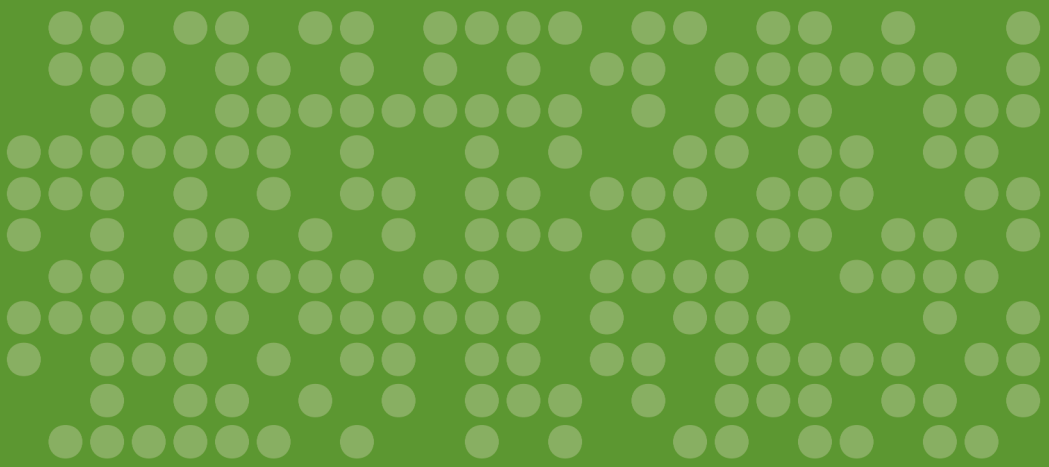
IMPROVING MENTAL HEALTH OUTCOMES IN VICTORIA

The Next Wave of Reform

Prepared by The BOSTON CONSULTING GROUP

July 2006



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ACKNOWLEDGEMENT

Many individuals in the Victorian Departments of Human Services, Premier and Cabinet and Treasury and Finance provided ongoing advice and feedback in the course of this review of Victoria's mental health system.

In addition, Jim Carlton, Professor Helen Herrman, Sally Wilkins, Tony Nicholson, Professor Graham Meadows and Professor Allan Fels provided valuable feedback on drafts of this report and other materials produced in the course of the engagement.

BCG is grateful for this assistance but takes full accountability for the content of this report. In acknowledging the valuable contributions made by the organisations and individuals named above, we do not in any way imply their endorsement of our findings and/or our recommendations.

GOVERNMENTS WORKING TOGETHER
IMPROVING MENTAL HEALTH OUTCOMES: THE NEXT WAVE OF REFORM
REPORT TO THE GOVERNMENT OF VICTORIA
JUNE 2006

THIS REPORT WAS PREPARED BY THE BOSTON CONSULTING GROUP

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VICTORIAN GOVERNMENT FOREWORD

Mental illness is estimated to cost the Australian economy around $20 billion each year. It causes distress and suffering for thousands of Victorians, their families and carers.

This report points the way to a new wave of mental health reform in Victoria. It demonstrates our strengths, and identifies gaps where Governments are not adequately meeting the needs of those with mental health problems, many of whom are among the most vulnerable and disadvantaged in the Victorian community.

It makes it clear that closing these gaps is a shared responsibility of the Commonwealth and State Government, and that there is a strong case for investment if the costs and benefits of reform can be shared fairly.

Our response to mental health combines two central themes in Victorian Government policy: A Fairer Victoria and the National Reform Agenda.

A Fairer Victoria is the Government's commitment to addressing disadvantage and creating opportunity. First released in April 2005, it included record investment in mental health services and sparked the current round of national reform.

The National Reform Agenda is the Council of Australian Governments' blueprint for increasing workforce participation and productivity. It relies on changing the way the Commonwealth, States and Territories work together, and argues that a third wave of national reform will be driven by improvements in human capital. Mental illness is central to this agenda, given that it causes nearly half of the disability experienced by Australians of prime working age.

Victoria welcomes the development of the National Mental Health Action Plan by the Council of Australian Governments. The Plan will significantly increase investment in this area and demonstrate that all Australian Governments take this issue seriously.

Victoria has played an active role in the development of the Plan, and will contribute at least $472 million over five years to its implementation. This investment builds on our strong starting position, and reinforces our leading role in Australian mental health policy.

However, the task of reform in mental health will not finish with the release of the National Action Plan. All Governments will need to continue to invest. We will need to continue to discuss and debate how Governments can work together more effectively to improve mental health outcomes.

This report is an important contribution to that debate. It will contribute to a further round of mental health reform in Victoria. It also could provide a catalyst for a new approach by both Commonwealth and State Governments – an approach which has real economic and social impact and better meets the needs of Victorian families and the community. We stand ready to work with the Commonwealth and other jurisdictions in this challenge.

Steve Bracks
Premier

John Thwaites
Deputy Premier

John Brumby
Treasurer

Bronwyn Pike
Minister for Health

NOTE TO READERS

The Victorian Government engaged The Boston Consulting Group (BCG) to lay out for consideration a vision for the reform of mental health services in Victoria over the next 10 years, and to identify short- to medium-term initiatives from both Commonwealth and State Governments to improve service delivery to consumers.

We took a holistic view of mental health that incorporates not only those consumers with high clinical needs but also a much broader group of individuals with diverse clinical and non-clinical needs, who are serviced by a range of different providers.

The recommended initiatives are designed to close gaps in service delivery from a consumer's perspective. Our focus was not to assign accountability for action to either the State or the Commonwealth specifically. In many cases, that accountability is clear. In some cases, accountability is more ambiguous. (Indeed, the 'grey areas' of responsibility between the State and Federal Governments are among the key problems identified in this review.) As a result, each level of Government could see much of the new investment recommended in this report as outside its normal area of responsibility. Resolution will require either an agreement on joint funding or the development of new funding models.

Given the tight timeframe of our engagement, we necessarily focussed on a sub-set of issues in mental health. For example, we did not specifically examine a number of important areas such as:

- The Aboriginal and Torres Straight Islander, Culturally and Linguistically Diverse and Aged consumer segments;
- Mental health care for prisoners;
- Mental health workforce challenges; and
- Promotion and primary prevention for adults.

However, we believe many of our findings and recommendations are applicable in these areas.

We have used a community 'case study' for 'Nelson'—a fictional outer metropolitan community – to illustrate the way in which adding a local interpretation to the recommended Commonwealth and State Government initiatives could improve outcomes for, and the experience of, mentally ill people and their carers. The 'case study' is attached as Addendum 2.

Many examples of best practices exist in today's public mental health services. Some of our proposed initiatives build on these examples. Where possible, we have identified existing best practices in this report.

EXECUTIVE SUMMARY

In February 2006, the Council of Australian Governments (COAG) identified mental health as an issue of national significance. A national mental health plan is expected to be considered by COAG at its meeting in July 2006. Mental health reform is being pursued in parallel with the broader National Reform Agenda (NRA), the overall aims of which are to improve workforce participation and productivity.

As an input to the policy development process for the July 2006 COAG meeting, the Victorian Government engaged The Boston Consulting Group (BCG) to lay out for consideration a long term-vision and way forward for mental health care reform in Victoria, and to recommend some short- to medium-term initiatives from both Commonwealth and State Governments to improve service delivery to consumers. This report summarises the findings and recommendations from that engagement.

Mental health is the subject of considerable debate in the press and in policy circles. This reflects its significant social impact in terms of suicide rates, crime rates and the despair of individuals and families in crisis. It also reflects the significant economic impact of mental illness, which we estimate to be around $5.4b annually in Victoria, driven in large part by diminished workforce participation and productivity. The multi-dimensional impacts of mental health and the scale of the challenges it presents highlight the need for agreement to be reached on mental health outcomes (and the measures to be used to assess those outcomes) so that investment priorities can be aligned and resources appropriately allocated (Chapter 1).

Mental health outcomes must be understood in the context of the existing Victorian mental health system, which includes services delivered and/or funded by either or both the State and the Commonwealth. These services include clinical services as well as support services used by persons with mental illnesses in areas such as employment, housing, and drug and alcohol treatment (Chapter 2).

This report focuses on three key issues in the services delivered by the mental health system in Victoria:

1. Insufficient access to clinical services, with around 50% of people with mental illness not receiving appropriate care for reasons including:

- Failure to seek care or navigate the complexities of the system;
- Under-capacity or poorly distributed capacity in both the State- and Commonwealth-funded sectors;
- Gaps in service targeting and eligibility between sectors, which result in poor access for some groups, including vulnerable clients who have very complex needs (e.g., co-morbidities), but do not match clinical criteria for specialist services; chronically ill people with a range of non-clinical support needs that vary in intensity over time; and children at risk of future mental illness who may or may not be involved in the child protection system.

2. Lack of connectedness between parts of the mental health system, with many individuals unable to navigate 'siloed' services such as housing and employment to obtain consistent, ongoing support; and
3. Limited investment in prevention and early intervention, with many children and young people in particular not receiving support designed to forestall or avoid the escalation of mental illness.

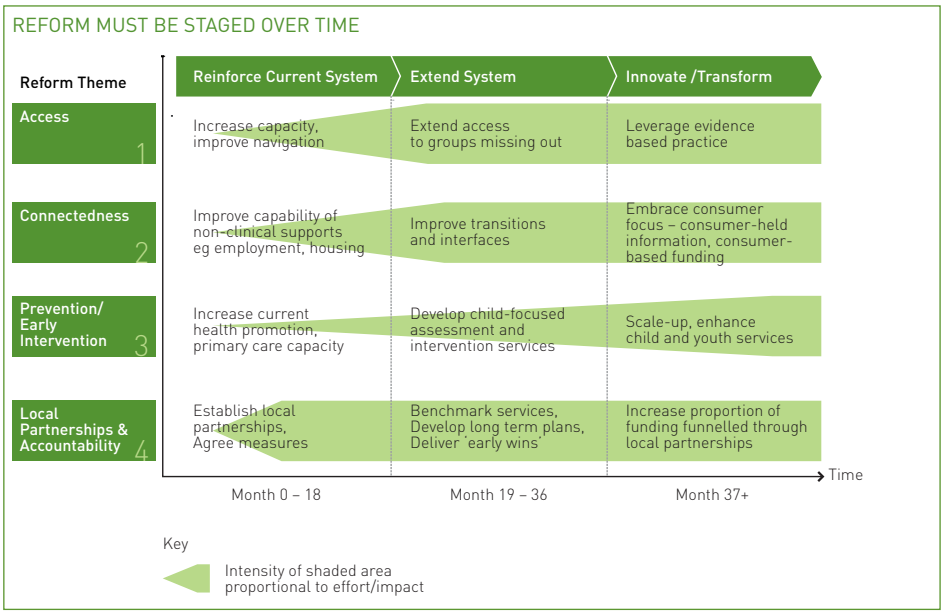
The governance and accountability structures in the mental health care system present a fourth and possibly more fundamental set of challenges. These include a lack of co-ordination between the Commonwealth and State, fragmentation in service delivery at the local level, and lack of alignment around a shared set of mental health outcomes measures (Chapter 3).

Reform that builds on the solid foundation established in Victoria over the past 10 years is required. This reform should move towards a vision for a consumer-centric mental health care system characterised by the four 'themes' described below.

1. Access to consumer-focused clinical services for all those in need;
2. Connectedness between the component parts of the extended mental health system to enable consumers to access the right services for their specific needs;
3. Prevention and early intervention to reduce the severity of the mental health problems faced by individuals over the longer term; and
4. Local partnerships and accountability to enhance the co-ordination of service delivery at the local level and ensure a more consumer-centric approach.

Each of these themes encompasses a range of initiatives with enduring impact. For each theme, the initial focus should largely be on reinforcing the current mental health system. Over time, the initiatives are designed to extend the system into new areas and, finally, to drive more fundamental transformation and innovation. Given the magnitude of the challenge, it will be necessary to stage implementation over a number of years (Exhibit 1).

EXHIBIT 1 • STAGED APPROACH TO REFORM



This report describes staged initiatives under each of the four themes:

1. Access: The initial focus is on increasing capacity and capabilities in the current system through targeted investments in a wider range of bed based options, improving throughput in the State-funded specialist sector, and improving the distribution and engagement of part-Commonwealth-funded providers in the primary sector. In the medium term, services should be extended to those who 'fall between the cracks' in the current system. This requires an explicit focus on services for people with multiple needs and the continued up-skilling of and support for GPs to enable them to manage more complex clients. In the longer term, wider adoption of evidence-based clinical practices will ensure ongoing improvement in service access and quality (Chapter 4, part 1).
2. Connectedness: The initial focus is on assisting non-clinical support services to enhance their ability to respond to the needs of people with mental illness – for example, by developing tailored employment support for the mentally ill, investing in stable housing, and providing mental health training for personnel in key services. Protocols for moving consumers between services should also be improved. In the longer term, the emphasis should be on empowering consumers to navigate their own way between services and more actively manage their own care through the development of consumer-held information and a move towards consumer-based funding (Chapter 4, part 2).
3. Prevention and early intervention: The initial focus is on reinforcing existing local mental health promotion and boosting, at the primary care level, early intervention and relapse prevention capabilities. In the medium and longer term, investment should be directed at early intervention for children in particular, to enhance assessment capabilities and provide new channels for early, family-focussed interventions (Chapter 4, part 3).
4. Local partnerships and outcomes: This requires the establishment of a new framework for State-Commonwealth collaboration in mental health, including a shared set of State-wide outcomes, local area partnerships between a broad range of clinical and support service providers, local outcomes leaders and new local outcomes metrics. These partnerships should drive continuous improvement at the local level through an ongoing cycle of planning, action and review. This local approach aligns with broader community-building agendas at both the State and the Commonwealth levels (Chapter 5 and Addendum 2).

The initiatives require increases in funding beyond those already announced by the State and Commonwealth Governments. Our high-level analysis, based on a range of third party data sources, suggests that there is a positive cost-benefit case for such investment. Our estimates suggest that a 1% reduction in the burden of mental health in Victoria would cost in the vicinity of $26m and could potentially deliver around $7m net benefit to the economy, when private economic benefit is added to the fiscal benefits accruing to both levels of Government from improved workforce productivity and participation. In addition, the investment will deliver better social outcomes (Chapter 6).

However, additional funding alone will not be enough. Success will require commitment to improving mental health workforce capacity and capabilities, and to more effective collaboration across the whole mental health system. If each level of Government continues to focus only on the areas that fit neatly into its own sphere of responsibility, some improvement will be possible, but some individuals will continue to fall through the cracks and the many who receive services funded by both levels of Government will continue to be frustrated by fragmentation and complexity. The result will be poorer clinical and social outcomes (Chapter 7).

We therefore recommend that:

- The Commonwealth and Victorian Governments jointly commit to using the framework and priorities proposed in this report as the basis for a further phase of national mental health reform, building on the current COAG plan;
- The Commonwealth and Victorian Governments agree that improving collaboration, reducing gaps between service systems and ensuring accountability for shared outcomes must underpin all future action and investment in this area;
- Both Governments agree to a joint implementation plan, taking into account those initiatives proposed in this report that require combined effort, as well as relevant elements of the current COAG plan; and
- The implementation of this joint plan be monitored and evaluated, and the achievement of improved outcomes considered as the basis for gain sharing arrangements in line with the proposed National Reform Agenda.

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CHAPTER 1: CURRENT OUTCOMES IN MENTAL HEALTH

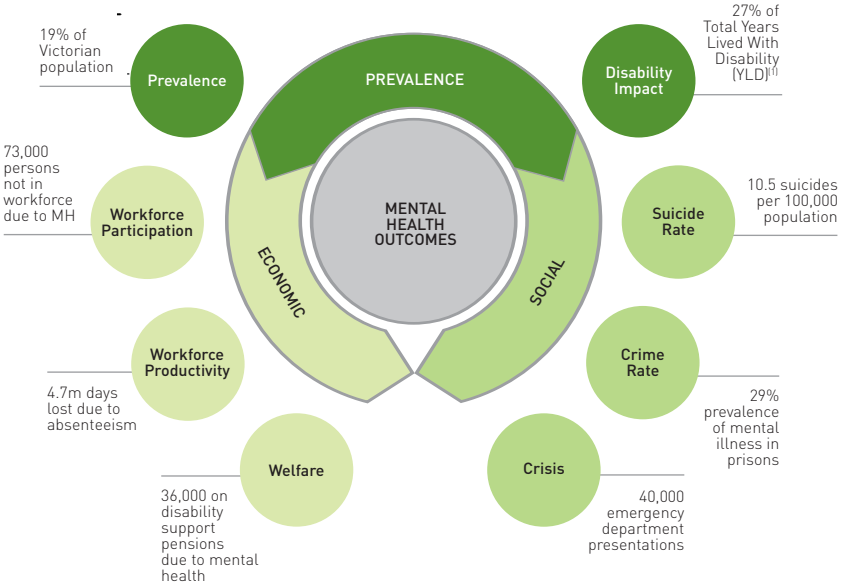
Mental health is the subject of considerable debate in the press and the broader community, as well as in the policy development arena. This stems from deep concerns about the adequacy of the mental health system in light of the debilitating impacts of mental illness on individuals, families and communities.

A number of recent reports, including 'Not for Service' and 'Out of Hospital, Out of Mind' highlight these inadequacies through very personal and often tragic stories. We refer readers to those reports. Quantitative outcome measures provide a complement to these very personal perspectives. Different outcome measures are relevant for children, adults and aged persons with mental illnesses. In the case of adults,[1] the measures need to capture three important, interdependent perspectives (Exhibit 2):

- The prevalence and severity of mental illness;
- Economic impacts such as workforce participation and productivity (the focus of the National Reform Agenda); and
- Impacts on the lives of those living with mental illness, their carers and their communities, including metrics around suicide rates, crime rates and crisis presentations.

EXHIBIT 2 • KEY MEASURES FOR THE MAGNITUDE OF MENTAL HEALTH CHALLENGE, ADULTS, VICTORIA

OUTCOME MEASURES FOR ADULTS SHOULD CAPTURE THREE INTERDEPENDENT PERSPECTIVES



(1) Years lived with disability is a measure of disability burden
Note: All estimated metrics are Victorian estimates; Outcomes for children and aged persons may be different

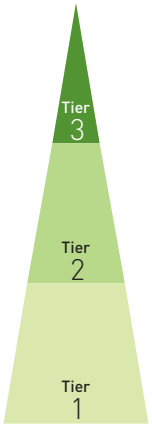
1. SIMILAR ISSUES EXIST FOR CHILDREN AND THE AGED, WITH A DIFFERENT EMPHASIS ON SOCIAL VERSUS ECONOMIC IMPACTS

Prevalence of Mental Illness

Mental illness is relatively widespread in Victoria, with 19% of Victorians each year experiencing some degree of mental illness. This group can be divided into three broad tiers according to the severity of their disability, as shown in Exhibit 3.

EXHIBIT 3 • THREE TIERS OF MENTAL ILLNESS

THERE ARE 3 TIERS OF MENTAL ILLNESS



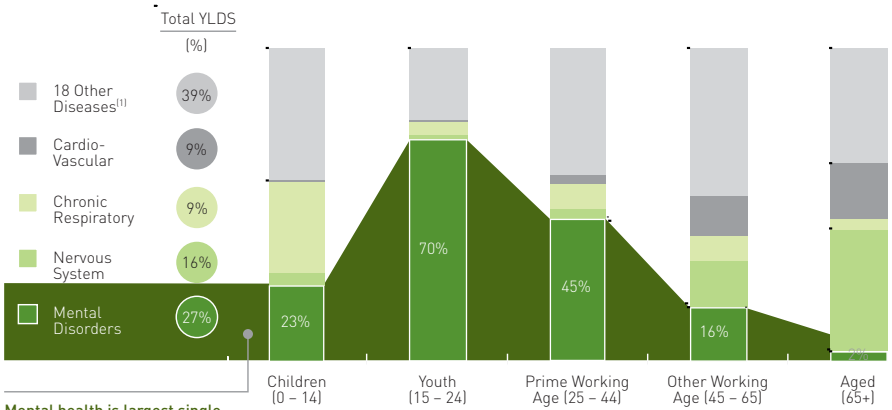
Prevalence	Key Disorders	Typical Example
3% (Severe Disability) →	> Psychotic Disorder > Bipolar Disorder > Severe Depression > Severe Anxiety > Severe Eating Disorder	37 yr old male who episodically hears voices. He also has severe depression and has attempted suicide several times. He is unemployed, lives in public housing and is alienated from friends and family.
4% (Moderate Disability) →	> Moderate Depression > Moderate Anxiety Disorder > Personality Disorder > Substance-Related Disorder > Eating Disorder > Adjustment Disorder	21 yr old male with chaotic behaviour and complex problems. He is suicidal, uses drugs heavily, and experiences panic attacks. Gets into fights and was arrested for assault 4 weeks ago. He can not hold onto a job and is currently unemployed.
12% (Mild Disability) →	> Mild Depressive Disorder > Mild Anxiety Disorder	42 yr old female who feels down, tearful, irritable and has withdrawn from friends over the past 4-6 months. She takes many sick days because she feels down.

The prevalence of mental illness varies by age. In children, it is estimated at ~14%, increasing to 27% among 18-24 year olds and declining to ~6% for those over 65 (excluding dementia).

The measure 'Years Lived with Disability' (YLDs) provides another lens on prevalence. According to this measure, mental illness is the largest single cause of disability, accounting for 27% of all years lived with disability and 45% for those in the prime working age group of 25-44 years (Exhibit 4).

EXHIBIT 4 • DISEASE CONTRIBUTION TO YEARS LIVED WITH DISABILITY, BY AGE (%)

MENTAL HEALTH IS THE LARGEST SINGLE CAUSE OF DISABILITY



Mental health is largest single contributor to disability burden, especially among youth and the prime working age population

(1) For example, includes diabetes, oral health, skin diseases, unintentional injuries, musculoskeletal diseases
Note: Years Lived With Disability is a measure of disability burden
Source: AIHW, Burden of Disease (2001)

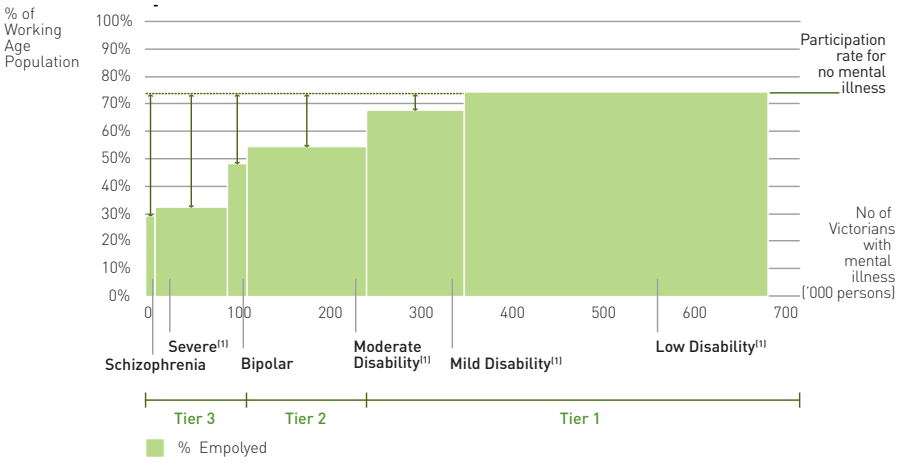
Economic Impacts of Mental Illness

Workforce Participation

Mental illness significantly affects the ability of affected individuals to participate in the workforce (Exhibit 5).

EXHIBIT 5 • WORKFORCE PARTICIPATION AMONG WORKING AGE VICTORIANS BY SEVERITY OF MENTAL ILLNESS (% PERSONS, '000 PERSONS)

IMPACT OF MENTAL HEALTH ON WORKFORCE PARTICIPATION IS SIGNIFICANT



(1) Includes other disorders such as depression, anxiety, substance abuse, OCD, Borderline PD, etc.
Source: ABS, 'Mental Health And Wellbeing Profile Of Adults Victoria' (1997); Low Prevalence Study (1997); BCG Analysis

In total, mental illness is estimated to reduce workforce participation among Victorian adults aged 18-65 by ~73,000 people. This comprises:

- ~41,000 people from tier 3 excluded from the workforce, representing a 65% non-participation rate;
- ~25,000 people from tier 2, representing a 46% non-participation rate; and
- ~7,000 people from tier 1, representing a 28% non-participation rate.

Based on the Australian average income of ~$37,000 per year, this suggests a loss of economic output to Victoria of ~ $2.7b.

Workforce productivity

Mental illness significantly affects workforce productivity. It is estimated that mental illness results in ~4.7m days of absenteeism a year in Victoria, of which ~80% is due to high prevalence mental illnesses such as depression and anxiety. This equates to a ~$660m a year loss to the Victorian economy – potentially a conservative estimate since it does not include the effects of lower productivity for those who continue to come to work while coping with a mental illness.

Welfare Costs

Mental illness also accounts for significant welfare costs. Of the ~150,000 Victorians receiving disability support pensions, ~24% (36,000) are suffering from a mental illness. At a weighted average weekly payment of ~$200, this amounts to a disability support spend of $370m on persons with mental illnesses in Victoria.

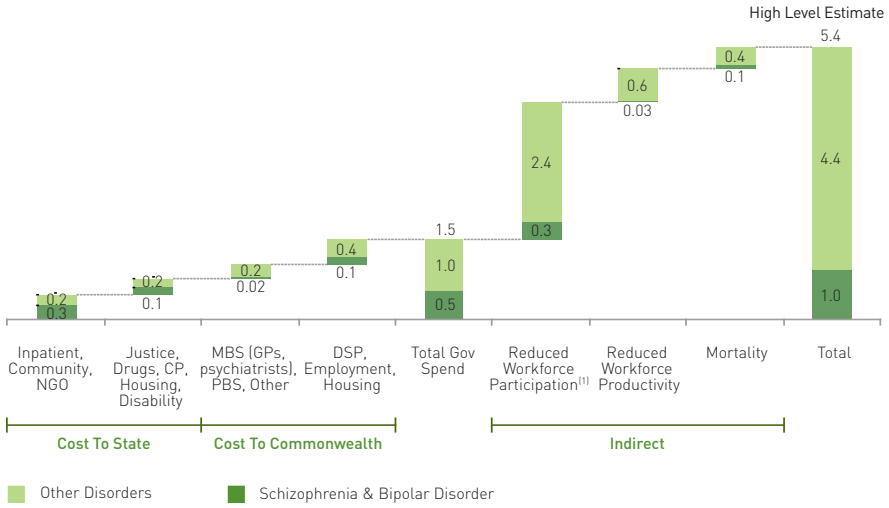
Total Economic Cost

As Exhibit 6 illustrates, mental health imposes costs totalling over $5 billion on the Victorian economy, through:

- Direct costs associated with health care;
- Significant additional direct costs associated with other service delivery, such as welfare, employment and housing; and
- Indirect costs associated with reduced workforce participation and productivity (discussed above).

EXHIBIT 6 • INDICATIVE TOTAL ECONOMIC COST OF MENTAL HEALTH, VICTORIA ($B)

TOTAL COST OF MENTAL HEALTH IS MORE THAN 7x CLINICAL SPEND AND ALMOST 4x DIRECT GOVERNMENT SPEND



(1) This calculation includes workforce participation among persons with mental illness but does not include reduced workforce participation among carers.

Note: Does not include spending on Aged (e.g. Dementia costs, DVA costs); Attribution of Cth indirect costs to MH based on Cth paper (2004); State indirect costs assume 04-05 budget. Attribution to MH based on escalated 30% prevalence and the assumption that for persons with mental illness, there is a 20% direct cost impact of mental health problems on services

Broad quantum is comparable to Layard's estimates of total cost of mental health in UK (adjusting for population and exchange rate)

Source: Commonwealth Indirect MH Cost Estimates (2004); Access Economics, Schizophrenia and Bipolar Costs (2001, 2003); VIC Budget Paper 3 (2006); Interviews; BCG Analysis

The total cost of mental illness in Victoria is almost four times direct Government spending on mental health services and seven times the spending on clinical services. As discussed in Chapter 6, the potential to reduce the economic loss associated with low workforce participation and productivity provides the foundation for the case for additional investment in reducing the burden of mental health.

Social Impacts of Mental Illness

Suicide Rates

Suicide rates are keenly debated as reliable measures of mental health outcomes, given the ambiguity in the circumstances surrounding some deaths. While mental illness is not the only driver of trends in suicide rates, such rates are useful indicators for the more extreme impacts of mental illness.

There were 521 suicides in Victoria in 2004, representing a suicide rate of 10.5 in every 100,000. Around 90 of those were people suffering from psychotic illnesses – representing a suicide rate for that group of 300 for every 100,000 people.

A number of recent reports have discussed cases where individuals who suicided may have benefited from an enhanced or more timely engagement with mental health services.

Relationship Between Mental Health and Crime

In the past, mentally ill people tended to be institutionalised in part because of a view that it was important to contain people perceived to be dangerous. The minimisation of risk to the community is still an important outcome in mental health care, but it is now known that mass institutionalisation is unwarranted.

Data on the mental status of newly remanded prisoners, using the referral decision scale, provide one set of measures for understanding the relationship between mental illness and crime. These data suggest that 28% of newly remanded criminals suffer from some level of mental illness, with ~8% suffering from schizophrenia or bipolar disorder. The prevalence of depression in prisons is at least 50% higher than that in the general population, and the prevalence of schizophrenia and bipolar disorder is almost 10 times greater.

In addition, 14% of Victorian males with low prevalence mental health disorders have been arrested in the previous 12 months. People with these disorders need good quality care not only for their own benefit but also to minimise risk for their communities. Such care is also of critical importance for prisoners and those who are released into the community.

Crisis Presentations

In 2005, there were ~40,000 recorded mental-health-related presentations to Victorian Emergency Departments (ED) by ~30,000 individuals. Of these, ~8,600 resulted in inpatient admissions. While not all the individuals who present to ED with mental-health-related problems are experiencing a mental health crisis, the sheer size of the number suggests that many individuals are living in distressing situations and see EDs as their only avenue to access care.

Conclusion

This examination of mental health outcomes in Victoria highlights the scale of the challenges to be addressed. Specifically:

- The prevalence and debilitating impact of mental illness;
- The economic costs of reduced workforce participation and productivity, coupled with welfare and other costs; and
- The social costs of mental illness, including suicide, crime and people living in crisis.

Outcome measures such as those discussed are useful not only to take stock of the current situation but also to provide a framework for determining priorities and allocating resources. There is no clear agreement among the various participants in today's mental health system on the outcome measures that should be used; nor is there agreement on the improvements that should be targeted in these outcomes over the next 5-10 years.

Securing agreement between the Commonwealth and State Governments on mental health outcomes and outcome metrics should be a priority on the COAG agenda. To monitor progress against the agreed target outcomes, an ongoing process should be put in place at the local level. This is described in Chapter 5.

CHAPTER 2:
THE MENTAL HEALTH SYSTEM IN VICTORIA

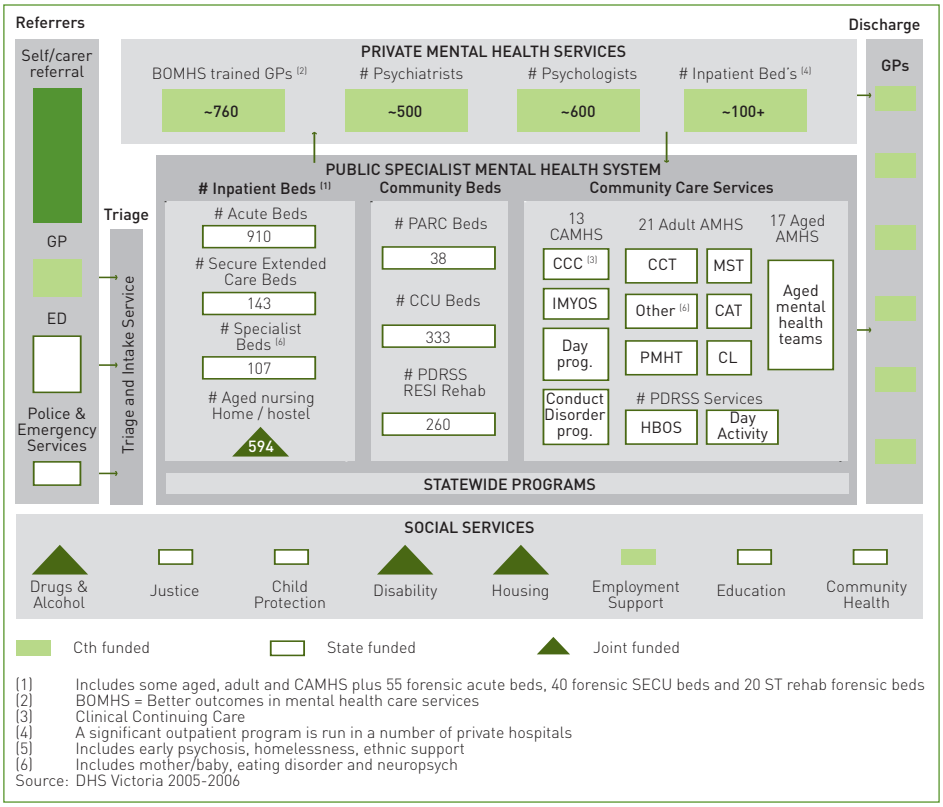
Overview

The 'mental health system' in Victoria is a complex set of interrelated services, some funded by the State, some by the Commonwealth and some by both Governments in concert. These services include:

- Clinical services, including the specialist public mental health system, local GPs and GP mental health specialists, private psychiatric hospitals and private psychiatrists and psychologists;
- General and specialist health services dealing with key co-morbidities (eg, drug and alcohol abuse);
- Support services used by people with mental illnesses (eg, employment, housing); and
- Other services that deal with people with mental illnesses (eg, police, hospital EDs).

Exhibit 7 illustrates the basic elements of the mental health system in Victoria. Addendum 1 provides a more detailed description.

EXHIBIT 7: SIMPLIFIED MAP OF THE MENTAL HEALTH SYSTEM IN VICTORIA



(1) Includes some aged, adult and CAMHS plus 55 forensic acute beds, 40 forensic SECU beds and 20 ST rehab forensic beds
(2) BOMHS = Better outcomes in mental health care services
(3) Clinical Continuing Care
(4) A significant outpatient program is run in a number of private hospitals
(5) Includes early psychosis, homelessness, ethnic support
(6) Includes mother/baby, eating disorder and neuropsych
Source: DHS Victoria 2005-2006

Significant Progress over Last 20 Years

Much progress has been made over the last 20 years in the delivery of mental health services in Victoria:

- The State-funded sector has seen a fundamental shift away from containment-focused institutionalisation to recovery-focused, community-based care. Victoria is an acknowledged leader in this area, having gone further than any other State in moving to community-based care and providing acute inpatient services in general hospitals. Victoria is also recognised for innovative programs such as Forensicare and EPPIC / ORYGEN, and for fostering the development of a flourishing non-Government psychiatric disability rehabilitation and support services (PDRSS) sector.
- The focus in the Commonwealth-funded sector is on high prevalence disorders such as anxiety and depression, with efforts directed towards enhancing the capability of GPs and other private providers to treat individuals affected by these disorders. A shift towards the 'mainstreaming' of mental health services is continuing, with private providers beginning to provide continuity of care for individuals serviced by the State specialist mental health service, as they do in the general medical sector. Recent initiatives such as the Better Outcomes in Mental Health Services Program and changes in the Medicare Benefits Schedule (MBS) funding for psychologists are contributing to this.

Addendum 1 details recent changes to Victoria's mental health system and shows how Victoria's system compares with those in the other States.

Roles of the State and Commonwealth

The Commonwealth and Victorian Governments fund a variety of services that collectively comprise 'the mental health system' in Victoria.

The State provides specialist clinical care and disability support for many of the most severely ill (including some individuals who are treated on an involuntary basis). It also provides counselling through Community Health Centres, supports GPs through Primary Mental Health Teams, and delivers mental health promotion and early intervention programs through a wide range of community agencies.

The State also funds and delivers services that provide treatment and non-clinical support (eg, treatment for drug and alcohol abuse) to people with mental illnesses or to people in their core client group (eg, Child Protection, Corrections) who are directly affected by mental illness. The costs of these services are driven by the prevalence of mental illness and the effectiveness of the services provided.

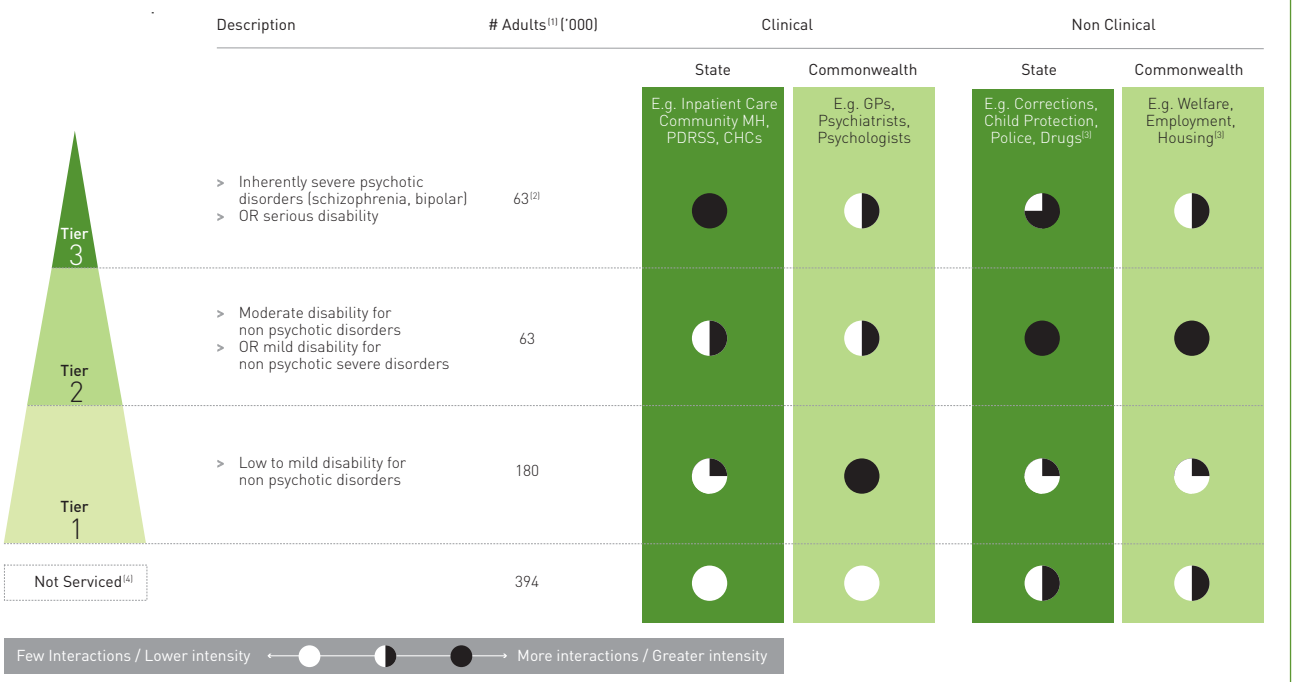
The Commonwealth partly funds privately provided services such as GPs, psychiatrists and, increasingly, psychologists. It also funds the Pharmaceutical Benefits System (PBS). These services are uncapped, constrained only by the need for consumer co-payments and the availability of service providers. In addition, the Commonwealth funds a range of non-clinical services used by people with mental illnesses, including income support through disability support payments and access to Job Network services.

The Commonwealth Government's approach to funding services is fundamentally different from the State's: while the State tends to fund agencies to provide services to specified client populations within fixed budgets, the Commonwealth increasingly favours the funding of services accessed by individuals, allowing the market to drive service delivery within regulatory constraints.

While both Governments operate or fund mental health services relatively independently, a high proportion of people with mental illness are shared clients of both the State and the Commonwealth, as Exhibit 8 shows.

EXHIBIT 8 • STATE AND COMMONWEALTH CLINICAL AND NON CLINICAL INTERACTIONS WITH PEOPLE WITH MENTAL ILLNESSES, BY TIER

A HIGH PROPORTION OF PEOPLE WITH MENTAL ILLNESS ARE SHARED CLIENTS OF BOTH THE STATE AND COMMONWEALTH



(1) Includes adults aged 18+; Includes aged persons but does not include Dementia
(2) ~2000 persons receive mainly State clinical care, ~45,000 persons receive State MH services with some GP / Psychiatrist contact, ~16,000 persons receive mostly Cth services (includes some CHC and PMH services)
(3) Drugs and alcohol, and housing non clinical services are a joint responsibility but are grouped as above for simplicity
(4) Persons not receiving clinical services for their mental illness in all tiers
Note: Community MH = Community Mental Health Services; PDRSS = Psychiatrist Disability Rehabilitation and Support Services; CHCs = Community Health Centres
Source: ABS, 'Mental Health and Wellbeing Profile of Adults Victoria' (1997); Gavin Andrews, Tolkien II Working Document (2006); RAPID; BCG Analysis

Most people who fall into tier 3 receive both State and Commonwealth services. Such services typically include acute care from the State-funded specialist mental health system, continuity of care from Commonwealth-funded primary care providers, and engagement with both State- and Commonwealth-funded support services, such as housing, employment and treatment for drug and alcohol abuse. At the same time, many (an estimated 16,000) in this tier receive clinical care chiefly or solely from private psychiatrists.

If disability support pensions are excluded, a very small group of people in tier 3 (<3000) receive only State-funded services (including people receiving long-term residential care in inpatient facilities and those in forensic mental health facilities or prisons). Similarly a small number of people in tier 3 are served only by Commonwealth-funded private psychiatrists and have few or no interactions with State services.

For people who fall into tiers 1 and 2, the Commonwealth is the main provider of clinical care through the private sector (i.e., GPs, private psychiatrists and private psychologists). However this clinical care is supplemented by State-funded Community Health Centres, Primary Mental Health Teams and specialist programs (e.g., those for post natal depression). People in Tier 2 frequently interact with both State-funded services (e.g., drug and alcohol treatment, police) and Commonwealth-funded services (e.g., employment support). Tier 2 clients with moderately disabling conditions and complex clinical issues are particularly prone to repeated cycling between services, and to falling between service gaps.

Both levels of Government interact to varying degrees with an overlapping collection of NGOs, which form an increasingly important part of Victoria's mental health service delivery system. The State has made particular efforts in recent years to nurture the development of the NGO sector, while the Commonwealth has signalled its desire to fund more mental health support services through the sector.

Recent Commonwealth and State Initiatives

The Commonwealth and Victoria each recently announced significant new funding for mental health services.

In its 2006-2007 budget, Victoria announced increased spending of $170 million over five years. In conjunction with the funds committed under A Fairer Victoria, this takes Victoria's total spending under the National Mental Health Action Plan to $472 million over the five years to 2010-11. This spending includes:

- New and expanded prevention/early intervention and research programs;
- An increase in community-based treatment and supported accommodation;
- Expansions of acute hospital treatment capacity and new step-up and step-down alternatives to hospitalisation;
- New facilities and the upgrading of existing facilities; and
- Expanded forensic mental health treatment capacity.

Similarly, the Commonwealth recently announced $1.85 billion in new spending on mental health over five years across all States. The key elements of the Commonwealth's initiatives are:

- Improved access to GPs, psychologists and psychiatrists;
- New 'personal helpers and mentors' for people with mental illnesses;
- New 'mental health nurses'; and
- A range of other programs in areas such as education and employment support.

However, despite substantial progress, and taking into account the significant additional investment announced in recent months, some issues in the mental health system in Victoria are likely to remain intractable. We describe these in the following chapter.

CHAPTER 3: CHALLENGES FACING THE CURRENT MENTAL HEALTH SYSTEM

PAGE >20

We have identified three key service delivery issues in the mental health system for Victorians:

- Insufficient access to clinical services;
- Lack of connectedness; and
- Limited investment in prevention and early intervention.

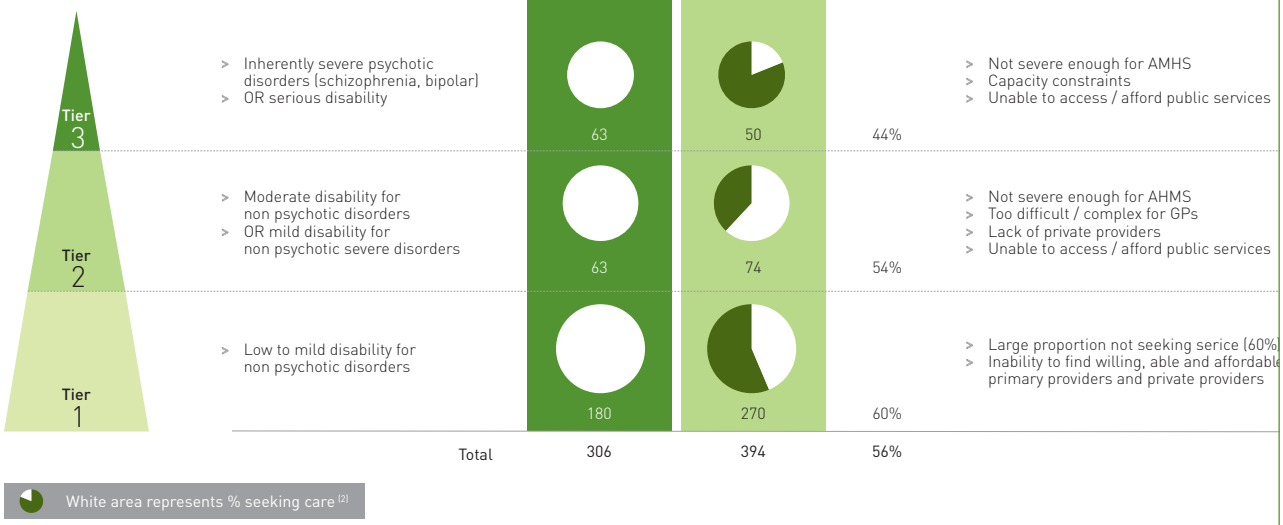
A fourth and possibly more fundamental issue that hinders progress is the inadequacy of the governance and accountability structure for mental health.

Insufficient Access to Clinical Services

As Exhibit 9 shows, access to both Commonwealth- and State-funded clinical services is a key issue for the mental health system in Victoria, as it is in the other States.

EXHIBIT 9 • NUMBER OF MENTALLY ILL ADULTS IN VICTORIA BY SEVERITY OF ILLNESS AND TYPE OF CLINICAL SERVICE PROVIDER ('000 PERSONS)

MANY VICTORIANS WITH MENTAL ILLNESS NOT SERVICED



(1) Includes adults aged 18+; Includes aged persons but does not include Dementia
(2) Based on ABS Mental Health and Wellbeing Profile (1997) for Tier 1; Estimated based on clinical experience for Tiers 2 and 3
Source: ABS, 'Mental Health and Wellbeing Profile of Adults Victoria' (1997); Gavin Andrews, Tolkien II Working Document (2006); RAPID; BCG Analysis

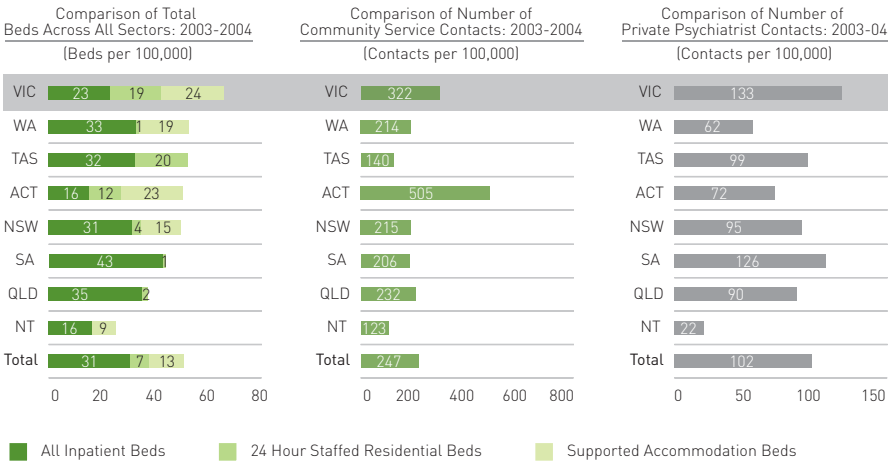
In any 12-month period, around 44% of people who are severely disabled by mental illness (tier 3) are not serviced by either the public (State-funded) or the private (mostly Commonwealth-funded) system. A much larger group (over 340,000 individuals) with mild to moderate mental illness receives no treatment in any one year. These figures do not represent a waiting list – they are broad estimates only, and a significant proportion of these people do not seek treatment—but they suggest a significant gap in access to mental health services.

Access gaps exist for a range of reasons.

First, despite the fact that Victoria leads Australia on a number of important dimensions of mental health capacity (Exhibit 10), Victoria still has too few beds and mental health clinicians, in both the State-funded and the Commonwealth-funded sectors, to provide services to the one in two individuals who do not access appropriate care at present. Problems with clinical capacity distribution exacerbate access gaps (Exhibit 11).

EXHIBIT 10 • CROSS-STATE COMPARISON OF MENTAL HEALTH CAPACITY

CAPACITY IN VICTORIA'S MENTAL HEALTH SYSTEM IS STRONG BUT DOES NOT FULLY MEET DEMAND



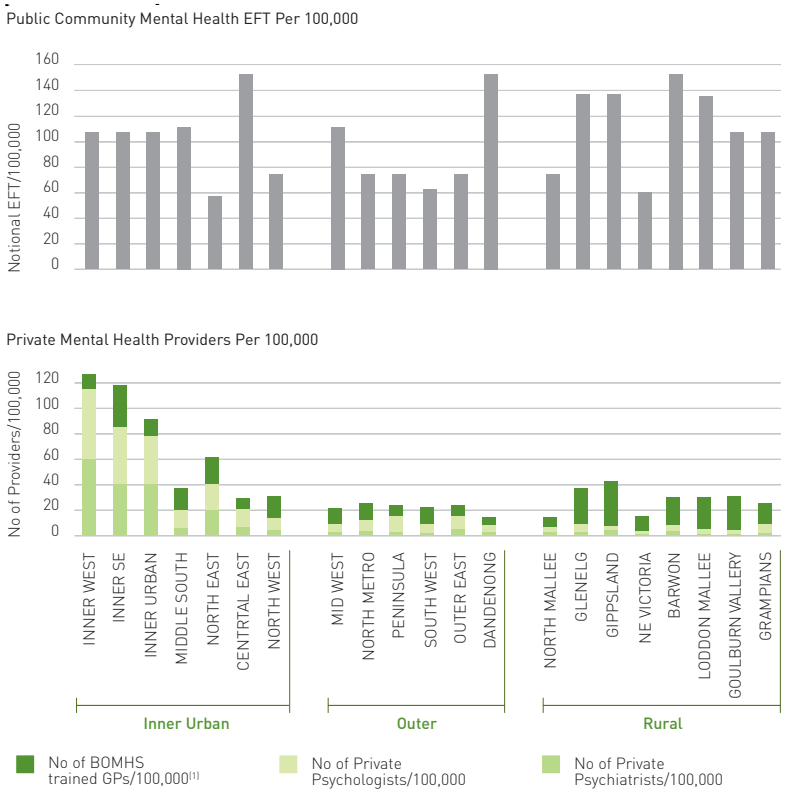
Source: National Mental Health Report (2005); AIHW (2004); BCG Analysis

State-funded clinical capacity varies significantly by each local area. This largely reflects historical decisions, coupled with very rapid population growth in outer metropolitan areas in particular.

Among mostly Commonwealth-funded private providers, the variation in clinical capacity between areas is even greater – for example, the availability of private psychiatrists in the inner suburbs of Melbourne is ~10 times greater than that in outer suburbs and rural areas. This raises some fundamental questions around the efficacy of many of the initiatives in the recently announced Commonwealth package. If new mental health services are disproportionately located in a few inner urban, high income areas, accessibility for consumers of mental health services may not be improved, and the hoped for gains in social and economic outcomes may not be achieved. The affordability of these services will also be an issue if the scheduled MBS fees do not minimise or eliminate co-payments for low income consumers.

EXHIBIT 11 • DISTRIBUTION OF CLINICAL PROVIDERS ACROSS LOCAL AREAS IN VICTORIA

LARGE DIFFERENCES IN DISTRIBUTION OF PRIVATE PROVIDERS



(1) Includes GPs who have achieved Level 1 BOMHS (Better Outcomes in Mental Health Services) training for 3 step mental health referral process

Note: Some provider numbers are estimated using data disaggregated from Vic Div of GP level and remapped to AMHS catchments

Source: APS, RANCZP, MBS, ABS; BCG Analysis

Another important access issue exists for particular groups of individuals who tend to 'fall between the cracks' of the Commonwealth- and State-funded parts of the mental health system. This is because there is ambiguity around which level of Government is responsible for them, and concern about 'net-widening' for the level of Government that extends services in this area. The groups affected include those who:

- Have mental illness of mild to moderate severity and complex needs, including co-morbidities, but who do not meet the clinical criteria (in terms of the severity of risk of harm to themselves or others) to receive service from the State system;
- Have complicating factors (such as homelessness or involvement with the police) that make them difficult clients for private providers;
- Have chronic mental illness and require stable, long-term housing and a wide range of support needs that vary in intensity over time; or
- Are children with significant behavioural problems or are otherwise 'at risk' of mental illness (through, for example, 'toxic' family environments or their parents' mental health problems), but who may or may not be involved in the State's child protection system.

Access issues for these groups are unlikely to be resolved until both levels of Government recognise the problems and take joint remedial action.

The last driver of poor access is unwillingness of the part of some individuals with mental illness to seek help, typically because they are concerned about the social stigma, are unaware of the services available, or are not motivated to seek help.

Lack of Connectedness

Seamless access to appropriate clinical and non-clinical support is critical to the mental health recovery process. Despite this:

- The State- and Commonwealth-funded clinical sectors are not sufficiently integrated, leading to poor continuity of care as individuals move between service providers;
- Some key non-clinical services cannot provide sufficient support to people with mental illness; and
- There is significant fragmentation and complexity at the local level in the overall system.

The often chronic and episodic nature of mental illness requires access for individuals to different levels and types of clinical care at different times. When their health is stable, people with mental illness will (or could, if the systems were better integrated and distributed) primarily interact with the Commonwealth-funded sector (ie, GPs, psychiatrists, psychologists), but when their illness becomes more acute and/or severe they tend to rely on the State-funded system. For an individual to receive appropriate, continuing clinical care, the two systems must work seamlessly together – this is hampered at present by a lack of co-ordination between them.

Access to appropriate non-clinical support services – for example, housing, employment and treatment for drug and alcohol abuse – is critical in recovery from, and the management of, mental illness. However, access to such services is hampered by problems ranging from insufficient capacity (e.g., housing), to the lack of tailored solutions for people with mental illnesses (e.g., housing, employment services), to lack of training for personnel in support services to enable them to respond effectively to people with mental illnesses.

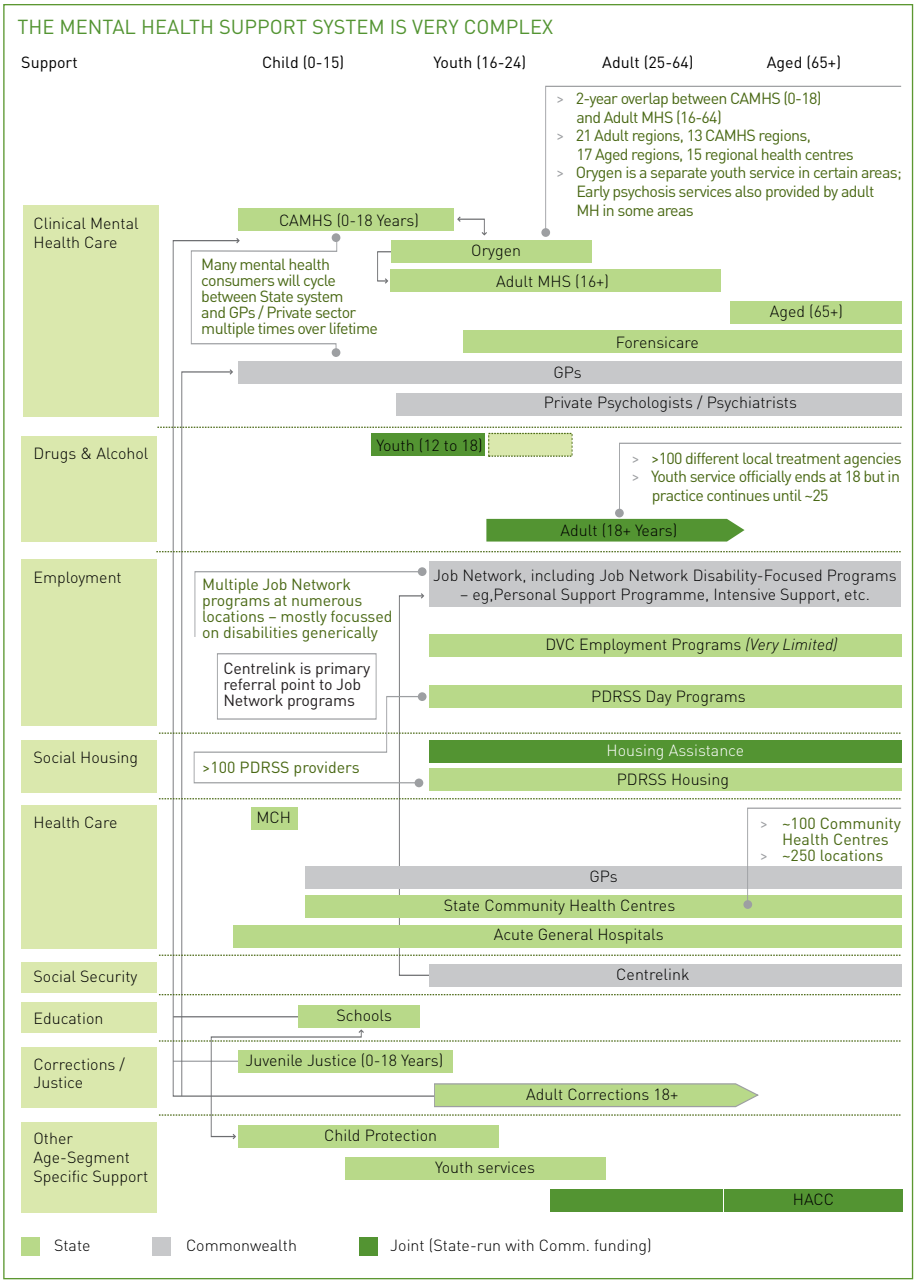
Finally, the mental health care and support system is so fragmented and complex (Exhibit 12) that even a knowledgeable, healthy consumer would find it difficult to navigate. There are multiple providers, different access points and criteria for obtaining services, variations in service models, and inter-service communication issues. The nature of mental illness (particularly severe mental illness) makes it even more difficult for those in real need to get the services they require.

Limited Investment in Prevention and Early Intervention

Prevention and early intervention to reduce the incidence and severity of mental illness have been the focus of attention in a number of mental health plans.

Considerable progress has been made in promoting awareness of mental health issues and addressing individual, social and environmental risk factors. VicHealth has taken a strong policy and funding role in this area. At the same time, we have seen the introduction of state and national initiatives such as beyondBlue (depression) and COPMI (Children of Parents with Mental Illness). More can be done to help reduce stigma and promote better mental health; we believe significant efforts beyond promotion are also required.

EXHIBIT 12 • FRAGMENTATION OF SERVICES FOR MENTAL HEALTH CONSUMERS



Early intervention for adults is primarily delivered through counselling services and GPs. Access issues and capability gaps in the primary care sector, as described above, significantly undermine the potential for early intervention and relapse prevention for this group.

Early intervention for children is even more problematic. Around 80,000 children and 150,000 youth in Victoria are believed to have some level of mental disorder.[2] However the number actually diagnosed and receiving appropriate services is incredibly small. This is despite emerging evidence from studies around the world that effective early intervention for children and youth can deliver significant social benefits, including a reduction in suicide and crime rates, as well as a strong economic return on investment.[3]

Underinvestment in prevention and early intervention is in part a function of Australia's federal system. Such investment tends to produce benefits over the longer term and does not necessarily deliver these benefits to the arm of Government that provided the

2. TAKING CHILDREN AS 4-12 YEARS AND YOUTH AS 13-25. MODELS BASED ON PREVALENCE DATA FROM SAWYER 2001, ZUBRICK 1998 AND SILBURN ET AL 1998

3. FOR EXAMPLE THE BROOKINGS INSTITUTE RECENTLY ESTIMATED THE AVERAGE COST BENEFIT TO BE AROUND $5.50 FOR EVERY $1 SPENT (SEE MUSTARD AND MCCAIN 2004)

funding. For example, the State Government would capture some of the benefits of early intervention by GPs to prevent escalation to the specialist State-funded sector government, but the Commonwealth would need to fund such services. Similarly, State-funded programs to improve school-to-work transitions for people with mental illnesses would primarily benefit the Commonwealth through improved income tax receipts and reduced welfare payments.

Inadequate Governance and Accountability Framework for Mental Health

The current governance and accountability framework in mental health has three key deficiencies:

- Insufficient co-ordination between the Commonwealth and State;
- Insufficient focus at the local level, where most of the service delivery takes place; and
- The lack of an overarching outcomes framework agreed by the Commonwealth and State.

As outlined in Chapter 2, collaboration between the State and Commonwealth Governments at the State-wide level, and between State- and Commonwealth-funded service providers at the local level, would deliver substantial improvements in the development and delivery of mental health services. Despite this, the State and Commonwealth have historically acted unilaterally on mental health services and programs, and engaged in limited joint planning.

Consumers interact with mental health service providers at the local level. It is at this level that the greatest potential exists for real collaboration, innovation, continuous learning and improvement (for example, innovative approaches to case management and cross-provider collaboration). In addition, differences in the prevalence and severity of mental illnesses across Victoria require differentiated strategies and approaches, based on local understanding of community needs and resources.

Currently, there is no agreement among the various participants in Victoria's mental health system on the core outcomes that the system must deliver. Nor is there a framework linking these outcomes to the outputs and inputs of individual service systems, as contemplated by the National Reform Agenda (NRA). Instead, services tend to rely on efficiency measures (e.g., bed utilisation, ALOS) and process effectiveness (eg, 28 day readmission rates, pre-admission continuity of care) for individual service systems.

Alignment between the Commonwealth and the State, and collaboration across service providers and between the Commonwealth and the State, will remain limited in the absence of an agreed set of outcome measures and an agreed mechanism to share the costs and benefits of reform fairly. Without shared goals, such as increasing the proportion of mentally ill people who are able to participate in the workforce, individual services are more likely to focus on optimising their own sub-systems rather than the system as a whole – for example, an inpatient facility could focus on improving patient throughput, when a more important system-wide measure for some groups of patients could be the proportion discharged to appropriate step-down supported residential care. In addition, a robust outcome measures framework is needed to assess the real impact of new funding and initiatives. Without such a framework in place, continuous learning across the system will be hindered, as will the development of funding models that provide incentives to deliver clear, agreed outcomes.

In the next chapter we summarise the actions needed to resolve each of the service delivery issues described above.

CHAPTER 4:
IMPROVING THE SERVICE DELIVERY MODEL

To address the fundamental challenges in mental health described in Chapter 3, the Commonwealth and Victorian Governments need to create a new wave of reform that builds on the solid foundation established over the past 10 years. This reform should move towards a vision for a consumer-centric mental health care system that delivers measurable improvements in social and economic outcomes.

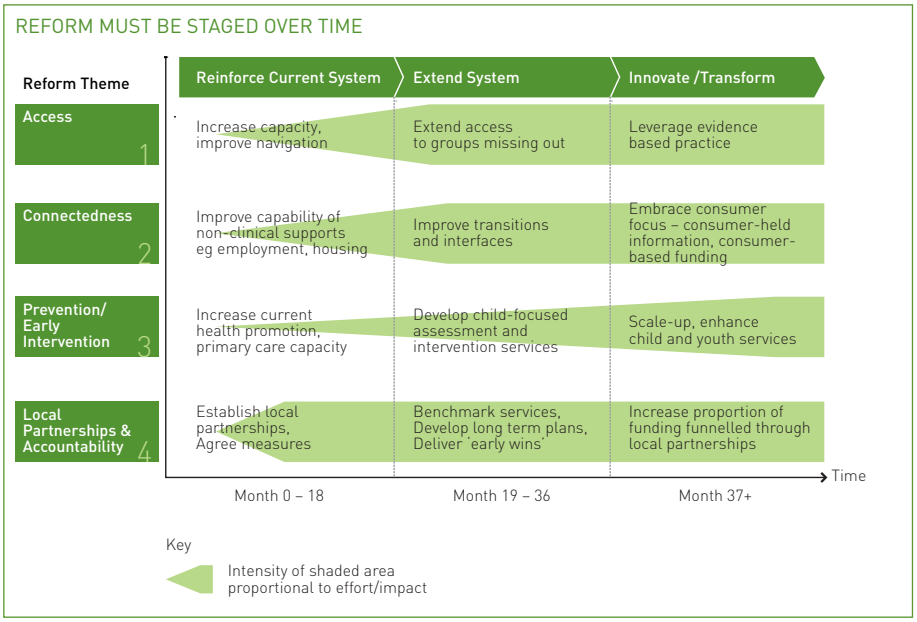
This consumer-centric reform is characterised by the following four 'themes' or principles:

- Access to consumer-focused services for those in need;
- Connectedness between all the parts of the mental health system to provide consumers with access to the right services to meet their individual needs;
- Prevention and early intervention to reduce the incidence and severity of mental health problems over the longer term; and
- Local partnerships and accountability to enhance the co-ordination of service delivery at the local level and provide a more consumer-centric approach.

This chapter summarises the key actions needed to achieve themes one to three – access, connectedness and prevention/early intervention. Chapter 5 summarises the actions for achieving theme four – local partnerships and accountability. Addendum 3 describes the specific initiatives recommended under each theme.

Each of these themes encompasses a range of initiatives with enduring impact. For each theme, the initial focus should largely be on reinforcing the current mental health system. Over time, the initiatives are designed to extend the system into new areas and, finally, to drive more fundamental transformation and innovation. Given the magnitude of the challenge, it will be necessary to stage implementation over a number of years (Exhibit 13).

EXHIBIT 13: STAGED APPROACH TO REFORM



Access

Approximately 120,000 individuals in Victoria with moderate to serious mental illness do not receive treatment in any 12-month period. This does not mean that there is a waiting list of this magnitude – many of these individuals do not seek help, for a variety of reasons – but a core reform objective should be to improve access over the next 10 years.

The immediate priority should be to reinforce the current system by increasing the capacity and capability of both Commonwealth- and State-funded services. This requires:

- Maximising the throughput of Victoria's State- funded bed-based services by moving to internal best practice, supported by the rollout of funding incentives linked to patient throughput, the dissemination of patient-flow best practices and the development of appropriate performance measures and benchmarks;
- Making targeted investments in new bed-based capacity, particularly in step-down/step-up facilities (PARC), long-term residential rehabilitation beds and secure extended care beds; improving capacity to provide home-based outreach; and ensuring all capacity-building investments are targeted to areas of greatest need and directed towards improving overall system efficiency;
- Improving access to private providers in under-serviced areas through the creation of specialist MBS-funded mental health GP positions located in outer Melbourne Community Health Centres; creating stronger incentives and supports for private providers to practise in outer suburbs; and making longer term investments in workforce capacity building through graduate training;
- Simplifying consumer navigation through the system, as well as referral and 'on-call' support, by providing an enhanced 1300 telephone service staffed by trained clinicians who can assess situations, make referrals and provide immediate counselling where appropriate.

In the medium term, the focus should shift towards extending services to consumers who 'fall between the cracks' of the current system. This should include:

- Continued capacity additions in both the private and public mental health sector;
- The development of specific services for consumers of mental health care who have multiple needs, through targeted investment in tailored services and the coordination of appropriate multi-agency responses including, for example, Child Protection, Corrections and providers of services to treat drug and alcohol abuse; and
- Continued up-skilling of and support for GPs to enable them to service more complex mental health cases, through the reinforcement of existing Better Outcomes in Mental Health training, as well as the development of closer links with private and public specialists to provide support, advice and secondary consultations.

In the longer term, ongoing improvements in access to services and the quality of services should be driven by identifying and rolling out evidence-based clinical practices that maximise the impact of supply-constrained clinical resources.

Connectedness

The chronic/episodic nature of many mental illnesses, coupled with the need for a supportive environment to facilitate recovery, drives the requirement for connectedness between the different parts of the extended mental health system.

The immediate priority to improve connectedness is to increase the capability of non-clinical support systems to respond to the needs of people with mental illnesses. This should include:

- Tailoring employment support for the mentally ill – for example, through the development of post-vocational support to help people with mental illnesses to remain in employment;
- Investment in new stable housing and housing assistance for people with mental illnesses, through joint Commonwealth-State action to provide a combination of public, NGO-provided and private housing, coupled with appropriate, scaled support; and
- Additional training for personnel in key support areas (eg, Police, Ambulance, Maternal and Child Health, Housing, Child Protection and Education) to improve their ability to identify and respond appropriately to people with mental health issues and their families.

In the medium term, the focus should shift to improving the protocols for transitioning consumers between services. This should include:

- Adopting a continuity of care approach, with GPs providing ongoing care to individuals with mental health issues and specialist services accessed from time to time as required – this is in accordance with the mainstream model for general health;
- Improving protocols for the transition of mentally ill prisoners into the community – for example, through the development of a 'fast-track' triage model in AMHS for ex-prisoners and the referral of prisoners to specialist mental health GPs; and
- Providing shared 'case management' services in the community for multiple GPs (ie, extending case management support to those cared for by private sector providers). The options here need to be explored but ideally should leverage the recently announced Commonwealth funding for 'personal helpers and mentors', as well as draw on volunteer resources.

In the longer term, a shift to a much more consumer-centric model is required. This includes:

- Development of consumer-held information that consumers can provide to selected service providers and that enables them to take a more active role in managing their own care; and
- Development of consumer-based funding models, where funding is allocated to individuals based on specific eligibility criteria and is used to 'purchase' the required services from a range of providers

Prevention and Early Intervention

Prevention and early intervention have been strong themes in health care over the past decade but there is a strong argument that too little has been done in mental health. This is despite emerging evidence that prevention and early intervention programs provide significant benefits in the long term, particularly when issues such as workforce participation and productivity are considered.

The immediate priority should be to reinforce existing initiatives in this area, including:

- Enhancing mental health promotion programs, in particular by consolidating and integrating local initiatives with broader plans and outcome measures associated with the new local governance model. This should be done as part of the shift to a stronger "social health" approach (see Chapter 5);
- Increasing the capacity of primary care providers to deliver early intervention and relapse prevention services by increasing the numbers of private providers in under-serviced areas and the continued upskilling of GPs as described above; and
- Improving State-funded services to people aged 16-24, by establishing a specialist youth service in the public mental health system (as either a new service or a sub-speciality in the existing adult service) and ensuring that this is strongly connected with other youth services.

In the medium term, services for children should be enhanced. This group is under-serviced in the current system because emerging mental health issues are difficult to identify in children and effective clinical services are in short supply. To remedy this:

- Develop a new capability to assess and refer 'at risk' children through the establishment of a unit, potentially in the Office for Children, that would provide assessment and referral services on an outreach basis for children identified as 'at risk' by teachers, maternal and child health nurses, child protection workers and other universal service providers.
- Develop a family-focused intervention capability that uses the services of private psychologists and counsellors.

In the longer term, pilot programs in this area should continue to be scaled up to provide a comprehensive State-wide service, with innovations in service delivery based on learnings from longitudinal outcome studies.

Commonwealth / State Collaboration

Accountability for many of the specific actions needed for the next wave of mental health reform rests clearly with either the State or the Commonwealth, and could be the basis of a State or Commonwealth Individual Implementation Plan (IIP), as shown in Exhibit 14. However, some initiatives require collaboration between both levels of Government and/or joint funding, as described in Chapter 7.

If the required collaboration is not achieved, some progress can still be made on the Commonwealth- and State-specific initiatives, and potentially on some limited Commonwealth or State only versions of the joint initiatives. This is discussed in Addendum 3. However, without effective collaboration, community aspirations for a consumer-oriented and connected mental health system will not be achieved.

EXHIBIT 14 • SUMMARY OF RECOMMENDED SERVICE DELIVERY INITIATIVES

	State	Commonwealth	Joint
Insufficient Access to Clinical Services	1.1 Maximise Victoria's specialist resources through moving to internal best practice 1.2 Make targeted investments in new bed-based capacity 1.5 Increase emergency and crisis response system	1.4 Improve access to private providers in under-serviced areas	1.3 Improve access for consumers with multiple needs 1.6 Simplify navigation and referral and provide greater on-call support 1.7 Improve clinical governance and evidence-based practice to ensure efficiency of care
Lack of Connectedness	2.2 Improve protocols for the transition of mentally ill prisoners into the community	2.4 Tailor employment support for mentally ill	2.1 Improve continuity of care between State system and GPs 2.3 Provide shared case management in the community for multiple GPs 2.5 Invest in stable housing for persons with mental illness 2.6 Enhance abilities of personnel in other services in mental health issues 2.7 Improve consumer information systems 2.8 Develop locally based community mental health partnerships
Limited Investment in Prevention and Early Intervention	3.1 Develop new capability for assessment and referral of children 'at risk' 3.3 Establish a specialist youth service in Mental Health Branch		3.2 Develop additional treatment capability for children 3.4 Integrate improved health promotion capacity into local area model

Note: Numbering refers to the initiatives in Addendum 3.

CHAPTER 5: PROPOSED NEW GOVERNANCE AND OUTCOMES MODEL AT THE LOCAL LEVEL

We believe a new governance model is required in mental health to:

- Improve Commonwealth-State collaboration;
- Ensure local ownership and accountability; and
- Implement a rigorous, jointly agreed outcomes framework.

Subject to full Commonwealth-State agreement and commitment, we propose the implementation of a new governance model with five principal elements:

1. Community Mental Health Partnerships that include the key mental health-related service providers in a community;
2. Community Mental Health Outcomes Leaders – new roles to facilitate and monitor the achievement of agreed mental health outcomes in each community;
3. Overall oversight and accountability for monitoring mental health outcomes residing in a single State-wide Government unit on behalf of both levels of Government (referred to here as the 'Lead Agency');
4. The Victorian Mental Health Outcomes Council – a new working group comprising senior officials from the State and Commonwealth agencies that play key roles in the mental health system; and
5. A new State-wide and local mental health outcomes framework, jointly agreed by the Commonwealth and State.

The proposed governance model offers significant benefits, as illustrated in Exhibit 15.

EXHIBIT 15 • BENEFITS OF THE PROPOSED LOCAL GOVERNANCE MODEL

PROPOSED MODEL REPRESENTS A SIGNIFICANT IMPROVEMENT OVER CURRENT APPROACH

FROM		TO
Lack of overarching alignment and coordination between the State and Commonwealth, and across State agencies	→	Formal Mental Health working group of senior representatives of all key State and Commonwealth agencies
Focus on improvement in outcomes for current Mental Health Branch consumers	→	Focus on mental health outcomes for the population at large
Limited local planning, monitoring or accountability	→	Clear community-based accountability and oversight structure
Weak linkages between public and private clinical mental health care sectors	→	Close collaboration between MH branch, GPs and private psychiatrists / psychologists
Inconsistent linkages between clinical mental health services and other support services	→	Coordinated 'partnerships' approach involving all key local service providers eg. Drugs & Alcohol
Lack of alignment on target outcomes and limited performance measures and accountability	→	Joint agreement on target outcomes, supported by a rigorous local and State-wide performance measurement and accountability framework

Proposed model provides greatly enhanced coordination among key players and a broader focus on a population's mental health

Our recommendations for the new governance model build on existing good practices in Victoria in relation to local partnerships (such as the Inner South Mental Health Alliance) and are consistent with a number of themes in Victoria's policy agenda, including:

- The Victorian Government's focus on local areas and communities in its community strengthening agenda;
- The collaboration and partnerships between communities, the non-government sector, business and other levels of government central to *A Fairer Victoria*; and
- The importance of measuring improvements in collaboration and community engagement at the local level (similar to those measured by the DVC's *Indicators of Community Strength in Victoria*), and of measuring the cumulative impact of service improvement outcomes for communities (similar to the Outcomes Framework in the *Building Stronger Communities* initiative).

Our recommendations are also congruent with themes in the Commonwealth's *Stronger Families and Communities Strategy* (first introduced in 2001 and later extended to 2009), and other Commonwealth initiatives aimed at strengthening communities.

Our recommendations are based on the minimum amount of change needed to deliver ongoing improvement in the system. They involve commitment to supporting new outcomes measures and partnership arrangements at the local level. A more radical solution would involve moving all responsibility to one level of government or the pooling of all funding. We do not believe such radical action is necessary or that it would necessarily be achievable.

The five elements of the proposed governance model are described in more detail below.

Community Mental Health Partnerships

Objectives

Community Mental Health Partnerships will have the following objectives:

- Ensure that the consumer/carer perspective is incorporated into local planning;
- Drive the development of efficient transition and continuity of care programs between the specialist mental health service and primary providers;
- Foster integration between clinical mental health services and PDRSS providers to enhance cost efficiency and provide other benefits;
- Ensure that mental health consumers receive adequate support from non-clinical support services;
- Refine crisis and emergency response procedures to ensure that local triage, Police, CAT team and Emergency Department resources are used efficiently;
- Develop local plans for prevention, promotion and early intervention;
- Review local mental health outcomes and perform community-based needs analysis and planning to address gaps in services or performance; and
- Develop information sharing mechanisms, subject to confidentiality requirements (eg, common intake tools, simplified referral processes).

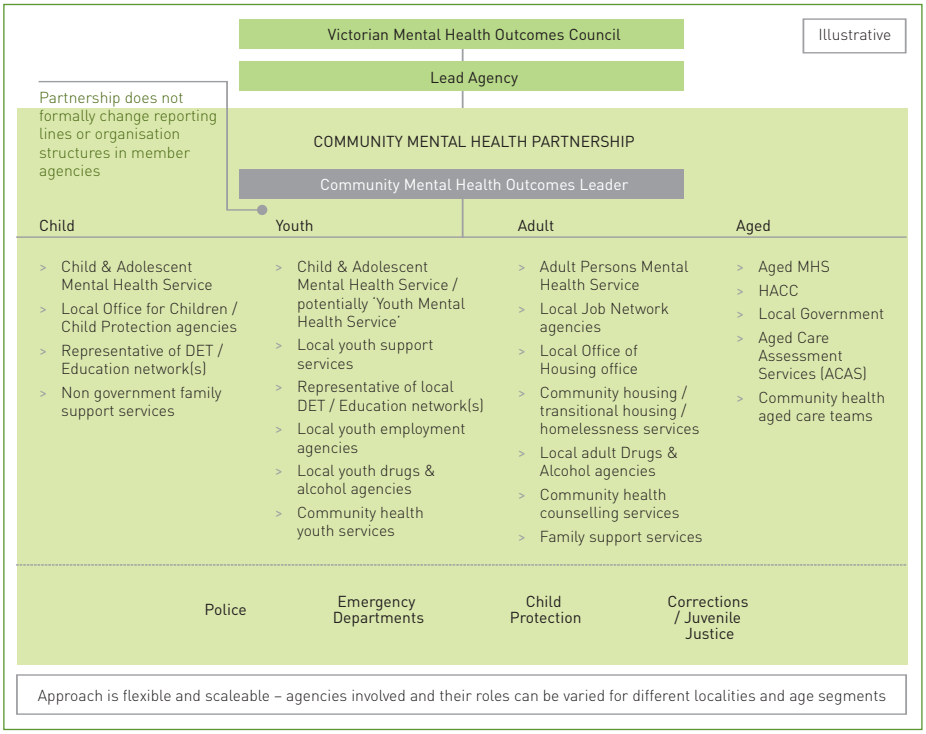
Membership

Membership of Community Mental Health Partnerships should include the Commonwealth- and State-funded agencies that provide mental health and supporting services in each community, for example:

- The Area Mental Health Service;
- The Division of GPs;
- Key PDRSS providers;
- Other health providers (eg, drugs and alcohol services, Community Health, representatives of private practitioner bodies);
- Consumer / carer groups; and
- Other key support providers (eg, housing, Jobs Network).

Exhibit 16 shows the membership of Community Mental Health Partnerships across the four age segments of Child, Youth, Adult and Aged.

EXHIBIT 16 • COMMUNITY MENTAL HEALTH PARTNERSHIP MEMBERSHIP



Structure, Funding and Meeting Cadence

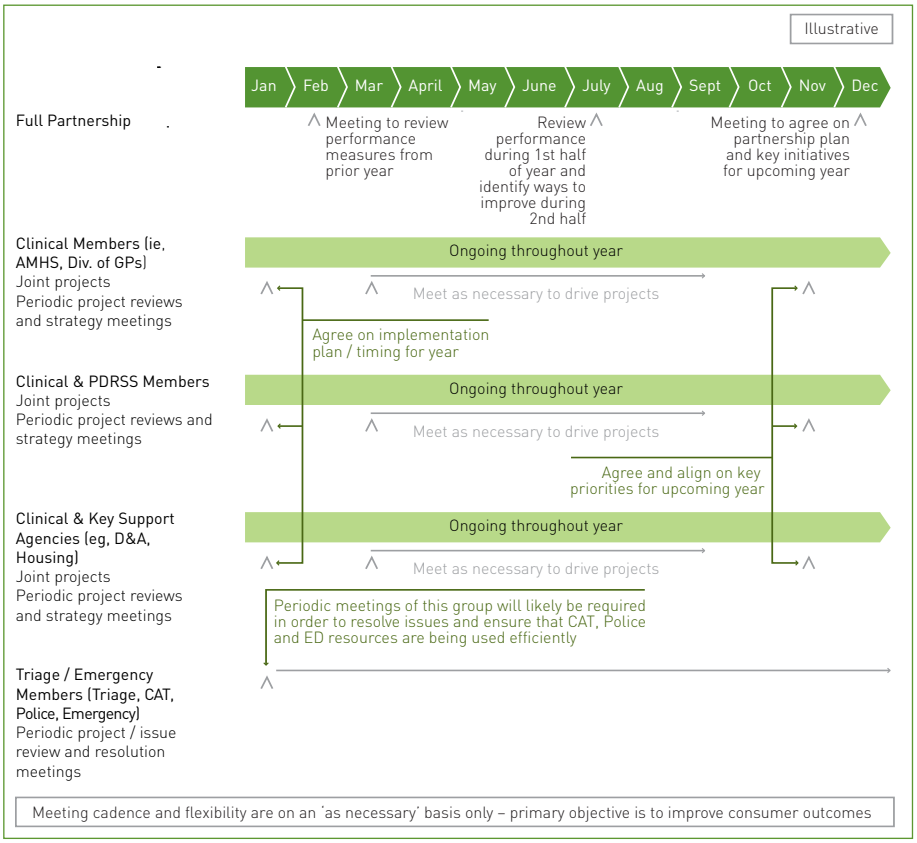
Community Mental Health Partnerships will be subject to MOUs (potentially based on Primary Care Partnership MOUs) but these will not change the reporting lines or organisational structures of member agencies. Similarly, the establishment of Community Mental Health Partnerships will not change the 'core' funding arrangements for the Mental Health Branch or other member agencies. However, we recommend that:

- For any local area, community-level funding of the initiatives described in this report be contingent on the establishment of a Community Mental Health Partnership; and
- A pool of discretionary funds be made available to the Community Mental Health Partnerships for joint projects by partnership members.

A number of methods could be used to define the Partnership area boundaries (at present, boundaries are too complex, with 21 Area Mental Health Services, 15 regional health services delivering mental health services and 31 Primary Care Partnerships). In determining the boundaries for the Community Mental Health Partnerships, it will be important to balance the successful implementation of the new governance model with the long-term need to align the boundaries of mental health services with those of other health and social services in Victoria.

Community Mental Health Partnerships will meet on an 'as needs' basis (in terms of both meeting frequency and meeting attendance). While some meetings that involve all members of the partnership will be necessary, we anticipate that this will be no more than three or four times per year. Exhibit 17 illustrates a potential meeting cadence for a Community Mental Health Partnership.

EXHIBIT 17 • COMMUNITY MENTAL HEALTH PARTNERSHIP MEETING CADENCE



Community Mental Health Outcomes Leaders

The Community Mental Health Outcomes Leader is a new role. Leaders will report directly to the Lead Agency (but may be co-located with the Area Mental Health Service or another relevant service organisation). We propose one full-time Community Mental Health Outcomes Leader for each community (equivalent to 20-30 state-wide), with access to shared administrative / analyst support from the Lead Agency.

Community Mental Health Outcomes Leaders will have the following responsibilities:

- Develop and drive the Community Mental Health Partnership (eg, identify and invite members, develop the MOU, chair meetings);
- Collect and analyse local data on mental health;
- Act as a local voice for the Lead Agency and be a conduit for feedback to the Lead Agency and Victorian Mental Health Outcomes Council;

- Develop business plans for the community for discretionary funding;
- Proactively seek to address key service gaps in the community; and
- Participate in State-wide meetings with other Community Mental Health Outcomes Leaders to share learnings and best practices.

Community Mental Health Outcomes Leaders will have no formal authority over member agencies in the Partnerships. However, we believe their central role in the Partnerships and their direct reporting line to the Lead Agency (and indirectly to the Victorian Mental Health Outcomes Council) will provide Outcome Leaders with sufficient influence to provide effective leadership for the Community Mental Health Partnerships.

Community Mental Health Outcomes Leaders will facilitate and monitor the achievement of agreed mental health outcomes in their respective communities. Working in conjunction with Partnership members, they will be responsible for identifying opportunities and developing initiatives to improve outcomes.

The calibre of the Community Mental Health Outcomes Leaders will be a critical factor in the success of the new governance model. Significant effort will therefore be needed to identify and recruit appropriately qualified and experienced individuals.

Single Government Agency with State-Wide Oversight and Accountability for Monitoring Mental Health Outcomes

As discussed elsewhere in this report, both the Commonwealth and the State (and agencies funded by each) play significant roles in the Victorian mental health system. However, we believe it is critical to establish a single point of oversight and accountability for monitoring mental health outcomes at the State level. Accordingly, we recommend that a single Government agency (the 'Lead Agency') assume this accountability. This is not a fund holding or pooling proposal and does not seek to alter Commonwealth-State service boundaries. However, the establishment of the Lead Agency model will clearly require agreement between the Commonwealth and the State, and full commitment from both levels of Government to the new governance model.

Assuming this agreement and commitment are achieved, the Commonwealth and State Governments should agree on the body to take on the Lead Agency role. If Victoria were to take on the role, it could be performed by a new unit in the Department of Human Services, or perhaps by the Mental Health Branch (with additional resourcing in light of the expanded role).

Some specific activities to be undertaken by the Lead Agency are:

- Recruiting and supporting Community Mental Health Outcomes Leaders;
- Establishing Community Mental Health Partnerships;
- Reviewing mental health outcomes in each community and identifying opportunities to improve them;
- Identifying State-wide issues and recommending actions to address them;
- Driving the new outcome measures framework;
- Actively engaging with the leadership of other agencies on mental health issues (eg, engaging with the Victorian Division of GPs on the distribution of specialist mental health GPs); and
- Developing a State-wide mental health strategy to be reviewed by the Victorian Mental Health Outcomes Council.

The Lead Agency would be supported in this expanded role by the Community Mental Health Outcomes Leaders. Additional resources in the centre would also be required.

Victorian Mental Health Outcomes Council

We recommend the formation of a new State-wide steering group – the Victorian Mental Health Outcomes Council – comprising senior officials from the key Commonwealth and State agencies that support the mental health system, including branches of DHS (Mental Health, Drugs & Alcohol, Housing, etc.), Corrections, DoHA, DEWR and Centrelink. A limited number of non-Governmental bodies (eg, the Victorian Division of GPs, the Strategic Planning Group for Private Psychiatric Services and carer and consumer advocacy groups) would also participate.

This steering group would meet two or three times each year. Additional meetings of sub-groups could be held on an 'as needs' basis.

The Victorian Mental Health Outcomes Council should have the following roles:

- Review State-wide and community outcomes and performance measures, and recommend actions to address issues on either a State-wide or a community basis;
- Develop (in conjunction with the Lead Agency) an overarching State-wide mental health strategy, including, among other things:
    - Resource allocation plans in the context of the State and Federal funding provided (note that this is *not* a budget-setting function – decisions on program funding and implementation would remain matters for individual participants, informed by better information and discussions with other stakeholders);
    - The relative focus on, and investment in, promotion, prevention and early intervention activities;
    - Key objectives for the short, medium and long term; and
- Ensure ongoing alignment and role clarity among Commonwealth and State-funded agencies and service providers.

The establishment of the Council would not alter the formal reporting lines or funding authority of the various members of the Council.

The Lead Agency, supported by the Community Mental Health Outcomes Leaders, would collect mental health outcomes data and present it to the Outcomes Council.

New Outcomes Framework

A new framework for outcome measures in mental health is required.

This should start with a set of high-level outcomes that form the basis for agreement between Governments on the improvements that their individual and joint efforts are intended to achieve.

Agreed progress measures are then required to evaluate these improvements and, potentially, provide a basis for gain-sharing arrangements. Movements in these indicators could be expected over three to five years. Intermediate progress measures would be the focus of monitoring and accountability. Input and efficiency metrics provide critical information to inform the assessment of the health and functioning of the mental health system. Accountability for funding and implementing initiatives to achieve these outcomes will rest in some instances with the State, in some with the Commonwealth, and in some with both Governments jointly.

Table 1 shows the types of outcomes that should be pursued and the associated measures that should be implemented to track progress.

TABLE 1 • PROPOSED OUTCOME MEASURES FOR MENTAL HEALTH

Framework Component	Example
Outcomes	• Lower prevalence of mental illness in the population
	• Increased economic participation & workforce productivity for people with mental illness
	• Lower mortality & morbidity resulting from mental illness
	• Increased community participation for people with a mental health problem
Progress Measures	• Rate of mental illness causing severe disability per 100,000 people
	• Rate of mental illness causing mild-moderate disability per 100,000 people
	• Proportion of people with mental illness participating in the workforce
	• Number of disability support pensions due to mental illness per 100,000 persons
	• Suicide rate per 100,000 persons
	• Number of educational discontinuations due to mental illness per 100,000
Intermediate progress measures	• Percentage of population receiving public mental health care
	• New client index (measure of throughput for outpatient services)
	• 90 day inpatient readmission rate
	• Percentage of population receiving private mental health care
	• Percentage of persons with mental illness in employment through Jobs Network
	• Percentage of persons employed one year after discharge from the public mental health system
	• Percentage of persons with mental illness in stable housing
	• Number of emergency department presentations for mental health reasons per 100,000 persons
	• Percentage of emergency department/CAT presentations that are re-presentations
	• Percentage of children with conduct disorder who finish Year 12
	• Number of persons with mental illness and co-morbid mental substance abuse problems per 100,000 persons
Inputs/efficiency metrics	• Number of beds per 100,000 persons
	• Amount of public mental health funding per capita
	• Average inpatient length of stay
	• Number of persons with mental illness who have PDRSS support
	• Number of EFT in State-funded mental health system per 100,000 persons
	• Number of BOMHs GPs per 100,000 persons
	• Number of private psychiatrists per 100,000 persons
	• Number of private psychologists per 100,000 persons
	• Amount of MBS funding on mental health care per capita
	• Number of persons with mental illness with GP discharge plans
	• Collaboration index score (measure of collaboration among service providers)

Overall, the new outcomes framework for mental health should have six principal elements:

- A comprehensive measurement framework at the local level;
- Population/community outcome measures based on a population survey;
- Measures of connectedness between clinical and non-clinical services;
- Longitudinal, follow-up measures;
- An integrated view of mental health resource investments; and
- Mechanisms to identify, capture and share best practices.

Comprehensive Measurement Framework at the Local Level

At the local level, the measures used must support performance benchmarking across areas; enable the identification of specific service weaknesses; and support the development of strategic responses at the local level.

A local area scorecard should be used to understand improvements over time, compare outcomes with those for other local areas and identify priority areas for improvement. To collect the required information, the Commonwealth and State agencies must agree to share area-based data to the maximum extent possible. Illustrative examples of local area scorecards are shown in Exhibits 24 and 27 in Addendum 2.

Addendum 2 provides further information on the central role a local area scorecard can play in driving service and other improvements at the local level.

Population/community outcome measures using a population survey

Surveys are an effective mechanism for understanding the prevalence and severity of mental illness in a community; the impacts of mental illness on workforce participation and other indicators of social wellbeing; community-level risk factors; and community perceptions of access to services and attitudes to mental illness. The 1997 ABS survey of mental health in Victoria is a good example of this. We propose that such a survey be conducted regularly (e.g., every three years), with a sample size sufficient to allow trends to be identified at the local level.

In addition, proxies for population measures should be used to enable more regular monitoring of outcomes. For example, the number of people in a local area who are in receipt of disability benefits for mental health reasons could be measured quarterly as a proxy for workforce participation.

Measures of connectedness between and within clinical and non-clinical services

Measures should be introduced to determine the degree of connectedness between services—for example, the number of GPs accepting consumers discharged from the public mental health service and the number of accepted referrals to mental health services from other services. The quality of these inter-service connections should also be assessed. We propose the use of a simple survey instrument, leveraging the commonly used VicHealth Partnerships Analysis Tool and the Primary Care Partnership surveys. Survey results can be used to target those areas where improvements in partnership quality are most needed.

Longitudinal, follow-up measures

Existing mental health care measures tend to focus on the quality of the services provided to individuals while they are in care. They are less useful in determining whether services improve the lives of consumers in the longer term.

We propose the introduction of a follow-up call for all consumers discharged from public specialist mental health facilities (eg, six months post-discharge). A similar program (the 'On Track' program) was recently introduced in Victoria to follow-up young people after they leave school. This proposed follow-up call should capture information such as whether the individual has a primary care provider, housing and employment, as well as his or her compliance with a drug or other therapeutic regime (if appropriate). This information could be used to develop a measure around the percentage of consumers who have all four of these elements in place six months after discharge.

Integration of resources across services

Existing measures relevant to mental health are contained in the 'silos' of the different service systems (e.g., State-funded clinical services versus MBS-funded clinical services). To provide a more holistic approach to local area measures, these services should share key data (aggregated at a local level to preserve privacy). For example, comprehensive measures of local area resources should include State-funded specialist resources, including bed capacity (inpatient and community) and clinical staff, as well as Commonwealth-funded resources (private psychiatrists, psychologists, and BOHMS qualified GPs, etc). Resource measures for related services (eg, drug and alcohol abuse treatment) should be selectively captured.

Mechanisms to identify, capture and share best practices

A small central group should be established in the Mental Health Branch to identify best practices in local areas, and codify and disseminate them across locations.

The suite of initiatives described above is designed to address identified issues in the Victorian mental health system and improve the key outcome metrics around prevalence, social impacts and economic impacts described in Chapter 1.

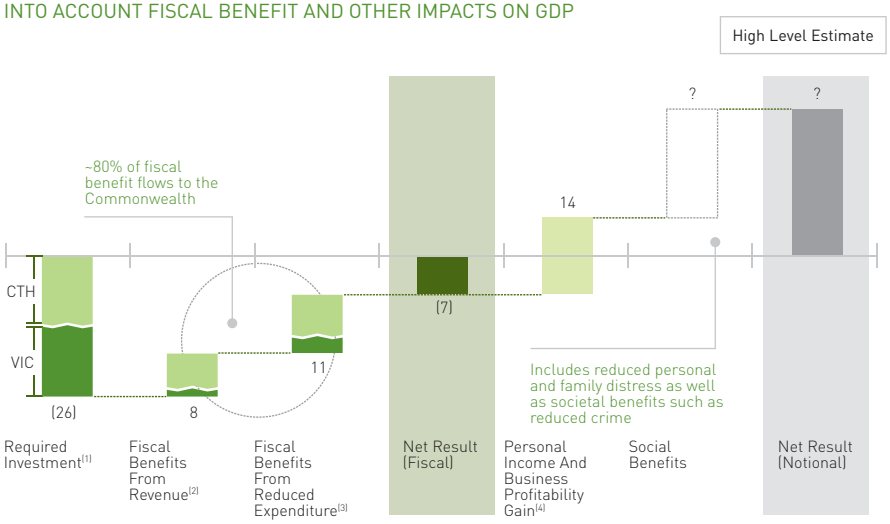
CHAPTER 6:
THE CASE FOR INVESTMENT

These initiatives are largely in addition to those recently announced by the Commonwealth and State Governments. As such, they will require incremental funding.

To understand whether there is a compelling case for this investment, we developed indicative estimates of the 'return on investment' in mental health. This analysis, which is summarised in Exhibit 18, suggests that there is solid case for investment if the overall gains to the economy are considered, even before the significant social benefits to individuals, carers and communities are taken into account.

EXHIBIT 18 • INDICATIVE COST-BENEFIT CASE FOR A 1% REDUCTION IN THE MENTAL HEALTH BURDEN, VICTORIA ($M)

THERE IS A POSITIVE ECONOMIC CASE FOR INVESTMENT TAKING INTO ACCOUNT FISCAL BENEFIT AND OTHER IMPACTS ON GDP



(1) Based on current cost efficiency of reducing a YLD as estimated by Gavin Andrews
(2) Taxation gain from participation (assuming wages of 25% below average) includes income tax (22.2%),GST on additional income (6% reduced rate assuming 40c/ additional $ is spent on non GST taxable goods) and payroll Tax; (5.5% for VIC); Absenteeism productivity gain includes company tax (all gain goes to business bottom line); Revenue gain from reduced absenteeism includes company tax (30% assuming all gain goes to bottom line); Does not include improved productivity of working persons with mental illness.
(3) Assumes reduced expense on Income support (based on # of non participating mentally ill unemployed), # of DSPs, and assuming remainder cared for by persons on carer payments; Includes estimates of reduction in justice, housing, child protection/services, disability, drug/alcohol services (assumes 30% prev for service clients, 20% direct impact of MH on services)
(4) Total GDP benefit less fiscal benefits due to tax, representing net individual income gain and business profitability gain
Note: Case based on assumption that a reduction of participation burden and productivity burden by 1% is equivalent to a 1% reduction in YLDs
Source: Gavin Andrews, Tolkien II Paper; Commonwealth Indirect MH Cost Estimates (2004); Schizophrenia and Bipolar Costs Papers (2001, 2003); VIC Budget Paper 3 (2006); BCG Analysis

This analysis shows the impact of a 1% reduction in the overall economic burden of mental illness. The cost to obtain such a reduction is estimated at ~$26m, and would deliver a ~$7m net gain to the economy, when private economic benefit is added to the fiscal benefits accruing to both levels of Government from improved workforce productivity and participation.

The cost estimate is derived from the average current cost to reduce the number of years lived with disability (YLDs) in Victoria by 1%, as estimated in the Tolkien II Report.[4]

4. ANDREWS ET AL (2006). WE HAVE USED THE MORE CONSERVATIVE CURRENT COST EFFICIENCY MODELLING IN TOLKIEN II, RATHER THAN THE OPTIMAL TREATMENT MODELLING, WHICH WOULD YIELD AN EVEN MORE POSITIVE OUTCOME.

The immediate economic benefit from a 1% reduction in the economic burden of mental illness is assumed to be a reduction in workforce non-participation by 1% (from 73,000 to 72,300 people) and a reduction in absenteeism by 1% (from 11.1 days/person with mental illness to 11 days/person with mental illness).

Governments capture a significant proportion of the resulting economic gain through taxation (income, payroll GST and company). Transfer payments (e.g., NewStart, Disability Support Pensions, and Carers payments) are also reduced, as is Government expenditure on other services (e.g., Justice, Child Protection, Housing). In aggregate, these fiscal benefits are estimated as sufficient to offset a significant portion of the investment required to improve outcomes.

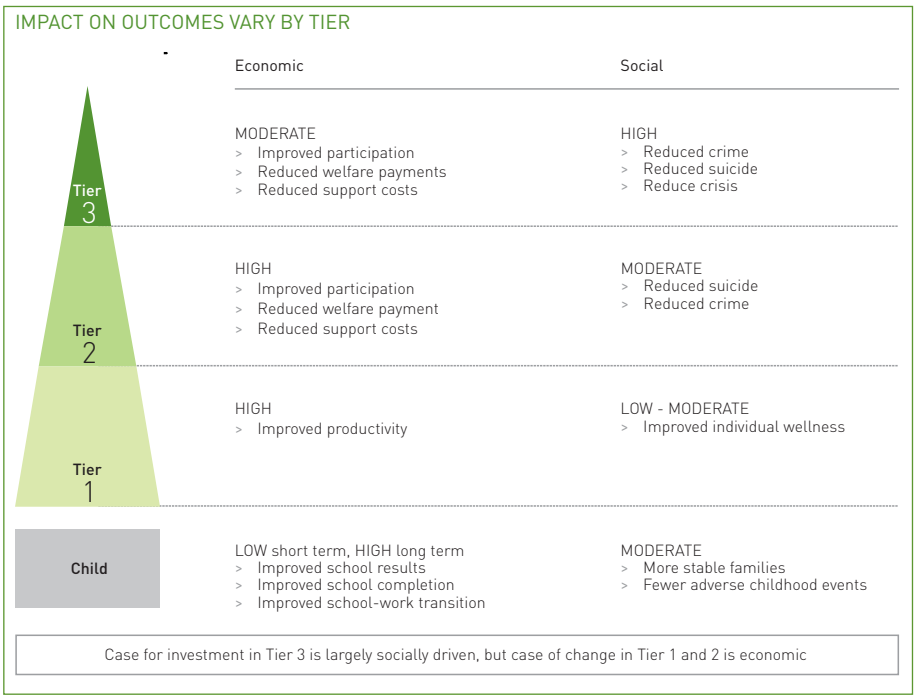
The fiscal gains vary between levels of Government, with the Commonwealth potentially seeing a positive fiscal return on investment and the State seeing a negative return. This underscores the importance of developing gain-sharing mechanisms between levels of Government to align incentives, as is contemplated by the National Reform Agenda.

In addition to the value captured by Governments, a reduction in the burden of mental illness generates economic gains for individuals and their employers, leading to an overall gain in GDP terms. On this measure, our high-level analysis suggests a net positive return on investment for the economy overall.

Improving the mental health system will also improve social outcomes. These gains may be greater than those to be had in many other areas of social policy, given the extreme distress that gaps in the treatment and support of people with mental illness can cause.

The recommended suite of initiatives delivers both economic and social benefits, but the relative weight of each varies by tier as shown in Exhibit 19.

EXHIBIT 19 • POTENTIAL TO IMPROVE ECONOMIC AND SOCIAL OUTCOMES BY TIER



In tier 3, the most significant gains are likely to be in improved social outcomes, with fewer crisis presentations, suicides and crimes committed by mentally ill people. However, the tier 3 group is small and severely ill, with limited options for cost-effective treatment, so the economic gains for this group are likely to be limited.

In contrast, tier 1 offers greater potential for economic uplift through improved workforce productivity, given the size of the group and the greater availability of cost-effective interventions at the primary care level. This group also offers the potential for very important social outcome gains through improving the quality of life for a large number of sufferers and their carers and families.

CHAPTER 7: PREREQUISITES FOR REFORM

There are three fundamental and interconnected prerequisites for delivering on the reform program described in this report:

- Increased funding;
- Collaboration between the State and the Commonwealth; and
- An increase in the capacity and capabilities of the mental health workforce in the required areas.

Achieving Increased Funding

Ongoing increases in funding are required, beyond the already significant increases announced by Victoria and the Commonwealth. The case for further investment is strong, but the path forward carries some obstacles. This is in part because the benefits will not necessarily flow to the level of Government that provides the funding, and also because Australia's federal system carries strong disincentives for one level of Government to increase spending in an area that is arguably the domain of another level of Government. This can result in underinvestment in areas where responsibilities are blurred or there is some ambiguity about funding responsibility. In the mental health system, this has led to the under-servicing of some consumers. For example:

- Consumers with a mental illness of mild to moderate severity but whose needs are complicated by interactions with agencies such as Police, Justice, Child Protection and Drugs and Alcohol – very often these are people who are involved with a wide variety of services, who present in complex and chaotic ways, but who are not of sufficient acuity to enter the State system;
- Consumers with chronic mental illness who require stable long-term housing – people in this group typically have a wide range of support needs that may vary in intensity over time, so a wider range of housing and assistance options is required to meet their needs; and
- Children who have significant behavioural problems or are otherwise 'at risk' of future mental illness – because of trauma, 'toxic' family environments or their parents' mental illness – and who may or may not be involved in the State's child protection system.

5. SUCH MECHANISMS INCLUDE MAJOR COMMONWEALTH-STATE SPECIAL PURPOSE PAYMENTS SUCH AS THE COMMONWEALTH STATE AND TERRITORY DISABILITY AGREEMENT AND THE AUSTRALIAN HEALTHCARE AGREEMENT.

Achieving Collaboration Between State and Commonwealth Governments

As outlined in this report, the next wave of reform requires collaboration between the State and Commonwealth Governments in several key areas. These include:

- Agreement on the mental health outcomes to be measured and monitored;
- Agreement to share data – to the maximum extent allowable – to enable those outcomes to be measured at the local and State levels;
- Agreement on the sharing of fiscal benefits from improved outcomes;
- Agreement to jointly support new governance arrangements at the local level;
- Agreement to jointly fund some initiatives; and
- Willingness to review funding arrangements where it is clear that they lead to sub-optimal resource allocation – this may include the greater use of existing cost-sharing mechanisms such as those used to fund programs in health, disability support, housing and homelessness, to focus on the mentally ill.[5]

Increasing Workforce Capacity and Capabilities in the Requisite Areas

Workforce shortages are among the biggest challenges facing the mental health system today. They include:

- Significant shortages of psychologists, psychiatrists and BOHMs accredited GPs, particularly in rural and outer metropolitan areas;
- Significant shortages of psychiatrists available to work in the public sector;
- General shortages of qualified psychiatric nurses;
- Difficulties in attracting clinical leaders to work in the public sector; and
- Shortages of staff in other sectors (e.g., schools, prisons, police) who are trained in providing services to mentally ill people.

New initiatives to increase service levels will aggravate workforce shortages in the short term. For example, the proposed Commonwealth initiative to allow MBS payments for psychologists is likely to attract psychologists to the private sector, increasing the shortage of psychologists available to work in the public sector.

Many of the initiatives we propose will require further increases in the capacity and capabilities of the mental health workforce, as outlined in Table 2.

TABLE 2 • MAP OF WORKFORCE ISSUES ACROSS INITIATIVES

Theme	Initiative	Workforce Issue
Insufficient access to clinical services	1.1 Improve public MH efficiency	Variable management ability
	1.2 Make targeted investments in PARC & SECU	More PDRSS workforce capacity required
	1.3 Improve access for consumers with multiple needs	Lack of AMHS community treatment capacity
	1.4i Incentives for private relocation/travel	Limited pool of qualified private providers and limited incentives to travel
	1.4ii Specialist MH GPs	Limited incentives for GPs to specialise in mental health
	1.5 Increased emergency & crisis response	Limited pool of qualified mental health workers; need for additional MH training
	1.6 Simplify navigation & referral	Lack of qualified triage clinicians (eg, psychiatric nurses
Lack of connectedness	2.1 Improve continuity of care by supporting GPs	Limited primary mental health team capacity
	2.2 Better protocols for prisoners being released	Need for additional MH-specific training & AMHS assessment capacity
	2.3 Community non-clinical case management	Need for additional MH-specific training
	2.4 Enhanced employment support for MI	Need for additional MH-specific training
	2.5 More housing for MI	Need for additional MH-specific training
	2.6 Enhance MH training for support services	Need for additional MH-specific training
Prevention & early intervention	3.1 Assessment for 'at risk' children	Limited CAMHS capacity to assess 'at risk' children
	3.2 Additional treatment capacity for children	Limited pool of qualified private providers, especially child specialists
	3.3 New specialist youth service	Limited pool of qualified MH workers; need for additional MH training
Local partners	4 Community MH partnerships	Need to attract & retain Outcome Leaders

Workforce issue related to training/upskilling existing personnel

Workforce issue related to recruitment/access to additional qualified personnel

Combination of recruitment/access and training/upskilling

Note: Numbering refers to the initiatives in Addendum 3

Investment to boost the mental health workforce should be a sustained priority for Governments, particularly the Commonwealth. Investment is needed to increase the number of medical and nursing training places as well as to upskill and retrain the existing workforce.

These three prerequisites are interdependent. For the reasons outlined in this report, increased funding alone will not deliver significant, sustainable improvements in outcomes. Enhanced collaboration between service providers and Governments is also needed, given the many interfaces with service providers experienced by mental health care consumers. Similarly, even if all the funding required were made available, workforce shortages – particularly in the areas of greatest need – would make it difficult to deliver the required service improvements.

As a result, the next wave of reform needs to be funded and delivered through sustained year-on-year increases over time, coupled with the implementation of targeted initiatives and continued policy development and refinement. These are not issues that can be fixed in one budget cycle or through one national plan.

ADDENDUM 1: SYSTEM BASELINE

Reform in the Mental Health System in Victoria

The last 15 years have seen very significant advances in mental health care in Australia and Victoria in particular. Together, the Commonwealth and Victorian Governments have made major strides in improving the mental health system in Victoria.

In 1992, the Commonwealth, State and Territory health ministers agreed on the 'National Mental Health Strategy',[6] with the aim of transferring services from an institutional to a community setting. Victoria led this reform, establishing Area Mental Health Services, a comprehensive, State-wide service delivery framework encompassing beds and community-based services.

Victoria also developed a number of innovative programs, highly regarded in Australia and overseas.[7] These include:

- EPPIC / ORYGEN, the leader in early psychosis treatment;
- Forensicare, the leader in forensic mental health care; and
- Primary Mental Health teams, the first teams of this nature to be established.

These programs complement the 'Better Outcomes in Mental Health Services' and other Commonwealth initiatives that have been rolled out across Australia.

System Baseline

People with mental illness in Victoria can access care through the following major services:

- Private providers of mental health care – local GPs, GP mental health specialists, MBS-funded private providers (eg, psychiatrists and psychologists);
- The specialist public mental health system; and
- Community health centre counsellors.

Access to these services is typically via GPs, Emergency Services, Police, other social services or self referral.

Private Providers of Mental Health Care

Three major providers of private psychiatric hospitals in Victoria (Ramsay, Healthscope and St. John of God) provide acute inpatient facilities and outpatient programs/services.

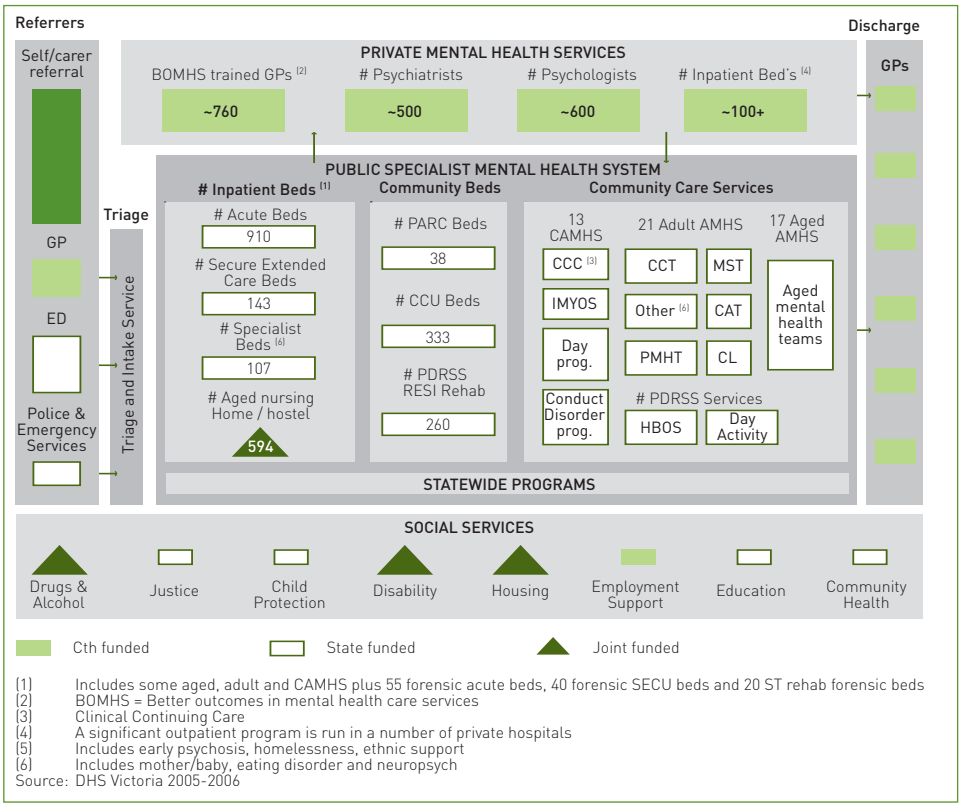
6. INCLUDING THE NATIONAL MENTAL HEALTH POLICY AND NATIONAL MENTAL HEALTH PLAN

7. THESE PROGRAMS HAVE BEEN RECOGNISED BY A NUMBER OF EXTERNAL GROUPS INCLUDING SANE AUSTRALIA, THE MENTAL HEALTH COUNCIL OF AUSTRALIA, AND THE SENATE COMMITTEE ON MENTAL HEALTH

In addition, approximately 1,100 private psychiatrists and psychologists, and 760 GPs with BOMHS (Better Outcomes in Mental Health Services) training provide community-based mental health care.

- BOMHS trained GPs can provide a limited range of non-medication, evidence-based therapies, through an MBS item at no cost to the consumer.
- Allied health professionals (psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications) can deliver up to six time-limited sessions with an option for up to a further six sessions following a mental health review by the referring GP. Divisions of General Practice act as fundholders in this component of the Better Outcomes in Mental Health Services program.
- Private psychiatrists and psychologists can also provide unlimited sessions. However the consumer pays for these sessions (typically sessions exceed $120 per hour).
- Private psychiatrists, through MBS, can provide GP support consultation and case conferencing on a consumer's behalf (with MBS rebates).

EXHIBIT 20 • SIMPLIFIED MAP OF THE MENTAL HEALTH SYSTEM IN VICTORIA



(1) Includes some aged, adult and CAMHS plus 55 forensic acute beds, 40 forensic SECU beds and 20 ST rehab forensic beds
(2) BOMHS = Better outcomes in mental health care services
(3) Clinical Continuing Care
(4) A significant outpatient program is run in a number of private hospitals
(5) Includes early psychosis, homelessness, ethnic support
(6) Includes mother/baby, eating disorder and neuropsych
Source: DHS Victoria 2005-2006

Victorian Public Mental Health System

The Victorian Public Mental Health System comprises three main programs, organised on the basis of geographically defined catchment areas. These programs are:

- Adult specialist mental health services;
- Child and Adolescent mental health services; and
- Aged persons mental health services.

Adult Specialist Mental Health Services

There are 21 Adult specialist mental health services in Victoria, aimed at people between 16-65 years who have serious mental illnesses and significant levels of disturbance and psychosocial disability due to their illness or disorder. Most Adult AMHS consist of:

- Secure Extended Care Unit (SECUs). These services provide medium to long-term inpatient treatment and rehabilitation for consumers who have unremitting and severe symptoms of mental illness, together with associated significant disturbance, that inhibit their capacity to live in the community. They are typically located on hospital sites with acute mental health units or other extended care bed based services. They represent the highest level of care on the continuum of mental health services and provide extended clinical treatment, supervision and support (SECU are not in all catchment areas).
- Adult Inpatient care. These services provide voluntary and involuntary short-term inpatient management and treatment during an acute phase of mental illness (these are unevenly distributed across Victoria).
- Prevention and Recovery Care (PARC). PARC is a step-down supported residential service for people experiencing a significant mental health problem who do not need or no longer require hospital admission. In the continuum of care, they sit between adult acute psychiatric inpatient units and a client's usual place of residence. PARC aims to assist in averting acute inpatient admissions and to facilitate earlier discharge from inpatient units. PARCs are not currently available in all catchment areas.
- Community Care Unit (CCUs). CCUs provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Average length of stay is approximately 12-18 months.
- Crisis Assessment and Treatment (CAT) team. These services operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. Some CAT teams also service hospital emergency departments.
- Mobile Support and Treatment team (MST). These services provide intensive long-term support using an assertive outreach approach and operate extended hours seven days a week. MSTs differ from CCTs in the frequency and intensity of intervention offered, and work more closely with psychiatric disability rehabilitation and support services.
- Continuing Care Team (CCT). These are the largest component of adult community based services and are clinic based. These services provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community.
- Homeless Outreach Psychiatric Service (HOPS). HOPS work in partnership with homelessness services and use assertive outreach. HOPS provide assessment and secondary consultation to homelessness services and other mental health workers. (Not available in all catchment areas.)
- Primary Mental Health And Early Intervention Team. These teams provide consultation, liaison, education and training services to GPs for both low and high prevalence disorders. They provide some short-term direct care treatment and assessment for these high prevalence disorders.
- Consultation and Liaison service (CL). This service provides assessment, treatment and prevention of psychiatric morbidity among physically ill patients who are patients of an acute general hospital. (Not available in all general hospitals.)

Some AMHS also have an Early Psychosis service for people between 16-25 years who are experiencing a first episode of psychosis (ORYGEN Youth Health).

Aged Persons Services

There are 17 aged area mental health services in Victoria, which primarily provide clinical services to people 65 years and older who have serious mental illness, and people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

- Acute inpatient services. These services provide short-term inpatient management and treatment during an acute phase of mental illness until the person can be treated effectively in the community.
- Aged persons mental health residential (APMH) care. APMH nursing homes and hostels specialise in caring for older persons with mental illnesses. They are jointly funded by the State and Commonwealth.
- Aged persons mental health teams. These are multidisciplinary teams that provide community-based assessment, treatment, rehabilitation and case management for older people.

Child and Adolescent Mental Health Services (CAMHS)

There are 13 CAMHS in Victoria, which primarily offer a community based assessment, treatment and liaison service for children and adolescents between the ages 0-18 years who have serious emotional disturbance. The following services are offered by CAMHS:

- Acute inpatient services. These services provide short-term assessment and/or inpatient treatment for children and adolescents who have a severe emotional disturbance that cannot be assessed satisfactorily or treated safely and effectively within the community.
- Clinical Continuing Care. These teams undertake assessment and treatment of children and adolescents experiencing significant psychological distress and/or mental illness.
- Intensive mobile youth outreach services (IMYOS). IMYOS provide intensive outreach mental health case management and support to adolescents who display substantial and prolonged psychological disturbance, and have complex needs that may include challenging, at risk and suicidal behaviours. These services work with young people who have been difficult to engage using less intensive treatment approaches.
- Day programs. CAMHS' adolescent day programs offer an integrated therapeutic and educational program for young people with behavioural difficulties; emotional problems such as severe depression and/or anxiety; emerging personality difficulties or a severe mental illness. Issues such as relationship and/or social difficulties and non-attendance at school are addressed through intensive group therapy. These programs are not available in all catchment areas.
- Conduct disorder programs. Conduct Disorder programs offer multilevel early intervention and prevention services designed to reduce the prevalence and impact of conduct disorder. They are in the pilot phase in Victoria and not available in all catchment areas

Psychiatric Disability Rehabilitation and Support Services (PDRSS)

The non-government PDRSS sector provides non clinical specialist mental health services. They work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community.

PDRSS are aimed at people with serious mental illness and associated significant psychiatric disability. Services cater primarily for people aged between 16 and 64 years. The precise eligibility criteria will depend on the type of service or program offered. Preferred consumers receiving case management services from the public mental health service are automatically eligible for support from the PDRSS. Service components include:

- Day Programs and Home Based Outreach Services (HBOS). These provide support to consumers living in their own homes. Training in social and living skills are provided at home, with a focus on the activities and interactions of everyday life.
- Residential rehabilitation. Residential rehabilitation services provide intensive psychosocial rehabilitation and support to people in group accommodation to prepare them for independent living.

Victorian State-wide and Regional Specialist Services

This comprises services including:

- Personality Disorder Service;
- Neuro-psychiatry Service/Brain Disorder Service;
- Victorian Transculutural Psychiatry Unit;
- Eating Disorder Services;
- Dual Diagnosis Services;
- Early Psychosis Services;
- Child Inpatient Unit;
- Dual Disability Service;
- Aboriginal Services (Koori);
- Mother-Baby Services; and
- Victorian Institute of Forensic Mental Health: Forensicare is the trading name for the Victorian Institute of Forensic Mental Health. Forensicare provides inpatient and community services to mentally ill offenders in Victoria. Forensicare offers inpatient services (at Thomas Embling), an acute assessment unit (Melbourne Assessment Prison) and Community Forensic Mental Health Services.

Specialist Services

People with mental illness interface with numerous other government-provided services such as:

- General health services (eg, Community Health, Maternal and Child Health);
- Services addressing key co-morbidities (eg, Drugs and Alcohol);
- Support services (eg, employment support, housing assistance);
- Services directly involved in mental health responses (eg, Police, Ambulance, Emergency Departments); and
- Other services that interact with people with mental illness as part of their core business (eg, Corrections, School Welfare Services).

These systems are sometimes points of referral into the mental health system. Depending on the nature of the service, they may also have ongoing contact with the individual.

The capabilities of personnel in these services to identify and support people with mental illness varies to a significant extent.

Similarly, there is significant variation in the extent to which these services tailor their service offering for people with mental illness. Some examples of mental health-specific initiatives (among others) are:

- Victorian Dual Diagnosis Initiative (joint initiative between the specialist mental health system and Drugs & Alcohol for people with co-morbid mental illness and substance use problems);
- ECAT (Emergency CAT), psychiatric liaison staff and mental health short-stay units in Emergency Departments;
- Developments in the mental health services provided in prisons, which have sought to provide more effective assessment and triage on reception, as well as a broader range of psychological and psychiatric service options for all prisoners; and
- Expansion of counselling services in Community Health Services to provide an accessible, brief or extended psychological and social intervention, complementing GP services, especially for people with complex but not necessarily severe problems.

Many of these services have expressed an intention (subject to funding constraints) to improve their capabilities in addressing mental illness-related issues and / or to provide better support to people with mental illness.

Victoria Compared to Other States

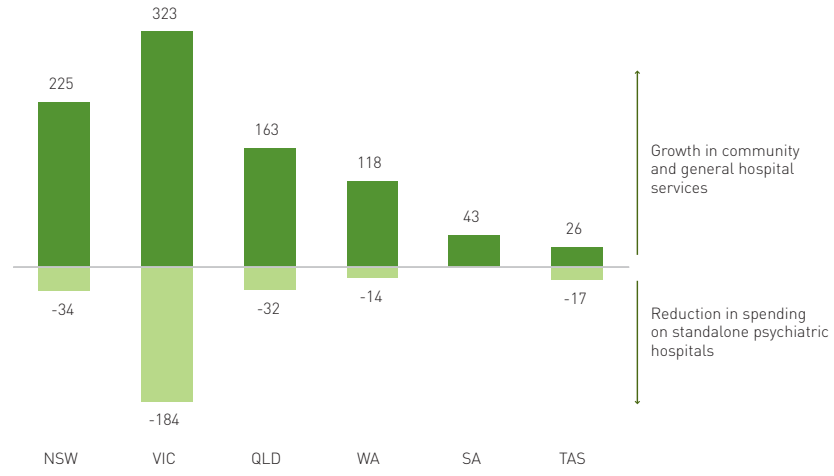
A comparison of Victoria's mental health services with those of other Australian states shows that Victoria is a national leader in most aspects of mental health service delivery.

Victoria has Moved More Effectively to Community Based Care

In spite of the 1993 Burdekin report, and subsequent National Mental Health Strategies, all mainland states except Victoria still have standalone psychiatric institutions. As Exhibit 21 shows, Victoria's early embrace of community based care allowed the reduction of inpatient costs through the provision of mental health services in the community rather than in psychiatric hospitals. By doing this, Victoria now has the highest rate of spending on NGOs as a proportion of its total mental health budget. A crucial part of this shift has been the innovative PDRSS sector.

EXHIBIT 21 • CHANGE IN SPENDING ON STANDALONE PSYCHIATRIC HOSPITALS & REPLACEMENT SERVICES, BY STATE: 1993-2003 ($M)

VICTORIA LEADS AUSTRALIA IN COMMUNITY BASED CARE



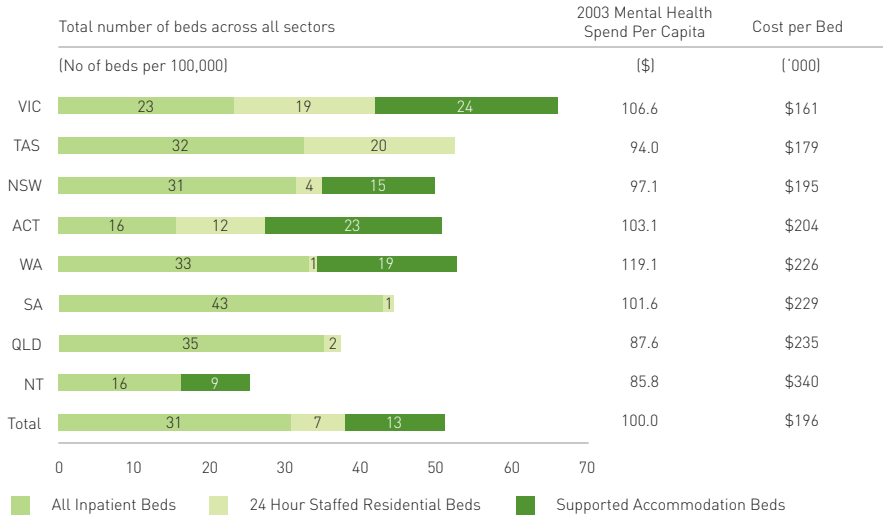
Source: National Mental Health Report (2005)

Victoria Appears to Have a More Efficient System

Victoria's early embrace of community based care, aside from having a number of social benefits, supports the more efficient use of high cost inpatient services. Victoria appears to use its money more efficiently than other states, having the most total beds across inpatient and community services, and the lowest per capita cost per bed in Australia, as Exhibit 22 shows.

EXHIBIT 22 • TOTAL NUMBER OF BEDS ACROSS ALL SECTORS, BY STATE & TERRITORY (NO. BEDS PER 100,000)

VICTORIA'S USE OF COMMUNITY CARE PROVIDES MORE BEDS AT LESS COST



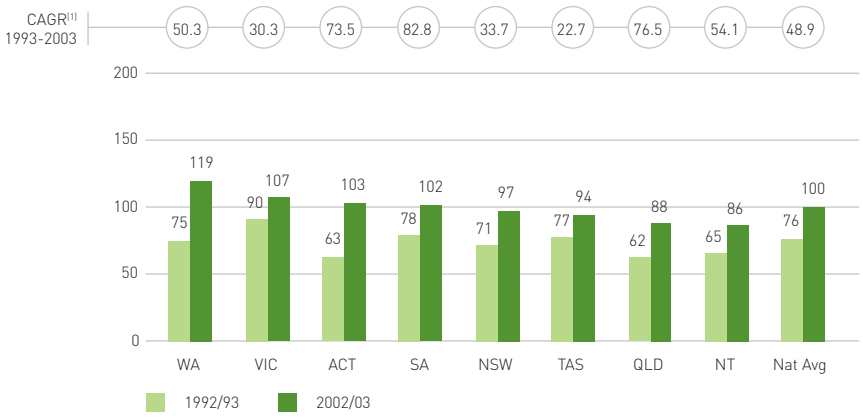
Source: National Mental Health Report 2005; AIHW Mental Health Spend Report 2004; BCG Analysis

Victoria's Spending Per Capita is Reasonably High but Growing More Slowly than in the Other States

In the early 90s, Victoria led the nation in per capita spending on State-funded mental health. However Victoria's relative spending lead has slowly declined as other states have rapidly increased their mental health budgets. In 2002-03, the last year of an official national budget review, Victoria had dropped to 2nd in per capita spending (as Exhibit 23 shows). Initial estimates based on recent State budget announcements suggest that this trend has continued.

EXHIBIT 23 • PER CAPITA SPENDING ON MENTAL HEALTH BY STATE & TERRITORY GOVERNMENTS: 1993-2003 ($ PER CAPITA)

VICTORIA'S SPENDING, ALTHOUGH GROWING SLOWLY, IS HIGH NATIONALLY



(1) Compound Average Growth Rate
Source: National Mental Health Report (2005); Respective state budget reports; BCG Analysis

ADDENDUM 2: COMMUNITY CASE STUDY: 'NELSON'

Community Story

To more closely understand the challenges facing people with mental illness today, we will examine a community in the outer suburbs of Melbourne. The community named 'Nelson' is fictional, but most of the data are based on a real community in Victoria.

2007

There are 270,000 people in Nelson, which covers a number of suburban fringe neighbourhoods. The area is growing rapidly and projected to double in size over the next 10 years. Many new families are moving into the area each week. There is an awareness that the mental health system is not working very well but very little awareness of the size of the problem.

At the beginning of 2007, a new Community Mental Health Outcomes Leader was appointed for Nelson. She has been collecting outcomes data for the area to report at the Nelson Community Mental Health Partnership annual meeting in July 2007. Attending the annual presentation on the area situation is a committee comprising of key representatives from:

- Regional Office of Housing;
- Job Network/Local Disability Open Employment Scheme Provider;
- Regional DET;
- Regional Victorian Police (and/or Ambulance service);
- Mental Health Branch (central or regional);
- Division of GP;
- Community Health Centre;
- Executive Officer of PCP;
- AMHS;
- Area Health Service (from hospital);
- PDRSS;
- Local Drugs and Alcohol Service;
- Consumer and carer groups; and
- Specialist local group (e.g., from Migrant Resource Centre, major youth service or religious group).

The scorecard that the Community Mental Health Outcomes Leader distributes to the committee is displayed in Exhibit 24. The Community Mental Health Outcomes Leader highlights the following facts on mental health in the community:

- There are ~54,000 people with mental illness;
- ~2,200 people have disability support pensions due to a mental illness (~18% higher than the State average); and
- There have been 25 suicides in the last 12 month which is a higher rate than other areas.

The Community Mental Health Outcomes Leader also highlights that there are areas where Nelson lags behind the other areas in its performance on key outcome metrics (see Exhibit 25).

EXHIBIT 24 • SCORECARD FOR 'NELSON' IN 2007

'NELSON' SCORECARD : 2007

Illustrative

		'Nelson'	State Avg
Overall Outcomes	Prevalence of mental illness causing severe disability	3%	2.4%
	Prevalence of mental illness causing mild – moderate disability	17%	15%
	Workforce participation for people with mental illness	64%	66%
	# of Disability Support Pensions Due to mental illness / 100k	830	700
	Suicide Rate / 100k	25	20
	# of educational discontinuations due to mental illness / 100k	19	20

	State	'Nelson'	State Avg	Commonwealth	'Nelson'	State Avg	Joint	'Nelson'	State Avg
Intermediate Outputs	% pop receiving State care	1.2%	1.8%	% pop receiving private care	8%	12%	% of MI in stable housing	80%	90%
	New client index	44	42	% of MI in jobs thru Job N/W	48%	50%	# of ED MH Presents /100k	850	780
	90 day readmission rate	21%	19%	% MI employed 1y post discharge	38%	42%	%ED/CAT re-presents	33%	35%
							# MI w drugs, alc prob/100k	3k	2.9k
							% child'n with conduct disorder finishing Yr 12	73%	70%
Inputs / Efficiency Metrics		'Nelson'	State Avg		'Nelson'	State Avg		'Nelson'	State Avg
	Beds / 100k	17.6	18.2	# BoMHs GPs / 100k	7.5	13	# MI w GP discharge plans	4%	5%
	$ public funding/capita	$36	$50	# private psychiatrists/100k	4	15	Collaboration index	20	30
	Inpatient av. length of stay	18	15.5	# private psychologists/100k	10	16			
	# MI with PDRSS support	100	120	$ MH MBS funding / capita	$12	$18			
	# public EFT / 100k	72	100						

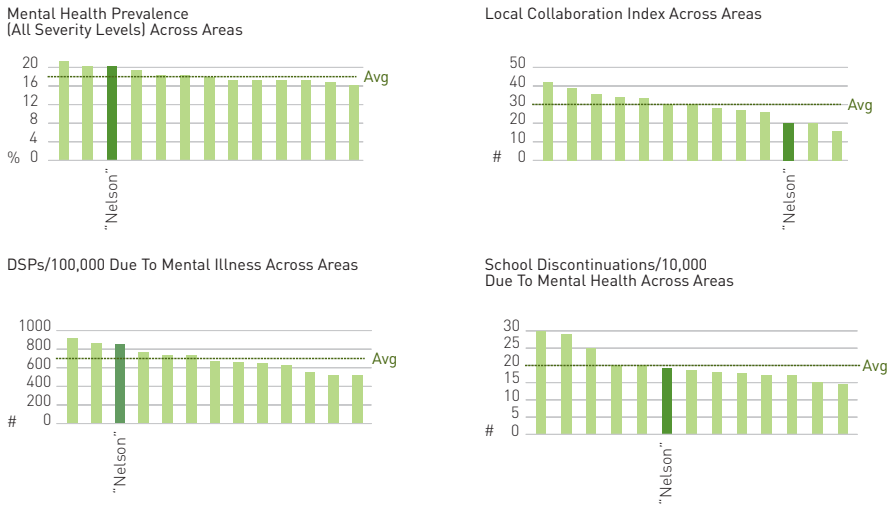
Worse Than State Average | In Line With / Close to State Average | Better Than State Average

Note: MI – Mentally ill; MH – Mental health; CP – Child Protection; ED – Emergency Department; New client index – Measure of throughput for outpatient services.

EXHIBIT 25 • NELSON COMPARISON WITH OTHER AREAS

SELECTED DATA PRESENTED TO STATEWIDE MENTAL HEALTH COUNCIL HIGHLIGHTS CONCERNS IN 'NELSON'

Illustrative



Note: Excludes rural areas

The Community Mental Health Outcomes Leader identifies the clear challenges for Nelson that need to be addressed:

- State Funded Services. There are problems with access to inpatient beds and Emergency Departments are overburdened by people presenting for mental health problems. This is due to high average inpatient length of stay, insufficient step-downs and secure extended care beds and people not knowing where to go when they are in crisis.
- Commonwealth Funded Services. There is a shortage of psychiatrists and psychologists relative to other areas. It is difficult to find GPs who are interested in mental health issues; the proportion of GPs who have been trained in Better Outcomes in Mental Health Services (BOMHS) is half the state average. The local Job Network providers are not geared up to place people with mental illness into secure jobs.
- Poor collaboration amongst providers. The collaboration index for Nelson is low, particularly between GPs and the State Mental Health sector. Many of those who exit the State sector are not finding a GP willing to pick up their care and they often cycle back into State care. There are also great difficulties in finding appropriate housing as the local housing personnel lack the training needed to serve mentally ill consumers

Given these challenges, and drawing on recently announced State and Commonwealth initiatives, an action plan is developed to close the gaps (see Exhibit 26). The action plan is presented to the State Wide Mental Health Council and identifies how Nelson will use the funding that had been made available through recent initiatives announced by the State and Commonwealth Governments.

EXHIBIT 26 • ACTION PLAN FOR NELSON 2007-2010

ACTION PLAN : 'NELSON' 2007-2010

	State	Commonwealth	Joint
Access	Achieve state best practice inpatient unit efficiency 3 additional step down beds Improved access for referrals of parents with children in Child Protection	Attract 4 more psychologists Incent 5 more specialist GPs to be trained	
Conectedness	4 mental health training programs for local housing staff	Attract new job network provider with focus on mental health Place 10 personnel with local NGOs	Develop CLIPP program to connect AMHS and GP's
Prevention / Early Intervention	Create youth-specific stream in local AMHS		

2010

Three years later, the Community Mental Health Outcomes Leader makes a presentation to the Nelson Community Mental Health Partnership. The new scorecard is as follows (see Exhibit 27).

EXHIBIT 27 • 2010 SCORECARD FOR NELSON

'NELSON' SCORECARD : 2010

Illustrative

		2007	2010	Change
Overall Outcomes	Prevalence of mental illness causing severe disability	3%	2.6%	0.4%
	Prevalence of mental illness causing mild – moderate disability	17%	16%	1%
	Workforce participation for people with mental illness	65%	67%	2%
	# of Disability Support Pensions Due to mental illness / 100k	830	800	30
	Suicide Rate / 100k	25	25	0
	# of educational discontinuations due to mental illness / 100k	19	19	0

	State	2007	2010	Change
Intermediate Outputs	% pop receiving State care	1.2%	1.6%	0.4%
	New client index	44	46	2
	90 day readmission rate	21%	20%	1%
Inputs / Efficiency Metrics	Beds / 100k	17.6	17.8	0.2
	$ public funding/capita	$36	$40	$4
	Inpatient av. length of stay	18	15	3
	# MI with PDRSS support	100	100	0
	# public EFT / 100k	72	80	8

	Commonwealth	2007	2010	Change
Intermediate Outputs	% pop receiving private care	8%	12%	4%
	% of MI in jobs thru Job N/W	48%	50%	2%
	% MI employed 1y post discharge	38%	38%	0%
Inputs / Efficiency Metrics	# BoMHs GPs / 100k	7.5	10	2.5
	# private psychiatrists/100k	4	4	0
	# private psychologists/100k	10	12	2
	$ MH MBS funding / capita	$12	$14	$2

	Joint	2007	2010	Change
Intermediate Outputs	% of MI in stable housing	80%	80%	0
	# of ED MH Presents /100k	850	830	30
	%ED/CAT re-presents	35%	32%	3
	# MI w drugs, alc prob/100k	3k	3.2k	0.2k
	% child'n with conduct disorder finishing Yr 12	73%	73%	0
Inputs / Efficiency Metrics	# MI w GP discharge plans	4%	5%	1%
	Collaboration index	20	30	10

Worse Little or no improvement Improved performance

Note: MI – Mentally ill; MH – Mental health; CP – Child Protection; ED – Emergency Department; New client index – Measure of throughput for outpatient services.

The Community Mental Health Outcomes Leader reports that there have been some improvements in mental health outcomes for Nelson over the past three years but less progress has been made in other areas.

- Prevalence of mental illness (particularly mild-moderate levels) has improved slightly from 20 to 18.6%;
- Workforce participation has improved from 64% to 66% and a number of Disability Support Pensions due to mental illness has dropped from 830 to 800 per 100,000;
- However, school discontinuation rates due to mental illness have not improved, and the number of persons with mental illness with co-morbid drug and alcohol problems has increased. These two issues in particular need to be a focus going forward.

Some of the Action Plan items have been implemented but some initiatives have been less successful than others.

Access for people with mental illness has improved.

- 1300 triage line has been successfully implemented and survey data suggest it is easier to navigate the system. This has probably contributed to the drop in mental health ED presentations.
- More step-down beds have increased acute access. There has been a small increase in the number of consumers coming into the system. However the inpatient unit is still well below best practice throughput rates and will require more attention.
- Additional AMHS EFT has been directed at treating parents with children who are under Child Protection. There has been small increase in this area.
- Nelson has developed a stronger primary and private mental health treatment/care sector and a number of psychologists have been attracted to the region. People with mental illness can now get an appointment with a private psychologist, psychiatrist or specialist mental health GP within 1-2 weeks and many do not have to pay a gap payment.

Connectedness between services has improved

- The collaboration survey shows that a number of services are working better together. Many of the local GPs have shared discharge plans with clear escalation protocols, and are happy with the level of support they receive from Primary Mental Health teams. This has probably contributed to increased access to mental health services.

More focus on children and youth is critical for Nelson

- A Y-AMHS (youth specific mental health service) began four months ago. It is too early to assess its impact.

Based on the learnings from what is working and what is not, a new action plan is developed for presentation to the Victorian Mental Health Outcomes Council.

ADDENDUM 3: RECOMMENDED SERVICE DELIVERY INITIATIVES

As summarised in Chapter 4, we recommend 19 initiatives to address the service delivery gaps identified in Chapter 3.

1. Insufficient Access to Clinical Services

1.1. Maximise the use of Victoria's specialist resources by moving to internal best practice

1.2. Make targeted investments in a range of new bed-based capacity

1.3. Improve access for consumers with multiple needs who may not receive mental health services based on current clinical criteria alone

1.4. Improve access to private providers in under-serviced areas through stronger incentives to practice in outer suburbs, and the provision of specialist mental health GP services

1.5. Improve the emergency and crisis response system

1.6. Improve access by simplifying navigation and referral mechanisms, and providing additional 'on-call' support

1.7. Improve clinical governance and evidence-based practice to ensure efficiency of care

2. Lack of Connectedness

2.1. Improve the continuity of care between the State mental health system and GPs

2.2. Improve protocols for the transition of mentally ill prisoners into the community

2.3. Provide shared non-clinical 'case management' services in the community for multiple GPs, and continue to evolve case management model

2.4. Tailor employment support for people with mental illnesses

2.5. Invest in additional new stable housing and housing assistance for people with mental illnesses

2.6. Enhance the ability of personnel in other services to identify and address mental health issues

2.7. Improve consumer information systems

2.8. Develop locally based community mental health partnerships

3. Limited Investment in Prevention and Early Intervention

3.1. Develop a new capability for the assessment and referral of children 'at risk'

3.2. Develop additional treatment capability for children

3.3. Establish a specialist youth service in the public mental health service system.

3.4. Integrate improved mental health promotion capacity into the new local level governance model

In addition, we recommend a new mental health governance and accountability model which is described in Chapter 5 of this document.

The initiatives we propose are in addition to the recent State and Commonwealth initiatives summarized in Chapter 2 of this document, although a portion of the Commonwealth monies announced could be used to fund some of them.

The accountability for many of them clearly rests with either the State or the Commonwealth, and could be the basis of a State or Commonwealth Individual Implementation Plan (IIP), as shown in Exhibit 28. Some initiatives will require collaboration between both levels of Government and / or joint funding. Commonwealth-State funding models are not the focus of this report; however, further investigation of the approach to funding areas of mental health where State and Commonwealth responsibilities overlap should be considered.

EXHIBIT 28 • SUMMARY OF RECOMMENDED SERVICE DELIVERY INITIATIVES

	State	Commonwealth	Joint
Insufficient Access to Clinical Services	1.1 Maximise Victoria's specialist resources through moving to internal best practice 1.2 Make targeted investments in new bed-based capacity 1.5 Increase emergency and crisis response system	1.4 Improve access to private providers in under-serviced areas	1.3 Improve access for consumers with multiple needs 1.6 Simplify navigation and referral and provide greater on-call support 1.7 Improve clinical governance and evidence-based practice to ensure efficiency of care
Lack of Connectedness	2.2 Improve protocols for the transition of mentally ill prisoners into the community	2.4 Tailor employment support for mentally ill	2.1 Improve continuity of care between State system and GPs 2.3 Provide shared case management in the community for multiple GPs 2.5 Invest in stable housing for persons with mental illness 2.6 Enhance abilities of personnel in other services in mental health issues 2.7 Improve consumer information systems 2.8 Develop locally based community mental health partnerships
Limited Investment in Prevention and Early Intervention	3.1 Develop new capability for assessment and referral of children 'at risk' 3.3 Establish a specialist youth service in Mental Health Branch		3.2 Develop additional treatment capability for children 3.4 Integrate improved health promotion capacity into local area model

Note: Numbering refers to the initiatives in Addendum 3.

As a result, while many initiatives can be implemented without State-Commonwealth collaboration, some initiatives require Commonwealth co-operation. Of these, certain initiatives may still be able to be implemented in a modified form. A summary highlighting this is presented in Table 3.

TABLE 3 • IMPACT OF STATE PURSUING INITIATIVES WITHOUT COMMONWEALTH SUPPORT AND COLLABORATION

Theme	Initiative	Impact of No Cwlth Participation	Comment
Insufficient access to clinical services	1.1 Improve public MH efficiency	Pursue	State only initiative
	1.2 Make targeted investments in PARC & SECU	Pursue	State only initiative
	1.3 Improve access for consumers with multiple needs	Pursue on modified basis	Coordination of care for multiple needs clients enhanced with Cwlth part funding but can be done as State only initiative
	1.4i Incentives for private relocation/travel	Don't pursue	Requires Cwlth funding
	1.4ii Specialist MH GPs	Pursue on modified basis	Leverages existing BOMHS prog; State could do to lesser degree without Cwlth participation (through Div of GPs)
	1.5 Increased emergency & crisis response	Pursue	State only initiative
	1.6 Simplify navigation & referral	Pursue on modified basis	Scope of referral service will depend on Cwlth participation; Cwlth should provide partial funding
	1.7 Improve clinical governance & evidence based practice	Pursue on modified basis	Ideally done at national level; could be done at State level
Lack of connectedness	2.1 Improve continuity of care through supporting GPs	Pursue on modified basis	Builds on current Cwlth initiatives (would benefit from changed/ additional MBS claims) but could be done on current MBS items
	2.2 Better protocols for prisoners being released	Pursue	State only initiative
	2.3 Community non clinical case management	Don't pursue	Cwlth personal support workers are critical to this initiative
	2.4 Enhanced employment support for people with MI	Don't pursue	Cwlth responsibility; State could potentially commence a new initiative through DVC Employment Programs
	2.5 More housing for people with MI	Pursue on modified basis	Can be implemented on smaller scale by the State investing in limited housing support packages together with NGOs
	2.6 Enhance MH training for support services	Pursue on modified basis	Scope of training will depend on Cwlth participation
	2.7 Improve consumer information systems	Pursue on modified basis	Can be implemented on State only basis
Prevention & early intervention	3.1 Assessment for 'at risk' children	Pursue on modified basis	Dependent on initiative 3.2; funding needs to be modified & split across both assessment & treatment capacity
	3.2 Additional treatment capability for children	Pursue on modified basis	Relies partly on Cwlth funding; State can provide some funding for clinicians, but the services will be far scarcer
	3.3 New specialist youth service	Pursue on modified basis	Primarily State only initiative; lack of additional Cwlth investment could limit ability to fund/resource co-located services
	3.4 Improved MH promotion capability	Pursue on modified basis	Will be most effective if pursued in partnership with Cwlth (leveraging existing Cwlth efforts); State can pursue independently
Local partnerships & outcomes	4. Community MH partnerships	Pursue on modified basis	Can be pursued on State only basis; but narrower scope, less central resourcing, etc

1. Insufficient Access to Clinical Services

As discussed in Chapter 3, there are significant gaps in service delivery across all three tiers of mental health.

Closing these gaps requires a combination of:

- Increasing access to specialist mental health services via improved throughput of existing services, targeted investment in new capacity (recommendations 1.1 & 1.2) and new triage rules for complex clients (recommendation 1.3);
- Increasing access to private providers via improved distribution (recommendation 1.4);
- Improving mechanisms for consumers to enter the system via enhanced crisis response and improved navigation (recommendation 1.5 & 1.6); and
- Use of best practice clinical governance and treatments (recommendation 1.7).

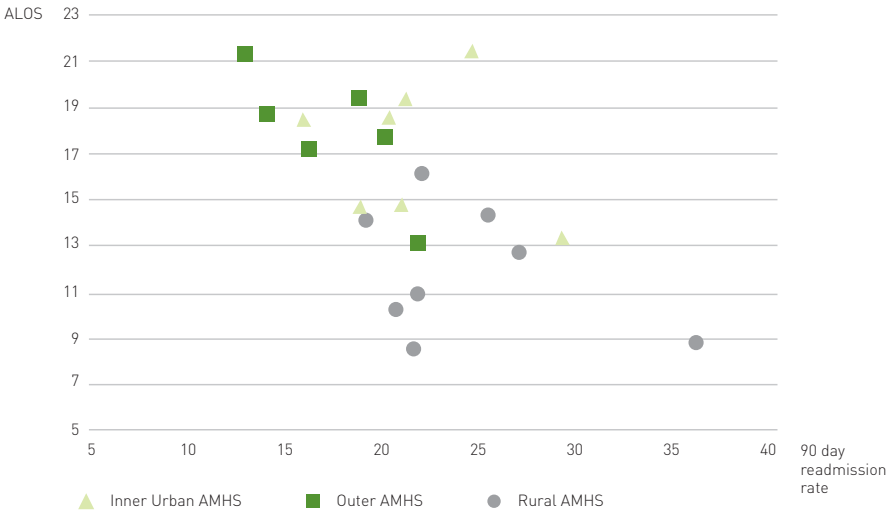
1.1 Maximise the use of Victoria's specialist resources by moving to internal best practice.

Throughput in acute inpatient units varies enormously as seen in the variations in average length of stay in Exhibit 29:

- Our analysis suggests that 50-60% of the variation in throughput can be explained by variations in the complexity of illness, bed capacity and location; and
- However the remaining 40-50% is due to differences in clinical and discharge practices.

EXHIBIT 29 • ANALYSIS OF THROUGHPUT VARIATION ACROSS HOSPITALS

AVERAGE LENGTH OF STAY VARIES FROM 8 TO 22 DAYS ACROSS LOCAL AREA



Note: Analysis only for adult inpatient units (ORYGEN omitted)
Source: RAPID 2004-2005

This suggests that there is potential to lift overall throughput in existing facilities by up to 15% if all inpatient units could match current top quartile performance. We recognise that this goal is challenging and recommend three actions to support its achievement.

- Funding incentives tied to patient throughput, re-admission rates, and in/out of area treatment targets. Funding incentives linked to targets or benchmarks could be weighted for area differences (ie, inner urban, Nelson and rural).
- Documentation & dissemination of best practice guidelines and detailed analyses and ongoing monitoring of patient flow measures. The MHB should be responsible for disseminating best practice guidelines (eg the discharge planning guidelines recently developed by Southern Health). Southern Health is a good example of an area with low throughput rates that has improved performance through the implementation of a new patient throughput model and discharge guidelines (see Vignette 1).

› Increasing training in clinical leadership and management skills for senior clinicians, as good leadership also drives improved performance. This can be achieved through more collaborative learning across hospitals and improved clinical leadership training. Incentives for senior clinicians may also need to be considered.

1.2 Make targeted investments in a range of new bed-based capacity

The throughput initiative described above will bridge some of the access gaps in mental health, however this alone will not be enough. Notwithstanding that Victoria has more beds per capita than the other States, additional investment in bed-based capacity will be required. This investment in new capacity should be targeted to provide the right types of beds in the right geographic locations.

Analysis of adult inpatient and community beds suggests that 46% of acute inpatient beds are blocked (Exhibit 30) due to:

(a) Voluntary short term stayers: ~5% of patients in an inpatient unit stay between one and three months;

(b) Involuntary short term stayers: ~20% of patients in an inpatient unit are admitted involuntarily and stay between one and three months;

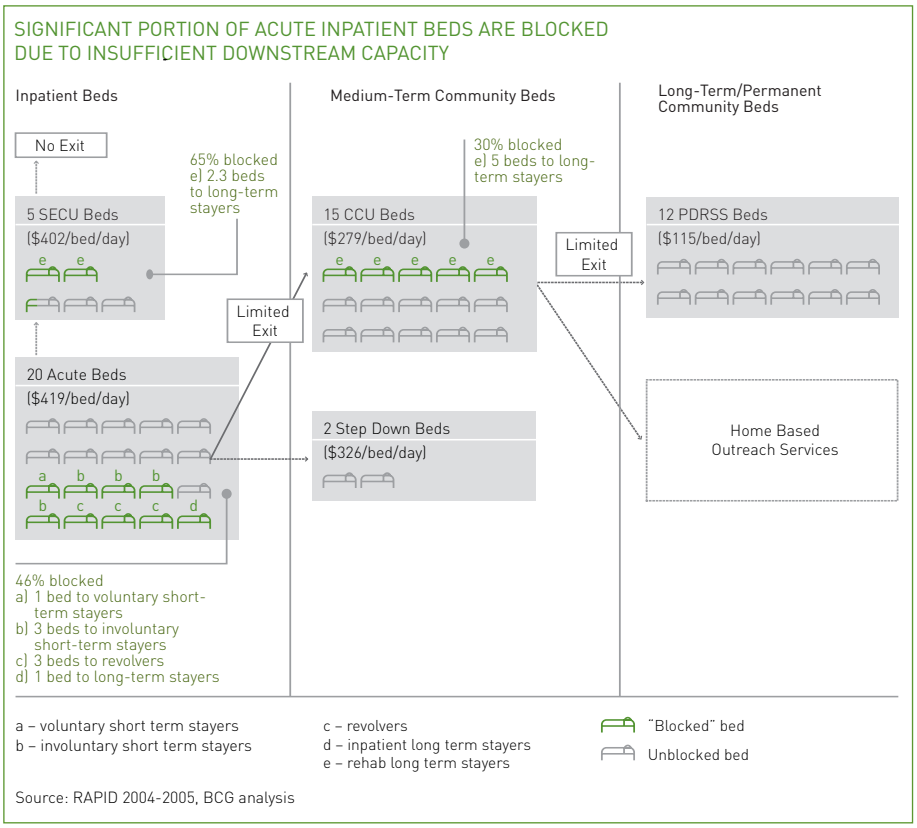
(c) Revolvers: ~16% of patients in an inpatient unit have multiple admissions each year; and

(d) Inpatient long-term stayers: ~6% of patients in an inpatient unit stay longer than three months

In addition, long-stay rehabilitation beds are blocked:

(e) ~65% of consumers in a Secure Extended Care Unit (SECU) and 30% of consumers in a Community Care Unit (CCU) stay more than 300 days (however, only 20% of SECU clients can be moved to less intensive units).

EXHIBIT 30 • AVERAGE BED CAPACITY IN AREA MENTAL HEALTH SERVICE (ILLUSTRATIVE)



Development of lower cost alternatives for these blocked inpatient beds should be a priority. This will in turn increase the throughput of the acute inpatient beds, thereby improving access. Investment is required in a range of downstream care options, targeted at under-serviced areas:

(a) Voluntary short-term stayers

- Invest in step-down facilities and move these consumers to step-down units after 14 days; and
- In addition, investing in more clinical community capacity to provide intensive post-inpatient discharge support (eg, through Crisis Assessment Team (CAT), Mobile Support Team (MST), Community Care Team (CCT)) may reduce length of stay.

(b) Involuntary short term stayers

- Invest in more SECUs to treat involuntary short-term stayers more effectively.

(c) Revolvers

- Invest in more Prevention and Recovery Care services (i.e. step-ups and step-downs). These facilities allow consumers to move from inpatient units to less intensive and lower cost facilities after the acuity of the episode or crisis reduces. For revolvers, step-ups also allow for crises to be managed more proactively through earlier intervention, which over time will more effectively manage the illness.
- In addition, investing in more clinical community capacity to provide intensive post-inpatient discharge support (eg, through CAT, MST or CCT) may reduce length of stay.

(d) Inpatient long term stayers

- Move to CCTs by moving CCU long-term stayers to downstream facilities.

(e) Rehab long-term stayers

- Increase Psychiatric Disability Rehabilitation and Support Services (PDRSS) long-term residential rehab beds;
- Develop PDRSS long-term residential non-rehab beds (with 24 hour non-clinical staffing for higher need CCU and SECU clients); and
- Increase PDRSS Home Based Outreach Service packages for people with severe mental illness in Government-funded housing (as discussed in initiative 2.5)

Implementation of these recommendations would shift consumers to lower-cost downstream accommodation options, which are also more conducive to recovery and prevent unnecessary hospitalisation.

These recommendations focus on capacity building in the adult specialist mental health system. Significant issues in the child youth and aged inpatient systems also need to be addressed. These systems raise complex issues such as the development of dedicated child/youth inpatient units and possible collaboration between the Commonwealth and the State to expand psychogeriatric nursing homes. Given the tight timeframes of this report, we have not been able to evaluate these options and recommend that further work be undertaken to determine solutions in these areas. As such, they warrant specific attention elsewhere.

1.3 Improve access for consumers with multiple needs who may not receive mental health services based on current clinical criteria alone.

Many Victorians have a mental illness and other co-morbidities (eg, substance abuse) and/ or complex behavioural problems. These consumers typically come into contact with several different Government agencies, but may not currently receive care from the specialist public mental health service as they do not meet the service's strict current clinical criteria. Ultimately, this can result in significant social and financial costs.

We therefore recommend the funding of additional resources in each AMHS to provide capacity for mental health care for selected consumers who do not meet strict current clinical criteria but are referred from programs such as Child Protection, Corrections / Justice (eg, individuals on community-based orders or who have been recently released from prison) and Drugs and Alcohol. In the longer term, further analysis should be performed to identify individuals who are heavy or complex users across multiple departments so that a co-ordinated, multiple-agency response can be provided (potentially by changing the Mental Health Branch's triage criteria, offering a variant of the service currently offered to 'complex needs' clients, and / or by developing new models with funding linked to the individual). In addition, efforts should be made to increase the ability of certain service providers (eg, Drugs and Alcohol, Child Protection) to provide primary mental health care and clarify the roles and responsibilities between the Mental Health Branch and other funded programs.

Appropriately servicing multiple needs clients may have workforce implications (eg, a different mix of workforce may be required due to the complexity of these consumers).

1.4 Improve access to private providers in under-serviced areas through stronger incentives to practise in outer suburbs and improve provision of specialist mental health GP services.

Consumers in some areas, particularly the outer suburbs of Melbourne, are disadvantaged because of a shortage of private providers and/or their inability to pay for private services. An increase in the services provided to the outer suburbs can be achieved through the following recommendations.

(i) Establish new specialist mental health GP positions in outer Melbourne suburbs. New specialist mental health GP positions should be developed in outer Melbourne areas to provide primary care mental health services for people who are financially disadvantaged. They should be integrated (i.e., co-located in Community Health Centres or inreach and bulk-bill their services.) These positions need to be financially attractive to the GPs involved and consequently may require a range of actions such as guaranteed workflow, free infrastructure and administrative support, and specific top-ups. Where possible, the Commonwealth teamwork incentives involving psychiatrists, psychologists, and allied health professionals should also be leveraged.

(ii) Create stronger incentives for private providers to practice in outer suburbs. Without such incentives there is a serious risk that a disproportionate share of the Commonwealth's significant new investment will go to areas of least need. Incentives/mechanisms to encourage private providers (psychiatrists and psychologists) to relocate to the outer suburbs should be explored. Possible options include:

- Financial incentives – upfront cash incentives or incremental MBS claim service payments;
- Infrastructure – infrastructure, logistical and administrative support through co-location with community health centres;
- Workflow incentives – first point of contact for appropriate discharge referrals or required support work;

- MBS provider numbers rules – eg, mechanisms to limit access to new providers numbers in areas with a large number of existing providers;
- Travel incentives – using programs similar to the MSOAP program (Medical Specialist Outreach Assistance Program) in rural areas; and
- Additional training places and new scholarships – tied to graduate positions in outer suburbs and rural areas.

1.5 Improve the emergency and crisis response system

Mental health crisis and emergency response is a complex system that involves Triage services, CAT teams, Police, Emergency Departments and Ambulance services, in conjunction with public mental health services, GPs and private psychiatrists. The problems with the current system include:

- Lack of effective identification and triaging of mental health-related crises;
- Police (often the first response in crisis situations) are not provided with specific mental health related training, which can potentially contribute to people with mental illness being arrested rather than diverted to emergency mental health care (although Victoria Police are currently actively considering additional training and other ways to address this issue);
- CAT teams are significantly under-resourced (there is only one CAT team in each of the 21 Area Mental Health Services), and community expectations about the role and availability of CAT teams are unrealistic;
- Emergency Departments are not adequately resourced to treat the individuals presenting in EDs with mental health issues;
- The lack of available inpatient beds in hospitals can result in people with mental illness remaining in Emergency Departments for lengthy periods; and
- The various elements of the system are not sufficiently integrated to provide a co-ordinated response.

A number of initiatives are already underway. For example:

- 'ECAT' (Emergency CAT) teams have been established;
- Mental health short-stay units have been established in some EDs; and
- Emergencies Services Liaison Committees have been established in each AMHS, involving many local participants in the crisis / emergency response system.

While these measures are producing positive results, further improvement is necessary. In the immediate term, we recommend the following:

- Funding of additional triage clinicians to support the new 1300 triage numbers in each AMHS (as discussed below), in order to reduce unnecessary calls to CAT teams and unnecessary mental health-related presentations to EDs;
- The provision of additional training to Police officers to help them respond to mental health-related incidents; and
- Making an enhanced emergency and crisis response system a key objective of Community Mental Health Partnerships (as described in Chapter 5 of this document).

None of these measures will be sufficient in isolation. We recommend that a review of the mental health crisis and emergency response system be conducted with the aims of improving access to emergency mental health care, increasing co-ordination and role clarity across key service providers, and ensuring that providers have the skills needed to respond to crisis situations and place people in care when required. This review should include an evaluation of the "Memphis model" (crisis and emergency response system implemented in Memphis) and similar models adopted in other cities.

1.6 Improve access by simplifying navigation and referral mechanisms, and providing additional 'on-call' support.

The current mental health system is difficult to navigate for consumers, carers, GPs and personnel in other support services (eg, teachers). There is no simple, user-friendly 'help service' (by telephone, online or in person) that can provide them with assistance. The Area Mental Health Services recently established single 1300 numbers for each area. We recommend that the 1300 numbers be staffed on a 24-hour, seven-day basis with clinicians who can assess situations, make appropriate referrals (AMHS, CAT teams, GPs, private psychiatrists, etc.) and provide immediate counselling in appropriate circumstances. A similar service was recently established by Southern Health (Vignette 2).

Vignette 2: Southern Health Triage System

95% decrease in 'walk in' consumers seeking assessment from community clinics;

Significant decrease in one-off assessments by CATS;

Significant decrease in call waiting time and lost calls for assistance; and

Significant increase in continuity of care for callers making repeated calls for assitance.

This community-focussed service would complement and be linked to the proposed mental health component of the National Health Call Centre (implemented initially in Victoria as the Nurse on Call service). In addition, a user-friendly website should be established to direct consumers to appropriate mental health services (including local GPs and / or community health centres). Finally, further work is needed to identify the optimal physical locations for non-emergency mental health 'walk-ins' (eg, a help desk) to ensure they are properly assessed and referred. Community Health Centres may be a logical choice (subject to workforce and infrastructure issues). Establishing and effectively marketing such a service would simplify navigation for consumers and reduce the number of unnecessary mental health presentations to emergency departments.

1.7 Improve clinical governance and evidence-based practice to ensure efficiency of care

Within the mental health research arena, there has been a shift towards evidence-based treatments and quantification of the cost-effectiveness of these therapies (eg, work by Gavin Andrews)[8]. Initial results are very promising, with up to 30% improvement in cost-efficiency. This direction has been supported by the Commonwealth MBS Better Outcomes in Mental Health Care program, which funds evidence-based psychological therapies (including psycho-education, cognitive behavioural therapy and interpersonal therapy).

However replication of such studies outside the research arena and in the clinical realm is limited to date. More support is required for research investigating the transferability, scalability and sustainability of treatment programs conducted in randomised control trials to the clinical realm. In particular, the transferability of these trial outcomes is unproven in the specialist mental health system for individuals who have significant co-morbidities and complex illnesses.

There is also a need for a governing body that develops and disseminates guidelines on mental health best practices. A peak professional body (e.g., The Royal Australian and New Zealand College of Psychiatrists, National Institute for Clinical Studies) or a larger national clinical guideline organisation akin to the UK's National Institute for Health and Clinical Excellence (NICE) could provide this service.

Given the potential for this type of initiative to significantly enhance system efficiency, further exploration into efficacy based practices and a governing body is required.

8. ANDREWS ET AL (2006), *TOLKEIN II EXECUTIVE SUMMARIES*

2. Lack of Connectedness

As discussed in Chapter 3, there is a lack of connectedness between the parts of the mental health system which means that 'whole-of-person' support provided to people with mental illness is often inadequate.

Addressing this requires a combination of the following:

- Improving the continuity of care between the State mental health system and GPs (recommendation 2.1) and for prisoners transitioning back into the community (recommendation 2.2);
- Providing greater access to case management (recommendation 2.3);
- Improving non-clinical support for people with mental illness by tailoring employment programs (recommendation 2.4), investing in additional housing targeted at people with mental illness (recommendation 2.5) and providing additional mental health training for personnel in non-clinical support services (recommendation 2.6);
- Better leveraging of consumer information to provide more seamless and co-ordinated service across providers (recommendation 2.7); and
- Establishing community partnerships of key local mental health stakeholders (recommendation 2.8).

2.1 Improve the continuity of care between the State mental health system and GPs.

Mental health is different from other areas of health in that GPs play a limited role. This is changing gradually as part of a broad drive towards mainstreaming mental health treatment. However this change needs to be accelerated, with mental illness becoming more like other illness in terms of the role of GPs.

To improve continuity of care for consumers whose level of illness escalates, primary mental health teams should provide more GPs with secondary consultations and advice to enable them to continue to care for these individuals. Psychiatrists and psychologists (working under teamwork arrangements) should assist in the provision of this support, utilising new and existing MBS items. This should be complemented by further Commonwealth investment in training and incentives for GPs under the BOMHS initiative.

In addition, shared care arrangements should be developed to encourage GPs to accept consumers discharged from specialist public mental health services. These arrangements should include the provision of specialist support and the ability to fast track re-entry into the specialist system in the event of relapse. A systematic follow-up mechanism should be introduced for consumers post-discharge to ensure they do not 'fall through the cracks' and tied to a longitudinal outcome measure as is described in Chapter 5. Vignette 3 describes a shared care program in North West region.

Vignette 3: Shared Care Program (CLIPP)

The 'Consultation and Liaison in Primary-care Psychiatry' model is part of North West AMHS in conjunction with North West Division of GPs.

It involves collaboration between AMHS, GPs and private psychiatrists.

The program provides shared care to support consumer and carer needs:

- Consultation for management of escalating illness; and
- Shared care on discharge.

The program is arguably not as strong as it once was in North West AMHS, but the model is still considered effective and is used by 20 mental health services nationally and internationally.

Finally, consideration should be given enhancing the role of GPs in primary mental health care. Potential approaches to achieving this include requiring all State mental health system consumers to be linked with a mental health trained GP or, on a longer-term basis, requiring that non-emergency consumers have a referral from a GP before they can access the State mental health system (as happens for other specialist health services).

2.2 Improve protocols for the transition of mentally ill prisoners into the community.[9]

Corrections personnel are expected to refer prisoners with mental illness to the AMHS. However, prisoners are often denied care by the AMHS, either because they are not sufficiently ill to meet AMHS triage criteria or because they do not have a fixed address in the AMHS catchment area. In addition, AHMS can take several days to make a decision on whether it will accept a prisoner for treatment, and weeks may then go by before the first appointment is available. Many prisoners don't have ongoing relationships with GPs at the time of their release and may have difficulty obtaining access to a GP. Finally, prisoners on mental illness medication receive only five days' medication upon release, but they may not be able to obtain appointments with the AMHS or a mental health GP for much longer than that.

Corrections, AMHS and the Division of GPs in each relevant community should work together to improve continuity of care for prisoners on release. For example:

- AMHS should implement 'fast-track' triage decisions and initial appointments for ex-prisoners;
- Requirements that a to-be-released prisoner have a residential address in the defined AMHS catchment area should be relaxed;
- Corrections personnel should maintain information on specialist mental health GPs in each community in order to be able to refer prisoners whose mental illness can be effectively treated by GPs; and
- Explore ability to provide ex-prisoners on medication with access to replacement medication in the event that they are not able to secure an appointment with AMHS or a GP within five days of release.

2.3 Provide shared non-clinical 'case management' services in the community for multiple GPs; and continue to evolve case management model.

Currently, community-based clinicians provide case management for clients of the State-funded specialist mental health system. People with mental illness who are not clients of the State system (eg, those being treated by GPs or private psychologists / psychiatrists) do not have access to case management. However, the Commonwealth recently announced the funding of 'personal helpers and mentors' to provide non-clinical care co-ordination (the Commonwealth also announced new mental health nurses, who may play a role in case management).

It is currently unclear how the Commonwealth-funded 'personal helpers and mentors' will be deployed (eg, geographic distribution, target consumer segments). We recommend that community-based non-clinical 'case management' services, shared across multiple GPs, be introduced to supplement the services provided by allied health professionals and the PDRSS sector. This should include personal helpers and workers, as well as the recently announced mental health nurses, with the required resources potentially co-located centrally (eg, in Community Health Centres or in the NGO sector).

More generally, further evaluation of the approach to case management (availability and operating model) is warranted. For example, in the State-funded system, all case management services are provided by trained clinicians. However, elements of case management could potentially be provided by the PDRSS sector or other non-clinically trained personnel, freeing up clinician capacity. Similarly, many 'multiple needs' clients may be receiving case management from other services and therefore have multiple case managers. As part of the broader need to re-evaluate integration of

9. AS NOTED EARLIER, WE HAVE NOT SPECIFICALLY FOCUSSED ON PRISONERS' MENTAL HEALTH IN THIS REPORT. HOWEVER, WE NOTE THAT: (1) THE PREVALENCE OF MENTAL ILLNESS AT ALL LEVELS OF SEVERITY IS SIGNIFICANTLY HIGHER AMONG PRISONERS THAN IN THE COMMUNITY, INCLUDING THE PREVALENCE OF DUAL DIAGNOSIS; (2) THERE IS CURRENTLY A SHORTAGE OF IN-PATIENT BEDS IN THE PRISON SYSTEM; (3) THE SHORTAGE OF IN-PATIENT BEDS CAUSES 'BLOCKAGES' AT MELBOURNE ASSESSMENT PRISON, THE MAIN INTAKE AND ASSESSMENT CENTRE FOR PRISONERS WITH MENTAL HEALTH PROBLEMS, WHICH HAS AN IMPACT ON THE ABILITY TO TRANSFER PRISONERS FROM POLICE CELLS TO THE PRISON SYSTEM; (4) THERE ARE LIMITED 'STEP-DOWN' FACILITIES IN THE PRISON SYSTEM FOR PRISONERS WHO NO LONGER REQUIRE IN-PATIENT CARE BUT NEED MORE CONSTANT SUPERVISION THAN THAT AVAILABLE IN THE GENERAL PRISON POPULATION; AND (5) THE CURRENT ARRANGEMENTS FOR PSYCHIATRIC AND PRIMARY MENTAL HEALTH SERVICE DELIVERY ACROSS THE CORRECTIONS SYSTEM IS FRAGMENTED ACROSS MULTIPLE PROVIDERS, AND INTEGRATION WITH OTHER PRISON HEALTH SERVICES IS NOT ALWAYS OPTIMAL.

   FURTHER CONSIDERATION OF THE MOST EFFECTIVE WAY TO ADDRESS THESE ISSUES (AND MENTAL HEALTH CARE FOR OFFENDERS IN VICTORIA MORE GENERALLY) IS WARRANTED. IN ADDITION, THE FUNDING AND CONTRACTING ARRANGEMENTS FOR MENTAL HEALTH CARE FOR PRISONERS ARE COMPLEX, WITH THE DEPARTMENT OF JUSTICE AND DEPARTMENT OF HUMAN SERVICE FUNDING DIFFERENT COMPONENTS AND SERVICE DELIVERY SPREAD AMONG MULTIPLE PROVIDERS. IN THE MEDIUM TERM, CONSIDERATION SHOULD BE GIVEN TO CONSOLIDATING POLICY, FUNDING AND SERVICE DELIVERY, INCLUDING RECONSIDERATION OF THE MOST EFFECTIVE PORTFOLIO RESPONSIBILITY.

10. THE COMMONWEALTH'S NEW WELFARE TO WORK CHANGES EFFECTIVE 1 JULY 2006, ESTABLISH NEW REQUIREMENTS FOR WORK CAPACITY ASSESSMENT AND ASSOCIATED ACTIVITY REQUIREMENTS (EG HOURS OF PARTICIPATION IN WORK, MEETING OBLIGATIONS SUCH AS PARTICIPATION IN JOB SEEKING OR RECOMMENDED SPECIALIST PROGRAMS). COMPLIANCE WITH THESE CHANGES AFFECTS DISABILITY INCOME SUPPORT AND OTHER ALLOWANCES.

11. WAGHORN, G, (2005) THE EMPLOYMENT OF PEOPLE WITH MENTAL ILLNESS.

service for 'multiple needs' clients (as discussed in recommendation 1.3), consideration should be given to consolidating case management for these clients.

Another potential avenue for additional support is the use of volunteers. The MATES program run by the Red Cross in Tasmania is a successful example of this. The program involves the use of screened and trained volunteers to supplement the traditional role of clinical case managers.

2.4 Tailor employment support for people with mental illnesses

Employment support for the mentally ill is currently provided by a number of services (eg, Job Network, Personal Support Programme, Disability Open Employment Services, CRS Australia). These are almost exclusively funded by the Commonwealth (the State Government's Department of Victorian Communities plays a small role in supporting employment programs for targeted population groups).[10]

In general, these employment programs:

- Are not specifically targeted at, or tailored to, the specific needs of people with mental illness;
- Are generally based on a funding model that encourages throughput rather than sustained assistance over the longer term;
- Do not provide meaningful support on commencement of employment (when people with mental illness often need support in maintaining employment); and
- Are not linked in any way to ongoing clinical care.

Moreover, these services are extremely fragmented (eg, the PSP focuses solely on pre-vocational assistance and then transitions clients to the Job Network to obtain employment). Surveys of providers of these services have also identified additional issues. For example, a survey of PSP providers indicated that funding was significantly insufficient, and a survey of Job Network providers found that personnel were not confident of their ability to effectively serve people with disabilities.

There is substantial evidence that the vocational rehabilitation needs of people with mental illnesses are not adequately addressed.[11] For example, a recent survey of over 3000 job seekers at disability employment service providers found that people with psychological or psychiatric illnesses fared worse than people with any other category of disability in securing and retaining employment. There is also evidence that collaboration between employment services and clinical care is an effective way to improve employment outcomes for people with mental illness (either through co-location or better linkages).

We recommend that the Commonwealth revise its current employment programs to provide support that is better tailored to people with mental illnesses. Specific areas to be addressed include:

- Enhancing post-placement support to help people with mental illness sustain employment;
- Improving collaboration both across Commonwealth-funded employment service and between employment services and clinical care (eg, mental health case managers); and
- Ensuring that personnel across the spectrum of employment services have the knowledge and skills needed to effectively assist people with mental illnesses.

2.5 Invest in additional new stable housing and housing assistance for people with mental illnesses.

Stable, affordable housing is both crucial to recovery from mental illness and in short supply for people with ongoing mental health problems. A range of actions have been taken by the Office of Housing to prioritise mental health clients, equip housing workers to respond to relevant issues, and support advocacy workers. However, the

current public housing model is not an effective solution for many clients because (1) the waiting period is often quite lengthy; (2) if public housing becomes available, it is often in high-density buildings where the concentration of people with mental illness is not conducive to recovery from mental illness; (3) many mental health consumers require continued support following the transition to self-housing; and (4) public housing personnel have limited capabilities in dealing with the mentally ill (and, in any event, are not an appropriate source of support/ rehabilitation).

Additional investment is therefore required in stable, long-term accommodation for people with mental illness, combined with in-reach support (with the extent of in-reach support varying based on clinical need) This should be provided by generic social housing agencies, and include increased nomination rights in public housing and negotiated places in new Housing Association properties. Mental health agencies should ideally be involved in the planning process to ensure optimal location and clustering. In reach support from the PDRSS, public mental health and/or primary care sectors, as well as Commonwealth-funded personal support workers, should be arranged concurrently with housing placement.

At the same time, greater use should be made of the Commonwealth Rental Assistance program to support people with mental illness to live in independent but supported accommodation, with fewer restrictions on the eligibility of private and community sector residential services. Linking private rental brokerage services with specialist mental health support services may also be useful in assisting clients to access suitable housing. The homelessness support sector also has an important role to play in linking mental health clients to housing assistance and helping them through key transitions such as post-discharge and movement form transitional to long term housing.

Models such as the Victorian Disability Housing Trust, which assist in leveraging funds from private and charitable sources with the active engagement of mental health agencies and the NSW HASI model should be considered in designing these programs.

One housing-related issue that needs to be resolved relates to funding. Investment in housing implies large upfront capital costs and, as consumers move along the continuum from State-funded inpatient units to permanent, stable housing (whether private or State), there is a middle zone where funding responsibilities are contentious (Exhibit 31). In particular, residential rehab falls into this middle zone. This is an area where investment is partially curtailed due to concerns on the part of both the State and the Commonwealth around responsibility for accommodation costs.

EXHIBIT 31 • COMMONWEALTH AND STATE FUNDED ACCOMMODATION FOR PEOPLE WITH MENTAL ILLNESS

		Short-term Highly Supported Accommodation			Long term/Permanent Supported Accommodation			Permanent Independent Living (limited support)		
		Psycho-geriatric inpatient	Acute inpatient	PARC	SECU/ CCU	PDRSS Resi rehab	PDRSS Supported Accom	Social Housing	SRS	Private Rental
Major Costs	Housing[1]	State/CW capital	State	State	State	State-Capital CW -rental payments	State/CW-capital CW -rental assistance	State/CW capital and rental	Private capital CW rental assistance	Private capital CW rental assistance
	Utilities	State	State	State	State/CW capital	CW pension/ private	CW pension/ private	CW pension/ private	CW pension/ private	CW pension/ private
	Food	State	State	State	CW pension/ private	CW pension/ private	CW pension/ private	CW pension/ private	CW pension/ private	CW pension/ private
	Non clinical support	State	State	State	HACC/ PDRSS	HACC/ PDRSS	HACC/ PDRSS	HACC	HACC	HACC

Continuum of accommodation options for people with mental illness

Funding responsibilities is complex for this area

Commonwealth (or Commonwealth and private) funding

State funding

Joint State - Commonwealth funding

2.6 Enhance the ability of personnel in other relevant services to identify and address mental health issues

Limited training has been provided to personnel in services outside the Mental Health Branch to help them to identify people with mental illnesses and provide them with effective support. Personnel from several Government agencies expressed the view to us that additional mental health training is required. Similarly, several stakeholders indicated the need for additional 'on-call' support to help personnel in other services deal with consumers with mental illnesses.

We therefore recommend that additional training be provided to personnel in areas such as Police, Ambulance, Maternal and Child Health, Corrections, Housing, Child Protection and Education to improve their ability to identify and respond to mental health issues. The training should be administered and funded by the services themselves, assisted by the Mental Health Branch. The additional triage and telephone support referred to above will also provide more accessible on-call support for personnel in other services. Finally, the establishment of Community Mental Health Partnerships (described in Chapter 5), and the network-building and improved dialogue that will result from the partnerships, will also be beneficial in this regard.

2.7 Improve consumer information systems

Consumer mental health information is fragmented, with limited sharing between service providers (for example, even within the Corrections system, electronic patient records do not follow offenders if they move from one prison to another). This can lead to inefficient service as providers do not have comprehensive information about consumers, who are required to repeatedly explain their situation to providers. Several efforts have been made to improve efficiency of consumer information sharing, subject to privacy issues (eg, the SCoTT tools and Service Co-ordination initiative in Primary Care Partnerships, the healthSMART initiative, and other areas of the Department of Human Services).

These efforts should be continued and expanded in order to streamline intake and referral processes and deliver integrated care to joint clients. Information sharing may range from manual / ad hoc exchanges in the immediate term to electronic information sharing in the medium and longer term (eg, expanded use of SCoTT tools or other electronic information sharing tools). The RAPID system should also be extended to cover the PDRSS sector as soon as is practicable. In addition, further consideration should be given to expanding the use of consumer-held information and, more generally, enabling consumers to expand their role in managing their own care. Existing investment in this area (eg, healthSMART and SCoTT tools) should be leveraged wherever possible.

2.8 Develop locally based community mental health partnerships

These are described in more detail in Chapter 5.

3. Limited Investment in Prevention and Early Intervention

Promotion, prevention and early intervention in mental health can generate considerable benefits at any age. However, the area as a whole suffers from significant underinvestment.

To remedy this, we propose prevention and intervention programs focused on three different groups; children, youth and the general population.

We recognise that prevention programs can have benefits in areas beyond those covered in this section. The role of primary care in prevention, for example, has considerable promise. We have, where possible, sought to embed the concepts of intervention and prevention in our recommendations in other areas. For example, the concept of relapse prevention is critical to our recommendations around continuity of

care. Similarly, shared care arrangements are based on the principle that intervention should occur as early as possible throughout the entire mental health system.

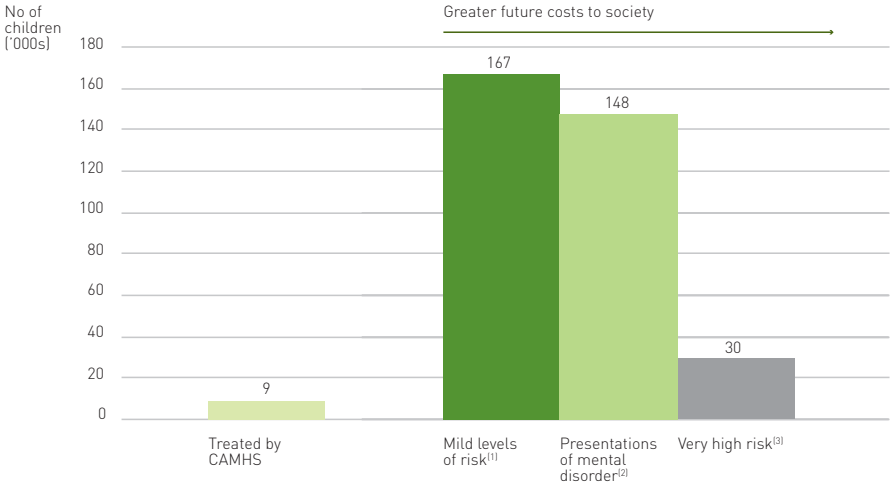
Children

While a number of universal service points (eg, Maternal and Child Health, Kindergarten, Child Care and Schools) already identify at-risk children, there is limited capability to clinically assess the mental health of these children or to provide clinical support to those that are identified to as in need.

The current system includes only one specialist treatment service for children with mental health problems: CAMHS.[12] CAMHS provides services to children with severe mental health issues. Children with mild to moderate social/emotional and behavioural disturbances are generally unable to access treatment. Exhibit 32 illustrates this gap in treatment.

EXHIBIT 32 • NUMBER OF 'AT RISK' CHILDREN BETWEEN 4 & 17 YEARS, VICTORIA ('000)

CAMHS IS ONLY ABLE TO TREAT A SMALL NUMBER OF POTENTIAL CLIENTS



(1) Child living in relative poverty
(2) Includes clients with co-morbidities, and all forms of disorders
(3) Currently in contact with Juvenile Justice, Child Protection and/or Early Childhood Intervention systems, or homeless
Source: Sawyer 2000; Zubrick 1995; BCG Analysis;

We propose the development of a new capability to assess the mental health condition of children with significant risk indicators. This will need to be supplemented by the provision of cost-effective clinical support to those children who need it. Developing targeted assessment and treatment capabilities has the potential to provide significant system-wide uplift to the treatment of children at risk.

These new capabilities are described below.

3.1 Develop a new capability for the assessment and referral of children 'at risk'

A triage capability involving specialist assessment, referral and secondary consultations for at risk children should be developed. We propose that a new unit be established to perform this role and track children across the universal service points. The unit could report into a number of different areas, but the Office for Children may be the most appropriate, given the need to provide a comprehensive and holistic intervention for at risk children across the State.

The triage capability would be a referral point for teachers and other universal staff workers, who would initially involve the family. Assessment would be conducted through outreach teams visiting the universal service points or through families taking their children to fixed locations. Assessment would be provided in each local area (potentially through accredited private providers).

Children in high-risk Office for Children programs, such as Child Protection and Juvenile Justice, could be referred directly to the new service. In the longer term, the service could

12. SOME OTHER SERVICES EXIST, SUCH AS TAKE TWO FOR CHILD PROTECTION, AND THE STUDENT WELFARE AND COUNSELLING SERVICES PROVIDED BY THE DEPARTMENT OF EDUCATION AND TRAINING, BUT CAMHS IS THE ONLY DEDICATED UNIVERSAL MENTAL HEALTH SERVICE FOR CHILDREN.

be integrated with the proposed new community model for family services and provide an additional pathway for the proposed Community Based Intake system.

The new unit should provide training for staff in universal service points on ways to increase the resilience of children and to identify at-risk children. It should also provide parenting and other prevention programs. In addition to providing specific support and training for staff, the unit should be responsible for strengthening the environments in which children operate through the provision of universal programs involving families, schools, CAMHS for specific clinical input, and possibly other Government departments if required (similar to the current CAST and KKPP programs).

3.2 Develop additional treatment capability for children

The relatively high cost CAMHS and Take Two programs (the latter being only available to children in Child Protection) should be supplemented with greater access to counselling services for children, based on early intervention and secondary prevention.

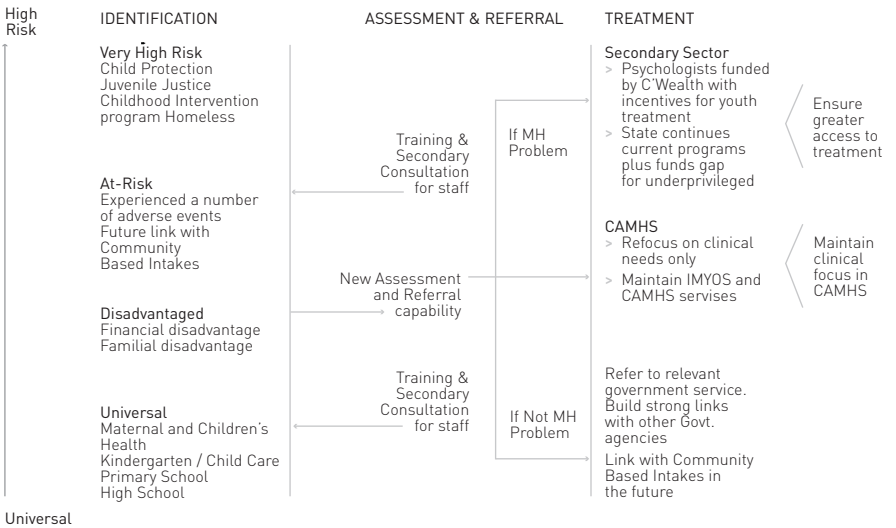
This capability should be provided by private psychologists part-funded through the MBS under the new Commonwealth proposals with the State government potentially funding gap payments for families who would otherwise be unable to access treatment.

In addition, the State would continue to fund existing counselling services such as those provided in the School Welfare programs in the Department of Education and Training. Programs such as the Primary Welfare Officers, Student Support Services Officers and Student Welfare Coordinators are critical to ensuring student engagement and school retention, as well as providing simple early intervention and treatment for mental illness. Linking these School Welfare programs with the new identification and referral capability, and with improved secondary treatment systems will give at risk children a greater range of services and improved continuity of care.

The improved treatment capability should also be accessible through referrals from the new assessment and referral capability in the Office for Children. Protocols should be established that would require private psychologists to work with the families of the children being treated. The use of preferred or recommended providers would encourage take-up of the appropriate protocols. By integrating treatment for children and parents with improved training for MCH, kindergarten, childcare and school staff, the different environments with which the child interacts can be harmonised.

This proposal carries significant workforce implications. For the system to reach scale, incentives will be needed to encourage more private psychologists to focus on children and to locate in areas of need.

EXHIBIT 33 • POTENTIAL FRAMEWORK FOR CHILDHOOD INTERVENTION



The creation of this secondary treatment system will allow CAMHS to maintain its focus on the clinical treatment children with severe mental disorders. Exhibit 33 outlines the proposal.

3.3 Establish a specialist youth service in the public mental health service system

There is significant evidence of the cost benefits of investment in early intervention in adolescence, as this is the point where the majority of severe mental health problems begin to emerge. The Mental Health Branch has recently increased its investment in treating early psychosis (based partially on the success of EPPIC/ORYGEN).

We recommend that the Mental Health Branch establish a specialist service focused on the 16-24 age segment. This could be achieved either by establishing a new Youth service category (ie, along with Child, Adult and Aged), or, potentially, by establishing a sub-specialty within the Adult Mental Health Services. Either way, this would involve some reorganisation of adolescent inpatient care to be more distinct from adult beds, with strong professional, management and referral links to a broader youth service.

At the same time, non-inpatient elements of the new youth service would, wherever possible, be co-located with other youth-oriented services in local communities, and would focus more strongly on early intervention. Connections between the new service and wider community strengthening and youth development initiatives will be essential to its success. Links with the new National Youth Mental Health Foundation will also be important in order to leverage their expertise and new research. A greater number of referral points in the community, local government and education sectors[13] will need to be embedded in the specialist youth service. The recommended local area governance framework and outcome measures (see Chapter 5) should be used to measure the success of this integration. Vignette 4 describes a co-located youth service that was established in Barwon.

Vignette 4: Specialist Youth Service, Jigsaw Youth Health Service

The 'Jigsaw Youth Health' service is a youth-focussed service offering co-located mental health services, drug treatment services, youth counselling, disability support and a bulk billing GP service.

The service is jointly operated by Barwon Health, clockwork Young People's Health Service (a Barwon GP Division initiative) and Pathways, the significant local PDRSS provider.

The service is offered in a youth-friendly environment in a shopping mall, and provides an intake process with a shared database / medical records.

3.4 Integrate improved mental health promotion capacity into the new local level governance model

At the broader population level, evidence shows that primary promotion and prevention programs can bring about considerable improvements in mental health at all ages.[14] At present, there are a number of service units with mental health promotion capacities at different levels of Government, including community health, PCPs and the MCH program. However, at a local level, there is no coherent plan for targeting mental health improvement initiatives, nor any accountability for their effectiveness. It will be important to target community settings where mental health issues first

13. INCLUDING NGOS, COMMUNITY HEALTH SERVICES, LOCAL GOVERNMENT SERVICES AND SCHOOL WELFARE SERVICES

14. INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION (2000). *THE EVIDENCE OF HEALTH PROMOTION EFFECTIVENESS: ASSESSING 20 YEARS EVIDENCE OF THE HEALTH, SOCIAL, ECONOMIC AND POLITICAL IMPACT OF HEALTH PROMOTION*. BRUSSELS

emerge. Stronger local communities can help to decrease the incidence of mental health problems, particularly anxiety and depression, through family, small group and whole of community based approaches to addressing known risk and protective factors.

Effort in this area will be dependent on sustaining, growing and better coordinating the non-recurrent investments provided by VicHealth, DHS (through Community Health Services for example) and the Commonwealth.

We propose that the Community Mental Health Partnerships become a focal point for mental health promotion activities, and that the State-wide strategic mental health plan be used to maintain the focus on promotion, prevention and early intervention. The success of initiatives in this area should be measured on an interim basis by the Community Mental Health Outcomes Leaders and the Lead Agency, with annual reports to the Mental Health Outcomes Council.

GLOSSARY

ABS: Australian Bureau of Statistics

ALOS: Average Length Of Stay. A measure of average time spent in hospital during treatment of all patients in a given period

AMHS: Area Mental Health Services. Located within the Mental Health Branch, Department of Human Services in the Victorian State Government

APS: Australian Psychological Society

ATSI: Aboriginal and Torres Strait Islander

BCG: The Boston Consulting Group

BOMHS: Better Outcomes for Mental Health Services program. An initiative of the Commonwealth Government to improve mental health training for GPs.

CALD: Culturally and Linguistically Diverse

CAMHS: Child and Adolescent Mental Health Services. Located within the Mental Health Branch, Department of Human Services in the Victorian State Government

CAST program: CAMHS and Schools Together program. A pilot program run between CAMHS, schools and families in the Grampians CAMHS region

CAT teams: Crisis Assessment and Treatment teams

CCT: Continuing care teams

CCU: Continuing care units.

CHC: Community Health Centre

CL: Consultation and Liaison service

CP: Child Protection. A part of the Office for Children in the Victorian Government

CRS: Commonwealth Rehabilitation Service

COAG: Council of Australian Governments. A body comprising the Commonwealth and respective State and Territory Governments.

DALY: Disability-adjusted life years

DET: Department of Education and Training. Part of the Government of Victoria

DEWR: Department of Employment and Workplace Relations. Part of the Commonwealth Government

DHS: Department of Human Services. Part of the Government of Victoria

DOES: Disability Open Employment Services. A service run by the Commonwealth Government to increase the employment of people with disabilities within the wider community

DoHA: Department of Health and Ageing. Part of the Commonwealth Government

DSP: Disability Support Pension. A payment made by the Commonwealth Government

DVA: Department of Veteran's Affairs. Part of the Commonwealth Government

DVC: Department of Victorian Communities. A branch of the Government of Victoria

ECAT: Emergency CAT team

ED: Emergency Department

EPPIC: Early Psychosis Prevention and Intervention Centre

GP: General Practitioner

HARP: Hospital Admission Risk Program. A Victorian government group of programs designed to manage increasing emergency demand pressures within the public hospital sector

HASI: Housing and Support Initiative. An initiative of the Government of New South Wales combining Health Services, the Department of Housing and Non-Government Organisations to provide residential outreach services for people with a mental illness

IIP: Individual Implementation Plan

Inpatient unit: Acute mental health residential treatment unit

Job Network: Commonwealth funded employment and support program

KKPP: Kool Kids Positive Parents. A program run between Eastern Health CAMHS, families and local schools to improve early intervention for children with challenging and difficult behaviours

KPI: Key Performance Indicators

LGA: Local Government Area

MBS: Medical Benefits Service. Paid by the Commonwealth Government

MCH: Maternal and Children's Health program. Program run by the Office for Children in the Victorian Government

MHB: Mental Health Branch.

MHS: Mental Health Services

MOU: Memorandum of Understanding

MSOAP: Medical Specialist Outreach Assistance Program

MSTT: Mobile Support and Treatment Teams

NGO: Non-governmental Organisation

NPV: Net Present Value

NRA: National Reform Agenda

OECD: Organisation for Economic Cooperation and Development

ORYGEN: Early psychosis prevention and early intervention body which provides mental health assessment and treatment to young people aged 15 to 24 years who live in the western and northwestern areas of Melbourne

PARC: Prevention And Recovery Care

PBS: Pharmaceutical Benefits Scheme

PCP: Primary Care Partnership. Victorian Government initiative to establish links between primary care providers

PDRSS: Psychiatric Disability Rehabilitation and Support Services

RANZCP: Royal Australian and New Zealand College of Psychiatrists

RAPID: Victorian mental health treatment database

ROI: Return On Investment

SANE Australia: Mental health advocacy group

SCOTT: Service Coordination and Tool Template. Group of common documentation developed for use across primary care services by Primary Care Partnerships

SECU: Secure extended care units

SMHS: Southern Health Mental Health Services

VicHealth: The Victorian Health Promotion Foundation. The peak body for health promotion in Victoria

WEIS: Weighted Inlier Equivalent Separations. A patient's WEIS value depends upon the amount of time they stay in hospital compared to other patients with similar conditions (inlier equivalence) and the relative cost of treating their condition compared to the cost of other illnesses (cost weight or relativity).

YLDs: Years lived with disability

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PREPARED BY
THE BOSTON CONSULTING GROUP

ONLINE
www.dpc.vic.gov.au/governmentsworkingtogether

PUBLISHED BY
Department of Premier and Cabinet
1 Treasury Place, Melbourne, June 2006

ISBN 1920921834