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# Victoria's Mental Health Service

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## The Framework for Service Delivery

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‘The improvement of facilities, treatment and care for our mentally ill will be one of the highest priorities of a Coalition Government.’ (Coalition Health Policy, September 1992, p. 20)

Reform of mental health services in Victoria remains a high priority for this Government. While it is easy to recognise examples of efficient and effective mental health services in the State, it remains important to ensure that the same high quality services are available to all Victorians.

In July 1993, the discussion paper, *Victoria’s Health Reform: Psychiatric Services*, was released. This paper opened up discussion about the future of mental health services and a large number of responses were received. Comments came from industry and professional groups, hospitals and non-government agencies, carers, as well as from individuals who have directly used the services.

This document, *Victoria’s Mental Health Service, The Framework for Service Delivery*, builds on the Discussion Paper and the responses to it, and provides a detailed framework upon which a comprehensive network of mental health services can be established. This framework provides a clear vision for the service system which will guide service redevelopment over the next five years. It will allow redevelopment and redistribution of services to take place in a uniform and consistent manner in all regions.

Most importantly, the document makes quite explicit, in a way that has not occurred previously, the Government’s expectations about how the mental health service system is to operate and be managed. This will allow new mainstreaming arrangements to be developed in an informed way where all parties can expect the same high standards in our mental health system as are expected in our general health system.

I am confident that this framework will provide a sound guide for the coming years. There is much to be done to reform and reshape the mental health service and I look forward to working

closely with those who will contribute to building on this framework across the State.

The Hon. Marie Tehan, MP  
MINISTER FOR HEALTH

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# Introduction

Services for people with mental illness have had a troubled history. Like many human services, they have often been too few in number, slow to respond to changes in knowledge and approach to service provision, and they have often responded more to the needs of staff and the apprehensions or misapprehensions of the community than to the needs of their clients. These circumstances may be found in many countries including Britain and the United States of America.

Victoria has its own legacy of mistakes reflected in the reports of abuses within psychiatric hospitals, past attempts at deinstitutionalisation, the slow rate of service system change and the acknowledged deficiencies and gaps in current services. Manifestations of these shortcomings have most recently been described in the 1993 report of the Human Rights and Equal Opportunity Commission. Despite the legacy of past failures, and the global commonality of characteristic service provision problems, the onus for resolving them rests squarely with those now responsible for the administration of the inherited service systems.

It is recognised that many people will experience some type of mental health problem in their lives and that they will gain help from a variety of personal and professional networks.

In Australia, the need for reform of services for those who have a mental illness has been recognised as a national priority by the Ministers for Health of the states and territories, and acknowledged by the Commonwealth. Cooperative effort at ministerial and departmental level has resulted in the establishment of a national mental health policy and plan, and agreement on a reform agenda to span the 1993–1997 period. Victoria's participation in this process is acknowledged and confirmed in the Medicare Agreement with the Commonwealth which was signed by the Minister for Health, The Hon. Marie Tehan, in 1993.

In July 1993, Mrs Tehan released the discussion paper *Victoria's Health Reforms: Psychiatric*

*Services* which confirmed the Government's commitment to improving services for people with a mental illness and described the broad directions that reform would take in Victoria. During three months of public consultation, a wide range of views were provided about the directions outlined in the paper. These views came from consumers, carers, clinicians and other staff, academia, professional associations, hospitals and other service providers and contributed significantly to the refinement of those ideas.

This report builds on that material and describes the means by which services for people with mental illness will be provided in Victoria over the next few years, and a progressive agenda for expansion and enhancement of those services.

Like other Australian states, Victoria has some services at the leading edge of modern service provision and others which lag behind. Our change agenda recognises the merit of the leading elements of Victorian services and sets them as benchmarks for others to match. The key change in Victoria must be to match in practice the long held aim of shifting the focus from a reliance on separate psychiatric hospitals as the preferred place of treatment. An expansion of general hospital psychiatric units for the treatment of acute patients in less stigmatising settings is required, along with the development of treatment and other services from community-based settings.

Innovative services which provide assessment and treatment in community settings both on a crisis and long-term basis, have demonstrated that for many people help is less disruptive and more effective when it is provided in their regular locality. More people can receive services in community settings than would ever be possible when only hospitals are used.

Hospital care should only be used when it is the most appropriate form of treatment. We need a much better balance between modern inpatient hospital services and expanded community services. Over the past decade there has been insufficient action on this. That balance will now be reversed.

Victoria will not repeat the mistakes of the recent past which saw many people discharged from psychiatric hospitals without adequate clinical or support services available in the community. Adequate hospital and community services will be maintained throughout the State. The expanded range of new community services will also mean that many of those discharged in the past who still need services will now be better able to receive them. The housing needs of people with mental illness are also recognised and the State has a strong commitment to providing more public housing stock.

Emphasis will be given to services which focus on prevention and early intervention to limit the effects of illness to the greatest degree possible. In addition, specific work will be undertaken to improve the level of awareness about mental illness in the community aided by Commonwealth funding of \$2.1 million.

This document describes the framework on which the future delivery of mental health services in Victoria will be based. It describes the way services will be organised and managed across the State and an improved method of providing funds for services. This will ensure the best value from the mental health budget. It will also outline the range of services that will be provided and describe the principles under which they will operate to ensure that the most severely mentally ill and the most disabled will have improved access to community and hospital base care. Finally, it will detail the specific service enhancements that will be achieved in Victoria over the next few years.

# The Basis for Mental Health Services in Victoria

## Key Principles for Service Provision

Provision of mental health services in Victoria follows from the overlapping but distinct policies of the State and Federal Governments. The Victorian Minister for Health, The Hon. Marie Tehan, has emphasised four principles on which health, aged and community services are to be based in Victoria. They are:

- To put people first, rather than institutions or systems.
- To ensure a fairer distribution of limited resources.
- To obtain value for taxpayer's funds.
- To provide a better health status and outcome for all Victorians.

These priorities underpin the framework described in this document and have radical implications relative to those prior to 1993 when institutional and industrial interests were allowed to retard widely supported reforms.

## The Legislative Framework

Currently the *Mental Health Act 1986* provides the legislative framework which guides and regulates the provision of services to persons with a mental illness. The Act clearly indicates that services operate so that:

- persons who are mentally ill receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given; and
- in providing for the care and treatment of persons who are mentally ill and the protection of members of the public, any restriction upon the liberty of patients and other persons who are mentally ill and any interference with their rights, dignity and self-respect is kept to the minimum necessary in the circumstances.

Clear directions are provided for the Victorian Department of Health and Community Services (H&CS) about

the way services are to be delivered. Services must:

- provide standards and conditions of care and treatment for persons who are mentally ill which are, in all possible respects, at least equal to those provided for persons suffering from other forms of illness;
- take into account the religious, cultural and language needs of persons who are mentally ill;
- minimise the adverse effects of mental illness in the community;
- be comprehensive, accessible and acceptable;
- be designed to reduce the incidence of mental illness in the community;
- provide for intervention at an early stage of mental illness; and
- support the patient in the community and coordinate with other community services.

Most importantly, the Act also defines the rules and safeguards which must apply when care is provided to any person on an involuntary basis. Victoria is currently participating in a national project which is examining the potential for greater uniformity in mental health legislation across the States and Territories.

The effect of implementing the service delivery framework detailed here will be to give these principles practical, rather than merely rhetorical, force.

## The National Agenda for Mental Health Reform

The National Mental Health Policy and Plan has been agreed to by all Australian Health Ministers and sets broad directions for service reform for the next five years. This was confirmed with the signing of the Medicare Agreement. Priorities for reform have included:

- The mainstreaming of mental health services within the wider health system.
- Delivery of a seamless, integrated and balanced range of services.

- An increase in the provision of acute inpatient care within general hospital settings.
- A redirection of funds into community treatment and support services.

In particular, the targeting of services towards those with a serious mental illness has been stressed together with a focus on continuity of care and recognition of the specific needs of some groups in the planning and delivery of services. A particular goal identified by Minister Tehan is to achieve an even split of funds between community and hospital based services by the end of the coming five-year period. This stands in contrast with past times, when the community-based elements of spending reached about 25% after many years of pious intentions coupled with official inertia and industrial resistance.

### Priority for Serious Mental Illness

About 30% of people attending general practitioners suffer identifiable psychiatric disorders, most commonly depression and/or anxiety. A decision to refer the person to a specialist mental health service is made in a minority of cases.

Approximately three to four per cent of Victorians at any given time will require treatment and/or support due to the impact of a serious mental illness. Many will have only one episode and, with appropriate treatment, will make a successful recovery. Others will have repeated episodes and some will suffer significant levels of disability. They will require access to specialist treatment and support services as well as general community services. In some cases, services may be required for many years or for lifetime duration.

Some people will also have other disabilities or disorders which can result in complex clinical presentations. Effective care and treatment will require assistance from a range of professionals operating within and across a range of public and private, hospital and community based settings. At

present, this care is rarely available outside the public mental health system and so the focus on the most seriously mentally ill in adult, child and adolescent and aged service areas remains critical. This direction is consistent with the National Mental Health Policy.

### Mainstreaming and Co-Location

The concept of mainstreaming encapsulates the desire to reduce the relative isolation of mental health services and thereby reduce consequential stigma and neglect which applied to those services and the people using them. The assumption has been made that common management of mental health services and general health services would automatically result in an increase in the quality of service provision and consumer outcomes. Arrangements for the management of hospitals differ between states and the practical application of mainstreaming meant quite different things in different parts of the country. In Victoria in the early nineties, this was translated into placing both community and hospital mental health services under the management of certain acute hospitals without any real direction on how the services were to be provided, what service elements were required or how the service elements would work together. This process was halted in 1993 in recognition that ideology on its own provided an insufficient base for service provision and redevelopment.

Since October 1992, significant steps have been taken to bring the overall management of mental health services into the same framework as the rest of the general health and welfare system. Some general hospitals have taken over the management and delivery of comprehensive psychiatric services with considerable success. Psychiatric Services managers now work alongside other elements of management of the health and welfare system in H&CS regional offices. This ended a long history of bureaucratic segregation of the Office of Psychiatric Services and its predecessors. Psychiatric Services managers share common reporting lines to a single Regional Director who will be responsible for configuring services according to this framework. Mental health service provision is now a mixture of contracted and directly managed services, in common with many other services provided by and through H&CS. Mental health services will no longer be isolated as in the years prior to October 1992.

The National Mental Health Policy also acknowledges the need to co-locate acute inpatient services with general hospital acute inpatient services to provide many of the benefits sought from the mainstreaming concept as identified above. Co-location is already being achieved in Victoria as new acute services are constructed and this, as a preferred model, will now continue. It must, however, be recognised in Victoria, as in some other states, that co-location does not require, nor necessarily imply, common management of all service elements in order to achieve those benefits.

## Delivering an Integrated Service

A comprehensive mental health service must encompass services which cater for both acute episodes and long-term care. It should include inpatient, community, and home based care options. Integration of service delivery is required to ensure continuity of care so that clients can move between service elements as their needs change and receive the most appropriate service response

at any time. This requires coordination at two levels:

- From a service system perspective, it relates to the deployment of a region's mental health budget in such a way as to ensure that the appropriate range of service options are available to meet the needs of the community it serves.
- From a client perspective, it reflects the need for case management so that each person is able to access the services they need, when they need them, and with one clinician accountable for ensuring, but not necessarily providing, their proper treatment and support.

In Victoria, services are available through a range of providers including:

- general hospitals;
- non-government organisations;
- private providers, including general practitioners and private psychiatrists; and
- directly through government agencies.

Effective case management processes will be critical to achieving and maintaining continuity of care for clients, including cases where clients have linkages with other services such as accommodation, child welfare, disability or drug and alcohol services. This approach recognises the critical role that carers play in the provision of support for people with mental illness. Services must be sensitive to this and support the involvement of carers wherever possible. Victoria will introduce standard approaches to case management through a common framework for client services delivery.

Together with an appropriate mix of services in each region, this should achieve integrated service delivery across the State.

## Putting It All Together

There is a high level of consistency through the various legislative and policy directions outlined above. Unfortunately, Victoria has lacked a consistent approach to the creation, redevelopment, and, indeed, the operation of its mental health services. The framework for the provision of services outlined in the following chapters will lead to greater consistency and quality in the type, range and operation of services across the State.

Through this framework, H&CS will ensure that:

- Mental health services will be responsive to the needs of clients.
- Choices for treatment and care are available.
- Services are delivered in a timely manner and in the least restrictive environment.
- The rights of the clients of mental health services are respected, protected and promoted.
- The providers of services are accountable.
- Services do not stigmatise patients.
- The best possible standards of care are used.
- Value for money is achieved.

# The Organisation of Services

## Organisation Through Regions and Local Areas

H&CS is organised through nine regions which span Victoria. Health and welfare services are delivered, either directly or indirectly on a contractual basis, through these nine regions. While the regional offices primarily serve an administrative function, the delivery and organisation of mental health services through a common administrative framework enables maximum use of generic services and skills. This facilitates coordination and liaison with other human services and will be particularly helpful when dealing with clients who also use services other than mental health. It provides a common base for planning and developing practical operational protocols and linkages to other services. Regional structures currently allow the provision of services on a statewide, regional or local area basis and this will continue to apply to the delivery of mental health services.

Within regions, psychiatric services will continue to be organised on a local area basis although the previous, formally defined sub-regional sectors may not all be maintained. Instead, each region will be responsible for identifying the most appropriate local areas around which to base the delivery of services. It is expected that these will be influenced by a range of features including:

- population characteristics such as age, ethnicity, family structures, socioeconomic status and other indicators;
- geographic features including transport and mobility factors;
- special needs such as recent and expected population growth, level of homelessness in the area, number of people with serious mental illness;
- service demand and utilisation data from both community-based and hospital services;
- the spread of mental health and other human services including government and non-government agencies; and

- the most effective deployment of resources.

Above all, local service areas should be established to support the most effective and efficient delivery of services. Accordingly, it is expected that local areas may vary significantly in size.

Working within a consistent regional structure will still enable the recognition of natural service catchment areas that may sit across regional boundaries. In these circumstances, the affected regions must agree on service delivery arrangements which will work with the least inconvenience to clients and in such a way that H&CS regional boundaries are invisible to users. Such arrangements will need to be formalised and may require the transfer of resources between regions on a purchase of service basis. The regional organisation of services must not arbitrarily restrict the choice of service available to consumers.

## Distribution of Resources to Regions and Areas

Historical concentrations of spending on mental health services in Victoria have focused around the large psychiatric hospitals and have matched neither the location nor the needs of the community. Redistribution of available funds is urgently required to rectify this. Allocation of funds to services based on individual client entitlements is preferred, but there is no mechanism currently available in the service system which can achieve this. In the interim, the budget will be redistributed to regions on the basis of a weighted population formula that combines both population and proxy measures of service need. It will also take into account the additional costs of delivering services in rural areas. Statewide services will be separately funded. See 'Resourcing Mental Health Services' for details of this approach to service funding.

The allocation of funds to local areas and service providers will be determined within each region to

obtain the best mix of service type and quantity for each area. This will proceed as quickly as the funds can be freed up from the state psychiatric hospitals and will have a significant impact on the provision of services, particularly in the traditionally under-served Eastern and Southern Metropolitan Regions.

The regional mental health budget will include all funds directed by H&CS into public mental health services, including funds directed to the non-government and acute hospital sectors. Regions must ensure that funds are deployed to obtain the best mix of services through the most effective service provider arrangements. All funding agreements will be time-limited and relate to specific service delivery targets. Historic distortions in the inter-regional allocation of funds will rapidly lose importance as a factor in future funding.

## Management of Services at a Regional Level

A key objective of the National Mental Health Policy is the establishment of an identifiable mental health program at central and area or regional levels. Such a regional mental health service should be part of the regional mainstream or general health administration and be responsible for planning all specialised mental health services. It should also manage the allocation of resources between the components of the local mental health service system. The area or regional mental health service should be the 'budget holder' for all specialised state-funded mental health services, whether delivered in separate or mainstreamed health settings. This approach is critical to achieving an adequate range of services which are balanced according to the needs of an area's population.

Requirements for integrated regional and area service delivery are assisted through regional managers having responsibility for:

- distributing the mental health budget equitably

throughout the region;

- improving integrated service delivery by implementing policies which relate to the design, style and operation of mental health services;
- ensuring the planning and provision of a balanced range of services to reflect local needs; and
- negotiating funding and service arrangements with agencies and monitoring standards of service delivery.

Local service planning and management will ensure the development of formal links with other components of the mental health and related service systems. Integration of public mental health with the activities of general practitioners and private psychiatrists offers particular promise and can best be approached on a local basis.

Planning the distribution of services and arrangements for service management must be completed so that agency responsibilities are clear and unequivocal and a prompt response can be made to any person in the region who requires treatment and/or support for a serious mental illness.

## Management of Service Elements

Each regional service system will consist of three mental health programs:

- child and adolescent;
- general adult; and
- aged persons.

Each of these programs will operate through a number of service elements, provided locally, regionally, or on a supra-regional or statewide basis.

Comprehensive mental health services are very different from the style of most services provided currently by general hospitals.

In implementing this framework, each H&CS regional office will identify the strengths, weaknesses and gaps in their present service delivery

systems. Strong and effective service elements will become the base around which future redevelopment takes place. Redirection of service arrangements must lead to improved service outcomes.

The preferred approach is for comprehensive and integrated area based services to be managed by a single hospital which has the interest and skill to provide a community-led mental health service. However, in some areas, acute inpatient services may be provided through a general hospital, with the community assessment and treatment services operated directly through the H&CS regional office. Rehabilitation and support services are provided through non-government agencies. Where there is no suitable auspice agency in an area, it might be necessary for H&CS to continue to directly provide some services. This, however, is not the preferred option and every effort will be made to identify suitable auspice agencies. It may also be the case that some existing general hospitals will not wish to deliver existing mainstreamed services in a community-led manner. Alternatives will be pursued where this is so.

There are major differences in the needs and opportunities in the nine regions. Each H&CS region will determine the most appropriate approach to management of mental health services. We will encourage stronger networks with general practitioners and the development and reliance on other agencies, including non-government managed disability support services and private providers. The development of networks and protocols will clearly be required. Protocols will also be developed to govern the interrelationship between child and adolescent, adult and aged mental health services.

The choice of providers by H&CS will be purely pragmatic—the arrangement which will lead to a better level of service delivery and improved consumer outcomes will be selected. Confidence that the auspice agency will deliver

the type of service with the right outcomes at the agreed price is paramount. In most cases that will involve agreement on the following issues:

- Focus on providing treatment for persons who are seriously mentally ill and/or have a severe level of associated disability.
- Commitment to maximise the amount of psychiatric treatment support provided through the community mental health services.
- Agreement that all publicly funded hospital beds be gazetted under s. 94 of the Mental Health Act to ensure the ability to treat clients admitted on an involuntary basis.
- Coverage of the catchment area defined by the Regional Office.
- A high level of confidence by the region that delivery of the service by the proposed agency would enhance service effectiveness.
- Ability to guarantee protection of funds provided for the psychiatric service and management of the service as a discrete program.
- Agreement that the service will operate at or below the prevailing state benchmark cost for that type of service and recognise the need for further reduction in future years.

Effective management arrangements are not to be confused with issues of continuity of individual patient care, which will be further addressed in the next chapter.

# The Provision of Services

## The Delivery of Services

The mental health service system will focus on three client groups within each region—children and adolescents, adults, and aged persons (see ‘Program Descriptions’). Common general principles and directions will apply to all three client groups, however, although programs are broadly organised around age levels and the needs of clients in those groups, they will not be segmented within the rigid age criteria that currently apply.

Matching of patients to services must be based on clinical criteria. For example, adolescents suffering early onset psychoses ought to receive services through the adult program since they will have ongoing service needs and clinically form part of a group generally aged between 14 and 30 years. Persons who have been in receipt

of services from the adult service ought not be automatically excluded when they reach age 65 unless their service needs would be better met through the aged persons program. Similarly, persons who have not reached 65 but who suffer from age-related conditions may get a better service response from the aged persons program. Individual case management will assist the matching of individual client needs and service provision within and across the three program areas.

Child, Adolescent and Family Mental Health Services

These are services for children and adolescents up to the age of 16 years with serious emotional disturbance. This includes young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth and development and/or

**Figure 5: Victoria’s Mental Health Services—The Framework for Service Delivery**

where there are serious difficulties in the person's social or family environment.

It is recognised that many children and adolescents with an emotional disturbance do not require specialist mental health services and are well supported by primary care and other health, educational and community services. It is therefore vital that specialist mental health services have strong linkages with the broader network of services for children and young people and, accordingly, specific protocols are being developed to support this direction.

#### Service Elements

- Child and adolescent assessment and treatment services
- Inpatient services

#### General Adult Mental Health Services

These are services for adults with serious mental illness, primarily between the ages of 16 and 64 years. The adult program is, and will probably remain, the largest of the three programs and includes a range of more specialist statewide services. The mental health service will provide specialist treatment and support but is not able to meet all the needs of a person who has a serious mental illness and will often need to work cooperatively with other community support services. In some cases, such as in forensic psychiatry, a self-contained service will be provided. Generally, however, strong formal linkages with other human services will be required. Liaison Psychiatry Services provide a consultation and treatment service to a range of medical and surgical units within general hospital.

#### Service Elements

- Crisis assessment and treatment services
- Mobile treatment and support services
- Continuing care, clinical and consultancy services
- Acute inpatient services
- Residential and non-residential rehabilitation

services

- Residential and non-residential disability support services
- Secure/extended care inpatient services

#### Aged Persons Mental Health Services

These services are primarily for people aged 65 years and over, including those with:

- a long-standing mental illness who have grown older;
- functional illnesses such as depression and psychoses which have developed in later life; and
- psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

People whose mental illness is of late onset or is characteristic of older patients should be treated as far as possible as part of the aged care service system, rather than as part of general adult or aged person psychiatry. Aged persons' mental health services, therefore, should operate with strong linkages with the broader network of health and community services for older persons.

#### Service Elements

- Psycho-geriatric assessment and treatment services
- Acute inpatient services
- Extended care inpatient services

## Community Oriented Service Delivery

This framework is based on the principle that the majority of people with mental illness can be effectively treated in community settings and that this practice will lead to improved consumer outcomes. The regional mental health service system must provide services which will ensure that consumers are treated, supported and rehabilitated in or near their usual place of residence and, as much as possible, in a community-based, or non-hospital setting. For this to occur, specific

service delivery targets must minimise the extent and use of inpatient services and maximise the ability of community-based services to respond quickly and effectively.

Service delivery will be driven through community-led mental health services and will recognise the interdependence of the public and private sectors for service provision and, most importantly, place the focus clearly on the needs of clients. In particular:

- Services will be provided on a local basis to allow improved access, clinical continuity and case management.
- Community-based service networks will become the nucleus of the service system, with hospital inpatient services providing appropriate support and back-up.
- The decision to admit to hospital will be based on a comprehensive assessment and formulation of a management plan which should consider a number of treatment options, including treatment in the community, if at all possible. Hospital admissions will be minimised and will only occur in the context of a community-based treatment and service delivery strategy, when community-based alternatives are either inappropriate or unavailable. Within this service system, inpatient admission must not be seen as a failure either by the patient or the community-based staff but as a valid treatment option.

To maximise community treatment, the management and clinical leadership of services is expected, for the most part, to be community-based. It is expected that each area will have a senior psychiatric position of Director of Clinical Services. This will be a joint appointment and will provide clinical leadership across hospital and community settings. Community services will be equipped with the ability and authority to purchase inpatient services as required. Services will be planned and/or delivered by multidisciplinary teams with a client's progress being supported by case management arrangements.

## Access to Mental Health Services

The public mental health service must be accessible to all Victorians. While the service system is targeted at people with serious mental illness, some consumers will pose particular difficulties for service providers. Regional service systems must be designed to ensure that all people living within the region have access to appropriate mental health services, and ensure that treatment and/or support is actually provided.

All mental health services will operate within clearly defined catchments and will be responsible for providing or arranging provision of services to all clients living within, or in the case of clients who are transient, originating from that area. Catchment areas will be defined within each region and will take into account urban/rural differences, population density, population dispersion, location of existing services, accessibility to services, and service utilisation patterns. The region of origin refers to a client's place of residence at the time the client is initially registered with the public mental health service system and regional responsibilities will continue until such a time as the person is:

- formally discharged from the mental health service system; or
- formally transferred to another region or local area service.

Protocols for the transfer of a client's treatment and care will be established to guide this process. These arrangements are necessary to ensure that responsibility for even the most demanding consumers is always clear and that services will not be able to assist their clients to move to other regions without making adequate arrangements for continued care. In some instances, these arrangements may involve a transfer of resources.

## Entry to the Service System

Public mental health services are targeted at people with a serious mental illness and services must remain focused on this group of persons. Loss of this focus would quickly result in service capacity being swamped by people with less serious mental disturbance and a consequential inability to respond to those most in need.

Initial assessment and treatment will be provided routinely through community mental health services with hospital inpatient admissions occurring only when required by the severity of the illness and the degree of risk. People may present at a crisis assessment and treatment (CAT) service, a community mental health service, or an intensive mobile treatment service. Each of these services performs an assessment function and may admit clients or make a more appropriate referral within or outside the service system.

All referrals for admission to acute inpatient mental health services will involve assessment by the CAT service. This includes referrals from within the inpatient services of a co-located facility (such as an acute general hospital), from accident and emergency (A&E) departments, outpatient departments, and from the community (including mental health services, other agencies, private practitioners and clients themselves).

Wherever possible, the community psychiatrist will be appointed to work across inpatient and community-based services. The community-based psychiatrist will have the responsibility for the clinical decisions of the CAT service and the decision to admit or not admit. A decision to admit is in fact a decision that appropriate treatment cannot be provided effectively within the community.

In situations where a referral to the inpatient service is generated from a hospital A&E department or from within the inpatient service of a co-located facility (such as a general hospital), the CAT service will work with the referring medical officer to determine the most appropriate treat-

ment options, with particular emphasis on community treatment. This arrangement is already working effectively in several general hospitals.

To ensure that the CAT operates as effectively as possible, protocols will be established to ensure efficient operation between community-based services and co-located facilities. Collaborative and explicit working arrangements will be an operational priority.

## Continuity of Care

The *National Health Strategy Issues Paper* identifies the common features of mental health services promoting continuity of care as:

- case management;
- a multidisciplinary approach;
- an assessment program that offers single point of entry into an integrated service; and
- an information system to support continuity and integration concepts.

In Victoria, a consistent approach to case management will provide the framework for individualised care, provided and actively managed for the duration of the person's illness. The primary objectives of this form of care are to:

- Enable a client's service needs to be met effectively and efficiently through the use of a common set of processes and functions.
- Enable planned and coordinated service provision to individual clients.
- Provide staff with a common practice framework.
- Strengthen links between service delivery and service planning.
- Establish a single point of responsibility for the delivery of services to a particular client.

Within this context, case management will be used to facilitate co-ordination, accountability and continuity of service delivery, and ensure the provision of the appropriate services in a timely and efficient manner. The case manager will guide

the client through the system, ensuring that client needs are assessed, planned for and met in a timely and effective manner. The level of intensity of case management support will vary according to the needs of the individual client. Clients with complex, multiple needs, requiring a range of services will need more intensive support from a case manager than will clients with less complex needs. Intensity of case management support will also vary as a client's needs change.

### The Key Features of a Good Regional Mental Health Service

- Services are organised around identified catchment areas which between them cover all localities within the region.
- Arrangements are in place for the delivery of a crisis mental health and mobile treatment and support service in all parts of the region.
- Maximum provision of treatment and support occurs in the community, with inpatient services being used only when necessary in the interests of the client.
- Acute inpatient services are provided by a general hospital and are co-located on the hospital campus.
- Services are targeted to people who are seriously mentally ill, with priority given to those most in need of intervention.
- The service monitors—and assists where necessary—the progress of all clients to ensure that service provision is targeted, coordinated and provided in the most effective way.
- Professional, service and community linkages and networks are developed, maintained and formalised with written protocols where appropriate.
- The service is available and accessible and is actively promoted across the region.

- Community education activities aimed at increasing the acceptance of people with mental illness in the community are undertaken.
- Services are provided to clients and carers by appropriately skilled medical, nursing and allied health staff.
- The use and demand for services is monitored and the budget applied to secure a balanced range of acute, long-term and support services across the region.
- The qualitative and quantitative performance of service providers is regularly reviewed and service agreements accurately and specifically define the expectations of funded agencies.

### Monitoring, Evaluation and Quality Assurance

The operation of an effective and efficient mental health service requires the development, maintenance and review of systems for monitoring and evaluating the effects of service delivery.

This framework for service delivery identifies a range of key service requirements for the overall regional service system, individual service networks and individual service components. The Psychiatric Services Branch, through the regions, will monitor standards that will apply uniformly to all service providers. Key performance indicators will be developed that will allow comparative evaluation and monitoring of service performance against identified targets within and across regions.

Funding and service agreements will be substantially developed to reflect these requirements and will form the basis for service monitoring. Existing agreements will need to be renegotiated to ensure that the funds provided deliver the type of service required. Service evaluation will include consumer and carer involvement in its design and implementation and is seen as a priority for the State.

In order to undertake effective service moni-

toring and evaluation, a relevant database and information system must be available. At present, there is a system-wide database and information system available to mental health services which reflects the current utilisation of most inpatient and community-based services. The Australian Health Ministers, through the Australian Health Ministers Advisory Committee (AHMAC), have made a commitment to establish a National Minimum Data Set for mental health services, covering both hospital and community-based services. H&CS is currently reviewing its data requirements in the context of this framework and the national project. It is expected that this review will determine the extent to which local systems can be developed to suit local regional and facility needs in a reliable and timely manner, while ensuring that H&CS has access to the necessary information to be confident that mental health services are being delivered appropriately.

Outcome orientated service delivery evaluation will increasingly become the focus of evaluation. The 1991 *Report of the Mental Health Task Force to the Australian Health Ministers Advisory Committee* identified three areas in which mental health outcome indicators should be developed:

- indicators related to agreed national resource priorities;
- indicators for establishing mechanisms to monitor and enforce service standards, and consumer rights and satisfaction; and
- indicators of progress towards nationally consistent mental health legislation.

The Australian Council of Health Care Standards accreditation will be the standard for all inpatient facilities but further development is required for the accreditation of community-based mental health services. Clinical indicators which measure the clinical management and outcome of care for mental health services are being developed for inclusion in the Australian Council of Health Care Standards survey process for accredi-

tation.

Quality assurance systems will be expected to form a routine part of clinical service activity. Such systems should be open to scrutiny and involve the participation of consumers and carers. The development of quality assurance processes will be required from each service provider.

# Program Descriptions

## Child, Adolescent and Family Mental Health Services

### **Child, Adolescent and Family Mental Health Services at a Glance**

#### **Objectives**

1. To alleviate serious emotional disturbance through the provision of a mental health assessment and treatment service which responds effectively and efficiently to the needs of children, adolescents and their families.
2. To provide direct services to children and adolescents where effective help is unable to be provided through other service systems.
3. To provide active support and consultancy to, and work in conjunction with, other services for children and adolescents.

#### **Target Group**

Services are targeted at children and adolescents up to the age of 16 years with serious emotional disturbance. That is, young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to psychosocial development and/or where it leads to serious difficulties in the person's social or family environment.

#### **Service Elements**

- Child and Adolescent Assessment and Treatment Services.
- Inpatient Services.

#### **Key Service Linkages**

- Child and family services (including protective services, child care services, kindergartens, maternal and child health nurses).
- Services for people with intellectual, physical or sensory disabilities.
- Health services including general practitioners, paediatricians, drug and alcohol services and private child psychiatrists.
- Education services.
- Other community services including juvenile justice, housing, police, emergency accommodation services and disaster/emergency management services.
- General adult psychiatric services.

### Objectives

1. To alleviate serious emotional disturbance through the provision of a mental health assessment and treatment service which responds effectively and efficiently to the needs of children, adolescents and their families.
2. To provide direct services to children and adolescents where effective help is unable to be provided through other service systems.
3. To provide active support and consultancy to

other services who are working with children and adolescents and to work in conjunction with those services wherever possible.

Specialist public mental health services for children and adolescents must focus on service provision for those who are most disturbed and whose needs cannot be met through other avenues.

Many children and adolescents with emotional problems will not require specialist mental health services. Some will be helped by their families and available social support networks and others will receive assistance from services available in the community. When a young person does not respond to these interventions and there is a likelihood of more serious disturbance emerging, specialist mental health services may be required. Recent reductions in general support systems are resulting in an increased demand for services from specialist mental health services.

In order to ensure access to comprehensive services, cooperative relationships and innovative service options will need to be developed by each region to ensure the provision of a network of core services for children, adolescents and their families. Some services will be provided on a local area basis whereas others will be provided on a regional or super-regional basis. Rural areas will continue to develop service arrangements with metropolitan areas so that their clients have access to a full range of service options.

It is particularly important that child, adolescent and family mental health services are responsive to their client group. Available funding for child, adolescent and family mental health services must therefore be carefully targeted and the type of service which is provided, continuously reviewed to ensure maximum effectiveness and value from these funds. The best use of funds should be achieved through:

- early intervention;
- maximum provision of services in community settings;
- minimising the use of hospitalisation; and
- use of the shortest term interventions possible to resolve the situation.

The challenge for child and adolescent services is to actively adapt these strategies to ensure that they provide effective services to the greatest number of clients.

#### Target Group

Child, adolescent and family mental health services provide services to children and adolescents with serious emotional disturbance. That is, young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to psychosocial development and/or where there are serious difficulties in the person's social or family environment.

Emotional disturbance in childhood and adolescence may present in a variety of ways. While symptoms may include impaired reality testing, hallucinations and suicidal behaviour, more often emotional disturbance in childhood and adolescence presents in other ways—hyperactivity, nightmares, depression, fearfulness, bed wetting, soiling, temper tantrums, stealing, poor impulse control, anti-social behaviour, obsessional behaviour, relationships problems, language problems, learning difficulties, refusal to go to school, unusual eating patterns and physical illness.

While many young people at some time in childhood will present with one or more of these behaviours or difficulties, usually children and adolescents are not considered to be emotionally disturbed unless a pattern of symptoms emerge which are inappropriate for that young person's age, stage of development or circumstances.

The highest priority for child, adolescent and family mental health services are those young people with the most severe symptoms or who are in a high risk group. Some disorders more commonly emerge at particular developmental stages.

Children and adolescents in the following circumstances are more likely to be at risk of a serious emotional disturbance:

- Victims of physical, sexual or emotional abuse.
- Those within the welfare and juvenile justice systems.
- Homeless youth.
- Those from severely disruptive homes.
- Those whose parents suffer from a mental illness

or a dependence on drugs or alcohol.

- Infants with attachment difficulties and where there are serious problems in parent/infant relationships.
- Those with developmental difficulties, learning difficulties and/or an intellectual disability.
- Those with chronic health problems and disabilities.
- Post trauma and post disaster victims.

It is recognised that many children and adolescents with emotional disturbance do not require specialist mental health services and are supported by primary care and other health, educational and support services available in the community. Specialist mental health services operate as part of a broader network of services for children and young people and must develop and maintain linkages with these services.

Work undertaken by the Early Psychosis Prevention and Intervention Centre (EPPIC) indicates that adolescents suffering early onset psychoses are best provided with services through a specialised stream of the adult program as they are likely to have ongoing service needs. The model of practice developed by EPPIC will form the future development of services for adolescents. This must be supported by the development of a statewide consultative role for EPPIC.

#### Service Elements

There are two types of public mental health services provided for young people and their families which ought to be available in, or able to be accessed from, each region:

- Child and adolescent assessment and treatment services
- Inpatient services

The current arrangements, whereby metropolitan child and adolescent services provide active support to service provision in rural regions, will continue until such time as appropriately trained professional staff can be recruited to

work in those areas. This provides some child psychiatric clinical support in those areas and formalises access to metropolitan inpatient services.

Child and adolescent forensic services are provided through the Child, Adolescent and Family Welfare Division of H&CS. Despite this, child and adolescent assessment and treatment service staff must still provide services to young people involved in the juvenile justice system on the same basis as would be done for other clients. Assessment with a view to treatment or support ought to be undertaken while that for the purpose of a court report is more properly the function of the forensic service.

#### Child and Adolescent Assessment and Treatment Services

These are community-based services which will offer a range of services including family therapy, parent counselling, individual therapy and group therapy and medication-based treatments. Services will be organised to enable a timely response to referrals, including crises, and be delivered on an outreach basis where appropriate. They should be present in each region.

*Key service requirements* for child and adolescent assessment and treatment services are:

- To intervene as early as possible to enhance healthy development and reduce the incidence of mental illness in children and adolescents.
- To routinely commence all treatment with brief interventions. The use of longer-term interventions will require careful consideration and justification.
- To minimise their contact with the young person and focus on enhancing and providing support to the young person's wider support system as many children and adolescents with emotional problems will not require specialist mental health services.

- To plan and deliver services in a manner appropriate to the different needs of children and adolescents, including consideration of the different developmental stages of the young person, the wishes of the individual and their family. They should be organised in a way that ensures a timely and mobile response.
- To assess and treat children and adolescents in the context of their families, other carers and their wider social support system.
- To provide services in the least restrictive environment and in a manner which is least intrusive to the child or adolescent. Periods of hospitalisation should be minimised.
- To allow children and adolescents access to services even if they are involved in child protection, juvenile justice or disability service systems. Similarly, young people must not be denied service because they are not suited to a particular style of intervention. Service provision must adapt to the circumstances of these young people.

#### Inpatient Services

Inpatient services are provided for children and adolescents who have severe emotional disturbance which cannot be treated in a less restrictive setting. Inpatient services will normally be co-located with hospitals. Regional service systems must include provision for access to inpatient care for young people even if it is provided out of their region. They must also organise service delivery in ways that minimise the young person's period of hospitalisation.

*Key service requirements* for child and adolescent inpatient services are:

- To ensure that all admissions to the service have the involvement of the community-based child and adolescent assessment and treatment service, periods in hospital are kept to a minimum, and appropriate follow-up arrangements are made through the assessment and treatment service following discharge.

- To provide service in the least restrictive environment and in a manner which is least intrusive to the child or adolescent.
- To ensure all beds are gazetted under s. 94 of the Mental Health Act and are accordingly able to admit involuntary patients.
- To manage young people who require a short-term secure environment and intensive support.

#### Linkages with Other Service Providers

The provision of specialised mental health services must occur in collaboration with other services to provide responsive service options. Child and adolescent mental health services staff will consult with and provide advice to other human service systems to assist their work with individual clients as well as improve their ability to support the emotional wellbeing of children and young people through their services and programs.

Formal links will be established with:

- Child and family services (including protective services, child care services, kindergartens, maternal and child health nurses).
- Services for people with intellectual, physical or sensory disabilities.
- Health services including general practitioners, paediatricians, drug and alcohol services and private child psychiatrists.
- Education services.
- Other community services including juvenile justice, police, emergency accommodation services and disaster/emergency management services.

Continued attention will be given to cross-program linkages both internal and external to H&CS. Protocols have recently been established with the Child, Adolescent and Family Welfare Division in relation to child and adolescents involved in the child welfare system. It is intended that clear protocols be developed at both a central and regional level to ensure the necessary coordi

nation of service provision to children and adolescents. This will include formalising the relationship with adult mental health services in relation to service delivery for adolescents with

early onset psychoses based on work done by EPPIC.

## General Adult Mental Health Services

### **General Adult Mental Health Services at a Glance**

#### **Objectives**

1. To assess and treat adults with a serious mental illness in a timely and effective way.
2. To monitor and coordinate the provision of services to clients to ensure continuity of care in the least restrictive environment.
3. To deliver a range of community and residential treatment and care programs on a continuous or intermittent basis.
4. To undertake prevention activities and community education to increase public awareness and understanding of mental illness.

#### **Target Group**

Adults with a serious mental illness aged between 15 and 64 years including those suffering from a severe personality disorder where the person's behaviour places themselves or others at risk of harm.

#### **Service Elements**

- Crisis assessment and treatment services.
- Mobile treatment and support services.
- Continuing care, clinical and consultancy services.
- Acute inpatient services.
- Residential and non-residential rehabilitation services.
- Residential and non-residential disability support services.
- Secure/extended care inpatient services.

#### **Key Service Linkages**

- Primary health care services including GPs, private psychiatrists, community health centres and general hospitals.
- Child and adolescent and aged persons' mental health services.
- Disability, drug and alcohol and child welfare services.
- Housing and accommodation, domiciliary care, social support and employment and training services.

## Objectives

General adult mental health services will incorporate a network of community focused adult mental health services providing assessment, treatment, and psychosocial rehabilitation services to people with serious mental illness and associated psychosocial disability. In summary the objectives of these services are:

1. To assess and treat persons with a serious mental illness in a timely and effective way.
2. To monitor and coordinate the provision of services to clients to ensure continuity of care in the least restrictive environment.
3. To deliver a range of community and residential treatment and care programs on a continuous or intermittent basis.
4. To undertake prevention activities and community education to increase public awareness and understanding of mental illness.

Each adult mental health service will be responsible for providing services to people residing in its catchment area. Services will be provided in a way which causes minimum intrusion and disruption into the person's life. This means that services should be available to consumers as close as possible to their local communities and their usual and familiar surrounds. It should also minimise the size and use of inpatient services and ensure that the maximum amount of service is provided through community service outlets.

Initial assessment and treatment will be provided routinely through community mental health services with hospital inpatient admissions occurring only when required by the severity of the illness and the degree of risk. People may present at a crisis assessment and treatment service, a community mental health service or an intensive mobile treatment service. Each of these elements performs an assessment function and may admit consumers to the service or make a more appropriate referral either within or outside

the service system.

Exceptions to these arrangements relate to hospital orders made under s. 15 of the Mental Health Act in relation to persons convicted of criminal offences. The provisions of this section allow the court to make a hospital order instead of passing sentence. Persons convicted of criminal offences may therefore be admitted to a psychiatric hospital following assessment by the authorised psychiatrist of that hospital and on the order of the court. People on court admissions enter the service system directly through the hospital system rather than through the community mental health services component.

The Mental Health Act also makes provision for the use of community treatment orders (CTOs) whereby involuntary patients receive treatment for their mental illness in the community. CTOs are used as an alternative to admission to a psychiatric inpatient service or where the patient's condition is such that continued hospitalisation is no longer the least restrictive environment in which the person can receive treatment.

## Target Group

Adult public mental health services will provide assessment, treatment and support services to people with serious mental illness and/or an associated significant level of psychosocial disability. This includes clients suffering from functional psychoses, both acute and persistent, severe mood or eating disorders, or with severe anxiety disorders, as well as those who present with situational crises which may lead to self-harm or inappropriate behaviour directed towards others. People with a severe personality disorder whose behaviour places themselves or others at risk of harm are included in the target group.

Services will be organised to address the needs of persons primarily between the ages of 15 and 64 years, although age alone will not be a sufficient criterion to exclude a person from service provision or to transfer them to other services such as aged care services. Similarly, the

decision about which program will provide services to a young person will be based on established criteria that reflect client need. Protocols will be developed to enable orderly and responsible transfer of case management services between program areas and to outline the clinical grounds on which a decision to transfer can be made.

Individuals whose primary diagnosis and service requirements relate to drug or alcohol dependence, developmental disability, brain damage or senile dementia, will, from time to time, be referred. It is, therefore, important that protocols are made between the Mental Health Service and other health and welfare services and agencies. Mental health services have neither the skills or services to manage or treat these people in isolation. For example, provision of care for those with senile dementia are primarily provided through the aged care service system. People who need forensic mental health services will receive specialist service input.

#### Service Elements

Each regional service system will consist of a number of service elements which must operate to ensure that a coordinated system of care is provided. The service elements are:

- Psychiatric crisis assessment and treatment services.
- Mobile treatment and support services.
- Continuing care, clinical and consultancy services.
- Acute inpatient services.
- Residential and non-residential rehabilitation services.
- Residential and non-residential disability support services.
- Secure/extended care inpatient services.

Each service must fulfil its responsibility as an element or component of the local service network. Service elements might be organised in different ways in different areas according to rural and metropolitan population differences, varying

auspice arrangements, and geographic and socio-demographic features within defined catchment areas. It will, however, be necessary for each local service network to organise entry to the mental health system via its community-based services. A number of specialist mental health services, such as adult forensic services, will be available on a statewide basis.

Each service element, and in particular the crisis and mobile treatment service, is expected to be functionally separate to ensure the integrity of service delivery. For example, the same staff cannot respond both to acute crises and also guarantee regular mobile treatment. Each service element is expected to have a single point of management responsibility. In addition to operating in accordance with the overall framework for service delivery, individual components of the general adult psychiatric service system will be expected to achieve and maintain specific service requirements as outlined below. Details are now provided for each of the service elements of the general adult mental health program.

#### The Crisis Assessment and Treatment Service (CAT)

This must be available on a 24-hour, seven-days-a-week basis and be a mobile service to provide effective intervention throughout the community. The service will assess all persons who are deemed appropriate for hospital admission and will determine whether the person can be managed effectively in a less restrictive setting. The service will provide support to, and liaison with, other mental health and general health workers and other service agencies as well as the client's family and carer network. The service will have the responsibility for screening of all inpatient bed admissions

(gatekeeping), urgent assessment where hospitalisation is considered an option, and crisis resolution and treatment of acutely ill clients referred to the service. These services may be structured differently in metropolitan and rural locations.

The CAT service will develop and work within the context of an overall treatment plan and may extend through a client's brief admission to hospital. The role of the CAT service will be to minimise unnecessary hospitalisation and facilitate the appropriate admission and early discharge where appropriate. Protocols must be established by regions and auspice agencies to ensure the necessary involvement of the CAT service prior to hospitalisation. In situations where the management of the CAT service is separate from that of the inpatient facility, joint assessment may be necessary where the initial contact has been with the inpatient service.

*Key service requirements* for CAT services are:

- To provide 24-hour crisis assessment and mental health treatment in a timely and client oriented manner to resolve mental health crises as effectively and efficiently as possible.
- To monitor all persons referred to, or presenting for admission to, hospital thus preventing unnecessary hospitalisation where services can be provided adequately in the community. All hospital admissions will involve the CAT service.
- To minimise a client's length of stay in acute inpatient facilities through expediting the earliest possible discharge with CAT or other service referral or follow-up.
- To ensure all referred clients are linked into appropriate follow-up care whether provided through the CAT service or not.
- To provide primary, secondary and tertiary consultation to other service providers in the community in relation to psychiatric crisis management and treatment.

The Mobile Support and Treatment Service

The Mobile Support and Treatment (MST) Service provides intensive long-term community support to clients with substantial and prolonged severe mental illness and associated disability. In many cases this service will avoid or minimise the need for repeated and lengthy hospital admissions. Most commonly the client will have a diagnosis of schizophrenia, however the specific focus of the MST service is the client group that:

- is especially prone to the relapse of their symptomatology and has a wide range of psychosocial rehabilitation needs that would typically result in the client's admission to hospital;
- is commonly not compliant with treatment regimes;
- typically requires intensive treatment from other community based services; and
- is typically lacking in motivation, ability to function independently and has a poor understanding of their mental illness despite repeated attempts at education.

The service will provide mobile and assertive treatment and care which is continuous and accessible on an extended hours basis with support from the CAT service as required. The service will assist many people living in special residential services and boarding houses.

*Key service requirements* for MST services are:

- To provide assertive outreach, intensive long-term support, treatment and rehabilitation to the most severely disabled clients in their own environment.
- To provide an extended hours service over seven days every week.
- To provide intensive community support and preventative interventions to reduce the likelihood of a client's need for hospitalisation.
- To provide or arrange rehabilitation to develop the client's daily living skills and enhance their capacity for independent community living.

- To provide support to reduce the client's length of stay in hospital when appropriate.
- To support the client in maintaining safe, secure and affordable accommodation.
- To educate the client, family and carers about mental illness and provide support as required.

#### Continuing Care, Clinical and Consultancy Services

A range of community-based services will be available to provide assessment, treatment and consultancy services in addition to continuing care and case management. These services will provide an initial assessment service for people requesting assistance where a CAT service response is not required. Ongoing case management will generally be provided by staff from these services, focusing on the seriously mentally ill who require treatment, monitoring and continuing support as well as more specialist individual, group and family therapy programs. Services will be closely linked with the bed based and other community-based services. Strong links will be required with local non-government agencies to enable clients to receive regular day program support as well as appropriate assistance in the development of a range of community living skills.

*Key service requirements* for continuing care, clinical and consultancy services are:

- To ensure that all clients of the service receive case management monitoring and support.
- To provide ongoing treatment, support and psychosocial rehabilitation programs.
- To provide clinical consultation to other primary health service providers in relation to mental illness management and treatment.
- To undertake community development and education activities to increase community awareness and

understanding of psychiatric disorders and develop community resources.

- To provide liaison and consultation to other service providers in the community in relation to psychiatric treatment and service delivery models.

#### Acute Inpatient Services

Acute inpatient units provide short-term inpatient management of seriously mentally ill clients referred generally by the community mental health service. They will be co-located with acute general hospitals wherever possible. The principal role of the acute inpatient units will be the provision of acute assessment and management of individuals who require inpatient treatment and intervention. Services will provide voluntary and involuntary short-term inpatient management during an acute phase of mental illness until sufficient recovery allows that treatment to be effectively provided in a community-based setting.

There are many occasions when a person suffering from a serious mental illness is unwilling, or unable, to seek or receive treatment. Recent analysis of the legal status of those admitted to psychiatric service inpatient facilities demonstrates that almost half of the admissions are involuntary. In order to avoid administrative barriers to treatment, all publicly funded acute inpatient services must be gazetted in accordance with s. 94 of the Mental Health Act and accordingly able to admit involuntary patients. Acute inpatient units must have a 'high dependency' area where clients who require secure and intensive management can be accommodated.

*Key service requirements* for acute inpatient services are:

- To provide a short-term, voluntary and involuntary assessment and treatment service during an acute phase of a client's mental illness until this can be managed in the community.
- To ensure all beds are gazetted in accordance

with

s. 94 of the Mental Health Act and accordingly are able to admit involuntary patients.

- To ensure all admissions to the unit have had involvement of the CAT service.
- To ensure all clients are considered by the crisis assessment and treatment service for management in the community subsequent to the person's inpatient stay and that a discharge plan is prepared.
- To ensure that clients who require a short-term secure environment and intensive support can be managed.

#### Residential and Non-Residential Rehabilitation Services

A key requirement in the management of severely mentally ill people who present with major psychosocial disabilities is the provision of a range of rehabilitation services. These services comprise bed and community-based components. An important function of services is to assist seriously disabled people to learn or re-learn everyday living skills necessary for their adjustment to successfully living in the community.

The purpose of this service is to enhance the functioning, self-esteem and independence of individuals with a serious mental illness to ensure their maximum involvement in community life. These services should, wherever possible, be provided in the client's own environment and have links with employment and recreational services provided by other agencies.

Residential rehabilitation services will be primarily provided through community care units (CCU). These are designed to accommodate people with serious mental illness and severe psychosocial disability who have been traditionally managed in the long stay wards of psychiatric hospitals. CCUs are purpose-built units providing a home-like environment that have access to 24-hour clinical support. The CCU represents a shift in the focus of service delivery that provides an

opportunity for community living that will enhance the client's quality of life. The appropriate design of a CCU has been modified based on experience with those already operational.

*Key service requirements* for rehabilitation services are:

- To provide a range of rehabilitation services to assist clients with significant disabilities to learn or re-learn everyday living skills necessary for their adjustment to successfully living in the community.
- To provide residential based rehabilitation services with access to 24-hour clinical support.
- To provide psychosocial rehabilitation programs designed to enhance the client's personal skills and facilitate community integration.
- To ensure all beds are gazetted in accordance with s. 94 of the Mental Health Act.

#### Residential and Non-Residential Disability Support Services

These services provide psychosocial rehabilitation and support in a variety of ways to people with seriously disabling mental health conditions to minimise stress, promote and maintain recovery and improve quality of life. These services complement the assessment and treatment functions of clinical services.

Residential services include staffed respite care, short-term residential services with on-site staff providing transitional rehabilitation, and longer-term residential services often with 24-hour staffing.

The link between stable housing and improved mental health and individual functioning is well established. Residential and accommodation support services provide a range of housing options for people with different levels of psychiatric disability. These range from intensively supported residential care through to housing in the community with support and assistance to improve daily living skills. The preferred approach is

to provide long-term accommodation with the level of support being adjusted according to the resident's actual need for assistance.

Non-residential disability support services provide independent living skills, training, using both centre-based and outreach approaches, information and support to carers and consumers based on mutual aid principles, and community education.

Some services, such as information and self-help services for consumers and carers, operate on a statewide basis while other services are more localised and form an integral part of local area service networks. Apart from those services clearly based around statewide coverage, disability support services are expected to meet the service needs of their local area or sector and to form effective linkages with local clinical services. These support services are expected to be present in all regions and will continue to be managed through the community-managed non-government sector wherever possible.

Services are predominantly provided through non-government agencies that receive funding from government and this area of service is expected to continue to increase. Some leisure activity programs for people with mental health disabilities are also provided through funds from the Victorian Department of Arts, Sport and Tourism.

*Key service requirements* for disability support services are:

- To provide services to people with serious psychiatric disabilities.
- To undertake community development and education within the local community to facilitate community acceptance of service participants as local community citizens.
- To provide psychosocial rehabilitation programs designed to enhance the participant's personal skills and social relationships.
- To provide programs which provide environmental change in order to reduce social handicaps.

#### Secure/Extended Care Inpatient Services

Secure/extended care inpatient services provide intensive treatment and support for clients who have unremitting and severe symptomatology together with an associated significant disturbance in behaviour that inhibits the client's capacity to live in the community. These services will generally be provided on a regional basis due to the low prevalence of client need. Each region will define the relationship between regional and local area services to ensure equitable access, continuity of care, and the return of clients to their local community as soon as they are able to live in a less restrictive setting. Facilities will have to be able to manage clients on an involuntary basis and therefore must be gazetted in accordance with s. 94 of the Mental Health Act.

*Key service requirements* for secure/extended care inpatient services are:

- To provide secure extended mental health treatment and care on an involuntary basis where necessary.
- To provide appropriate psychosocial rehabilitation and behaviour management programs to help modify disruptive behaviours and maximise social and personal functioning.
- To maintain active individualised care planning to monitor the changing needs of clients and their suitability for less restrictive treatment and care.
- To provide family support and educational programs to foster continued links between clients, their relatives and the community.
- To facilitate client access to other services appropriate to their health and welfare needs.
- To develop and maintain links with referring agencies, other service system elements, and service providers to ensure effective admission, discharge and follow-up planning.
- To provide liaison and consultation services to other agencies on the treatment and management of clients with treatment resistant illnesses and difficult behaviours.

### Linkages with Other Service Providers

General practitioners, general hospitals and private psychiatrists are significant providers of health services to mentally ill people. Each mental health service must develop strong linkages with these services so that support, guidance and early responses can be provided to clients who require specialist assessment, treatment and care. This will also help to ensure provision of ongoing, follow-up, support services. Shared care arrangements are to be encouraged and supported wherever possible.

Because of the varied needs of people with psychiatric disability, linkages need to be developed with other services. This will include housing and accommodation services, social support services, community health services, domiciliary care, and employment and training services. The linkages may take the form of providing cooperative care arrangements for clients of these services, advice and support to staff of the other service systems on mental health issues, or joint planning for the development of programs to more appropriately meet the needs of people with a psychiatric disability.

Adult mental health services will need to develop cooperative arrangements with child and adolescent mental health services and aged persons mental health services to assist with the client's transition through the mental health services network where this is necessary. Effective inter-program linkages will assist in the development of appropriate and more effective treatment options for service users.

## Aged Persons Mental Health Services

### **Aged Persons Mental Health Services at a Glance**

#### **Objectives**

1. To provide effective and efficient assessment, treatment and support to care for clients within their familiar surroundings in the community as long as possible.
2. To ensure care is monitored and coordinated in conjunction with general health and community support services.
3. To provide health education and health promotion programs for older people with a psychiatric disorder and their carers which incorporate information on ageing, mental illness and strategies for healthy adjustment to these processes.

#### **Target Group**

Services are provided primarily to people aged 65 years and over including:

- people with a long-standing mental illness who have grown older;
- people with functional illnesses such as depression and psychoses which have developed in later life; and
- people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

#### **Service Elements**

- Psychogeriatric assessment and treatment services.
- Acute inpatient services.
- Extended care inpatient services.

#### **Key Service Linkages**

- Extended care centres, nursing homes and hospice care services.
- Aged care assessment teams.
- District nursing services and community health services.
- Home and Community Care services and other local government services for older people.
- General practitioners.
- Public and private hospitals with particular reference to discharge planning.
- Non-government operated nursing homes, hostels and supported residential services.

### Objectives

Older people represent a growing proportion of the Victorian population, as a result of the combined impact of increased longevity and the higher proportion of the population over 60 years of age. These two changes result in a significant

increase in older people's use of public, private and voluntary health services. Not only are there more older people requiring these services, but increased longevity is changing the nature of service needs. Mental health services have to respond to increased demand and the changing

nature of this demand.

Over the next 20 years there will be:

- A significant increase in the incidence of dementia, including Alzheimers disease, as the 'older old' are the fastest growing population group in the community.
- An increase in the numbers and life span of people with pre-existing psychiatric disorders.
- Increased prevalence of physical disorders and disabilities which give rise to social and psychological problems.

Historically, aged persons mental health services were largely inpatient services for people who grew old with a pre-existing psychiatric disorder. Older people who experience a psychiatric disorder in later life may or may not receive a specialist aged persons mental health service.

Those patterns have now changed. Aged persons mental health services must take into account the complex mix of physical, neurological and psychosocial issues relating to the older person with a long-standing or late life disorder. Specific characteristics of age related mental illness must be considered including:

- medical and psychological issues;
- cultural and social issues for the client such as family supports, social networks, community supports and financial circumstances; and
- life history including preferred coping mechanisms, work history and personal hobbies and interests.

Older people with a psychiatric disorder receive services in a wide range of health and community support agencies. These agencies can be considered at three different levels.

#### Geriatric Health and Community Care Services

Geriatric services play an important role in the continuing care of older people with a mental illness. These services may be inpatient or com-

munity-based.

Most geriatric inpatient services are provided in extended care centres that have established services for psychogeriatric assessment and psychogeriatric care alongside other specialised geriatric health services such as rehabilitation, palliative care and some acute medical services.

There are other services within geriatric health, residential care and community care services which make a particular contribution to older people with a psychiatric illness. Dementia units in residential facilities are an important part of the services to frail older people with severe dementia or Alzheimers disease. Some intensive community support services which have a case management function are responsible for assisting older people with varying degrees of dementia or other forms of psychiatric disorder live within their own homes. Some of these services are funded either through the Linkages Projects which are part of the Victorian Home and Community Care Program, or through the Commonwealth National Action Plan on Dementia. The variety and diversity of these services means that a wide number of geriatric health and aged care services have direct involvement in the provision of services to older people with a psychiatric illness.

#### Other Aged Residential and Community Care Services

A significant number of home and community care services, private and voluntary hostels and nursing homes, and community-based aged care agencies have a major role in the care and support of older people with psychiatric disorders, particularly dementia. Some of these services have established programs to provide

appropriate and relevant services. Many are able to adapt their services to provide not only good quality care to older people with psychiatric illness, but also to enable their clients to maintain maximum feasible levels of independence. The majority of older people with dementia are cared for by these services and will not require the dedicated aged persons mental health services discussed in detail below.

#### Dedicated Aged Persons Mental Health Services

These are the psychogeriatric assessment, treatment, acute inpatient and extended care inpatient services of the Psychiatric Services Program. The objectives of these services are:

1. To provide effective and efficient assessment, treatment and support to care for clients within their familiar surroundings in the community as long as possible.
2. To ensure care is monitored and coordinated in conjunction with general health and community

support services.

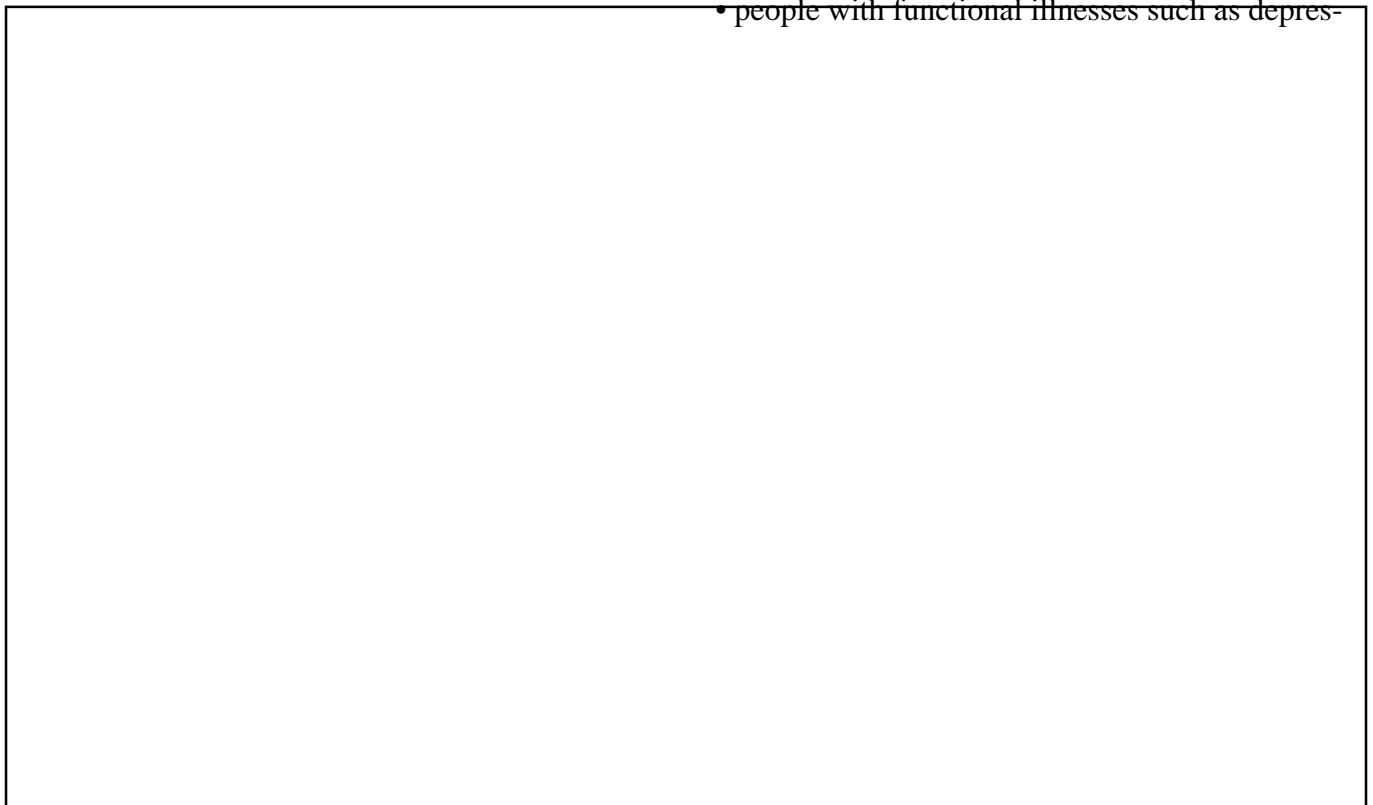
3. To provide health education and health promotion programs for older people with a psychiatric disorder and their carers which incorporate information on ageing, mental illness and strategies for healthy adjustment to these processes.

Dedicated aged mental health services are critical to the overall mental health system as they have specific expertise to provide interventions that do not rely on chemical and physical restraint and promote care in the least restrictive environment. An increasing number of clients enter these services because their level of behavioural disturbance cannot be managed by other health and community care service providers.

#### Target Group

Aged persons mental health services provide services primarily to people aged 65 years and over. The client group includes:

- people with a long-standing mental illness who have grown older;
- people with functional illnesses such as depres-



sion and psychoses which have developed in later life; and

- people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

People whose mental illness is of late onset or is characteristic of older patients should be treated as far as possible as part of the aged care system rather than as part of general adult psychiatry which extends from 15 years of age. Aged persons mental health services, therefore, should operate with strong linkages with the broader network of health and community services for older persons.

Service provision to people who are mentally ill and who are over the age of 65 years becomes more complex as the effects of the ageing process become more prominent and clinical approaches differ according to the cause of the condition. Detection of age-related conditions is more likely to occur in a service which specialises in aged persons rather than in one which deals with people from 15 years of age. This also allows transition to the aged care service to be managed in a manner that is sensitive and orientated to the client's need at a time when the client can best adapt to that change, that is, in the absence of changing clinical needs. The use of age as a guideline acknowledges that people over the age of 65 years with mental illness often have co-existing physical problems which need attention from aged care services. This is particularly pertinent to the 'very old', that is those over 85 years who are more likely to suffer chronic illness, progressive disability, poorer recovery rates and physical frailty.

#### Functional Disorders

A small but significant proportion of people over the age of 65 years will suffer a functional disorder and require treatment and care for the first time. The most prevalent disorders that develop in this age group are depression, paranoid psychosis and heightened anxiety states. People

who have a long-standing mental illness continuing past 65 years of age, may also have complicating issues related to ageing. These may be in the form of physical frailty, psychological stress and/or significant changes in their social circumstances.

#### Organic Disorders

Organic disorders are characterised by physiological changes in the brain with the person experiencing a deterioration in their intellect, judgement and memory, and significant personality changes. The most prevalent organic disorder in the elderly is dementia, with Alzheimer's disease and Multi-Infarct dementia being the most common. Severe dementia affects four to five per cent of the population over 65 years. There is a relatively small number of people who develop dementia before the age of 65. Between 65 and 75 years the proportion increases up to six per cent and over 75 years there is a very marked increase in the incidence of a person developing dementia.

Aged persons mental health services will be available to clients with dementia with a significant level of behavioural disturbance that presents considerable difficulties for the aged health and community care system. Mental health services will be able to provide a secure environment with intensive treatment, care and support.

In addition, aged mental health services will provide assessment and care to the small number of people under 65 years of age who develop organic disorders

related to the ageing process and other conditions. The Psychiatric Services Branch will establish formal links between the statewide Organic Brain Disorders Unit and regional services with regard to the management of the early onset of organic disorders where it may not be appropriate to manage the younger person in the aged care system.

#### Service Elements

Each region will provide services through a number of elements including:

- Psychogeriatric assessment and treatment services.
- Acute inpatient services.
- Extended care inpatient services.

Services provided through these elements will include early intervention, prevention and education, assessment and diagnosis, case management, acute inpatient services, continuing care, respite care, carer support and education, and liaison and consultation with other service providers.

The service system will ensure that services are delivered in a flexible manner to meet client's individual needs. Some services will need to be locally-based promoting easy access for the person living at home. Other services should be offered on a regional basis. The manner in which each of the component functions is delivered will reflect regional and area differences, however, a number of specific services will be required as detailed below.

#### Psychogeriatric Assessment and Treatment Services

Initial assessment and treatment will routinely be provided through the Psychogeriatric Assessment and Treatment Service (PGATS). The PGATS are a focal point in the aged persons mental health service providing, in most cases, the first point of contact with clients and their families. In addition to the assessment role, they pro-

vide a treatment, rehabilitation and case management service. All admissions to acute beds should occur with involvement of the PGATS in order to ensure that clients are managed in the least restrictive setting. There will be an increasing focus on achieving a more coordinated assessment service with the geriatric assessment teams.

Services will be delivered through multidisciplinary teams able to provide clinical expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions. The services will be community-focused in the assessment and treatment of the older person and incorporate case management, access to acute or extended care inpatient facilities, education for the consumer and carer, and consultation and advice to other agencies.

The number and pattern of admissions to inpatient care is insufficient to justify provision of PGATS on a 24-hour basis. Accordingly, the after hours crisis response will usually be provided by the adult service CAT services with later transfer to the aged persons mental health service where appropriate.

*Key service requirements* for PGATS are:

- To provide assessment, treatment and rehabilitation in a timely and client orientated manner in community settings.
- To monitor all persons referred to or presenting for admission to hospital, thus preventing unnecessary hospitalisation where services can be provided adequately in the community. All admissions to the aged care acute or extended care units will involve the PGATS.
- To minimise a client's length of stay in acute inpatient facilities through the earliest possible discharge with appropriate referrals and service follow-up.
- To ensure all consumers are linked into appropriate follow-up care, including those referred to

but not accepted for PGAT services.

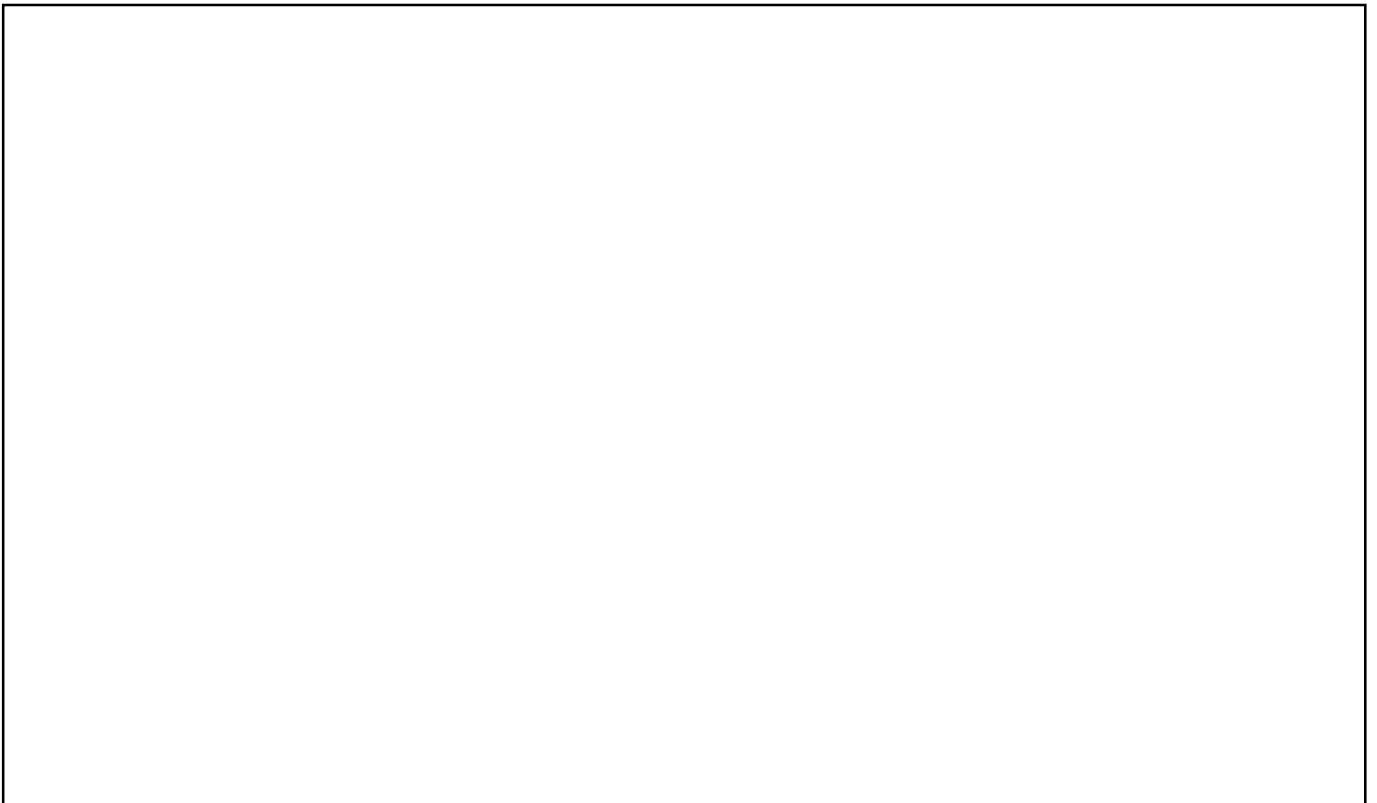
- To provide primary, secondary and tertiary consultation to other service providers in the community in relation to psychogeriatric management and treatment.
- To provide ongoing case management services.

#### Acute Inpatient Services

These hospital units provide assessment and treatment for older people with acute symptoms who cannot safely be cared for or supported within the community by the PGATS or the generic aged care system. The assessment function enables the accurate diagnosis of the older person when their presentation is more complex or when their symptoms are creating acute distress or jeopardising their safety. Where possible, all aged mental health inpatient facilities will be co-located with general aged care services.

*Key service requirements* for acute inpatient services are:

- To provide an inpatient service that enables the assessment and treatment of a clients mental, physical and social state.
- To provide a short-term, voluntary and involuntary treatment service during an acute phase of a client's mental illness where this cannot be managed in the community.
- To ensure all beds are gazetted in accordance with s. 94 of the Mental Health Act and accordingly able to admit involuntary patients.
- To ensure all admissions to the unit have had involvement of the PGATS.
- To ensure that clients who require a short-term secure environment and intensive support can be managed.



### Extended Care Inpatient Services

Extended care inpatient services are provided in psychogeriatric nursing homes situated in community settings. These services will provide a range of inpatient services for aged clients who cannot be managed in the general aged care system due to their level of persistent cognitive, emotional or behavioural disturbance. They must be sufficiently flexible to enable long-term accommodation, ongoing assessment, treatment and care of residents, rehabilitation, and respite care.

A generic brief for the development of these units has been designed that will be applied in future developments. The design of these units will enable the necessary flexibility of care to be provided.

Respite care should be available to meet the needs of both carers and consumers. Although each element of the service system will play a significant role in the support and education of carers, linkages with relevant carer support services need to occur.

*Key service requirements* for extended care inpatient services are:

- To provide extended mental health inpatient treatment and rehabilitation to all clients who are unable to be managed in generic aged care facilities.
- To provide respite care to clients (and for relatives) who cannot be managed in aged health and community care facilities.
- To transfer clients to generic aged care services in the least disruptive manner as soon as their condition permits.

### Linkages with Other Service Providers

Aged persons mental health services operate within the context of the general aged care system. Collaborative working relationships must be developed to complement the elements in each service system in assessing and/or treating the client. A significant number of people assessed by

aged persons mental health services have either progressed from or will go onto receive services provided by generic aged care services.

Provision must be made for the development of collaborative care arrangements for the older person, or the provision of specialist input from aged persons mental health services to services for older people. In particular, linkages need to be developed with:

- Extended care centres, nursing homes and hospice care services.
- Aged care assessment teams.
- District nursing services and community health services.
- Home and Community Care services and other local government services for older people.
- General practitioners.
- Public and private hospitals with particular reference to discharge planning.
- Non-government operated nursing homes, hostels and supported residential services.

It is essential that when an older person is able to receive continuing care and treatment in a general aged care service that this should occur. In the main, it is the level of behavioural disturbance associated with mental illness in the elderly that requires specialist aged mental health involvement. Usually, the person's level of behavioural disturbance will reduce in severity over time making a referral to a nursing home or other geriatric facility possible and more appropriate in order to ensure the least restrictive setting for care.

As with general aged care services, collaborative working relationships need to be developed and maintained with general adult mental health services as both service systems will at times need to complement each other in assessing and/or treating the client.

The Psychiatric Services Division and the Aged Care Division of H&CS will continue to work cooperatively to develop and manage the delivery of mental health services to the Victorian

aged population. While future service development will occur in the context of mental health services being based within generic aged care services rather than psychiatric or general health services, the Psychiatric Services Division will maintain program and budget responsibility. This level of cooperation must similarly occur at a regional level.

# Services for People with Specific Needs

## Protocols for Multi-Agency Involvement

The complex needs of some clients requires a coordinated and cooperative approach to service provision between specialist mental health services and other agencies. This is particularly so for people with intellectual, sensory or physical disabilities, head injuries or those requiring drug and alcohol services. Protocols are called for which identify the roles and responsibilities of services and detail the way in which coordination and cooperation will occur.

To date, formal protocols have been developed in relation to disability services and child protection services. The Psychiatric Services Branch will continue to develop and refine specific approaches and protocols with other service providers in relation to responding to a severe mental illness for the following groups of people:

- Families and other carers.
- Aboriginal people.
- People with a disability or sensory impairment.
- People with drug and alcohol problems.
- People with HIV/AIDS.
- People who are homeless.
- People from Non-English-speaking backgrounds.
- Women.

The provision of specialist mental health services must take into account the specific needs of these groups of clients so that access is facilitated and services provided in ways that are most effective. Too often they have been victims of endless buck-passing. Service provision should be integrated, as far as possible, within existing mental health service networks. It is essential, therefore, that mental health service staff are trained to respond to the needs of such people, both through direct service delivery and by liaison and involvement with other agencies.

## Support Services for Families and Other Carers

Families and other carers have an important role in the care of people with a mental illness. Funds have been provided to organisations which provide information, support and advocacy for carers. A program to train clinical staff in working with families is currently being piloted by North Eastern Metropolitan Psychiatric Services in conjunction with the Schizophrenia Fellowship and Bouverie Family Therapy Centre. This project will aid the development of statewide staff training, and will assist with the establishment of statewide guidelines on family and care support.

Respite care is another area of particular significance for carers, especially with more targeted use of inpatient services. Each Region must consider options for access to respite care services, including residential as well as in-home services. A pilot respite care service in the Eastern Region using a staffed residential facility has been established through the Schizophrenia Fellowship. The evaluation of this service will provide direction for service development in other regions.

## Services for Aboriginal People

Aboriginal people with a serious mental illness have specific needs determined by a number of factors which may include loss of culture and identity, loss of control of destiny, poor physical health, inadequate education, family dislocation, unemployment and alcohol and substance abuse. These factors can be further compounded by the considerable disadvantage experienced by the Aboriginal community and the deprivation they may suffer as a result.

The statewide Aboriginal Mental Health Network was established in recognition of the special needs of Aboriginal people with serious mental illness and associated disabilities, and the importance of effective linkages with other Aboriginal services, especially

health services. Inpatient services are currently provided through North Eastern Metropolitan Psychiatric Services with outpatient services and community liaison through the Aboriginal Health Service. Establishment of community-based services must be examined including the establishment of a staffed community residential service to provide transitional rehabilitation as an alternative to inpatient admission. Development of satellite services in rural areas with well-established Aboriginal communities will also be explored.

### Services for People with a Disability or a Sensory Impairment

In order to provide satisfactory services for clients who also have a physical and/or intellectual disability or a sensory impairment, specialist mental health service providers will need specific skills and knowledge. Access to appropriate training for mental health workers will be required and services need to maintain appropriate liaison with disability services to obtain information and advice where necessary.

A number of people with an intellectual disability and a serious mental illness are presently receiving services from community mental health services or are inpatients in hospital services. Access to specialist assessment and treatment services by this client group must be an integral part of a comprehensive mental health service system, with collaboration between services from different program areas to ensure that service provision is coordinated and effective.

Guidelines for joint service provision are the focus of the formal protocol developed between the Psychiatric Services Branch and the H&CS Disability Services Branch. Implementation of the protocol will be accompanied by targeted staff training. Liaison will continue with the Disabilities Services Branch and regular consultation with consumer and disability organisations should be an integral part of service planning.

### Services for People with Drug and Alcohol Problems

Substance abuse amongst people with serious mental illness is increasingly common, and raises complex issues of assessment and treatment. The complexity and social costs of dual disorders mean that these clients are often in contact with an array of services including general health services, accident and emergency services in general hospitals, the police, social welfare agencies, agencies for homeless persons, drug and alcohol services, and mental health services.

Mental health services have a responsibility to provide assessment services in situations of differential diagnosis, dual diagnosis of mental illness and drug/alcohol dependency. Mental health services will be provided for clients with dual diagnosis of mental illness and a substance abuse disorder, in collaboration with other services such as drug and alcohol agencies. Assessment and consultation services will continue to be made available for people with severe alcohol-related brain damage.

Mental health services on their own have neither the skills nor the facilities to treat, manage or rehabilitate people with drug or alcohol dependence. Intervention for serious mental illness cannot reasonable commence until the dependence is being suitably managed.

### Services for People with HIV/AIDS

The number of people with serious mental illness and HIV/AIDS infection is not known and includes those with a pre-existing mental illness as well as others whose mental illness is a consequence of the HIV/AIDS infection. The individual client's primary need for care will determine which agency is responsible for coordination of service provision across different program areas, including access to specialist assessment and treatment services as appropriate. Mental health services will take responsibility for service

provision to clients from their respective catchment areas who require specialist clinical services. The exception is those persons with AIDS-related dementia and associated behavioural problems who require inpatient care in a secure facility. Specialist inpatient treatment will continue to be provided for these people on the North Eastern Metropolitan Psychiatric Services campus.

### Services for Homeless Persons

The inner city areas of metropolitan Melbourne have a higher proportion of people who are homeless or at risk of homelessness, and staff of night shelters and other services for homeless people consistently report a significant number of people with a psychiatric disability seeking services. A survey of homeless people in inner Melbourne undertaken in 1987 found that around 18% had current symptoms of a psychotic disorder.

Shelters, refuges, boarding houses and special residential services play an important part in meeting the needs of homeless people. The mentally ill who are homeless have a right to access these services. Given the choice, many of these homeless people would choose to be in the community rather than be contained in psychiatric hospitals. Treatment provided in community settings does not lead to the negative consequences of institutionalisation.

Psychiatric support is and will continue to be provided to people in the community and will be responsive to the service needs of homeless people with serious mental illness and associated disabilities. Effective service responses include assessment and treatment provided on an outreach basis as well as services aimed at stabilising the person's housing and improving their quality of life. Regions characterised by high levels of homelessness will also have special services targeting the homeless mentally ill.

The outreach assessment and treatment service provided by the Homeless Persons' Serv-

ice of the Inner North Mental Health Service has proved effective in making clinical services accessible to residents of night shelters. Based on the success of this service it will be extended during 1994 by increasing the number of clinical staff working on an outreach basis in the localities of St. Kilda and Collingwood, Fitzroy and Richmond where there are also known to be concentrations of homeless people. In addition, a number of non-government disability support services have been established which work directly with homeless people. These include individual support services, day activity programs and accommodation support.

Access to stable low-cost housing is another essential component of services for homeless people. Through inter-departmental housing and support projects, new housing places with associated accommodation support have already been established, and other projects are being planned. A number of these projects target homeless people in the inner city. Victoria has a strong commitment to providing public housing stock to people who are mentally ill.

Accommodation support is also provided to people with psychiatric disabilities living in shared housing allocated through the Victorian Department of Planning and Development's Group Home Program. An important innovation has been the funding by the Department of non-government organisations to provide accommodation support for people with psychiatric disabilities, as part of Housing and Support Projects. These projects are based on low-cost long-term housing being provided by the Victorian Department of Planning and Development in conjunction with the provision of funded accommodation support from a non-government service.

## Services for Persons from Non-English-Speaking Backgrounds

Language and cultural barriers can present a significant obstacle to people from non-English-speaking backgrounds (NESB) in gaining access to mental health services and receiving optimum treatment. Improving access requires:

- the availability and appropriate use of trained interpreters;
- staff who incorporate sensitivity to cultural differences into their practice; and
- services which cater for the needs of people from varied ethnic backgrounds.

Effective provision of community treatment and care often requires liaison and consultation with relevant ethnic agencies and bilingual health service practitioners as well as the provision of information and support for families and other carers. The Mental Health Interpreter Service provides access to trained interpreters for clinical services.

The Victorian Transcultural Psychiatry Unit was established to improve understanding of psychiatric problems experienced by different ethnic groups and to provide training and consultation on transcultural psychiatric issues for clinical staff. It also provides a limited outpatient service. In addition, particular clinical services are undertaking service development projects to improve the responsiveness of their services to people from non-English-speaking backgrounds. This is particularly important in areas with significant numbers of recent or newly arrived migrants as well as those with more established ethnic communities.

A number of psychiatric disability support services actively support access from NESB people with psychiatric disabilities. Services already operating include independent living skills programs, accommodation support, and information provision.

## Services for Women

Planning and delivery of mental health services must be sensitive to the needs of women according to their age, cultural background and social circumstances. Specific programs for women may also be developed. Services will need to address particular issues faced by women with a serious mental illness including the risk of sexual assault and abuse, and their responsibility for infants, children and older family members. Planning should include liaison with women's services such as information and health services and sexual assault centres.

There are a number of service developments and projects which address these objectives. For instance, in 1992, a women's advisory group was established by North Eastern Metropolitan Psychiatric Services to improve service responsiveness to the needs of women clients. Initiatives include health screening for women inpatients in extended care and psychogeriatric wards, development of health assessment protocols for women in acute care, staff training in sexuality education, and sexuality education for clients. Psychiatric services in other regions have also introduced sexuality education programs for clients, and particular hospitals have redesigned their acute units to ensure greater safety for women inpatients.

A resource and training kit is being published by Healthsharing Women aimed at improving the knowledge and skills of staff working with women with psychiatric disabilities. Based on consultation with clients and staff, the kit will provide a valuable tool for staff training in psychiatric services and the non-government disability support sector. Disability support services in several regions have already established independent living skills programs specifically designed for women clients with one service publishing a guide to program development for use by other services.

Housing for women with psychiatric disabilities is also receiving attention in a number of metropolitan regions, with homeless women being

given priority. For example, a housing and support project in the inner city has resulted in the provision of six units for homeless women with psychiatric disabilities together with the employment of an accommodation support worker.

The particular needs of women with dependent children are being addressed through different types of services. Two psychiatric inpatient services and a general maternity hospital have made special provision for the treatment of women with postnatal disorders accompanied by their babies. In addition, a non-government residential service is providing short-term accommodation and support to women with acute psychiatric problems who have dependent children. Funding is also provided to a family support agency to employ staff able to assist parents with psychiatric disabilities in undertaking their parental roles.

# Resourcing Mental Health Services

## Source of Funds

Public expenditure must target the provision of appropriate services to the seriously mentally ill. It is vital that scarce public dollars should be spent in the most efficient and effective way

possible.

Public funding for mental health services in Victoria is available from a number of sources.

Table 1: Funding for Mental Health Services in Victoria 1993-94

	\$ Million	Per Cent of Total Current Funding
<i>Current</i>		
Commonwealth Medical Benefits Scheme (1991-92 estimate)	51.0	15
– private psychiatric services		
Commonwealth-State Disability Agreement	11.8	4
– Commonwealth and State funding		
National Mental Health Reform and Incentive Grants	4.2	1
– Commonwealth funding		
Psychiatric Services Program	250.2	74
– State funding		
Hospital and Charities Fund	19.5	6
– State funding		
<b>Total Current Funding</b>	<b>336.7</b>	<b>100</b>
<i>Capital</i>		
Works & Services funding (including Commonwealth Building Better Cities funding)	9.7	–
<b>Total Funding</b>	<b>346.4</b>	<b>–</b>

**Figure 7: Funding Sources**

**Figure 8: Estimated Per Capita Real Cost of Specialised Mental Health Services 1992–93.**

Victoria already spends more on mental health services per head of population than any other Australian state or territory. Funds for the redevelopment of mental health services are being found from within the mental health budget through the introduction of more efficient work practices and the move to modern and more effective styles of service delivery. Funds made available to Victoria under the National Mental Health Strategy have facilitated the early introduction of some of these changes, which will continue over the next few years.

### **Principles of Resource Allocation**

In allocating public resources for mental health services, the following objectives will be pursued by H&CS:

- Priority will be given to services for the seriously mentally ill.

- Resources will be redirected from hospital-based to community-based services wherever possible, with a target that 50% of resources are to be devoted to community-based services by 1997.
- Resources will be re-allocated to promote more equitable access to services across different geographic areas and needs-groups.
- Allocations will be targeted to meet the needs of the mentally ill and not to the support of existing institutions and infrastructure.
- Efficiency will be encouraged so that the available mental health funding will provide the maximum quantity of high-quality services—that is, value for money.

To achieve these objectives, a number of strategies will be applied, including:

- The introduction of unit-cost standards for services.

- Global budget allocations to regions rather than to individual institutions.
- A redistribution of resources between regions and services according to need.

## Casemix and Unit Costs

Public hospital resourcing in Victoria is currently undergoing extensive reform through the introduction of 'casemix' funding. Under casemix, a significant part of a public hospital's funding is determined by its weighted throughput—that is, the number of episodes of care weighted by indices based on Diagnosis Related Groups (DRGs). This system provides incentives for hospitals to treat more cases and to reduce waiting lists.

The theory behind casemix is that individual episodes of care can be divided into clinically consistent DRGs on the basis that the total quantity of resources required to treat each care episode within the group is, on average, roughly equal. Unfortunately this is not currently possible in mental health services, because diagnosis is not a good predictor of the type or length of care a patient will require, and thus the resources required for that patient's care. Work is proceeding at a national level to develop a measure equivalent to the DRGs used in acute hospitals, but this may take several years. Nevertheless, incentives to achieve many of the same objectives as casemix are being incorporated into the new funding framework for mental health services in Victoria.

In the past, funding for mental health services was allocated according to historical precedent. Large psychiatric hospitals were allocated the same resources they received in former years without critical analysis of efficiency or appropriateness. From 1994–95, funding for inpatient services will be managed within a unit cost standard for occupied-bed-days in each type of service. These standard unit costs have been developed through the analysis of expenditure and outputs of existing services and on the assumption that

inefficient work-practices will be phased out. Although it is not yet possible to assess the level of resources required to treat a particular patient, it is possible to set a target for the average cost of each day that a patient requires hospitalisation. Budget savings in 1994–95 will be achieved predominantly through application of the unit-cost standards as well as through reforms to work practices.

Average unit costs for inpatient mental health services are higher in Victoria than in other states. Over time, the unit cost targets for Victoria's services will be reduced, so that more resources can be devoted to community-based services.

Initially there will be no unit cost standards for community-based services, largely because an appropriate, measurable and comparable unit of output has not yet been defined. Although these services record 'contacts' with mentally ill patients, a contact can range from a five-minute phone call to a three-hour home visit, with considerably different resource implications. Data will be collected and guidelines will be developed during 1994–95 to enable unit cost targets to be established for community-based services in 1995–96.

On their own, unit cost standards for inpatient services might lead to incentives for hospitals to admit more patients for longer periods—this would work against the objective of only treating the mentally ill in hospital-based services where necessary. Moreover, limiting the cost of inpatient services does not ensure that those services are equitably distributed according to need. Accordingly, an overall funding framework, which incorporates the unit-cost standards but provides a more equitable statewide distribution with appropriate incentives, is being adopted.

## The 'Planning Norms' Approach to Resource Allocation

One way to allocate resources more equitably is to use standard ratios of service levels to population—for instance, 15 acute inpatient beds per 100,000 population as used in some other states. Using the unit cost standards for each bed day, an overall budget allocation could be generated for each region. However this 'planning norms' approach does not recognise the varying needs for some service types depending on the availability and effectiveness of other services types. For example, experience has shown that effective CAT services reduce the need for acute inpatient beds. This approach also fails to recognise that mental health services must be planned within a fixed overall budget. For these reasons, the 'planning norms' approach will not be pursued in Victoria.

## The Needs-Based Purchaser-Provider Approach

There is a considerable body of evidence to suggest that an area's population, socioeconomic profile and population structure (in terms of age, marital status and gender) are good estimators of that area's need for and utilisation of mental health services. Measures of these factors will be used from 1994–95 to establish regional 'shares' of the mental health budget, which will act as a target for resource distribution over the next few years. Shifts in resources between regions to match these new targets will be phased in over a number of years.

Under this approach, global budget allocations for mental health services will be made to regions to enable flexibility within regions and an effective capacity for regional and area-based planning. Regional directors and psychiatric

**Figure 9: Location of 1992–93 Expenditure by Region in Victoria on Per Capita Basis**

services managers will determine the most appropriate mix and structure of services in each area, after considering the distribution of population and demand for services. Services will either be 'purchased' from a hospital or a non-government organisation, or where this is not possible, provided directly by H&CS. To enable the necessary changes to staffing and infrastructure, purchaser regions will need to give an agreed period of notice before shifting resources between different regions.

The average cost of inpatient services will be restricted to a unit cost standard. As community-based services become better established and more effective, there will be less need for relatively expensive inpatient services, and as inpatient services become more efficient, less resources will be required in inpatient settings. Redistribution of resources from the high cost services will permit expansion of the range and quantity of community-based mental health services, and consequently increase the overall number of people who can be treated. The approach provides appropriate incentives for efficiency and best use of inpatient services so that the total number of services delivered can thus be increased.

### Incentives in the Private Health Sector

Despite a lack of agreement upon the definition of serious mental illness, a recent study revealed that approximately one-third of the clients seen by private psychiatrists have a serious mental illness compared with two-thirds of those seen by public psychiatrists. There are however, continued problems in the recruitment and retention of adequate numbers of psychiatrists in the public system and so greater incentives must be found for private psychiatrists to treat the seriously mentally ill. They must include recognition that:

- People with serious mental illness often require both psychiatric treatment and disability support

services, but private psychiatrists have more difficulty in accessing these support services.

- People with serious mental illness can be unresponsive to treatment resulting in a need for support from other mental health and allied health staff, but this support is less likely to be available in the private sector.
- There is a lack of financial incentives for private psychiatrists to take on more difficult and complicated cases.
- There is relatively higher remuneration for private psychiatrists over (typically) salaried public sector psychiatrists.

The Commonwealth Medical Benefits Scheme (CMBS) provides significant funds for mental health services, with estimated rebates for consultant psychiatrist services in Victoria in 1991–92 totalling approximately \$51 million. The CMBS essentially provides a time-based rebate rather than a rebate related to the complexity of the service offered. Accordingly, although treating the seriously mentally ill is much more difficult and complicated, the financial rewards from the CMBS are no higher. This can provide a disincentive to work with more seriously ill patients.

While the CMBS appears to over-reward private psychiatry provided by specialists, it also appears to discourage care for psychiatric patients by general practitioners, who do not have access to time-based payments. Severe distortions are hence imparted to the allocation of clinical effort by distortions within the CMBS.

It is somewhat incongruous that the significant level of funds which flow into Victoria from the medical benefits scheme are not more directly targeted towards people with serious mental illness at a time when the difficulties in providing services to that group are under such scrutiny in each state. Victoria is involved in a national working party which is providing advice on ways in which these barriers might be overcome and will continue to raise these matters with the

Commonwealth Government who carry the responsibility for the CMBS.

H&CS is also examining options for shared care arrangements with private practitioners so that people with serious mental illness can better access the range of resources available in the private sector.

# A Strong and Skilled Workforce

## The Mix of Skills

The quality of provision of mental health services is directly influenced by the clinical staff providing treatment, rehabilitation and support. Staff are required from different professional backgrounds and the service system will continue to utilise a multidisciplinary approach to mental health services. Clinical leadership will continue to be important as the service system becomes more focused around community settings. Particular attention must be given by managers to ensure that staff are able to work cooperatively and effectively with other professionals in other service areas and in the private sector as this will become increasingly important in the future. In addition, managers must ensure that appropriate arrangements for clinical supervision are in place and that lines of clinical accountability and decision making are clear and explicit in all settings.

## The Role of Psychiatrists in Public Mental Health Services

Psychiatric care in community-based services, and some hospitals, is now delivered through the combined expertise of multidisciplinary teams that include nurses, psychiatrists, psychologists, and social workers, among others. This multidisciplinary approach supports the provision of comprehensive care. High levels of psychiatric disability amongst clients typically call for the establishment of a long-term relationship, treatment and a management plan for clients of the service.

As with a hospital-based service, a community-based service must provide appropriate medical and psychiatric services. There has been some confusion on this point in some of the more ideological driven elements of community mental health services. The responsibility for clinical standards in such a service must lie with a consultant psychiatrist who is fully trained and qualified to provide appropriate supervision and oversight with respect to the assessment, diagnosis, treat-

ment planning and clinical services.

The psychiatrist's most significant role is clinical leadership. Such leadership is increasingly important given increased emphasis on accountability for the performance of mental health services. Supervision of other professionals in clinical matters is an important element of the role of the psychiatrist within both hospital and community-based services.

The Mental Health Act gives certain authority and responsibilities to psychiatrists with regard to the performance of their duties that no other professional group bears. Section 12(5)(b) of the Act provides the overall statutory responsibility and authority for the care of patients admitted under the Act. Such responsibilities include the ability to:

- detain, assess and review the need for involuntary hospitalisation;
- carry out the 24-hour examination;
- place persons on community treatment orders;
- consent to psychiatric and non-psychiatric treatment;
- grant leave and discharge persons under the Act;
- give authority to their transfer and accept transfers from other services;
- give reports to courts under the Sentencing Act; and produce the certificate of psychiatrists with regard to that Act.

As well, psychiatrists are qualified, on appointment, to sit on the Mental Health Review Board. Along with other more junior medical staff, they are responsible for:

- the prescription of medication;
- the recommendation of persons for involuntary hospitalisation;
- the ability to admit or refuse to admit persons presenting for voluntary admission;
- the production of doctor's certificates;
- giving intravenous medication;

- administering ECT; and
- directing non-medical staff in the medical management of their patients.

They perform a critical clinical role in mental health service delivery.

The role of psychiatrists will continue to remain central to treatment and clinical service delivery in the future although the emphasis will shift to one appropriate for a community-led service rather than one based on inpatient services. Psychiatrists who can provide strong clinical leadership in community settings and in fact champion a community-led service system, will quickly become Victoria's professional psychiatric leaders.

## Recruitment and Retention of Psychiatrists

One of the issues which faces Victoria, along with other public mental health services in Australia, is that of maintaining adequate numbers of trained psychiatrists in the service. Despite the considerable numbers of psychiatrists who are trained in this State, there remains a continuing need to recruit from overseas to maintain adequate levels of service, particularly in rural areas. Significant factors contributing to this problem include:

- the ease with which psychiatrists can move into private practice once their training is completed;
- the functioning of the Commonwealth Medical Benefits Scheme (CMBS) which can easily ensure a relatively high income to the private psychiatrist;
- the perceived attractiveness of the autonomous working conditions of private practice to those of psychiatrists who continue to work in the public sector; and
- the less complex and less demanding characteristics of many private clients who are less likely to suffer from a serious mental illness.

H&CS has commenced a review of the issues impacting on recruitment and retention of public psychiatrists in Victoria. The review will:

- identify the trends and factors affecting recruitment and retention of psychiatrists in the public sector;
- explore the options which may resolve the problem; and
- make recommendations on viable strategies for change.

This review will also explore the viability of:

- extending sessional employment of private psychiatrists in public psychiatric services;
- contracting services out to private psychiatrists operating from public facilities;
- contracting all or some psychiatrist services through public hospitals; and
- encouraging public sector psychiatrists to take up a percentage of private practice.

## The Public and Private Workforce

Public mental health services must find ways of working cooperatively with professionals in private practice. General practitioners provide services to a great many people who are mentally ill and this treatment would be far more effective with back-up from specialist mental health services. While the role of GPs is clearly recognised in the National Mental Health Policy, little work has yet been done to examine systematic ways of providing specialist back-up to GPs. Four new projects are being established in Victoria to explore the practical ways that effective shared-care working arrangements can be organised in both metropolitan and rural locations. Provisions in the Commonwealth Medical Benefits Scheme which place barriers in the way of this style of working will be examined. Close liaison is being established with the Australian and New Zealand College of General Practitioners on this and related issues.

## **Nursing and Allied Health Staff**

While clinical leadership is the responsibility of the psychiatrist, other roles critical to the care and management of both inpatient and community-based clients are assumed by nursing and a range of allied health staff. Each service component will determine the appropriate mix of these staff to ensure the highest quality outcomes.

In community settings, nursing and allied health staff will have a lead role in the provision of case management. Individual professionals will, at the same time, offer specific expertise relevant to their discipline.

The major factor in the success of interdisciplinary teams is the appropriate application of the collective skills and knowledge of a range of disciplines to create the best outcomes for clients.

## **A Focus on Staff Development**

There has been little systematic training provided to the department's mental health staff in relation to working within particular service settings. There has been a reliance on individual service units developing their own practices and procedures which has meant that staff roles and approaches are quite different across like services. Diversity has real value when it allows comparisons against benchmarks, and diffusion of innovations or superior standards. Unfortunately, the past framework allowed poor quality local practice standards in some state psychiatric hospitals to become entrenched only to be uncovered when a public disaster occurred. In future local innovation will be encouraged, but within a framework which guarantees acceptable basic standards of practice. Greater consistency in service delivery will be assisted through the development of statewide guidelines for the delivery of particular services and the provision of regular training opportunities for staff. In this way, there will be greater consistency in the skills staff develop and, therefore, in the way they provide services.

# Taking Victoria Forward—Initiatives for 1994

This framework seeks to clarify many of the issues that have recently limited the further development of mental health services in Victoria. Many promising activities and redevelopment projects have been unable to progress without certainty about the type of services sought for this State. This period of waiting was unavoidable but is now over.

This document will provide the context in which future service redevelopment will occur over the next five years and will allow realistic time frames for change to be developed. These will, of course, be linked to the availability of funds for service redevelopment.

The following initiatives, which will be commenced in 1994, will fundamentally take the service system a major step forward. They provide for a dramatic increase in community-based services, as well as a significant redevelopment and relocation of services from stand alone psychiatric hospitals.

**Figure 10: Trends in Inpatient Services**

## Expanded Community Crisis Assessment and Treatment Services

New or expanded crisis services will be put in place in Victoria prior to June 1994 in the areas where the current crisis teams either do not yet exist, or are unable to respond to the full demand. Coverage will be provided throughout the whole of metropolitan Melbourne and for all major population centres in country Victoria. Most Victorians, except those in sparsely populated rural areas, will then have access to community-based crisis response services. This will produce better quality services for clients at a reduced cost and will further reduce the demand for inpatient care in hospitals.

This initiative is based on the benchmark crisis services already operating in some parts of Melbourne and in rural locations such as Traralgon and Ballarat.

A total of 80 new treatment staff at an annual cost of \$4.1 million will be appointed to new and expanded services throughout metropolitan Melbourne and in major rural centres. Included in this initiative are new services in the areas of Knox, Sherbrooke, Upper Yarra, the Mornington Peninsula (Frankston, Mornington, Hastings, Flinders), and selected areas in the Western metropolitan region. The inner Melbourne services focusing on Fitzroy, Carlton, Collingwood, Richmond, Kew, Camberwell and Hawthorn will be substantially extended. New country services will be established in Mildura and Shepparton and its environs. The service in the central sector of Gippsland will be expanded.

### Expanded Community Mobile Treatment Services

Mobile treatment services already play a significant role in providing intensive treatment and support to those with chronic mental illness. These teams focus on prevention as well as treatment, working intensively with a small number of clients at risk of readmission due to recurrent crises and continuing disability. The teams also provide a range of social and vocational rehabilitation services in the client's own environment. These services operate on an extended hours basis and work to prevent treatment breakdown and possible readmission to hospital. The support they provide will help eliminate the 'revolving door syndrome' which has seen some clients constantly readmitted to hospital because of the absence of treatment and support in their community.

Four new services are proposed in both metropolitan and rural areas including eastern metropolitan Melbourne and the Barwon, Hume and Loddon Mallee Regions at an annual cost of \$0.7 million to provide an additional 17.5 mobile treatment staff.

### Expansion of Specialist Mental Health Services for Homeless Persons

The needs of homeless people who suffer from a mental illness are well recognised. For some time a specialised psychiatric team has operated out of the Inner North Community Mental Health Service in Carlton providing an outreach service to homeless persons in the North Melbourne, Flemington and Kensington municipalities. Based on the proven success of this service it will now be expanded to cover the St. Kilda and Collingwood, Fitzroy, Richmond localities where there are also known to be concentrations of homeless people. This initiative will result in a major improvement in service provision to this particularly disadvantaged group of Victorians.

The new services will be staffed at an annual cost of \$0.3 million.

### New Community Continuing Care Services

Community care units provide a supported residential service with clinical support and rehabilitation services. They provide a community alternative for the long-term rehabilitation wards in psychiatric hospitals offering new opportunities for clients who need that level of service. Built as 20 bed units, these are based on like services which are successfully operating in Canterbury and Geelong. Funded from the Building Better Cities Program and the State's Capital Works Budget, new units will be established in St Kilda, Ringwood, Brunswick and St Albans. These are at various stages of design and construction and are expected to become operational in the period 1994–1995.

Initially many of these units will provide alternative services for clients who are currently long-term patients in the large psychiatric hospitals but will increasingly be available for new clients from the community. The

average construction cost per unit is \$1.2 million and they operate at an annual cost of approximately \$1.3 million.

### **New Acute Units Co-Located in General Hospitals**

The relocation of acute inpatient units out of stand-alone psychiatric hospital settings into general hospital settings is a key strategy of the National Mental Health Policy. A new 25 bed service located in the Box Hill Hospital will commence this year to replace part of the service currently provided through the North Eastern Metropolitan Psychiatric Service at Bundoora. The new service will operate from a modern facility in the locality that it will serve at an annual cost of approximately \$2.5 million.

Planning and specification will continue in 1994 for the rebuilding and relocation of other services from the North Eastern Metropolitan Psychiatric Service's site. Further new inpatient services to replace those in other country psychiatric hospitals is also being planned. Construction is expected to proceed throughout 1995–1996.

### **Shared-Care Projects with General Practitioners**

General practitioners are important providers of services to persons with mental illness however they have often operated without support from specialist community mental health services. Significant benefits will accrue from a better supported and more expert GP population. An increased number of mentally ill persons will receive treatment and support from their GP with back-up from the specialist mental health services, who will be able to focus on more intensive work with those who might otherwise be at risk of hospitalisation.

Four new projects, at a cost of \$0.4 million, are being established in three metropolitan and one rural location and are designed to examine the most effective and efficient way to raise the level

of support and integration of GP services into the community mental health network. Close liaison will be maintained with the Australian and New Zealand College of General Practitioners on this and related issues.

### **Expanded Child, Adolescent and Family Mental Health Services**

The addition of new staff to the Grampians Region Community Child and Adolescent Psychiatric Service will enable the region to implement an integrated case management approach to service provision. Access to community-based treatment and support for geographically isolated young people will be improved through the linking of a range of specialist services. Emphasis will be given to early intervention and support for the client and the family. This initiative will cost \$171,000.

The need to explore new ways of delivering psychiatric services to adolescents has prompted the need for the development of innovative projects in this field. These will focus on young people who are displaying symptoms of mental illness, complicated by factors associated either with social and/or economic disadvantage or other forms of illness. These projects have a full-year cost of approximately \$250,000.

### **Redeveloped and Expanded Forensic Services**

Services for adult forensic clients will be completely redeveloped and strengthened through the construction of a purpose-built security hospital in metropolitan Melbourne. This will allow consolidation of these specialist services on one site and will result in major service improvements and an expanded service capacity.

The new facility will offer enhanced community protection through more effective physical security and control as well as the provision of modern forensic treatment and rehabilitation programs. While the facility will predominantly cater for mentally ill offenders, it will also have capacity for the small number of intellectually disabled offenders who require a high security environment.

### Expanded Mental Health Services for Aged Persons

Under the Building Better Cities Program, Victoria will commission new services for aged persons who have a serious mental illness including 32 hostel beds, 55 acute hospital beds and additional nursing home beds across the State. The hostel, at Jacana, will open in 1994–95 while the remaining beds will be commissioned in 1995–96. The first of the nursing home/acute unit developments will be commissioned at Caulfield Hospital in 1995–96.

The provision of two new staff to the Gippsland Region will allow a new approach to providing specialist service support to carers and generic nursing homes who have aged persons with a mental illness. This approach is expected to improve the accessibility of these services to mentally ill persons and ensure the continuity of linkages between consumers, carers, family and the community. This new support team will operate at an annual cost of \$96,000.

### Introduction of Teleconferencing Technology

The first pilot of teleconferencing in psychiatric service provision in Victoria will be established during 1994. This treatment mode uses video-conference technology and will increase access of more isolated, rural communities to specialist mental health services. The project will cost \$85,000 and will link Swan Hill in northern Victoria to Bendigo.

### Future Regional Planning for Optimal Service Delivery

The initiatives listed above will lead to a significant improvement in the mental health service system for Victoria. While the merits of community-based services have long been demonstrated both nationally and internationally, this represents the first time that a systematic and uniform approach has been taken to ensuring that the necessary services are available, integrated and linked in all parts of the State. This is the way that further service planning will take place.

Taking the framework described in this document, regions will now commence the task of planning a service system which aims for self-sufficiency in their locality. For the first time, they will know their share of the State's mental health budget and will be able to plan services which will get the best value from those funds. Victorians can be confident that funds will be equitably distributed across the State so that no one area gets services at the expense of others. The focus of expenditure of funds on institutions rather than clients will cease.

The typical planning stages will be:

- Identification of regional factors that will lead to demand for mental health services such as population characteristics.
- Identification of current services and their current geographical coverage.
- Identification of gaps in service provision in each of the program areas against the framework in this document.
- Identification of funds required for desired mix of service elements.

- Examination of costs of existing services and identification of potential to redeploy existing funds into new services.
- Identification of priorities for regional service redevelopment.

Each region will establish service planning and coordination groups involving representation from major service providers in their region such as hospitals and non-government agencies, clients and carers as well as those with whom the mental health services share responsibility for client care such as disability, child welfare and drug and alcohol services. Consultation with these groups will help ensure that funds are distributed in the most effective way and that the best mix of services is provided within that locality. Regional plans will provide the base for further service redevelopment across the State. Plans should be completed by December 1994.

### 1995 onwards

Service change and development must continue to occur with the following directions being pursued over the next three to five years. In the context of this framework for service delivery, the Psychiatric Services Division has identified a range of gaps in the service system. The following priorities have been identified to address these.

- Accelerate the co-location of acute units with general acute hospital services. This will be achieved initially in areas where service provision will be most enhanced through this type of redevelopment.
- Building mobile support and treatment services up to an optimal level across the entire state. Along with recent developments in community based services (for example expansion of CAT services), these will form the core of community-based service provision.
- Relocation of services out of segregated psychiatric hospitals into new services in local communities that they serve.

- Review of the mental health legislative framework. This will take place in late 1994 following national work on the development of common legislative provisions for all states and territories which is due to be completed in August 1994.
- Development and implementation of minimal standards for service delivery and consistent measures of service performance and client outcomes. This will build upon national projects.
- Continued investigation of possible funding mechanisms for mental health services with a particular emphasis on the application of funds for individual client needs.
- Improvement of targets and configuration of child and adolescent mental health services.
- Development of service capacity and expertise for people with severe personality disorders.
- Extension of the skill, support and coordination of primary care services. This will build on the psychiatric shared care projects commencing in 1994 and spread across the State.
- Extension of teleconferencing technology to link services with rural and remote areas, with particular emphasis on child and adolescent services.
- Systematic development of secure extended care service capacity in all regions.
- Development and implementation of community education activities in Victoria to improve the perception and understanding of people with mental illness and their services. This will build upon planned national initiatives in this area.
- Review and expansion of professional education and training opportunities in Victoria. Staff skill levels are important and new methods of updating knowledge and skill must be formed. This will build upon the State's considerable investment in academic positions and specialist services.

- In conjunction with the Mental Health Research Institute, enhance the level of research undertaken in mental health in Victoria including that undertaken by universities and the major teaching hospitals. Options to be explored include the development of a state agenda for research (both applied and pure), encouragement of greater national funding and improving the coordination and targeting of research undertaken through state funded academic positions.

This framework provides the context for further service redevelopment for the next three to five years. The level of change that can be supported will always be dependent upon the level of funds available however much can be done by effective use of the current allocation. Commencing with the development of regional service plans, it will now be possible for firm plans and timelines to be defined and for targeted change to proceed.