Blueprint for better health

A community report on mental health, alcohol and other drugs and suicide prevention in the north western Melbourne region.

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phn
NORTH WESTERN MELBOURNE
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We would like to thank and acknowledge the many community members, people with lived experience, and their carers and families, who have contributed time and shared their experiences and insight to inform the process and the recommendations for change. Their contribution has been invaluable.

We would also like to thank the many people who have represented organisations from the region. Their valuable insights and enthusiastic contribution have both supported this process and a partnership approach. (See Appendix 2: Partners in planning the Blueprint for a list of contributing organisations.)

A reference group consisting of expert advisors from peak bodies and a Local Hospital Network (LHN) group provided critical guidance throughout the development of this plan.

As part of an ongoing partnership with North Western Melbourne Primary Health Network (NWMPHN), Master of Design students at RMIT made this Blueprint the focus of their Future Design Practice unit. We are grateful for their informed insights, which have helped shape and enrich the Blueprint.

This report is endorsed by NWMPHN's Mental Health, Alcohol and Other Drugs, GP Expert Advisory Groups, Clinical and Community councils. We thank them for their guidance in developing the Blueprint.

NWMPHN acknowledges the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

Disclaimer

Design by Plural Agency

Photography by Leigh Henningham on Contents and pages 10, 17, 23, 24, 30, 33, 38, 44 and 53.

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This Blueprint is the first step towards better mental health care in our region.

It maps what's working, and what isn't, according to those with direct experience of mental illness and related support services.

We are grateful to all those who shared their stories, insight and advice. You've helped us better understand how people use the system. You've also helped us understand the factors that prevent people from getting the right help, at the right time, and in the right place.

Your responses, combined with analysis of health data and policies, have exposed common problems and areas for improvement across mental health, suicide prevention and alcohol and other drugs (AOD) services. These include improving how services work together and making care more accessible and personalised.

Like the first drawings for a building, this Blueprint is the basis for a more detailed set of plans. From here we will work with service providers, our partners and the community on a detailed action plan to create better supports and a better system to improve the experiences of people using services in our region.

The Blueprint has been written amid rapidly changing state and national policies for mental health, and during the COVID-19 pandemic, which has had a significant impact on mental health.

In addition, two major inquiries were underway during the development of this document – the Royal Commission into Victoria's Mental Health System, and the Productivity Commission Inquiry into Mental Health. The next phase of planning, the comprehensive services plan, must be responsive to the outcomes and recommendations of both inquiries and to the ongoing impacts of the COVID-19 pandemic. Some of the opportunities outlined in this Blueprint may need to be adjusted accordingly.

This is an abridged version of several documents, including a data pack that were developed as part of the Blueprint.

> My community keeps me safe, offers me support.

— Person with lived experience

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About the Blueprint

This Blueprint has been led by North Western Melbourne Primary Health Network (NWMPHN) in conjunction with our community, people with lived experience, their carers and families, and local partner organisations, including hospitals. NWMPHN is part of a nationwide system of primary health networks (PHNs) working with all levels of government, as well as services, partners and the community, to make health care more efficient and effective.

Recently, the Australian Government called on PHNs to work with Local Hospital Networks (LHNs) to develop joint regional plans to improve and better integrate the mental health system, as part of its commitment to the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan).

In line with the Fifth Plan, the objectives of this Blueprint are to:

- understand how the system works for people who interact with it
- identify opportunities to better integrate services across the system
- build on existing relationships and work with consumer advocates, peak bodies, expert advisors and hospitals in responding to challenges.

The Blueprint (or foundation plan) is the first stage of a two-stage planning process, with a Comprehensive Plan being developed from 2021.

The Productivity Commission Inquiry into Mental Health and The Royal Commission into Victoria's Mental Health System are important factors that inform the Blueprint and the outcomes of both Commissions will be critical in shaping the Comprehensive Services Plan.

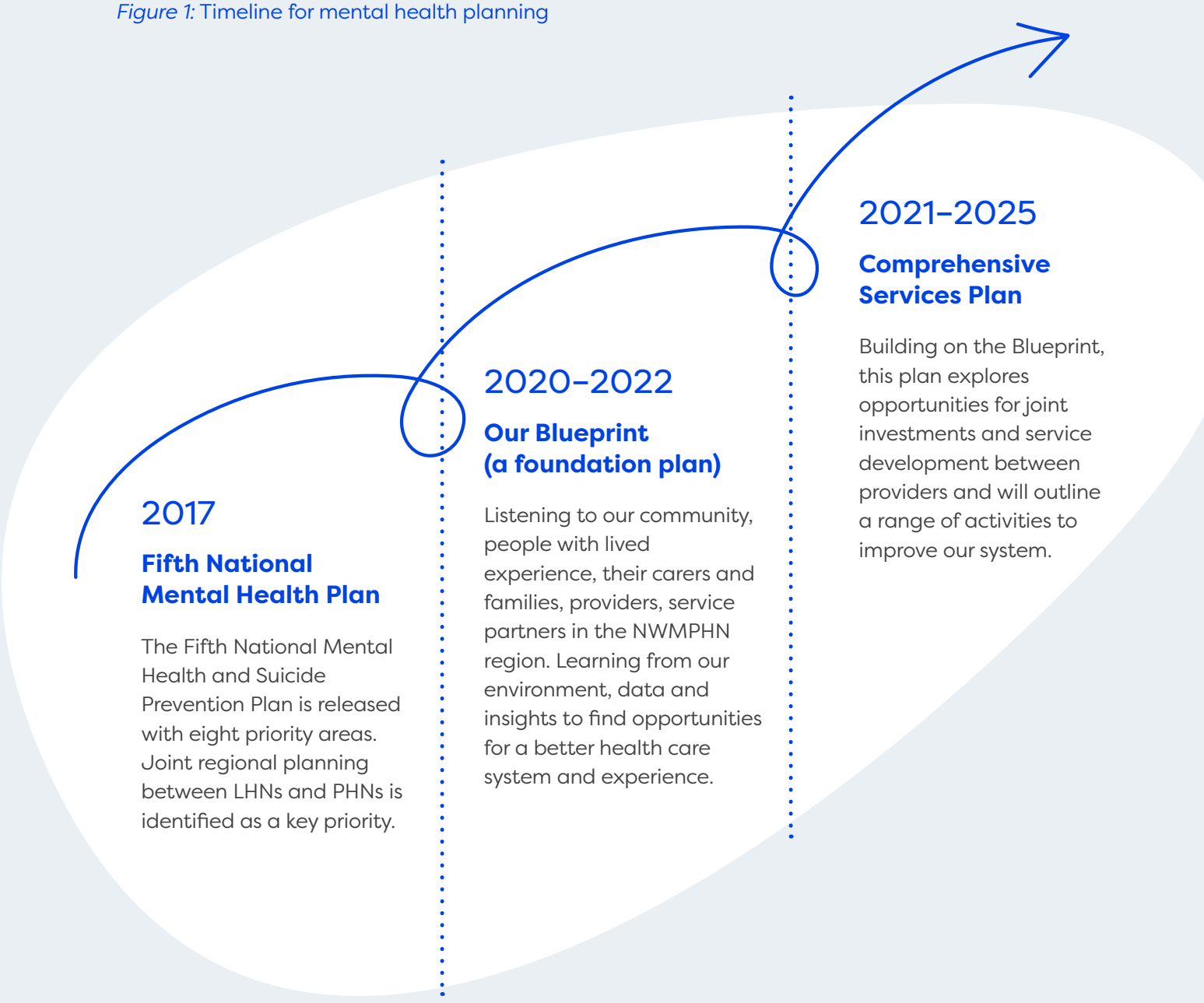
What is the scope of the Blueprint?

This Blueprint is the first step in the development of a local response and plan for mental health, Alcohol and Other Drugs (AOD) and suicide prevention in the central and north western region of Melbourne.

The scope of the Blueprint was to investigate and document the local data and insights from our community members and sector service providers to gain a deep understanding of the local context, challenges and opportunities. The scope was also to consider these issues within the context and complexities of a broader environment which includes funding, reforms, and more recently the impact of COVID-19 pandemic.

The Blueprint covers the North Western Melbourne Primary Health Network geographic region which extends from inner-suburban Richmond, just east of the CBD, to beyond Bacchus Marsh in the west, and from coastal Cocoroc in the south-west to Lancefield and beyond in the peri-urban north (see Figure 6). This catchment is as large as it is diverse. It is home to more than 1.64 million people, with over 41% of the population born overseas and more than 220 languages spoken in homes.[1]

Figure 1: Timeline for mental health planning



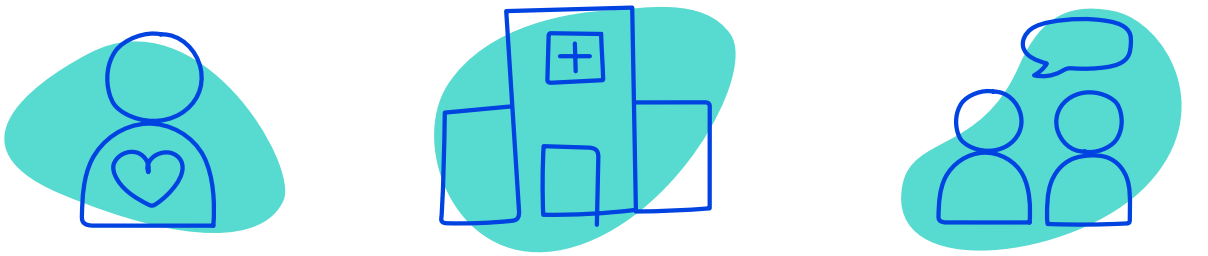
1 *Australian Bureau of Statistics (ABS). (2018). Regional Population Growth. ABS Cat no. 3218.0. Retrieved from abs.gov.au*

How was the Blueprint developed?

To begin with, we drew on existing relationships. Two groups were formed: a reference group with expert advisors from peak bodies, and representatives from our local hospitals, as well as some from neighbouring regions. See Appendix 2 for a list of organisations involved in the development of the Blueprint.

These groups helped us understand the best way to consult with the community. They also guided us in testing what we found through further consultation work. Altogether, close to 700 people were consulted, using techniques that made sure we spoke to the right people and asked the right questions.

Figure 2: Groups contributing to the plan



People with lived experience, their family and friends

Hospitals and other health organisations

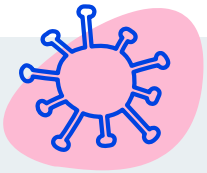
Peak organisations and expert advisors

A collective approach

This Blueprint recognises the complexity of the system by collectively addressing mental health, suicide prevention and AOD services.

Mental health and AOD services are increasingly working with people who have had a 'dual diagnosis': one or more mental health problems together with substance use. There are also overlaps in the experiences of those using mental health and AOD services, as well as a clear connection between mental health and suicide prevention services.

A collective approach is vital: people who work in and use the system say it could be dramatically improved through better integration, including across and between mental health, suicide prevention and AOD services, and other parts of the health system.



COVID-19

Engagement activities for this Blueprint concluded in May 2020. This was around the time COVID-19 cases spiked in Victoria and the first lockdown period started. This Blueprint notes the dramatic effects of COVID-19 on consumers and services since then, using available health data. The NWMPHN region has been the hardest hit region in Australia, accounting for approximately 60% of the total confirmed cases of COVID-19 in Victoria.[2] The next stage of planning will include more consultation, detail and analysis about the impact of COVID-19.

Consultation

The first step was to decide who to consult, and what to ask. Figure 3 shows the theoretical framework we used. The framework helped to ensure that our questions and conversations considered the fact that mental health needs can range from mild to severe and complex, and that mental illness can affect people of all ages.

Our framework also helped us to keep in mind that external factors play an important role in mental health. Higher rates of mental illness are associated with social disadvantage, lack of social support, critical life events, unemployment and income inequality.[3]

This is evident in our region where Brimbank, Hume and Melton Local Government Areas (LGAs) show the highest rates of very high/high psychological distress, and also have the highest socio-economic disadvantages.

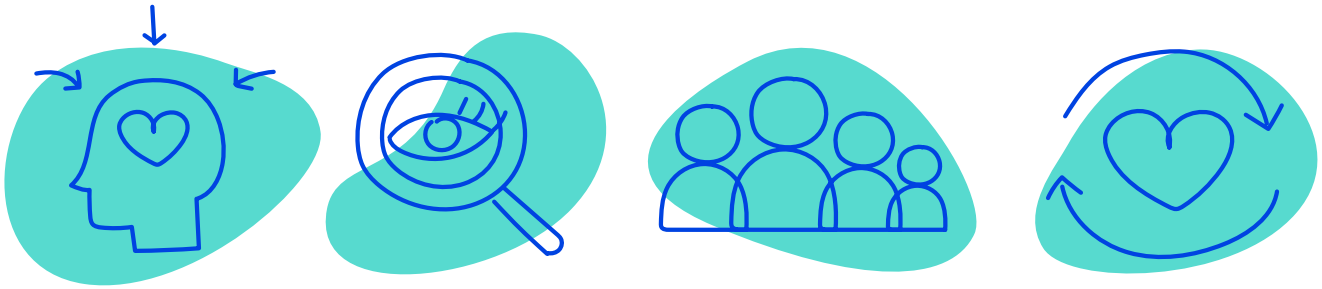
Consultation with the community was a strong focus. This included consulting people with lived experience of mental illness, alcohol or other drug issues or suicide, their families, carers and friends. Health providers were also included in the consultation. They included staff from hospitals, community health, general practice and peak bodies. An overview of consultation methods is outlined in Figure 4.

2 *Department of Health and Human Services (DHHS) (2020) Department of Health and Human Services media release – Coronavirus update for Victoria – 2 November 2020. Retrieved from dhhs.vic.gov.au/media-hub-coronavirus-disease-covid-19*

3 *World Health Organization and Calouste Gulbenkian (2014), Foundation Social Determinants of Mental Health. Geneva: World Health Organization.*

Figure 3: Framework for consultation

The Blueprint looked at:



The social determinants of health, including:

- Housing
- Employment
- Education and training

Priority populations

- Aboriginal communities
- Homeless
- LGBTIQ+
- CALD
- Refugee and asylum seekers
- People who have been incarcerated

A whole life approach

- Infants and children
- Youth
- Adults
- Older adults

The range of mental health needs from mild to severe and complex

Figure 4: Overview of consultation methods and participation

#CroakeyGo

Social listening – social media and interviews

Interviews, focus groups and workshops

Total input from community members

Social listening

The 'social listening' approach is a flexible yet rigorous way to understand the 'what' and 'why' of people's attitudes, behaviours and feelings. Using the 'social listening' technique, we gathered perspectives and experiences from 470 people, primarily through social media platforms. People were invited to share their experiences and insights in their own words. From these insights, themes and trends emerged which were then tested in interviews, focus groups and workshops.

Interviews, focus groups and workshops

We held interviews with a further 65 community members, online and over the phone. More themes and ideas emerged, and these were tested and expanded on in focus groups and design workshops with another 50 people. A final round of interviews and focus groups were conducted with 50 people to test and finalise findings.

#CroakeyGo – 'walking the talk'

Our first consultation event, in August 2019, was innovative, informative and influential.

We worked with public interest journalism organisation Croakey to run a guided walk through Carlton and Fitzroy, tracing some of the paths of people who use mental health services. Over 90 people took part, including those who use mental health services, their family and friends. Along the way, walkers heard from those working in or using the system.

The event highlighted the importance of understanding, rather than making assumptions, about people's experiences and needs. It also highlighted the importance of looking at our system from as many perspectives as possible – no matter how confronting or challenging.

Image: Walking together, CroakeyGO. Photographed by Norm Oorloff

Analysis

We analysed the findings, along with data such as health statistics, to develop five key areas for improvement.

We looked at the information we gathered from those who work in or use the system in relation to:

- statistical and other qualitative data, including inpatient data, primary care data and Australian Bureau of Statistics (ABS) data
- submissions to the Royal Commission into Victoria's Mental Health System, and to the Productivity Commission Inquiry into Mental Health, by organisations in our region.

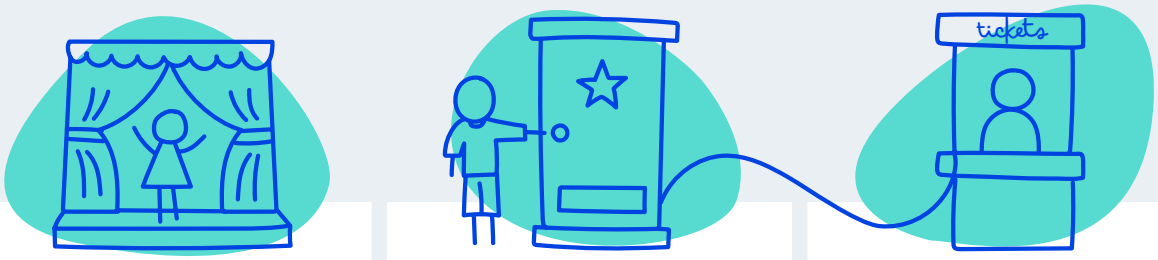
To understand how people experience services, in the context of a broader system, we drew on the concept of a theatre stage. This is a human centred design methodology which focuses on improving or designing services based on deep engagement with people who use the services.

Figure 5 illustrates the stage concept. It shows what is happening 'on stage' (people's experience of the service) and how care is supported by many people 'back stage' (service workers and organisations). Behind this are influencing features – such as funding, public policy, regulations and infrastructure ('behind the scenes').

This Blueprint takes a seat in the 'audience' – looking up to the stage – to understand issues people consider when accessing services, which will in turn inform potential changes to the way services are organised and delivered. By contrast, in the next phase of planning, the perspective will shift to the back stage – how services are delivered.

> "Our mental challenges are only one part of our lives; it's not the whole story. It is a situation we find ourselves in at different times of our life."
>
> — Person with lived experience

Figure 5: Setting the stage – conceptualising how the sector works



Front Stage

The front stage is where all the action happens and is the focus of this Blueprint.

People need to navigate the health system and there are many issues and barriers to consider that may even prevent people from being able to access to care.

These may include:

Navigating the service system

- Cultural safety
- Stigma
- Time
- Access
- Location
- Language
- Connectivity
- Public or private
- Cost
- Medicare rebate
- Reviews and ratings

Back Stage

Back stage there are also a lot of decisions to be made. The organisations that provide services determine how the service is delivered.

Services may include:

Self help

- Online
- Helplines

Primary Health & Community Care

- General practices
- Pharmacy
- Dental practice
- Allied health
- Primary Health Networks
- Community care
- Aged care
- Mental health services
- Alcohol and other drug services
- Not for profit

Specialist, acute and residential care

- Diagnostic and pathology
- Residential care
- Secondary and tertiary hospitals (public and private)

Behind the Scenes

Those features of the system that are hidden but can have a profound impact, including policies and funding mechanisms.

Features may include:

Funding

- Medicare Benefits Schedule
- Hospital funding
- Aged care
- Pharmaceutical benefits scheme
- Private health insurance
- Other programs

Supporting regulations and infrastructure

- Research and data analytics
- Information technology
- Quality and safety
- Infrastructure
- Workforce

Other

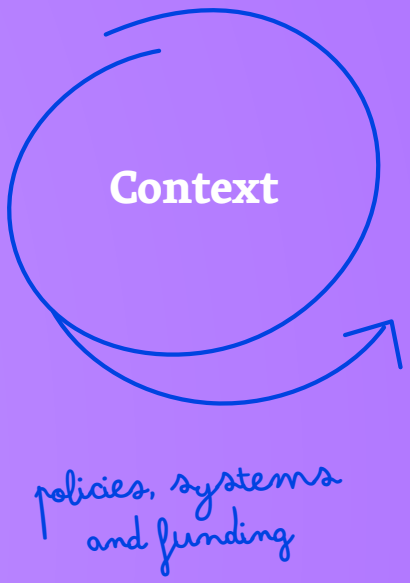
- Media
- Public policy
- Advocacy

“I think people with mental health issues need full time support, in and also out of the hospitals.”

– John

Context

This section provides a data snap shot of the region and summarises the ‘invisible’ elements of our system that still have a deep impact: policies, systems, funding and other factors.



Challenges

What did we learn from the community?

Opportunities

Opportunities and areas for improvement

Our region

Population and growth

The central, north and western region of Melbourne is as large as it is diverse. Our population is rapidly growing. In 2019 the NWMPHN region had a population of 1.64 million people. This is expected to grow to more than 2.8 million by 2036.[4]

- The Wathaurung, Woiwurrung (Wurundjeri), Taungurung, Dja Wurrung and Boonwurrung are the Traditional Owners of the various parts of the region and have a deep, continuous connection with the area.
- The region takes in the Central Business District (CBD) and caters to a commuter population of 900,000: that is, people travelling to the area for work and for health care.[5]
- The areas of highest projected growth are the Local Government Areas (LGAs) of Melton and Wyndham which together are expected to account for more than one-third of Victoria's population growth by 2036.[6]
- Approximately 37.6% of Victoria's homelessness population are located within our region, including high numbers in the CBD.[7]
- More than 41 per cent of people were born overseas, and more than 220 languages are spoken at home. Approximately 31% of the region's population was born in a country that does not predominately speak English.[8]
- The outer suburban areas of Brimbank, Hume and Melton experience greater levels of disadvantage.[9]

Services and support

The region has thirteen LGAs and some of the largest hospital and health services in the state, as well as leading education, health care and research institutions, some of which provide statewide service and support.

In response to the needs of our growing population the Victorian Government has committed to building acute hospitals in Melton and Footscray, and community hospitals at Craigieburn, Sunbury and Point Cook. It is anticipated that these new community hospitals will deliver, among other things, community mental health and AOD services.

4 *Australian Bureau of Statistics (ABS). (2018). Regional Population Growth. ABS Cat no. 3218.0. Retrieved from abs.gov.au*

5 *City of Melbourne (2016), Census of Land Use and Employment. Retrieved from melbourne.vic.gov.au*

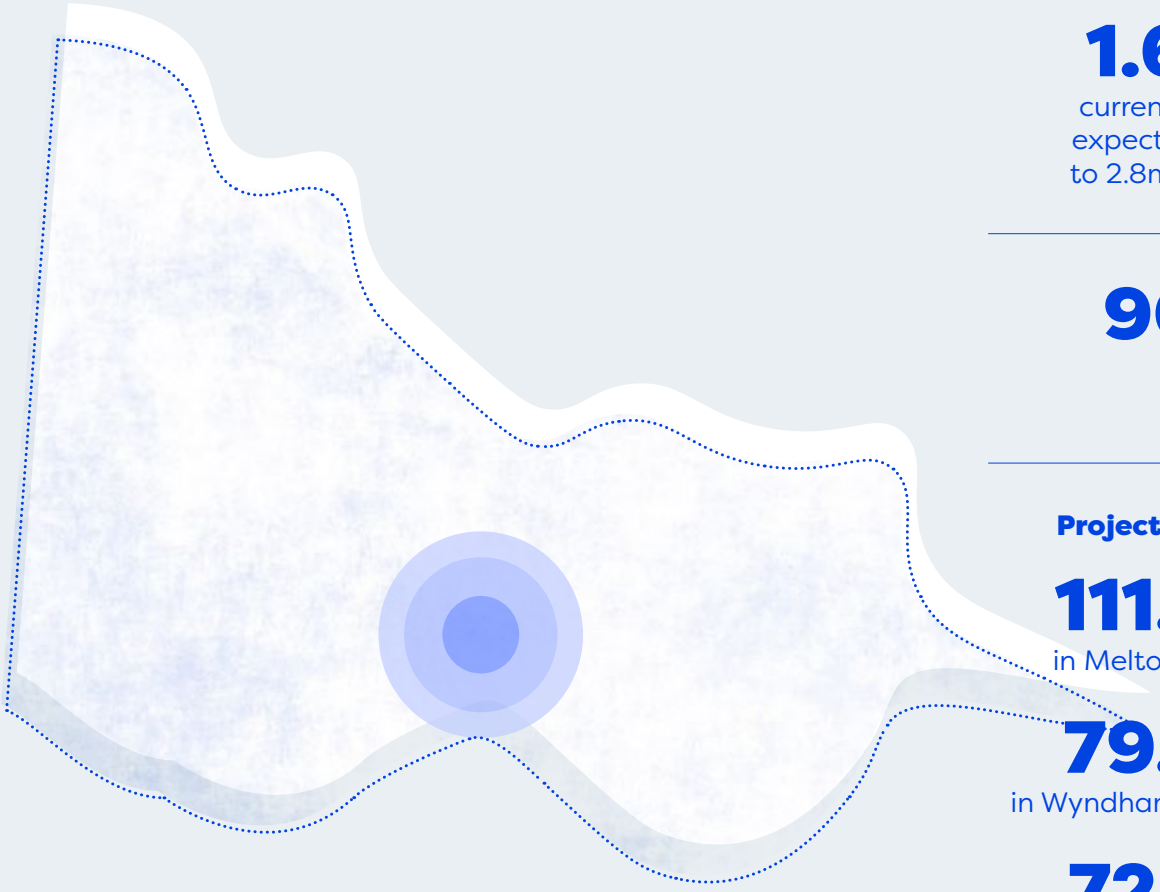
6 *Australian Bureau of Statistics (ABS) (2018), Regional population growth. Victorian in Future. Retrieved from abs.gov.au*

7 *Australian Bureau of Statistics (ABS). Census 2016. Retrieved from abs.gov.au*

8 *Public Health Information Development Unit (PHIDU) 2016.*

9 *Australian Bureau of Statistics (ABS) (2016) IRSD score, Retrieved from abs.gov.au*

Figure 6: A snapshot of the North Western Melbourne PHN region



1.64M
current residents, expected to grow to 2.8m by 2036[10]

900K
commuter population

Projected Growth

111.9%
in Melton by 2036[11]

79.9%
in Wyndham by 2036[11]

72.2%
in Melbourne by 2036[11]

Services

13
LGAs

570
general practices

22
providers of mental health inpatient services

1327
providers of mental health outpatient services

10 *Australian Bureau of Statistics (2016) Census. Retrieved from abs.gov.au*

11 *Australian Bureau of Statistics (ABS). (2018). Regional Population Growth. ABS Cat no. 3218.0. Retrieved from abs.gov.au*

Other services include:

- There are 13 LGAs in the region: Brimbank, Darebin, Hobsons Bay, Hume, Macedon Ranges, Maribyrnong, Melbourne, Melton, Moonee Valley, Moorabool, Moreland, Wyndham, and Yarra.
- Our local health and hospital network includes organisations such as Austin Health, Ballarat Health Service, Bendigo Health, Melbourne Health, Mercy Health, Northern Health, Orygen, St Vincent's Hospital, and Western Health.
- Leading health education, health care and research institutions, include the Comprehensive Cancer Centre, the Walter and Eliza Hall Institute and the Howard Florey Institute.
- There are more that 570 general practices in the region.
- There are over 1300 providers of mental health outpatient services and 22 providers of mental health inpatient services in the region.[12]

Priority populations

Within the NWMPHN region, there are several specific population groups at greater risk of poorer health outcomes. These groups may benefit more from tailored care and services delivered with an understanding of the cultural and social context. These population groups include:

- Aboriginal and Torres Strait Islander communities
- people who are lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ)
- people experiencing homelessness
- people from culturally and linguistically diverse (CALD) communities
- refugees and asylum seekers
- people who have been incarcerated.

More information about each population group can be found in the next section of the report.

Mental health, AOD and Suicide: a data snapshot of our region

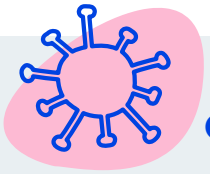
- An estimated 250,000 residents (about 14 per cent) will experience mild-to-moderate mental illness per year, and 57,000 (about 3 per cent) will experience severe mental illness.[13, 14]

12 *National Health Services Directory, 2020*

13 *The University of Queensland. (2019). Introduction to the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health. Version AUS v2.2. The University of Queensland: Brisbane*

14 *Public Health Information Development Unit (PHIDU) 2019*

- The LGAs of Brimbank, Hume and Melton experience the most socio-economic disadvantage, as well as the highest rates of high/very high psychological distress.[15]
- The rate of suicide-related presentations to emergency departments is associated with socio-economic disadvantage and is highest in the youth (15–25 years) cohort and Aboriginal communities.[16]
- Three local government areas Macedon Ranges, Moorabool and Melton have the highest rate of suicide in the region.[17]
- ABS data from 2018 shows that 19 per cent of people in the region self-reported mental health and behavioural problems, and 14 per cent self-reported high or very high psychological distress.[18]
- On average, 11.1% of people in the region aged over 18 years consumed more than two standard drinks per day, lower than the Victorian average of 14.5% but higher than the lifetime risk guidelines of no more than two standard drinks a day. Three local government areas in the region reported rates higher than the Victorian average including Macedon Ranges (19.8%), Yarra (17.9%) and Moorabool (16.3%).[19]



Children and youth during COVID-19

The rates of mental health presentations in children and young people attending Victorian Emergency Departments (EDs) is accelerating with increases 3-times higher than those of physical health presentations.[20] With the COVID-19 pandemic and associated restrictions, paediatric mental health presentations have continued to surge, with a 35% increase compared with ED presentations for other conditions which have largely declined.[21]

15 *Victorian Emergency Minimum Dataset (VEMD) 2016–2019*

16 *Victorian Emergency Minimum Dataset (VEMD) 2014–2019*

17 *Public Health Information Development Unit (PHIDU) 2013–2017*

18 *Public Health Information Development Unit (PHIDU) 2017–2018*

19 *Extracted from PHIDU, 2020 based on direct estimates from the 2017–18 National Health Survey, ABS Survey TableBuilder*

20 *Hiscock H, Neely RJ, Lei S, Freed G. Paediatric mental and physical health presentations to emergency departments, Victoria, 2008–15. Medical Journal of Australia [Epub] 2018 Apr*

21 *Cheek J, Hiscock H, Craig S, West A, Lewena S. (2020). Emergency Department utilisation by vulnerable paediatric populations during COVID-19 pandemic. EMA 23 July 2020*

Figure 7: A snapshot of priority populations data for the region

41%
born overseas

220+
languages
spoken in homes

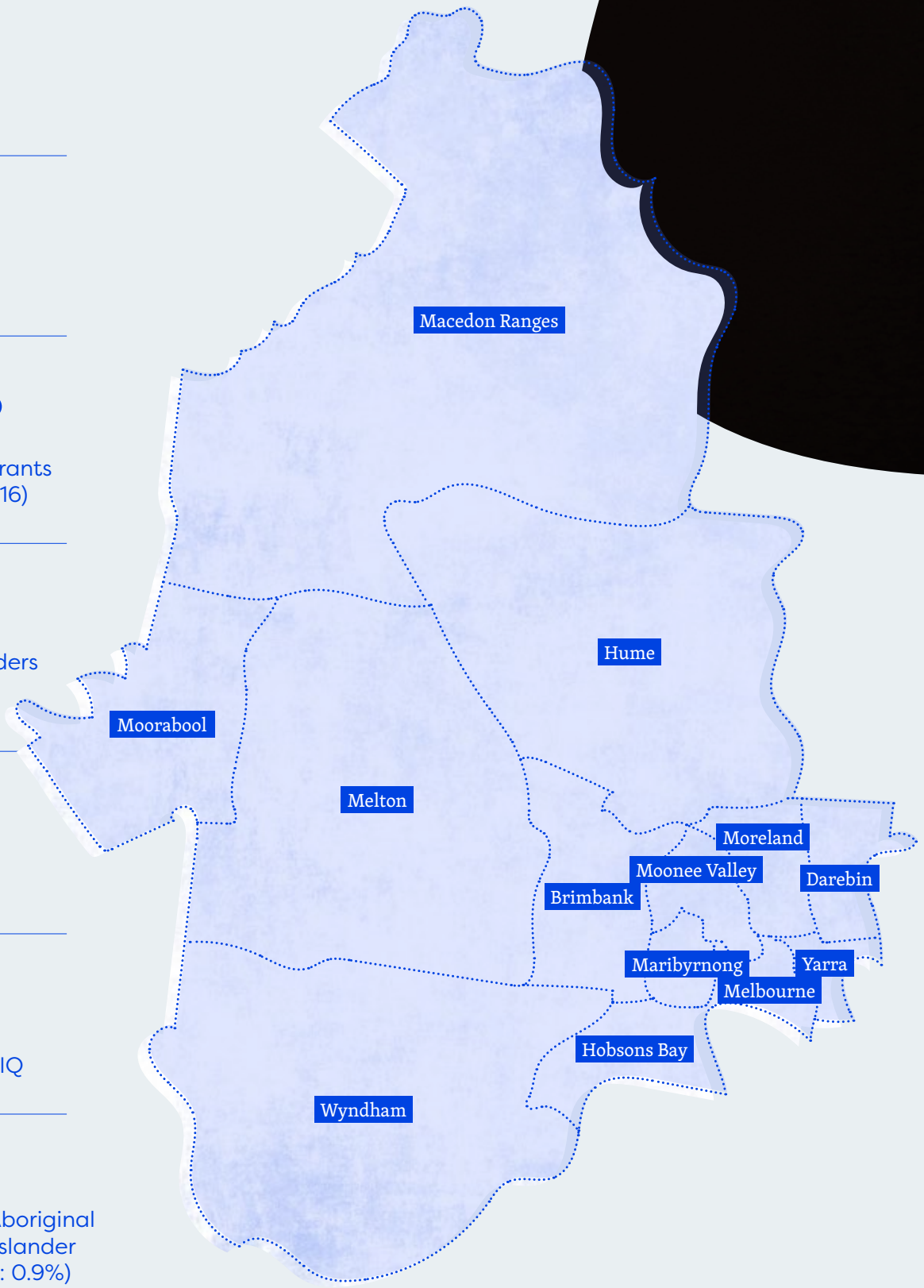
47.6%
of Victoria's
humanitarian entrants
settled (2000–2016)

19.4%
of Victorian offenders
(2017–2018)

37.6%
of Victoria's
homelessness
population

3%
of population
identifies as LGBTIQ

0.7%
of population of Aboriginal
and Torres Strait Islander
decent (state avg: 0.9%)



Photographed by Leigh Henningham

Figure 8: A snapshot of mental health data in our region

Mental health

Rates of suicide are above the state average in Macedon Ranges, Moorabool and Melton LGAs

Greater levels of disadvantage and rates of very high psychological distress in Brimbank, Hume and Melton LGAs

AOD

Consumption of more than two standard drinks per day: 14.5% Victorian average, 11.1% NWMPHN region average.

- → 19.8% Macedon Ranges
- → 17.9% Yarra
- → 16.3% Moorabool

COVID related

There are three times more mental health presentations than physical health presentations in children and young at ED.

14%
will experience mild to moderate mental illness (per year)

3%
will experience severe mental illness (per year)

19%
self reported mental health and behavioural problems

14%
self reported high or very high psychological distress

A complex environment

People's needs are diverse and changing. The system is fragmented and complex, and services are needing to respond quickly to change. There have been many shifts in national and state policies about mental health, AOD and suicide prevention since 2014, and changes are expected to continue. (See Appendix 1: Summary of national and state mental health reforms for more detail.)

COVID-19 is creating significant new challenges. It has affected how we live our daily lives, engage with our community and access care.

The effects of climate change, including extreme weather, are also expected to impact wellbeing, including by increasing anxiety.

Policy changes that will continue to impact the sector

There are policy reforms and recommendations that seek to improve the system and outcomes, including for Aboriginal and Torres Strait Islander peoples, AOD services, suicide prevention and mental health.

An example of this is services' continued adaptation to the National Disability Insurance Scheme (NDIS), which started in 2016. NDIS supports people with disability, and their families and carers, and is one of the largest service system reforms of our generation. There have also been major reports and recommendations relating to alcohol and other drugs, and to Aboriginal and Torres Strait Islander peoples.

Interim reports have been issued by the Productivity Commission into Mental Health and the Royal Commission into Victoria's Mental Health System, with final reports due in late 2020 and early 2021.

The Royal Commission's interim report (November 2019) found that almost one in five Victorians will have a mental illness each year. It recommended, among other things, an increase in mental health beds – many of which would be allocated to our region. Further recommendations are expected with the final report early next year.

> "Our mental challenges are only one part of our lives; it's not the whole story. It is a situation we find ourselves in at different times of our life."
>
> — Person with lived experience

Image: COVID in Melbourne. Photographed by Craig Dingle via Shutterstock.com

Global events impact local health needs

COVID-19

In May 2020, the Australian Government warned of a 'significant negative mental health impact' from the COVID-19 virus and the measures needed to control it – such as lockdowns and 'social distancing'.

Since then, many services in the NWMPHN region have had to radically change how they operate. There has been a significant increase in General Practitioner (GP) telehealth services from March to June 2020, with 56 per cent of services now offered by phone. Video consultation by GPs has increased in the same period from less than 1 per cent to about 10 per cent.[22] Mental health and AOD services, including hospital and outpatient appointments, have also shifted rapidly to telehealth models.

Climate change

On top of this, the intense bushfires of the summer of 2019–20 increased the need for mental health services in the NWMPHN region, particularly by those sheltering here from other parts of the state.

Extreme weather events are expected to become more frequent, and the Victorian Government and the World Health Organization have recognised the direct and indirect effects of climate change on health, including mental distress. In engagement with the community, many people, particularly younger people, said that they felt pessimistic about the future and reported higher levels of anxiety and distress in relation to the impacts of climate change.

Note that the reference group and LHN group have sought to ensure that mental health planning accommodates the effects of COVID-19, and the measures needed to prevent it, particularly in the next stages of planning.

22 *PMHC-MDS (2020), Primary Health Minimum Data Set*

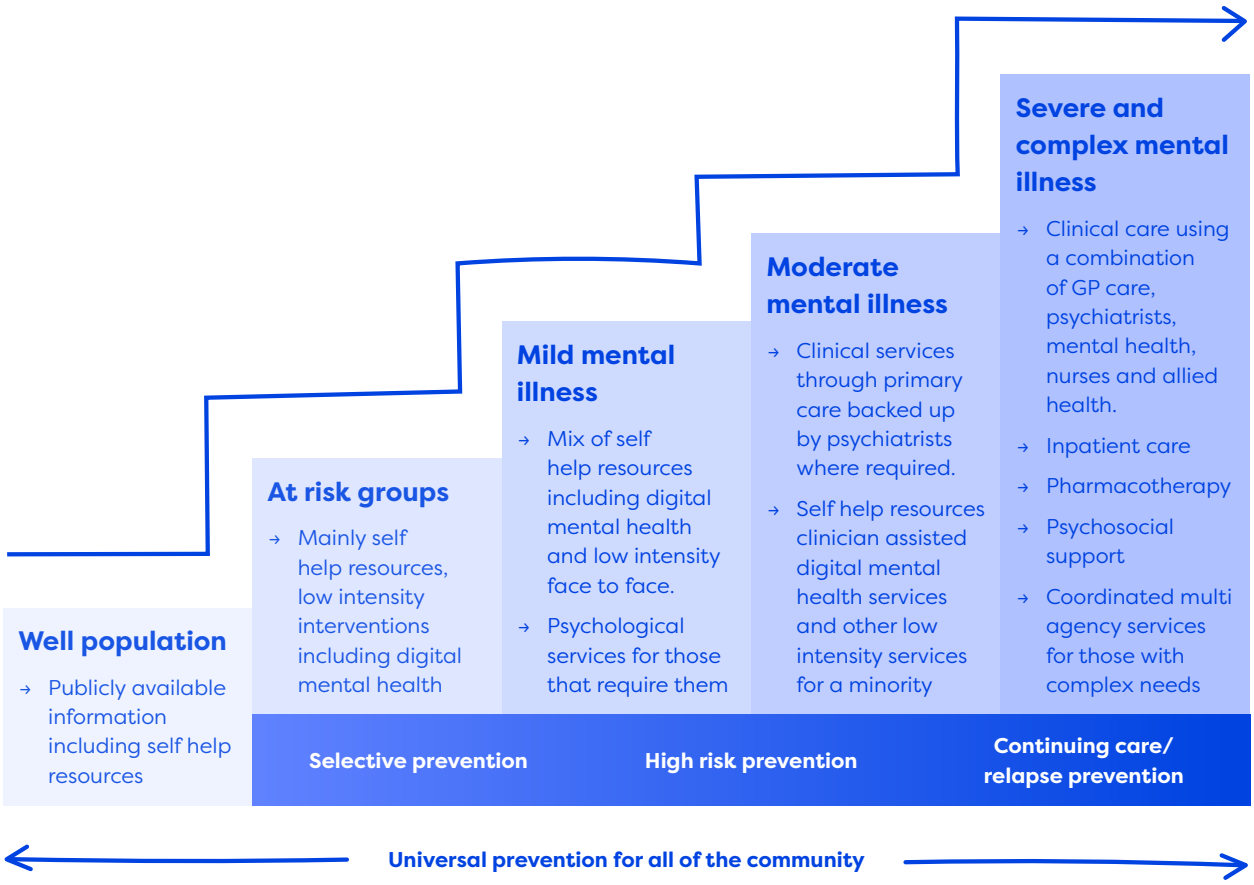
Our role

Primary Health Networks (PHNs) are expected to lead mental health reforms in their regions. Each is directed by the Australian Government to commission mental health services according to a 'stepped care' framework.

A stepped care framework provides a range of options of varying intensity to match people's level of need. Stepped care relates the use of resources more directly to the needs of individuals and populations. It begins with a focus on self-care and individual and community wellbeing, and advances through various steps of resourcing, based on stratification of risk and need.[23] NWMPHN's stepped care model is shown in Figure 9.

NWMPHN takes a broad view of mental health, to include the external factors that contribute to mental health. Investment in prevention, early intervention and recovery services is required to support the system and foster healthy communities.

Figure 9: NWMPHN 'stepped care' framework



23 *National Mental Health Commission (2014). Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services. Retrieved from mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx*

Reforms underway

There are three main types of reforms underway in our region – those commissioned by NWMPHN; state and Australian Government activities; and initiatives related to COVID-19. Examples of each are summarised below.

Social prescribing trial

'Social prescribing' means referring people at risk of loneliness or isolation to local, 'non-clinical' groups and services, such as arts groups, learning groups or walking groups, or financial or legal services. This program aims to improve the physical, mental and psychosocial health of people. The trial is also helping to test whether the model would work for general practice.

Enrich

This program is designed for young people experiencing, or at risk of, complex mental health presentations. The funding approach by NWMPHN to this program is innovative and includes pooled funding across a number of areas. This has resulted in developing a flexible model to respond to the needs of young people in their local setting, addressing the issue often referred to as the 'missing middle'.

Peer work

As part of commissioned mental health programs, providers can engage 'peer workers' to support people's recovery. This includes the development of a primary health peer workforce. A peer worker provides emotional and social support to others with whom they share a common experience. They focus on building a mutual relationship that fosters hope and optimism.

> "There is a need to grow the peer workforce so that all parts of the service have a lived experience person employed in it."
>
> — Service Provider

National and state activities

Additional mental health beds

There will be additional mental health beds, due by 2023, shared between Barwon Health and Melbourne Health, according to need, as per the Royal Commission into Victoria's Mental Health System interim report. The beds will be provided by Melbourne Health, in alliance with Western Health.

New hospitals

The Victorian Government has committed to the development of two new major hospitals in Melton and Footscray, operated by Western Health. Footscray hospital will include two new mental health inpatient units, one each for adults and youth. The range of services to be provided at Melton Hospital is yet to be determined.

Adult mental health centres

The Commonwealth Government is consulting on a proposed model for these centres, which are intended to provide a welcoming, low-stigma, 'no wrong door' way for adults to access mental health information, services and supports. The centres are intended to complement, not replace or duplicate, mental health services already provided in the community. For some people, attending a centre may be their first experience engaging with a mental health service. Funded by the Australian Government, eight centres are being trialled across Australia.

HeadtoHelp

In August 2020, the Prime Minister announced $26.9 million to create 15 mental health hubs across Victoria, funding is for 12 months. From 14 September 2020, people in the north, west and centre of Melbourne can access support through the 1800 595 212 intake and assessment number or at three HeadtoHelp mental health hubs at Wyndham Vale, Broadmeadows and Brunswick East.

In developing the hubs, insight was drawn from community consultations that were conducted as part of the Blueprint. The HeadtoHelp service directly correlates to the strategic opportunities for improvement outlined in this Blueprint; offering a 'no wrong door' approach and assistance with navigating the service system.

HeadtoHelp is for everyone who needs mental health and wellbeing support, whether their mental health issues are pre-existing or have emerged during the pandemic. It will help to guide people seeking help to the support that best meets their individual situation, linking to existing Victorian and Commonwealth funded mental health support services and other services in the community.

Image: Drive-through COVID-19 testing in Bacchus Marsh. Photographed by Leigh Henningham

COVID-19 response

The COVID-19 pandemic has impacted on the way services are delivered, requiring significant adaptation by service providers. Some initiatives planned for implementation have been brought forward during the pandemic, including e-prescribing and most recently the Victorian HeadtoHelp mental health hubs.

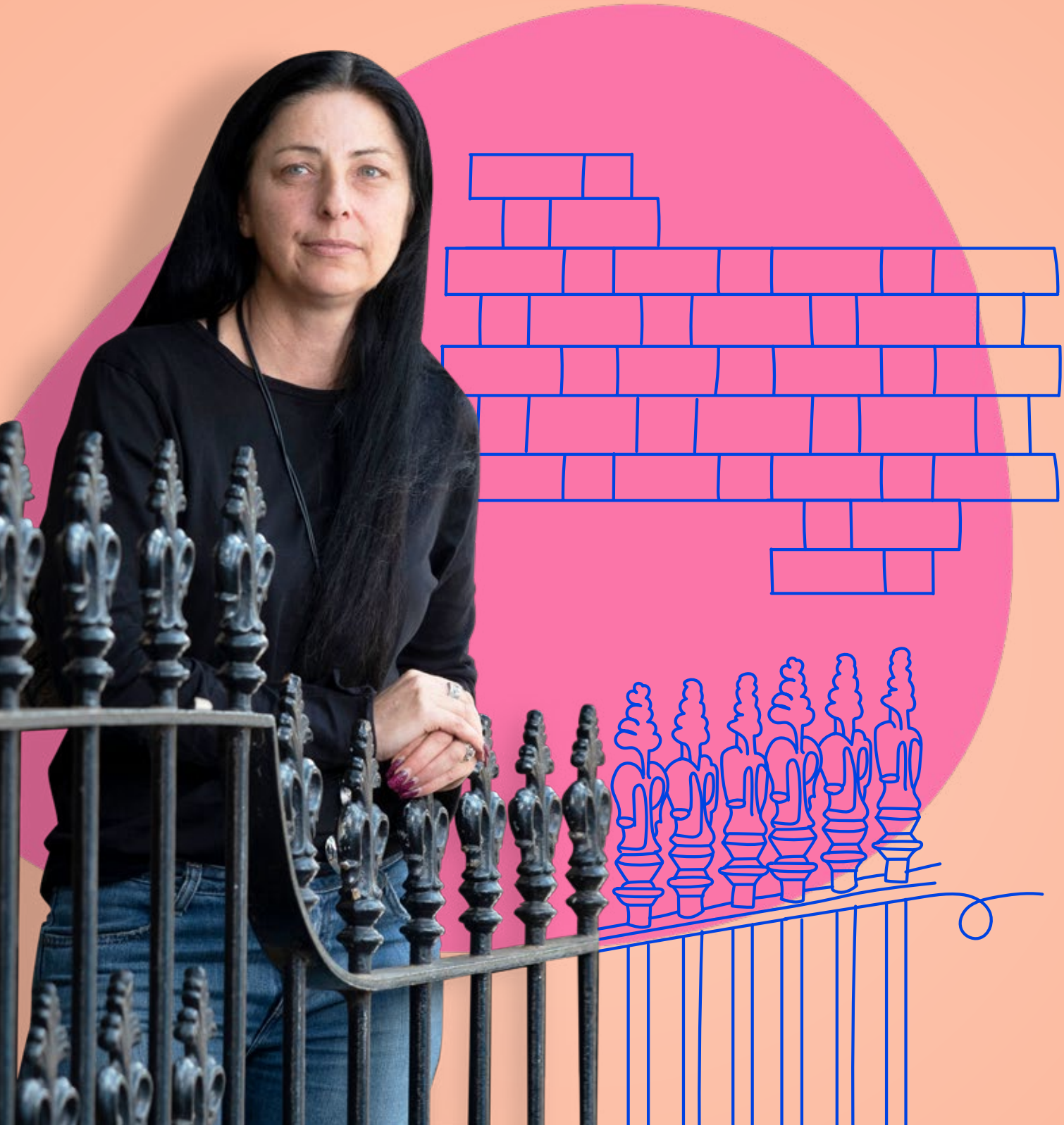
Other examples of adaptation and service enhancement include:

- **Rapid expansion of telehealth:** There have been significant and rapid moves by general practice, mental health and AOD services, specialists and hospital outpatient units to telehealth. 'Hospital in the home' has also expanded to include telehealth and monitoring via telehealth.
- **Housing for people experiencing homelessness:** This has included pop-up facilities that provide health care and supported accommodation for rough sleepers in metropolitan Melbourne. In addition, the National Mental Health and Wellbeing Pandemic Response Plan details how mental health should be considered as Australia responds to, and recovers from, the COVID-19 pandemic.

> "So, these [HeadtoHelp] services complement, enhance and provide greater integration to the mental health service sector."
>
> — Professor Ruth Vine, Deputy Chief Medical Officer for Mental Health

“I would have a much stronger plan for people that included intensive care, inpatient and outpatient.”

– Jody



Challenges

What's working and what's not? This section summarises what we learned from the community and from our data about mental health, AOD and suicide prevention services in the region.

General experiences

Overall, what we learned from the community was in line with the findings of current reviews into the mental health system, such as the Royal Commission and the Productivity Commission inquiries.

Commonly cited barriers

Commonly cited barriers in the mental health, AOD and suicide prevention service system included that the system:

- is fragmented and difficult to navigate
- is expensive
- is under-resourced
- has significant service gaps (especially in the non-crisis phase)
- is poorly designed (considers the structure rather than the person)
- makes it difficult for people to be heard.

> “It is confusing to have so many places to find information when you are feeling overwhelmed and stressed; this just adds to the confusion and pressure and makes it feel harder.”

— Person with lived experience

Photographed by Janusz Mollinski

Four main insights

Four main insights emerged from our initial consultation activities, shown in Figure 10. These ideas were tested and explored in focus groups, interviews and workshops.

Figure 10: Four main insights

Insight #1

"It's hard to know when to ask for help, or where to go to get help."

Issues include:

- poor awareness about the signs and symptoms of mental ill health
- reluctance or denial to seek help
- services operating as distinct 'silos', rather than collaborating, creating unnecessary complications for those with AOD and mental health issues.

Insight #2

"When attending services, people often do not feel safe, heard or understood."

Issues include:

- not 'seeing the whole person'
- discrimination and stigmatisation, particularly of those from diverse population groups.

Insight #3

"GPs' role is critical, but there are barriers to appropriate GP care."

Issues include:

- difficulty finding the right GP (including the right 'cultural fit')
- patients feeling rushed in appointments
- those already unwell can struggle to negotiate the next steps in treatment
- practical barriers, such as cost, travel and child-care burdens.

Insight #4

"There are few options between primary and crisis care."

Issues include:

- challenges in understanding how to access specialist and crisis care
- long waiting times
- high cost
- low availability of community-based and group-based care, including psychosocial support.

What did our priority communities say?

Aboriginal and Torres Strait Islander communities

What the data shows

ABS data from 2016 showed that the region was home to about 13,000 people who identified as being of Aboriginal and Torres Strait Islander descent (0.7 per cent of the region's total population, and slightly less than the state average of 0.9 per cent). The majority lived in Wyndham (2090), Hume (1775) and Melton (1559).

The community experience: What we heard

Aboriginal community members and service workers said poor mental health outcomes for Aboriginal and Torres Strait Islander peoples were connected to the ongoing effects of colonisation. These are explained below.

Racism, discrimination and stigma

Aboriginal and Torres Strait Islander peoples reported racism, discrimination and stigmatisation when accessing services. For example, health providers assuming a substance abuse issue. Aboriginal and Torres Strait Islander peoples who are Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer/Questioning (LGBTIQ) reported further stigmatisation, particularly younger people.

During consultations it was reported that many people in Aboriginal and Torres Strait Islander communities are believed to have undiagnosed mental health and AOD issues due to a reluctance to seek help due to racism, discrimination and stigma.

Social determinants of health

Health outcomes can be affected by social and economic disadvantage, such as unemployment and homelessness. Aboriginal and Torres Strait Islander peoples can have poor mental health literacy, which can mean they delay seeking help.

Disconnection from Country, culture and community has resulted in many experiencing feelings of isolation. Aboriginal and Torres Strait Islander peoples also described, in their own words, experiences of 'lateral violence'. This refers to 'the organised, harmful behaviours that we do to each other collectively as part of an oppressed group: within our families, within our organisations, and within our communities'.

Trauma

Trauma can include intergenerational trauma and community-based trauma. Trauma can be associated with the removal of children from parents – whether as part of the Stolen Generations, or through current child protection activities, marred by institutional racism.

Complex health issues

These include comorbidity (presence of two or more diseases) and chronic health issues. There are high numbers of people who self-medicate through drug and alcohol use and who have dual diagnoses (mental health issues combined with problematic use of alcohol and other drugs).

The welfare of the Aboriginal health workforce is also critical, as many workers also experience trauma and complex health issues.

> "Organisations are too clinical – doesn't work for our mob... We need to be innovative and have different approaches and think outside the box to consider new ways of dealing with mental health."
>
> — Community member

Image: Vinay Cooper, working with the Integrated Team Care program. Photographed by John Donegan

Culturally and linguistically diverse communities

What the data shows

ABS data shows that about 44 per cent of the region's population were born in a country other than Australia (compared to a state average of about 35 per cent). About 30 per cent were born in a country that did not predominately speak English (compared to the state average of 22 per cent). The Melbourne LGA had the highest proportion born in a predominately non-English speaking country (49 per cent), followed by Brimbank (44.7 per cent) and Maribyrnong (34.5 per cent).

The community experience: What we heard

Many culturally and linguistically diverse (CALD) community members said mental ill health carried a stigma, which reduced the likelihood of a person seeking help. This was particularly true for older community members. Use of interpreter services was also an issue.

> "I would like to see mental health services working more collaboratively with culturally and linguistically diverse communities and bicultural workers, to improve community access to mental health services and cultural safety for all."

— Chin Chin, Bicultural worker

Image: Chin Chin, bicultural worker. Photographed by Leigh Henningham

Stigma

CALD community members described high levels of stigma associated with mental health, within their families and communities. They described how this created a significant barrier to accessing services, and often resulted in people delaying seeking assistance, seeking spiritual treatment in their country of origin, or waiting until they were acutely unwell to access treatment.

Use of interpreters

In many smaller CALD communities, interpreters and those seeking help are likely to know one another. This can deter people from seeking help, or from speaking freely.

Generational barriers

Some CALD community members explained how older generations did not understand or had a different understanding of mental health issues. In some instances, there may be a preference for spiritual therapies that are driven by stigma or cultural practices.

Lack of appropriate services

While there are some practitioners who offer culturally appropriate mental and primary health services, in many cases there are not enough to meet demand. Adding to this is that some of the nuances of the CALD community are not met by existing providers. This shortage is made worse by the high cost of accessing services, particularly specialist services.

Reluctance to seek help online or via phone

CALD community members described a particular reluctance to engage with services via the phone or online. This was related to all four barriers described above.

> “Being given websites to look up. I've got plenty of access to information. That's not what I need. I need a person to help me – without passing onto some other service where I could drop off again.”
>
> — Person with lived experience

Image: Local shopping in Flemington. Photographed by Shuang Li via Shutterstock.com

Refugees and asylum seekers

What the data shows

Almost half of all humanitarian entrants who settled in Victoria between 2000 and 2016 settled in our region (about 30,000 people). Of these, about 32 per cent settled in Hume, 20 per cent in Wyndham and 20 per cent in Brimbank.

The community experience: What we heard

Feedback, although limited, was consistent with what we learned from CALD communities: respondents described a need for more culturally appropriate services. They also described issues with interpreters and using online and telephone help services.

They also referred to a five-year factor. That is, only being linked to services in the first five years after arrival. After this formal support stops, people do not know where to go to access services through the mainstream service system.

People experiencing, or at risk of homelessness

What the data shows

About 25,000 people reported experiencing homelessness in the 2016 Census. Almost 10,000 of these people were from the NWMPHN region. Melbourne accounted for 18.5 per cent of these, followed by Brimbank (15.8 per cent) and Darebin (10.4 per cent).

The community experience: What we heard

Services found by 'sheer luck'

We learned that people experiencing, or at risk of homelessness, often discover services by 'sheer luck', or through word-of-mouth.

Inappropriate and hard to navigate

Navigating the system is difficult. People are discharged from hospital to a system that does not meet their needs. Safer options or wrap-around services are not being explored, and people's needs are not being taken into consideration. For example, a person recovered or recovering from AOD issues, or with a background of AOD issues, might be placed in a rooming house with people with AOD issues.

Image: Collingwood homeless services (L–R) John, Nigel, Jody, and Dave. Photographed by Leigh Henningham

Waiting until really sick

People experiencing, or at risk of homelessness, often wait until they are acutely unwell before they seek help. This includes when someone is so unwell that they are 'over and beyond crisis point'.

Appropriate versus adequate care and support

The gap between appropriate and adequate support is contributing to people's unwillingness to engage with services. The perspective of the community and consumer is consistently being overlooked by what 'the system' thinks the community needs. Further, a negative experience of services results in heightened, ongoing distrust and unwillingness to engage with services in the future.

No support to maintain health

People felt the system was geared to making you well, but did not support you to maintain wellness. They said it was very difficult to maintain a health care plan on top of day to day living that regularly saw people experiencing homelessness juggling issues in relation to storing medication, access to nutritious food and maintaining housing.

Affordability was also an issue in accessing GPs and allied health services – such as psychologists, physiotherapists and psychiatrists. Community members said long wait lists and complex referral pathways were also barriers.

> "People are unaware of what they are entitled to access and then in turn do not know how or where to access this support."
>
> — Person with lived experience

Image: Karen Field, drummond street services CEO says our approach to mental health needs to be holistic. Photographed by Norm Oorloff

Lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ)

What the data shows

While service providers and others attest to a high proportion of LGBTIQ people in the region, there is no publicly available data in particular for intersex and transgender people/communities. In the 2014 General Social Survey by the ABS, 3 per cent of adults identified as gay or lesbian, or as having an 'other' sexual orientation.[24] While simplistic, applying this to our region would equate to about 45,000 LGBQ people.

The community experience: What we heard

Stigma and discrimination

Stigma and discrimination contribute to poorer mental health outcomes and are also a barrier to accessing appropriate and safe support. Many LGBTIQ people are vigilant and fearful of mainstream mental health services.

Sexuality and gender as an illness

Members of the LGBTIQ communities reported experiences of services that treated their gender and/or sexuality as a medical condition or illness. Others described services treating everyone the same, and failing to recognise the impact of oppression and historical institutionalisation of LGBTIQ people. They also spoke about their gender and sexuality not being considered part of their identity.

24 *Australian Institute of Health and Welfare (AIHW). (2018). Australia's Health 2018. Canberra: AIHW.*

People who have been incarcerated, or have had significant interactions with the justice system

What the data shows

There are four prisons in the region: Parkville Youth Justice Precinct and three private prisons. Data about the proportion of residents who have been incarcerated or have had significant interactions with the justice system is limited.

Data from Corrections Victoria suggests that of the 13,817 offenders in Victoria in 2017–18, about 20 per cent were processed in the region. Of these, about 77 per cent were aged between 21 to 44 years, 85 per cent were male, 19 per cent were born in non-English speaking countries and 5 per cent identified as being of Aboriginal and Torres Strait Islander descent.[25] In addition, 52 per cent had been imprisoned previously.

Health providers in the region, consulted for the Blueprint reported that this population experienced higher levels of mental distress, and often had 'dual diagnoses' (one or more mental health issue combined with problematic drug or alcohol use).

The community experience: What we heard

Poor continuity of care

Community members described having to re-tell their story multiple times between services. They said there were no connections or pathways to services when released from prison, and little information or direction provided upon release.

Accessibility and navigation

Community members called for better support to access services (such as free train tickets) and better information from services. They described services setting unrealistic expectations, such as that access to rehabilitation is likely, when it isn't.

25 *Corrections Victoria. (2018). Annual Offender Statistical Profile 2007-07 to 2017–18. Retrieved from corrections.vic.gov.au/prisons/prisoner-and-offender-statistics*

Stigma, discrimination and judgement

People described feeling dismissed, ignored and intimidated. They noticed negative body language from people, including health professionals, and people making negative assumptions based on appearance. They also described self-secluding at services (for example, sitting at the back of a room) due to feeling discriminated against and 'different'.

Long waiting times

People described long waits for services, and no support during this period. They also described short appointments that did not address their needs, and that made them feel rushed and dismissed, as well as a lack of patience and understanding from service providers.

> "I have a homeless 49-year-old brother who is an alcoholic...Just found out he has been jailed for a drunken incident but am too anxious to find out any more...I find comfort knowing he has food and shelter in jail. It saddens me that he has no psychological help or that surely, he could get disability pension and access some kind of accommodation where he is looked after."
>
> — Carer

Further engagement will occur in the next stage of planning

NWMPHN is committed to understanding the service system from the perspective of people with lived experience, their friends and family. Further engagement with a wide range of community will continue to occur as planning continues. This will include engagement with priority population groups, with community in geographic regions and with other groups who may have particular needs, such as international students living in the region.

“I’d continue to demystify mental illness, and to let people know that it’s okay to feel down, and that everybody does.”

— Gabrielle

Opportunities

This section describes ideas for changing how we design services, and the five main areas for improvement. These were decided after thorough consultation and analysis. The design ideas and areas for improvement have also been tested with the community and with service providers, and refined accordingly.

Context

Policies, systems and funding

Challenges

What did we learn from the community?

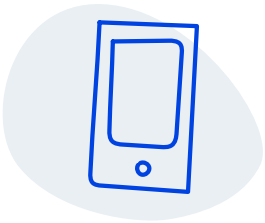
Insights about redesigning our services

As consultation progressed, the reference group identified common themes in terms of essential considerations when designing services.

These ideas were tested with the community, and the final version is shown in Figure 11. It's expected that these 'essential qualities of service design' will be further developed in the next phase of planning and will guide the creation or improvement of activities and services.

Figure 11: Essential qualities of service design

Reference groups identified the essential qualities of a service:



A range of ways to deliver services

online, phone, home, face to face

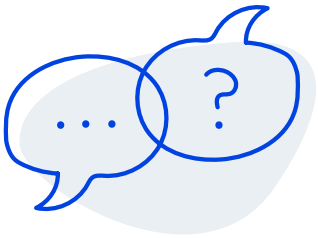
Recognition of supporting relationships

family members and significant other

Connection/links

to community, legal and physical health

Peer-led approaches



A range of therapeutic approaches and methods

both group and individual

Five strategic opportunities for improvement

We identified five key areas where reforms to mental health, AOD and suicide prevention services will be most effective. This was based on what we learned from extensive community consultation, testing ideas and looking at other available data and reports.

Figure 12: Summary of strategic opportunities

1. Improve service integration and innovation

Enabling better coordination and collaboration in the service system through exploring innovative models of care.

Possible activities identified by community:

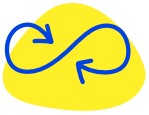
- Peer navigators
- One-stop-shop for care to integrate and coordinate health and social care possibly provided virtually

2. Build community and workforce capacity

Responding to distress in culturally safe and trauma informed ways.

Possible activities identified by community:

- Community campaigns
- Capacity-building in the community
- Workforce training including harm minimisation and trauma-informed care



3. Enable accessibility across the system

Tailoring service delivery that is appropriate to the needs of the individual.

Possible activities identified by community:

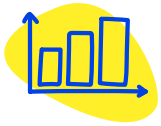
- Improved online directory
- Telehealth and apps
- Improved affordability

4. Strengthen supportive networks

Building the resilience of the individual's network.

Possible activities identified by community:

- Responding to the needs of the whole person including physical and mental health
- Services that provide social and emotional wellbeing support



5. Enhance data capability

Developing transparent, reliable and accessible data.

Possible activities identified by community:

- Address barriers to shared data sets
- Improve data collection practices

1 Improve service integration and innovation

Improve coordination of services, and the ways in which services work together. This could include innovative models of care.

Why is this important?

Health care systems should respond to a person's needs throughout their life, in the most seamless way possible.

Better coordination and collaboration improves health outcomes by ensuring people get the support they need, when they need it, in a user-friendly way.

However, our community consultation findings suggested that in north-western Melbourne, clinical, primary health and social services systems remain somewhat fragmented.

Families, in particular, said the service system was focused on acute care and crisis presentations, rather than prevention and primary care.

Families and others with experience of crisis, separation and ongoing care expressed frustration at a complex, confusing system. They said navigating it could be overwhelming and often added to their distress.

Links with Fifth National Mental Health and Suicide Prevention Plan priority areas:

- achieving integrated regional planning and service delivery
- co-ordinating treatment and supports for people with severe and complex mental health
- improving the physical health of people living with mental illness and reducing early mortality.

Community members within priority populations also found the system difficult to navigate. Some expressed frustration at having to constantly re-tell their story to health care providers. Those with traumatic stories were particularly unsettled by this.

Indeed, for many priority populations, including Aboriginal peoples, the way information is transferred between services remains a significant issue, and problems are often exacerbated by the current system. The need for better links between services, and for integration of services, was made clear. More work is needed to better understand challenges and opportunities relating to how people are referred, assessed and treated, and how they are supported to move between services.

> “Particularly crisis or mental health teams in public hospitals have been difficult for myself and people close to me due to lack of understanding of complex needs... I often feel scared of going to the emergency room when I’m in crisis because I fear how I’m going to be dealt with.”
>
> — Person with lived experience

Potential activities identified by community members

Community members showed a strong preference for innovative models of care – models that are holistic and integrate a range of services, including private, public and non-government services. This will mean ensuring health and welfare concerns are not separated.

Community members also said services needed to respond better to the episodic and varying nature of psychological distress and mental illness. The increased use of ‘peer navigators’ (people with similar experiences or backgrounds helping people navigate care) was identified by community members.

The new HeadtoHelp intake and hubs provide integrated intake and assessment for the whole of Victoria to help people find the services they need. This is an example of an innovative service focused on service integration. Another example of service innovation is social prescribing where health providers can prescribe a person to non-medical services such as social or financial support.

Open dialogue or ‘dialogical practices’

Community members said exploring approaches such as ‘Open Dialogue’ could help build people’s interpersonal networks. This is a consistent social network approach to an emotional crisis, in which services are structured to be more responsive to people’s needs. The emphasis is on developing a ‘shared language’ with people in crisis and their social networks or communities.

In this approach, support is provided in context, and responses are flexible to meet the needs of different networks. There’s an opportunity for early intervention, including identifying supports that would build the resilience of a person and their identified network. This approach can be undertaken at any point across the lifespan.

Creating a one stop shop

Community members said it was important to have a ‘safe space’ in the community that provides a range of holistic services from a variety of providers. These should address, but not be limited to, social, welfare, mental and physical health services. The space should connect those seeking support, develop their skills and deliver support across the continuum of care.

Community members suggested a ‘one stop shop’ to support diverse issues. Support would not necessarily have to be delivered solely in person: technology could also be used to create virtual hubs. However, the overwhelming preference was for in-person, multi-agency environments.

Image: Di Nally and Lee-Ann Boyle discuss psychosocial supports in the community. Photographed by Leigh Henningham

2 Build community and workforce capacity

Help our workforce and community respond to distress appropriately, using concepts such as cultural safety and trauma-informed practice.

Why is this important?

Many groups, including culturally and linguistically diverse groups and Aboriginal communities, spoke of stigma and discrimination when accessing services. These issues ultimately result in people delaying or avoiding accessing services.

Action is required to ensure that health care is 'culturally safe'. The Victorian Aboriginal Community Controlled Health Organisation defines cultural safety as: 'being acceptable to difference, having the ability to analyse power imbalances, institutional discrimination, colonisation and relationships with settlers. Cultural safety is about providing quality health care that fits with the familiar cultural values and norms of the person accessing the service, that may differ from your own and/or the dominant culture'.

Health care systems and workers also need a strong understanding of the effects of trauma. Child Family Community Australia defines 'trauma-informed care' as a framework for human services based on knowledge and understanding of how trauma affects people's lives, as well as their service needs and use.

Links with Fifth National Mental Health and Suicide Prevention Plan priority areas:

- improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- reducing stigma and discrimination
- effective suicide prevention.

Potential activities identified by community members

Community members spoke about ensuring that health care approaches were informed by an understanding of trauma and harm minimisation. Workforce capacity-building and education were identified as potential areas of focus. Greater flexibility and responsiveness to mental illness (with an understanding that mental illness is often episodic, and varies in intensity) were also cited. This could also include work to educate the broader community about the effects of trauma, and strategies to minimise harm.

Public awareness campaigns

Community members identified these as a means of addressing issues of stigmatisation and discrimination. Their purpose would be to educate the broader public about the effects of discrimination, stigma, intergenerational trauma and racism on mental health and wellbeing. Community members said these campaigns should be co-created with members of the relevant community (and, potentially, with different levels of government), so that they are culturally appropriate and accessible to a broad audience.

A similar public campaign is already underway as part of the Commonwealth-funded suicide prevention trials for the LGBTIQ communities. The campaign aims to reduce stigma and discrimination against LGBTIQ people, including by the health system, and create a more supportive and accepting societal environment.

The campaign is multifaceted. It involves raising community awareness through mainstream and LGBTIQ media platforms, and community events and spokespeople, and uses marketing strategies and funding to increase its visibility. The campaign will be run in conjunction with 'gatekeeper training' for GPs, sporting clubs, small business, venues, as well as with the wider LGBTIQ populations. Ongoing evaluation of this campaign will help to demonstrate the effectiveness of similar interventions, and support future campaigns for other priority populations.

Building the skills of the community

Community members expressed how important culturally appropriate and peer-run education was in addressing issues of stigma and discrimination. They said this should focus on improving the ability of families and community members, such as coaches, librarians and teachers, to notice the early signs of mental distress; to understand how to respond; and to seek help when needed. Programs that were recommended included 'emotion CPR' (eCPR) – a public health education program designed to teach people to assist others through an emotional crisis.

Education and training should be in common and accessible community environments, such as at schools, sporting or recreational clubs, neighbourhood houses or libraries. This would help to 'normalise' conversations about mental health and reduce fear and stigma. In addition, community environments could act as 'walk-in street kiosks' that have a range of accessible resources, demonstrating that mental health is integral to the health of the community.

A trial focusing on building the capacity of the LGBTIQ communities to recognise and respond to potential suicide is currently underway. This, as part of the Commonwealth-funded suicide prevention trials, focuses on the LGBTIQ communities. Again, there is an opportunity to learn from and use this work to support capacity-building among priority populations and the broader community.

Image: Dr Ralph Audehm, Carlton Family Medical centre – talks to a packed room at CroakeyGO. Photographed by Norm Oorloff

> "There needs to be a 'no wrong door' approach. We need to be able to refer someone with confidence to know, yes, they will accept it."
>
> — Ralph Audehm, General Practitioner

Consistent workforce training regarding trauma

Community members said training for the health workforce in harm minimisation and integrated trauma-informed care was needed to improve confidence and feelings of safety when accessing services. Community members said such approaches were integral to improving their engagement with and experiences of health care.

Trauma-informed training aims to support professionals to understand the type, prevalence, neurobiology and impacts of trauma to reframe challenging emotions and adaptive responses to trauma. This is particularly important when working with the Aboriginal and Torres Strait Islander community.

Harm minimisation aims to address AOD issues by reducing the harmful effects of AOD on individuals and society. It is based on the following concepts:

- drug use, both licit and illicit, is an inevitable part of society
- drug use occurs across a continuum, ranging from occasional use to dependent use
- a range of harms are associated with different types and patterns of AOD use
- a range of approaches can be used to respond to these harms.

Community members cited harm minimisation activities, including the Alcohol and Other Drugs GP Education Program. This resource can be adapted to suit the unique circumstances of different vulnerable populations. It encourages collaboration to develop a whole-of-practice approach to appropriate prescribing of pharmaceuticals, with the aim of implementing best-practice approaches to safely and effectively support people to minimise harm and improve health and wellbeing.

CASE STUDY:

The Aboriginal and Torres Strait Islander community

Cultural safety approaches need to reflect Aboriginal culture and past traumas. Care should be delivered in a way that reflects Social and Emotional Wellbeing (SEWB) – a holistic concept that is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. Figure 13 is one way of representing this concept.

Figure 13: Seven sources of social and emotional wellbeing

Source: National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

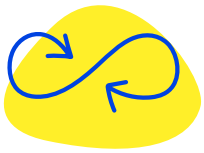
This model describes each source of wellbeing and gives examples of associated risk and protective factors. For example, 'connection to body' involves physical health – feeling strong and healthy and being able to participate as fully as possible in life. Risk factors (for poor connection to body) include poor diet, smoking and chronic diseases. Protective factors can include exercise, having access to a nutritious diet and having access to culturally safe and competent health services.

The model recognises that the SEWB of individuals and communities will be affected by a wide range of overlapping historical, political and social factors. These could include past injustices associated with colonisation; unresolved grief and loss issues, trauma and abuse, domestic violence, issues associated with legislated removal of children, substance misuse, physical health problems, genetic and child developmental problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage.

As such, to ensure a culturally appropriate and trauma-informed approach, the concept of SEWB must be prioritised.

> “Our mental challenges are only one part of our lives; it’s not the whole story. It is a situation we find ourselves in at different times of our life.”
>
> — Person with lived experience

Image: Lionel Austin speaks to the CroakeyGO crowd at the Victorian Aboriginal Health Service (VAHS). Photographed by Norm Oorloff



3 Enable accessibility in the system

Improve accessibility across the system and ensure services meet individual needs.

Why is this important?

For services to be effective, they must be accessible to and line up with the community's needs. Various barriers continue to limit access to services for people in our region.

In addition to the barriers relating to cultural safety and trauma-informed care are barriers such as cost, availability and lack of knowledge about services and support.

Cost

Cost is a significant barrier to accessing services, especially specialist services and ongoing therapy. Community members said the limit on the number of sessions paid for by Medicare made them worry about receiving the care they needed. Some felt rushed through the system, unable to develop a productive relationship with mental health practitioners.

Availability

Services' hours are generally limited to working hours, limiting many people's options.

Lack of knowledge about services

NWMPHN has commissioned providers to deliver mental health, suicide prevention and AOD services throughout the region. Services funded by the Victorian Government and other organisations are also available in addition to a wide range of private services.

However, there is a need for clearer information about what's available and who can access services. Information about eligibility for services, specialty services and the need for referrals is also creating confusion. This is another barrier to seeking or accessing support.

> "Mental health care needs to be provided as soon as it is needed and integrated with social support to best respond to conditions before they require acute, complex care."
>
> — cohealth on Twitter

Inability to refer directly

People described how challenging and time-consuming it could be to get an appropriate referral. Complex referral paths were even more challenging for those who do not speak English well (or well enough to manage to advocate for an effective referral).

Transport and distance

A person's location and access to transport directly affects how easily they can access services. This is a particular problem in the outer-urban and regional LGAs of Macedon Ranges, Moorabool and Melton. Further, many community members spoke of travelling significant distances for mental health support that suited their needs.

Potential activities identified by community members

Community members called for investment to reduce these barriers, and to give them greater choice and control in terms of the services they receive. They said this should extend to the nature of the therapeutic interventions, engaging diverse communities to design services, the way services are delivered, and to improving community understanding about clinicians and their skills. This would help them make informed choices.

> "People are being discharged/released into a system that does not meet their needs e.g. leave hospital and be given a number for a rooming house. Safer options or wrap around services are not being explored and the persons need are not being taken into consideration."
>
> — Service provider in the homeless sector

Improved use of technology

Delivering services digitally can help increase accessibility – reaching people in different locations, and at different times than might otherwise be possible. They have also become a necessary measure to help stop the spread of the COVID-19 virus. (However, it is important to note that benefits do not extend to those who are not 'technologically literate' or who do not have access to the right technology.)

Benefits of digital solutions can include:

- **convenience and availability** – in theory, support can take place anytime, anywhere. Among other benefits, this can allow services to reach people in remote areas or at times of sudden need, or to provide round-the-clock monitoring or intervention support

- **anonymity** – clients can seek treatment options without involving other people
- **affordability** – some apps are free or cheaper than traditional services
- **interest** – to some (including young people), digital solutions can be more appealing
- **consistency** – technology can offer the same treatment program to all users
- **ongoing support** – technology can complement traditional therapy by extending an in-person session, reinforcing new skills, and providing support and monitoring.

Community members identified a range of ways technology could improve accessibility. The two identified as highest priority are explained below.

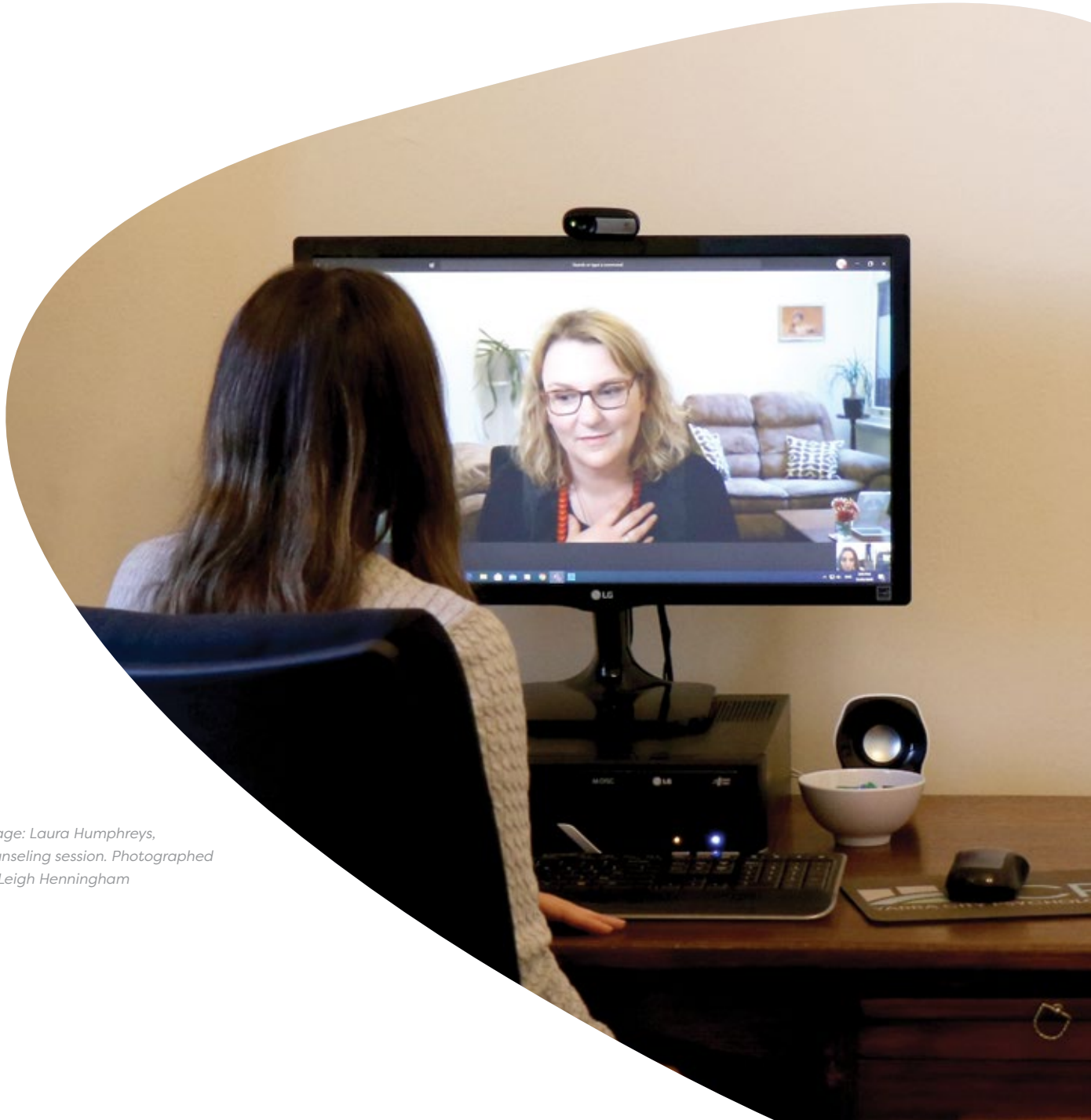


Image: Laura Humphreys, counseling session. Photographed by Leigh Henningham

Single online directory

Community members are keen to have a single online directory that provides information, orientation and referral to services available in the region. This should be accessible for people with disabilities and available in different community languages.

They named several important functions:

- filters for services supporting priority populations
- filters for geographic areas
- filters for areas of specialty
- the ability to make direct referrals
- 'push notifications' to reach people who are socially isolated
- virtual tours to support orientation with services, including the location and physical characteristics of a service, such as car parking, reception and interview rooms
- ratings of service providers.

Community members said such a directory could be promoted in several ways, including as part of a broader community awareness campaign.

Telehealth and online applications

Community members stressed the importance of choice and flexibility in the way services are delivered, which would help to make sure they met individual needs.

Delivering services remotely, via online technology or phone, was raised. As noted in the COVID-19 section, there have been significant and rapid moves by general practices, allied health, specialists and hospital outpatient units to telehealth.

Improving affordability

Community members want more affordable services, to improve both access and continuity of care. Cost is a barrier to accessing service providers generally, as well as to accessing providers of choice.

Options include investing in initiatives that supplement existing funding, or offering more therapy sessions. Addressing cost issues could have a particular benefit for priority populations.

4 Strengthen supportive networks

Help people develop stronger, more supportive personal networks.

Why is this important?

A person's connection to their community, and their relationships, directly affect physical and mental health.

Community members said mental health, AOD and suicide prevention services often did not support a person's connection to family, culture, social supports, work, education and community. Some also noted that the introduction of the NDIS further reinforced individualised support, rather than group or social connection.

Image: Practice Nurse Kylie McLaughlin at IPC Health's social prescribing program. Photographed by Norm Oorloff

Potential activities identified by community members

Community members said the service system should be aware of and integrated with an individual's social networks. For the Aboriginal community in the region, this is particularly important: connection to family and kinship is critical when developing and implementing any form of wellbeing or mental health measures.

'Peer navigators'

Community members said 'peer navigators' could help those who feel uncomfortable or who are unable to access services. Peer navigators could support people on-site when they first present and help them identify appropriate services tailored to their specific qualities and needs.

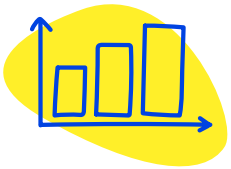
Peer navigators are part of a growing peer support workforce, which recognises support as 'a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful'.

Peer navigators could improve co-ordination, facilitate warm referrals, support handover, and reduce the re-telling of one's story to multiple providers.

Community members said employment of peer navigators could also help the workforce better reflect the community it serves. In line with the concept of 'co-design', a workforce that reflects the community improves access to and delivery of services, and increases the satisfaction of people with direct experience of mental illness, leading to better health outcomes.

Links with Fifth National Mental Health and Suicide Prevention Plan priority areas:

- → achieving integrated regional planning and service delivery
- → effective suicide prevention
- → coordinating treatment and supports for people with severe and complex mental illness.



5 Enhance data capability

Work towards data that is more transparent, reliable and useful.

Why is this important?

Effective and efficient data collection is needed to inform planning, design and evaluation – both for people who use services, and for system planners and designers.

Data can play a significant role in an individual's experience of health care. For example, sharing information efficiently and effectively (including privately) can mean that a person does not need to repeat their story, potentially avoiding the trauma of re-telling their story.

Effective and efficient data recording and sharing also provides critical information for the design (or re-design) of services.

Currently, however, there is a lack of data routinely collected for a number of the priority populations. This includes the LGBTIQ, refugee, CALD, and the Aboriginal and Torres Strait Islander communities. There are issues with data collection infrastructure and the sophistication of service providers and system administrators (those who mandate the data collection requirements).

There is also a disconnection between health and other relevant data sets, such as those for justice, disability, housing and employment. This limits, for example, the ability to plan and design services to meet the needs of people who have been incarcerated, or who have had recent interactions with the justice system.

Links with Fifth National Mental Health and Suicide Prevention Plan priority areas:

- making safety and quality central to mental health service delivery
- ensuring that the enablers of effective system performance and system improvement are in place
- effective suicide prevention.

Evaluation

Monitoring, evaluation and feedback are essential elements of any planning and restructuring processes in health.

This Blueprint has been developed according to the understanding that people who use mental health, suicide prevention and AOD services are best-placed to identify problems and potential solutions.

Like the early sketches for a building, this Blueprint outlines the shape of future development. It does not indicate specific targets. Instead, during the development of the Blueprint, we monitored the following elements:

- How well are we prioritising the voices of diverse community members?
- Does the Blueprint reflect what we heard from community members?

We regularly reflected on these questions during development of the Blueprint. This included monitoring whom we had engaged with and where gaps existed. This information guided the advice and input from the reference group and LHN group, who met regularly throughout the development of the Blueprint and advised on strategies to address these gaps.

For example, the intention of the social listening activity was to engage with a broad range of community members to identify common themes, and then later to test these themes with diverse population groups. By continually analysing who we were engaging with, we were able to pinpoint when certain voices were missing. As such, additional focus groups were held with people who have experienced homelessness, people who have been incarcerated, Aboriginal community members, young people and people from particular local government areas.

> “It's important to remember basic human connectedness, so when people are at their most distressed like I have been in the past... basically I would've needed someone to... tell me it's okay.”
>
> — Nikki, community member

Image: Nikki shares her story at a Blueprint community event. Photographed by Jeremy Kennett

Image: Uncle Colin Hunter provides Welcome to Country at VAHS. Photographed by Norm Oorloff

Next Steps

Work on a comprehensive services plan will begin in 2021. This plan will include details about joint investments and services to be developed by providers in our region.

Future planning will take into account the final recommendations of the Productivity Commission in late 2020, and the Victorian Royal Commission in February 2021. These recommendations will likely play a significant role in shaping future reforms across the nation and the state, as well as in the NWMPHN region. This Blueprint has been developed in recognition of these parallel pieces of work and will seek to complement this work.

This Blueprint will be publicly available on blueprintforhealth.org.au and we encourage community members to continue to provide input through this website.

Community consultation will remain a cornerstone of future planning and service design. We look forward to continuing to work with people with lived experience of mental health, AOD use and suicide, as well as with carers and health care providers, to further improve mental health, AOD and suicide prevention services.

Appendices

Appendix 1: Summary of national and state mental health reforms

Figure 14: Australian Government reforms/reports

2014

Contributing Lives, Thriving Communities

Summary: This was the National Mental Health Commission's report of the National Review of Mental Health Programmes and Services. It recommended system reform for person-centred care and reinvestment of funding.

2016 (moved from trial phase to full roll-out)

National roll out of National Disability Insurance Scheme (NDIS)

Summary: NDIS is a major reform of disability support based on a market-style system. Funding is distributed directly to consumers, rather than to service providers. It is intended to give consumers more choice and control.

2017–2022

Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan)

Summary: A plan for a national, collaborative approach across all levels of government, covering eight priority areas. Among the priority areas was joint regional planning between LHNs and PHNs. This Blueprint is an outcome of this plan.

2017–2026

National Drug Strategy

Summary: A ten-year framework that aims to reduce and prevent the harmful effects of alcohol, tobacco and other drugs.

2017–2023

Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing

Summary: Designed to complement the Fifth Plan, the Framework focuses on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health.

Draft in 2019; final report due in late 2020

Mental Health Productivity Commission

Summary: This inquiry is focused on improving mental health to support economic participation and enhance the productivity and economic growth of all Australians.

2020

National Mental Health and Wellbeing Pandemic Response Plan

Summary: This plan details how mental health should be considered as Australia responds to, and recovers from, the COVID-19 pandemic. It requires action from all levels of government.

2020–2021

HeadtoHelp

Summary: Rapid response funding to support COVID-19 driven mental health needs in Victoria, initially for 12 months. Focus is to reduce mental health distress caused by COVID-19, improve access to support, and complement, enhance and better integrate the mental health service sector.

Figure 15: Victorian Government reforms/reports

2015–2025

10-Year Mental Health Plan

Summary: Focuses on greater efforts in prevention and providing better integrated services and support for the most vulnerable people in the community.

2016–2025

Victorian Suicide Prevention Framework, including HOPE

Summary: The 10-year plan for Victoria. The Hospital Outreach Post-suicidal engagement (HOPE) strategy is part of the Victorian strategy to improve care following a suicide attempt.

2017–2022

Balit Marrup: Aboriginal social and emotional wellbeing framework

Summary: This plan provides an overarching framework for action to improve the health, wellbeing and safety of Aboriginal Victorians by providing high-level strategic actions to reform the health and human services sector in order to advance Aboriginal self-determination in health, wellbeing and safety.

2019

Equally Well in Victoria

Summary: Acknowledges that every time a consumer interacts with a mental health service, this presents an opportunity to also focus on physical health issues and how they impact on recovery goals, and to provide support to address them.

Interim report in 2019; final report due in Feb 2021

Royal Commission into Victoria's Mental Health System

Summary: The terms of reference include 'how the Victorian mental health system can most effectively prevent mental illness and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future'.

Appendix 2: Partners in planning the Blueprint

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An Australian Government Initiative

LHNs group

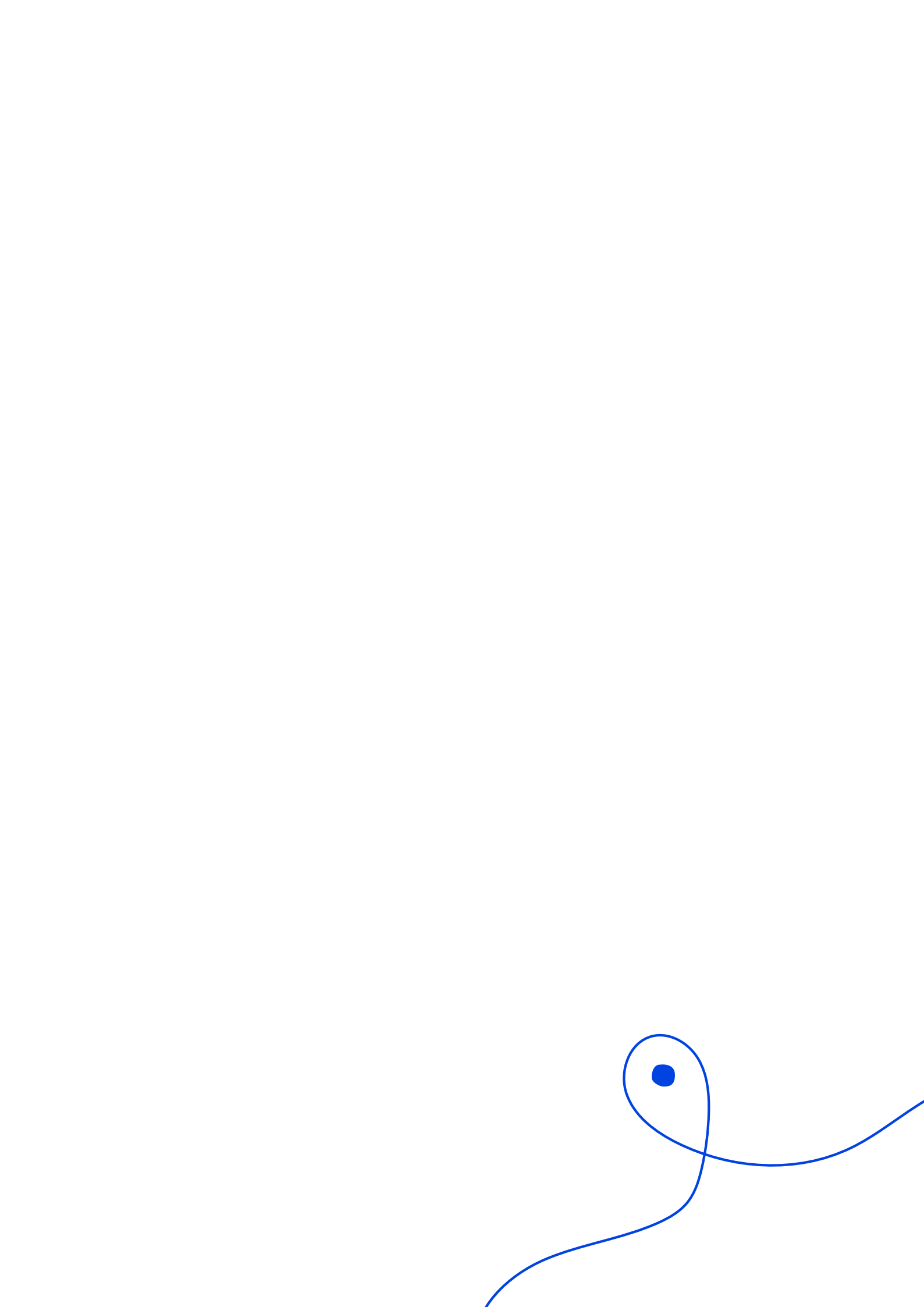
Austin Health
Bendigo Health
Northern Health
orygen
The Royal Melbourne Hospital NorthWestern Mental Health
Western Health
St Vincent's Hospital Melbourne
Mercy Health Care first

Reference group

Carers VIC Australia
LGBTI National LGBTI Health Alliance
vaada
Harm Reduction Victoria www.hrvic.org.au
MentalHealth Victoria
VMIAC by and for consumers
Victorian Transcultural Mental Health
tandem representing Victorian mental health carers

The Blueprint has been endorsed by:

- NWMPHN Community Council and Clinical Council
- NWMPHN GP, Mental Health and Alcohol and Other Drugs expert advisory groups



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