South-Eastern Melbourne's Plan for Mental Health, Suicide Prevention and Alcohol and Other Drugs

2020-2025

Australian Government

VICTORIA State Government

Alfred Health, Monash Health, Peninsula Health and the South-Eastern Melbourne Primary Health Network respectfully acknowledge the Wurundjeri and Boon Wurrung / Bunurong People as the Traditional Owners and Custodians of the land on which we work. We pay our respects to all Aboriginal Elders, past, present and emerging.

We acknowledge those people with a lived experience of mental ill-health, their families, friends and supporters and thank them for their contribution to the development of this plan.

We value inclusion and diversity and are committed to providing services that are safe, culturally appropriate and inclusive to people of all races, ethnicities, faiths, physical abilities, socioeconomic status, age, religious/faith beliefs, political beliefs, gender identities and sexual orientation.

phn SOUTH EASTERN MELBOURNE
An Australian Government Initiative

AlfredHealth

Monash Health

Peninsula Health

Foreword

Mental health and suicide prevention are among the greatest challenges we face as a community, particularly in light of the COVID-19 pandemic.

Through the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), the Commonwealth and all State and Territory governments have set out a blueprint for how we will collectively address these challenges. Joint regional planning is the first priority of the Fifth Plan and a critical step in much-needed reform.

Alfred Health, Monash Health, Peninsula Health and the South-Eastern Melbourne Primary Health Network jointly commit to working together to support the community members of South-Eastern Melbourne in improving their mental health and reducing the risk of suicide.

Underpinned by the stepped care model, this foundation Regional Plan sets out the important first steps to developing a systematic approach to service provision and ensuring those needing support can access the right care in the right place at the right time.

We would like to thank the project team and steering committee members for their hard work in putting together the plan and the community and service providers of South-Eastern Melbourne who have shared their valuable insights.

We recognise that there is a long road ahead of us and more work to be done, particularly in the six priority areas outlined in this plan. We look forward to working with our community members and organisations to better understand their needs in developing a comprehensive Regional Plan by 2022 and to continue the journey towards a happier, healthier South-Eastern Melbourne.

We would like to thank you all for being involved in the development of this plan through sharing your stories with us, being involved in working groups, or for taking the time to read this plan. We welcome any feedback, which can be sent via email to regionalplanning@semphn.org.au.

Andrew Stripp
CEO Monash Health

Prof Andrew Way AM
CE Alfred Health

Felicity Topp
CEO Peninsula Health

Elizabeth Deveny
CEO SEMPHN


Welcome to
Frankston Pier

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Key terms

Better Access Initiative – the aim of the Better Access Initiative is to improve the treatment and management of people living with mental illness.[1]

Carer/s – people who provide unpaid care and support to family members and friends who have a mental illness or an alcohol or drug-related issue.[2]

Chronic disease – long-lasting condition with persistent effects. Their social and economic consequences can affect people's quality of life.[3]

Clinical governance – the responsibilities of a service to ensure good clinical outcomes. Clinical governance helps to ensure that systems are in place to deliver safe, high-quality care and continuously improve services.

Commissioning – a strategic, evidence-based approach to planning and purchasing services. It is intended to be outcomes-focused, with health services centred on the needs of patients. The commissioning process provides a holistic approach to service procurement, with the outcomes from each commissioning cycle factored into the next.[4]

Consumer – a person who is using, or has previously used, a mental health, suicide prevention, alcohol or other drug (or other health) service. 'Consumer' may also be used to describe a person who might need to use a mental health service (National Standards for Mental Health Services). Consumers are also people who identify as having a living or lived experience of mental illness, irrespective of whether they have a clinical diagnosis, and have accessed mental health services and/or received treatment.[5]

Governance – encompasses the system by which an organisation is controlled and operates and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements of governance.[6]

Lived experience – people with lived experience identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or suicide.[7]

Mental health – a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.[8]

Mental health services – services in which the primary function is to provide clinical treatment, rehabilitation or community support for people affected by mental illness or psychiatric disability and/or their families and carers.

Mental health workforce – a variety of health and social care professionals, including psychiatrists, psychologists, nurses, general practitioners and social workers, who provide a range of mental health-related services to Australians.[9]

Mental illness – a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.[10]

Model of care – a 'model of care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.[11]

Multidisciplinary care – care that occurs when professionals from a range of disciplines bring complementary skills, knowledge and experience to provide the best possible care for an individual.

Partners – comprising the four regional planning partners who are Alfred Health, Monash Health, Peninsula Health and South-Eastern Melbourne Primary Health Network.

Primary health care – community-based services that often constitute the first point of contact for people and their families experiencing a mental health problem or a mental illness. The primary care sector includes general practitioners, emergency departments and community health centres.[12]

Primary Health Networks (PHNs) – entities contracted by the Commonwealth to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.[13]

Region – the South-Eastern Melbourne region as defined by the South-Eastern Melbourne Primary Health Network boundaries.

Referral pathways – a series of steps including clinical intervention taken by health care providers in response to a new diagnosis or with recurrent or progressive disease.[14]

The Plan – this South-Eastern Melbourne's plan for Mental Health, Suicide Prevention and Alcohol and Other Drugs 2020-2025. (This Regional Plan is the Foundation Plan referred to in the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan).)

Severe mental illness – characterised by a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning.[15]

Stepped care – a stepped care approach promotes person-centred care that targets the needs of the individual. Rather than offering a one-size-fits-all approach to care, individuals will be more likely to receive a service that more optimally matches their needs, does not under or over-service them, and makes the best use of workforce and technology. A stepped care approach also presumes early intervention – providing the right service at the right time and having lower intensity steps available to support individuals before an illness develops or gets worse.[16]

Stigma – stigma may apply to people with mental illness and can involve a variety of myths, prejudices and negative stereotypes. Stigma includes inaccurate or harmful representations of people as violent, comical or incompetent.[17] Stigma may also apply to those with alcohol or drug dependence and include representations of people as weak-willed, criminal, low-functioning or intoxicated.

Acronyms

AOD
alcohol and other drugs

CALD
culturally and linguistically diverse

DOH
Department of Health

DHHS
Department of Health and Human Services

GP
general practitioner

HOPE
Hospital Outreach Post Suicidal Engagement team

LGAs
local government areas

LGBTQIA+
lesbian, gay, bisexual, transgender, queer, intersex and asexual or allied

LIFE
The Living is for Everyone Framework

LHN
Local Hospital Network also referred to as Victorian public hospitals and health services

MBS
Medicare Benefits Schedule

NDIS
National Disability Insurance Scheme

NGO
non-government organisation

NMHSPF
National Mental Health Service Planning Framework

PHN
Primary Health Network

POLAR
Population Level Analysis and Reporting

RACGP
Royal Australian College of General Practitioners

RACFs
registered aged care facilities

SEMPHN
South-Eastern Melbourne Primary Health Network

VAGO
Victorian Auditor-General's Office

Executive summary

Under the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), Federal, State and Territory governments agreed to share responsibility for improving mental health services.

This Mental Health, Suicide Prevention, Alcohol and Other Drugs Regional Plan (The Plan) has been developed to address Priority 1 of the Fifth Plan.

The Regional Plan partners who have developed this Plan are Alfred Health, Monash Health, Peninsula Health and South-Eastern Melbourne Primary Health Network (SEMPHN) in consultation with the sector, stakeholders and local communities.

Regional Plan aim

The Regional Plan partners recognise the importance of working together in the areas of prevention, diagnosis, treatment and recovery and are committed to working together at a regional level to support integrated service planning and delivery. Our work aims to improve the health, wellbeing and experiences of people living in South-Eastern Melbourne.

Current system-wide reviews

The Productivity Commission's Mental Health Draft Report (2019) and the Royal Commission into Victoria's Mental Health System Interim Report (2019) are important system-wide reviews underway that will recommend improvements to our mental health system. Findings in the draft and interim reports have informed the development of this Plan.

Understanding the needs of the community

Mental illness

In 2017-18 about 310,000 people in the region had a mental illness and/or behavioural concerns, including 30,000 people aged 4 to 17 years. Within the region, Frankston has the highest proportion of residents living with mental illness (25.7%), followed by Port Phillip (23.7%) and the Mornington Peninsula (21.7%).

People with severe mental illness and a co-occurring physical illness can live up to 25 years less than the general population.

Suicide

Suicide is the leading cause of death for people living in Australia aged 15–44 years and accounts for about one-third of deaths among people aged 15–24. Despite ongoing efforts to make suicide prevention more effective, there has been no significant or sustained reduction in the death rate from suicide over the past decade.

Co-occurring illness

Up to 50% of people with severe mental health problems experience co-occurring substance abuse (dual diagnosis) and often need treatment or support for both issues. The number of people with a dual mental health/AOD diagnosis is increasing; more than half of the people admitted to hospital for an AOD disorder also have a mental illness.

Community diversity

The health and wellbeing of children, youth and older people who live in South-Eastern Melbourne are a priority for Regional Plan partners. Risks to mental health begin before birth and can develop at different points in a person's life.

Age, language barriers, cultural differences and religious beliefs, stigma, discrimination, socioeconomic disadvantage and intergenerational trauma shape people's identities and experiences. People who identify as Aboriginal and Torres Strait Islander, LGBTQIA+, culturally and linguistically diverse, and refugees and people seeking asylum experience poorer health outcomes compared with the general population.

Workforce

The availability of a skilled mental health workforce to deliver a range of interventions and services across the region is critical to support people's mental health treatment needs. However, there can be challenges in recruiting and retaining mental health professionals.

Service utilisation and gaps

In South-Eastern Melbourne, 65% of people with a mental illness were provided with care by a GP, psychologist or psychiatrist. Yet 110,000 (35%) people are not accessing mental health services.

Service gaps include very low provision of acute and non-acute day care or day programs and limited options for inpatient care provided outside the hospital setting (particularly with 24-hour physician coverage).

Regional Plan priorities

Gaining an understanding of the system and the needs of people living in South-Eastern Melbourne through primary, community and tertiary lenses has enabled the Regional Plan partners to define six key priorities.

Priority 1: Ensure services support the diverse needs of consumers.

Priority 2: Ensure services and activities are developed to maximise accessibility.

Priority 3: Ensure consumers' physical and mental health care needs are addressed.

Priority 4: Establish a systematic and coordinated approach to suicide prevention that is region-wide.

Priority 5: Expand workforce training and support to ensure a consistently competent and empowered workforce.

Priority 6: Strengthen partnerships and embed governance models that promote cross-sector and catchment collaboration and planning.

The implementation phase of the Regional Plan is due to begin in January 2021. A phased approach to implementation will be undertaken due to the extent and complexity of the priorities and actions. This approach will allow the Regional Plan partners time to consult with key stakeholders, which will also support the development of the Comprehensive Service Development Plan (CDSP). This will supersede the Foundation Plan (this Regional Plan) in 2022.

Introduction

Through the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), all governments have committed to work together towards integrated service planning and delivery at a regional level.

This will be achieved through collaboration between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (also referred to as Victorian public hospitals and health services).

This Mental Health, Suicide Prevention, Alcohol and Other Drugs Regional Plan (the Plan) has been developed to address Priority 1 (the Foundation Plan) of the Fifth Plan:

Achieving integrated regional planning and services delivery will be approached with the development of two Regional Plans:

- **Foundation Plan: completed in December 2020**
- **Comprehensive Service Development Plan: due June 2022.**

The partners who have developed this Plan are Alfred Health, Monash Health, Peninsula Health and South-Eastern Melbourne Primary Health Network in consultation with the sector, stakeholders and local communities.

Service mapping, data collection and consultation with those who have lived experience, their families and carers and health professionals has been fundamental to understanding the gaps and inefficiencies within the system. Feedback from these consultations demonstrates the importance of working together and strengthening service integration, particularly for those with complex needs.

The Plan identifies service gaps, barriers and workforce shortages, and highlights the diverse needs of people in South-Eastern Melbourne.

The Plan has also been informed by:

- findings from the Royal Commission into Victoria's Mental Health System
- submissions from partner organisations
- a thematic analysis of key resources including the Royal Commission's into Victoria's Mental Health System Interim Report (2019), the Productivity Commission Mental Health Draft Report (2019), the VAGO Mental Health Access Report (2019), and policies such as Victoria's 10-year Mental Health Plan.

Six priority areas with specific goals and actions, unpinned by partnership and collaboration across the PHN, LHNs and the health sector, have been identified in the Plan (Part C).

A collaborative and phased approach to completing the activities has been defined for each priority area (Part D). Accountability and ongoing governance arrangements will support the Plan's implementation.

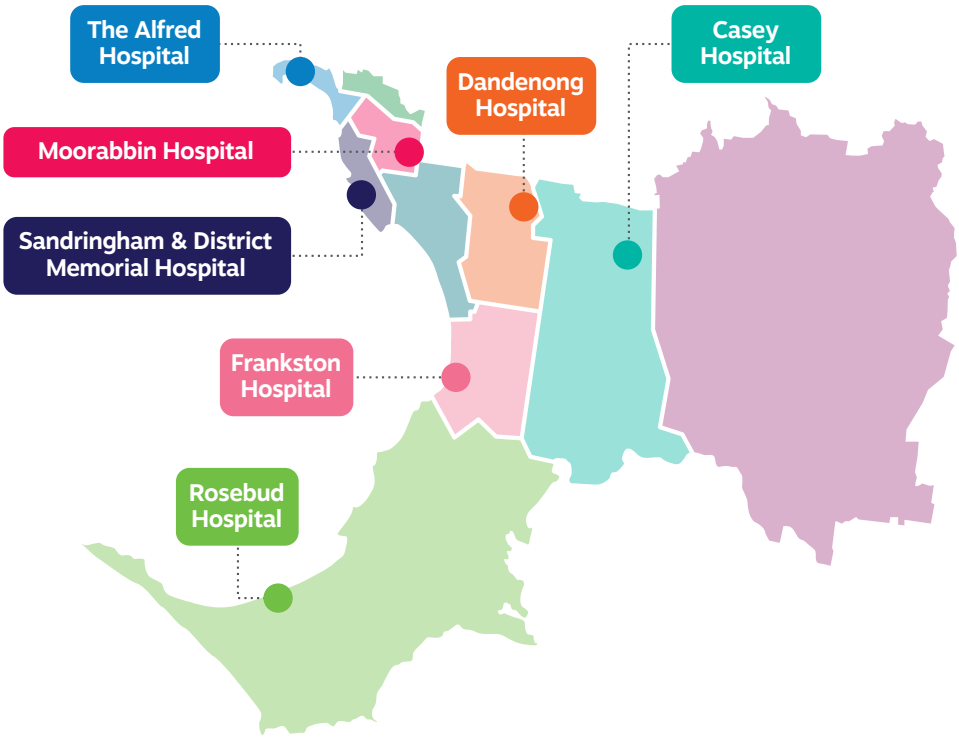
This Plan highlights a commitment to a more integrated approach to support individuals who may be falling through the gaps or have been affected by a fragmented system. By working together, the Regional Plan partners will continue to build on a more holistic approach to mental health, suicide prevention and AOD support in South-Eastern Melbourne.

Part A:

System and Context

Improving mental health, preventing suicide and reducing unhealthy alcohol and other drug consumption are priorities of State and Federal governments, health services and Primary Health Networks.

The Regional Plan partners recognise the importance of working together in the areas of prevention, diagnosis, treatment and recovery and are committed to working together at a regional level to support integrated service planning and delivery. Our work aims to improve the health, wellbeing and experiences of people living in South-Eastern Melbourne.



Policy and frameworks

Several policies, frameworks and strategies at State and Commonwealth level support the mental health, suicide prevention and AOD sectors (Figure 1). These documents guide service planning and development and provide the scope of clinical service delivery for organisations.

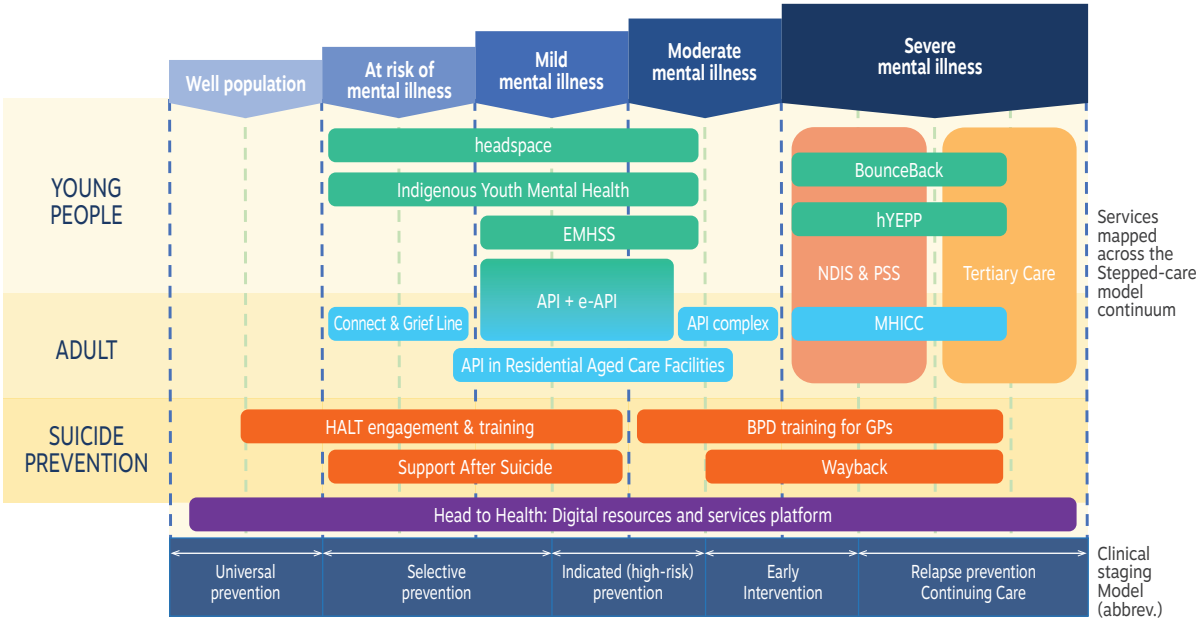
The need for strong governance structures to support the implementation of these guiding documents is essential. Challenges exist at State and Commonwealth level in defining appropriate governance structures and lines of accountability affecting the health of people, and this should be addressed urgently.[18]

Under the Fifth Plan, Federal, State and Territory governments agreed to share responsibility for improving mental health services.[19]

The Fifth Plan highlights a set of nationally agreed priority areas and indicators aiming to improve the lives of people with mental illness. The first objective of the Fifth Plan is the achievement of joint regional planning to improve integration of care pathways and reduce treatment entry thresholds.[20]

Figure 1: Related policies, frameworks and strategies
Refer to Appendix 1 for a full list of these documents.

Figure 2: Stepped model of care



API: Accessible Psychological Intervention; BPD: Borderline Personality Disorder; EMHSS: Enhancing Mental Health Supports in Schools; GP: General Practioner; HALT: Hope Assistance Local Tradies; hYEPP: headspace Youth Early Psychosis Program; MHICC: Mental Health Integrated Complex Care; NDIS: National Disability Insurance Scheme; PSS: Psychosocial Support Services.

Source: SEMPHN 2.

Mental health and suicide prevention service system

Commonwealth, State, community, private and jointly funded organisations provide care in a range of settings such as primary care, community, outpatient and inpatient environments. A range of non-clinical organisations support people's socio-environmental needs, including housing, education and welfare.

The Commonwealth has responsibility for delivering primary health care. The Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) provide subsidised treatment and supports for a wide range of health conditions – including mental illness, people at risk of suicide and people with AOD problems – delivered by general practitioners, psychiatrists, psychologists and other allied health practitioners.[21]

The stepped care model (Figure 2), on the opposite page, is an approach to the commissioning of mental health services for PHNs in Australia and supports joint regional mental health and suicide prevention service planning.[22]

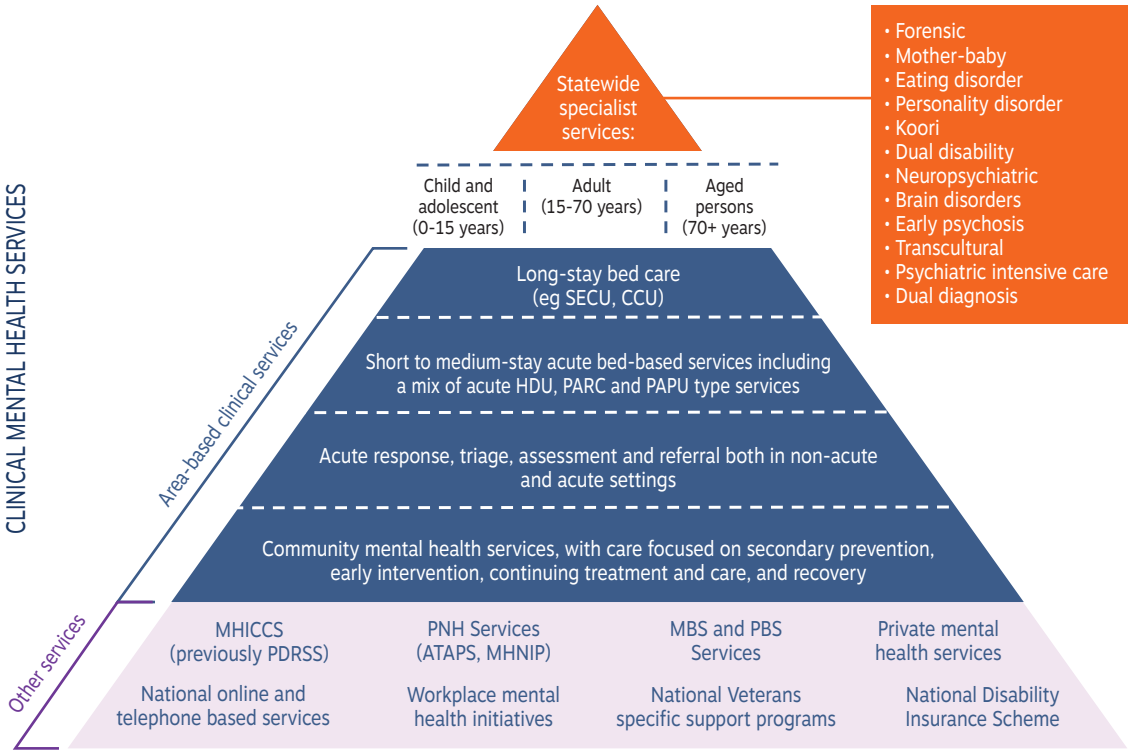
The model aims to match services to a person's needs from low intensity, early intervention services to specialised clinical care, where people with the highest need receive the highest level of care, with that person moving through the stepped care model as their needs change.

State and Territory governments are responsible for acute mental health care including clinical assessment, treatment, case management in the community and hospital inpatient settings (see Figure 3).[23]

The services people access and the services provided to them ought to vary depending on the person's need from time to time.

As shown in Table 1, the type of service needed will tend to vary depending on the severity of a person's mental illness. This highlights the importance of strong governance arrangements and an integrated health system.

Figure 3: Organisation of mental health services



Note: CCU = community care unit, SECU = secure extended care unit, HDU = high dependency unit, PARC = prevention and recovery care, PAPU = psychiatric assessment and planning unit, MHICSS = Mental Health Community Support Services, PHN = Primary Health Network, ATAPS = Access to Allied Psychological Services, MHNIP =m Mental Health Nurse Incentive Program, MBS = Medicare Benefits Schedule, PBS = Pharmaceutical Benefits Scheme.

Source: VAGO, based on Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, DHHS, 2017.

Table 1: Service needs, South-East Melbourne

Severity of illness	People living with a mental illness (%)	Approximate number of people living with a mental illness (n)	People requiring treatment (%)	Approximate number of people requiring treatment (n)	Primary government responsibility
Mild	9.0	142,000	50	66,400	Commonwealth
Moderate	4.6	72,700	80	53,900	State/ Commonwealth
Severe	3.1	49,000	100	45,500	State
Total (with a mental illness)	**16.7**	**263,700**	**-**	**165,800**	**-**

Source: Australian Government Department of Health, Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services, 2018.

Fragmentation of the current system

Victoria's mental health and suicide prevention systems are affected by multiple funding streams, misaligned boundaries and activity-based performance measures.

"The current health system in Australia is fragmented, making it difficult for people to get well-coordinated care. There is a complex split between the Commonwealth and State governments, and the not-for-profit and private sectors, regarding who is responsible for planning, funding and delivering different services".[24]

The lack of sufficient access to low and moderate intensity programs has led to the mental health system often being crisis-driven and focusing heavily on acute inpatient care. There needs to be sufficient investment to ensure availability of services across the stepped care model.

There are people living with moderate to severe mental illness who are not accessing State-funded mental health services. Some people who are living with moderate to severe illness require more specialised treatment than is available in primary care but are not yet acutely or severely unwell enough to meet the eligibility criteria for State-funded mental health services.[26]

"Navigating different systems is complex for anyone, and more so for someone who is experiencing mental illness and does not have a stable home. Poor coordination between different service systems can contribute to persistent homelessness and illness."[25]

- Consumer

This group of people is often referred to as the 'missing middle'. They experience combinations of moderate and complex mental illness, issues with alcohol and other drugs, comorbid physical conditions and other social issues, and are at risk of falling through the service gaps within the health system.[27]

Evidence suggests that the Better Access Initiative could improve its targeting mechanisms to ensure consumers are accessing services that are most appropriate for their needs.[28] It is estimated that more than one-third of people who access MBS-rebated individual psychological therapy (including through headspace centres) could have their treatment needs equally well met through services that are of lower intensity and offer the consumer a lower treatment burden (in terms of time and cost).[29]

An uneven distribution of the mental health workforce, including workforce shortages, affects the region's capacity to meet the increasing demand for mental health services. Gaps in the workforce reduce access to services for some consumers and make it challenging for the health sector to respond to disasters or emergencies when demand for services increases significantly, e.g. bushfires. Inadequate workforce capacity further contributes to disjointed service delivery.

"Overwhelmingly the mental health system failed to support the person who was suffering mental illness and it failed to support us, the parents and caregivers." [30]

- Carer

System reform

It is widely recognised that system reform is needed to support and improve health outcomes for people living with mental illness, at risk of or bereaved by suicide, or consuming alcohol or other drugs at harmful levels, their families, carers and the community.

The Productivity Commission's Mental Health Draft Report (2019)[33] and the Royal Commission into Victoria's Mental Health System Interim Report (2019)[34] are important system-wide reviews underway that will recommend improvements to our mental health system.

Findings in the draft and interim reports have informed the development of this Plan. It is noted that recommendations identified in the final reports may result in future system changes, which may influence the direction of the Comprehensive Service Development Plan and implementation of the Foundation (Regional) Plan priorities.

"Services are too insular, don't communicate effectively with clinicians, impacting on consumers' wellbeing: 'When I have to keep repeating everything that's crap in my life, it feels like no one is listening and no one cares'." [31]

- Consumer

The need for regional planning

Enhancing regional planning and integration of mental health services, suicide supports and AOD services are fundamental to achieving the recommendations in the Fifth Plan.

LHNs and PHNs support the needs of many people in South-Eastern Melbourne. However, the complexity of the system makes it difficult for people to navigate and leads to some falling through service gaps. A whole-of-system approach is needed to better support collaboration between mental health service providers to improve consumer health.

The Regional Plan partners have worked together to identify priority areas in mental health, suicide prevention and AOD with a commitment to improving service delivery through joint planning and implementation.

"The strengthening of the mental health workforce is the key to a responsive system." [32]

- Workforce

ABOUT us

Population 2018

Victoria	SEMPHN	Casey	Bayside
6,460,675	1,582,258	340,419	105,718

Planning (adapted from). Land use and population research (online).
At: https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future/tab-pages/victoria-in-future-data-tables

Projected growth 2020-2025

Victoria	SEMPHN	Cardinia	Bayside
1.7%	13.73%	18.95%	4.40%

Planning (adapted from). Land use and population research (online).
At: https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future/tab-pages/victoria-in-future-data-tables

Aboriginal and Torres Strait Islander people

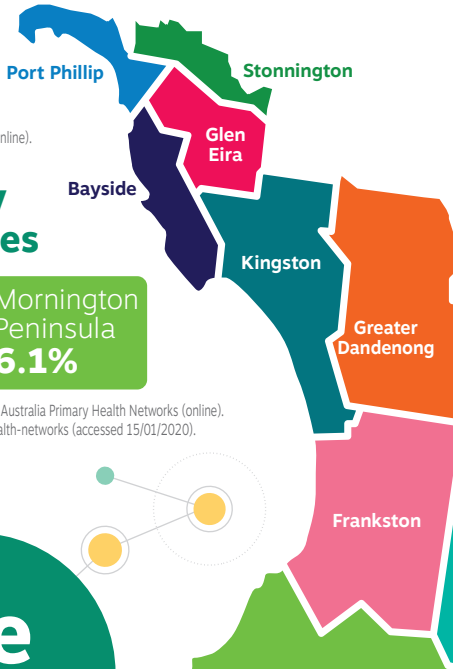
Victoria	SEMPHN	Frankston	Bayside
0.8%	0.5%	1.0%	0.2%

Total population who are Aboriginal or Torres Strait Islanders by LGA, 2016. PHIDU. Social Health atlas of Australia Primary Health Networks (online).
At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 15/01/2020).

People born in predominantly non-English speaking countries

Victoria	SEMPHN	Greater Dandenong	Mornington Peninsula
22.0%	23.8%	54.2%	6.1%

People born in predominantly non-English speaking countries (%) 2016. PHIDU. Social Health atlas of Australia Primary Health Networks (online).
At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 15/01/2020).



we EXPERIENCE

Highly disadvantaged areas

Victoria	SEMPHN	Greater Dandenong	Glen Eira
20%	18.7%	76.7%	0%

Health.vic. Southern Melbourne Area Profiles (online). At: https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future/tab-pages/victoria-in-future-data-tables (accessed 15/01/2020).

Social isolation

Victoria	SEMPHN	Greater Dandenong	Bayside
17.3%	17.6%	25.9%	8.5%

Victorian Population Health Survey 2014: Quick statistics at local government area (online). At: https://www2.health.vic.gov.au/Api/downloadmedia/%7B471B15DC-0712-4BD7-B89F-C67F18D735AA%7D.

Homelessness

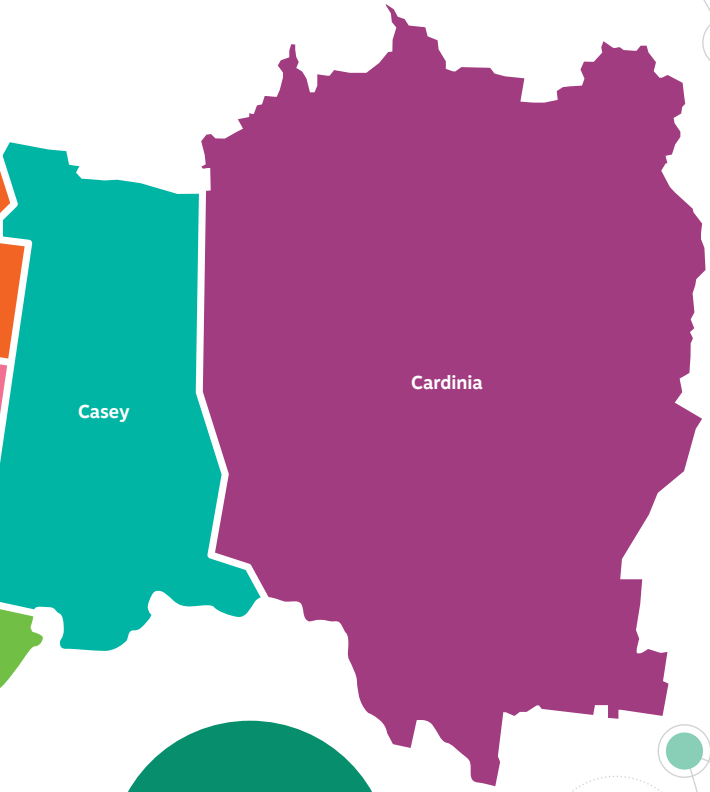
Victoria	SEMPHN	Port Phillip	Cardinia
400	460	1,530	170

Rate per 100,000 population. Homelessness rate by LGA, 2015. DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online).
At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017).

A SNAPSHOT OF

South-East Melbourne

Mental health and suicide prevention risk factors in South-East Melbourne.



Suicide & self-harm

Victoria	SEMPHN	Frankston	Greater Dandenong
10.1	10.1	14.8	7.3

Deaths from suicide and self-inflicted injuries, persons aged 0 to 74 years (Average annual ASR per 100,000) 2013-2017. PHIDU. Social Health atlas of Australia Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 15/01/2020).

Overnight hospitalisations

INTENTIONAL SELF-HARM

Victoria	SEMPHN	Frankston	Glen Eira
99.1[16]	127.6	262.3	74.9

Rates per 100,000. Admissions for intentional self-harm 2016/2017. VAED Victorian Admitted Episode Database accessed 13-05-2020.

MENTAL HEALTH RELATED

Victoria	SEMPHN	Frankston	Stonnington
833.0	963.6	1,345.8	608.5

ASR per 100,000. Admissions for mental health related conditions – public hospitals 2017/18. PHIDU. Social Health atlas of Australia Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 15/01/2020).

THAT CAN **lead to**

Psychological distress

Victoria	SEMPHN	Greater Dandenong	Bayside
13,300	13,100	17,400	9,100

ASR/100,000. People aged 18 years and over with high or very high psychological distress by LGA (2017-2018). PHIDU. Social Health atlas of Australia Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 15/01/2020).

Mental health and behavioural problems

Victoria	SEMPHN	Frankston	Greater Dandenong
20,000	20,200	25,700	16,200

ASR per 100,000. Estimated number of people with mental and behavioural problems, by LGA. 2017-2018. PHIDU. Social Health atlas of Australia Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/ data#social-health-atlas-of-australia-primary-health-networks (accessed 15/01/2020).

Part B:

Understanding the Needs of the Community

More than 1.6 million people call South-Eastern Melbourne home. The region includes 10 local government areas (LGAs):

- City of Bayside (Bayside)
- Cardinia Shire Council (Cardinia)
- City of Casey (Casey)
- City of Glen Eira (Glen Eira)
- City of Greater Dandenong (Greater Dandenong)
- City of Frankston (Frankston)
- Mornington Peninsula Shire (Mornington Peninsula)
- City of Port Phillip (Port Phillip)
- City of Stonnington (Stonnington).

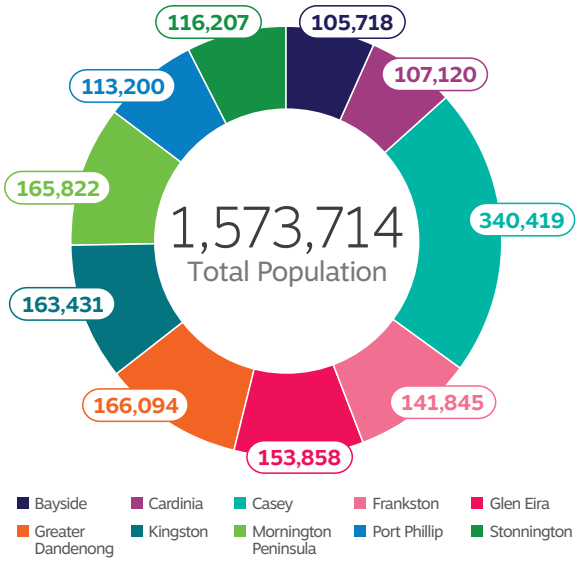
Understanding the needs of our region is an important step in being able to develop and deliver services to support people's needs. Consultation with those with a lived experience, carers and health care providers was undertaken to help identify community needs that underpin development of the Plan (Appendix 2).

Around 9000 Aboriginal and Torres Strait Islander people live in South-Eastern Melbourne. The largest number live in Casey (1941), Frankston (1640) and the Mornington Peninsula (1618).[35]

In South-Eastern Melbourne:[36]

- 468,000 people (33%) were born overseas, compared with 28% in Victoria
- 342,000 people (24%) were born in a non-English speaking country
- 51,000 people (3.8%) have low English proficiency.

2020 Population



Life stressors and social determinants affecting several populations in the region:[37]

- Financial stress: Greater Dandenong has the highest proportion of people unemployed in the catchment and highest rates of gaming machine losses. The highest rates of mortgage and rental stress were observed in Casey.
- Unemployment: As of June 2017, 39,860 people received unemployment benefits in South-Eastern Melbourne. Of these, 70% are from Casey, Frankston, Greater Dandenong and Mornington Peninsula.
- Homelessness: In 2019 there were 6916 people classified as homeless in the region. Greater Dandenong, Port Phillip and Casey had the highest number of people experiencing homelessness.
- School retention and education: Participation in higher education is lowest in Mornington Peninsula, Cardinia and Frankston.
- Psychological distress: 157,641 people living in the region experience high or very high levels of psychological distress.
- Social connection: 17% of people in the region experience high or very high social isolation. Residents of Greater Dandenong (26%) and Casey (21%) have the highest reported rates of isolation.
- Life satisfaction: people living in Casey are most likely to be dissatisfied or very dissatisfied with life (10.4%), followed by Frankston (9.1%)
- People living with disability: The highest number of people with a profound or severe disability who live in the community reside in Casey (14,068) and Greater Dandenong (9632).
- "Social and emotional wellbeing is the foundation for physical and mental health for Indigenous Australians."[38] However, the Aboriginal and Torres Strait Islanders are more than twice as likely to smoke, 1.2 times more likely to be obese, eat fewer fruits and vegetables and are three times more likely to report high or very high levels of psychological distress than non-Indigenous people.[39]

Many of these are expected to have significantly worsened as a result of the COVID-19 pandemic.

Note: For further information and a breakdown of life stressors and social determinants in the region refer to Our Community and their Needs on pages 24-25.

Our Community and their Needs

Life Stressors and Social Determinants

Port Phillip

DEMOGRAPHIC RISK
- Highest proportion of women with fair or poor self-reported health (64.0%)

RISK FACTOR
- Highest number of ambulance attendances for alcohol, illicit drugs and methamphetamine (810, 603.4, 11.2 respectively per 10,000)

OUTCOME
- High admissions for illicit substance (70.2 people per 10,000)

Stonnington

DEMOGRAPHIC RISK
- High socioeconomic status (IRSD 1087)

RISK FACTOR
- High number of people who consumed 2 or more standard drinks per day (18.6 per 100)

OUTCOME
- High number of people living with anxiety or depression (25.2%)

Glen Eira

DEMOGRAPHIC RISK
- 9.5% of people migrated from China or India

RISK FACTOR
- 61.2% overweight or obese

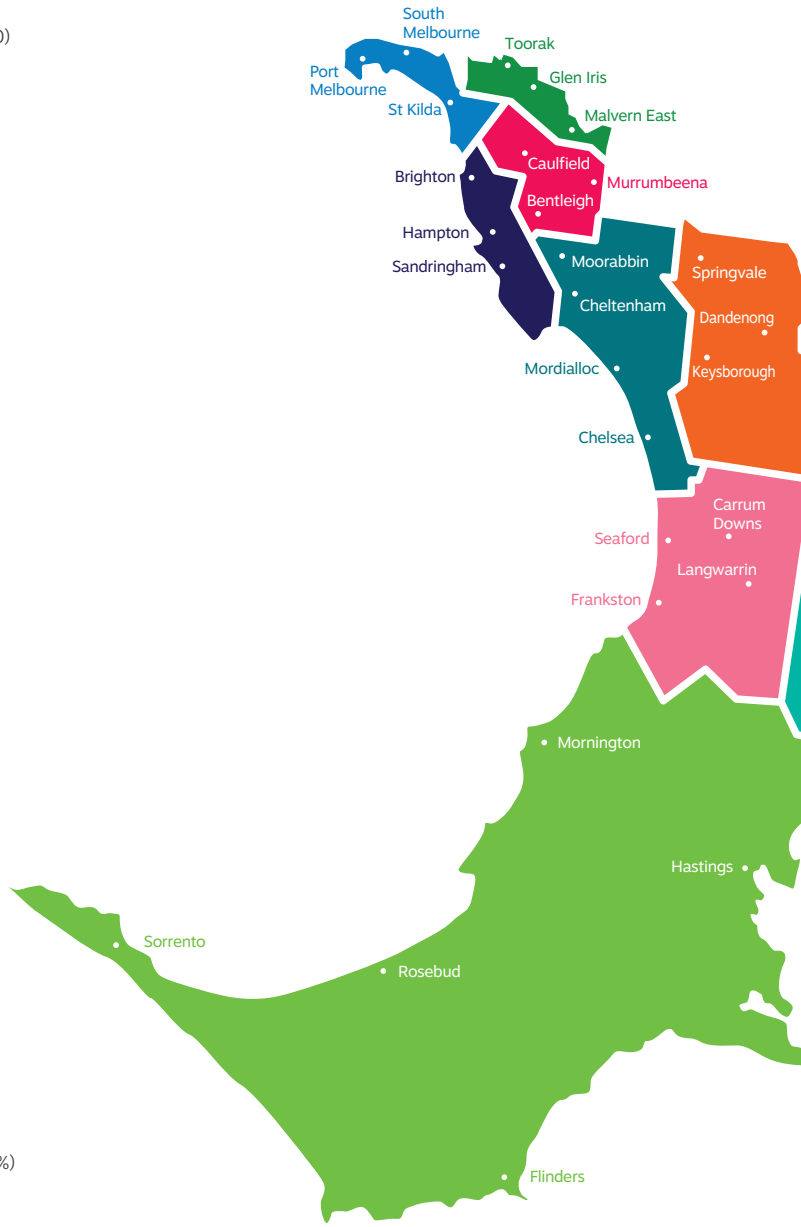
OUTCOME
- Highest rate of admissions for mental health conditions (261.0 ASR per 10,000)
- Lowest proportion of men who have high or very high psychological distress (8.5%)
- Highest number of people being seen by a psychiatrist or clinical psychologist (3,932/4,576)

Bayside

DEMOGRAPHIC RISK
- Highest socioeconomic status (IRSD 1097)

RISK FACTOR
- High percentage of people who are overweight or obese (60.9%)

OUTCOME
- Highest rates of hospital admissions for alcohol (119.3 per 10,000 people)
- High rate of hospitalisations for intentional self-harm (98 per 100,000)



Source: PHIDU PHN data - with component LGAs

Greater Dandenong

DEMOGRAPHIC RISK
- Highest proportion of low income households (51.8%)
- Highest number of people experiencing homelessness (1,942)
- Highest number of people born overseas who do not speak English well, if at all (20,995)

RISK FACTOR
- High unemployment (9.4%)
- Highest proportion of people with high or very high social isolation (25.5%)
- Highest proportion of people with fair or poor self-assessed health (17.5 ASR per 100)

OUTCOME
- Lowest number of people living with mental or behavioural problems who were employed (6.9 ASR per 100)
- Highest rate of overnight hospitalisations for schizophrenia and delusional disorders (752 per 10,000)
- Highest proportion of people with high or very high psychological distress (24 ASR per 100)

Kingston

DEMOGRAPHIC RISK
- High number of 0-14 year olds (17%)
- Least number of people who can get help from friends (75.5%)

RISK FACTOR
- $668 Gambling losses / person
- Lowest proportion of people with high or very high psychological distress (20.0%)

OUTCOME
- High percentage of people who have at least one chronic condition (41.9%)

Casey

DEMOGRAPHIC RISK
- 22.9% 0-14 years old
- Highest number of people who left school at Year 10 or below, or did not go to school (66,264 people)

RISK FACTOR
- High unemployment (7%)
- High psych distress (15.4 per 100 people ASR)
- High levels of people being dissatisfied or very dissatisfied with life (10.4%)

OUTCOME
- Highest number of people with mental or behavioural problems (58,650)

Cardinia

DEMOGRAPHIC RISK
- Area with the most young people aged 0 to 14 years (23.2%)
- Highest population growth rate (4.4% annual growth rate)

RISK FACTOR
- Highest number of people who are obese (36.7 per 100)

OUTCOME
- Highest rates of overnight hospitalisations for depressive disorders (194 per 100,000)

Mornington Peninsula

DEMOGRAPHIC RISK
- Highest proportion of people aged 65 and over (24.4%)

RISK FACTOR
- High number of people who consumed 2 or more standard drinks per day (21.3 per 100)
- Highest proportion of women with a low or medium feeling of life being worthwhile (21.4%)

OUTCOME
- Highest number of 4-11 year olds with mental disorders (14.7%)
- Highest number of people who received a mental-health related prescription (45,907)

Frankston

DEMOGRAPHIC RISK
- High percentage of single parent families with children <15 years of age (24.5%)

RISK FACTOR
- Highest number of ambulance attendances for opioids (39.4 per 10,000 people)
- Area with the highest number of definite or possible alcohol related family violence (36.7 per 10,000)

OUTCOME
- Highest levels of people living with mental and behavioural problems (25.7 ASR per 100)
- 45% of women have anxiety or depression

Mental illness

In 2017-18 about 310,000 people in the region had a mental illness and/or behavioural concerns, including 30,000 people aged 4 to 17 years.[40] Within the region, Frankston has the highest proportion of residents living with mental illness (25.7%), followed by Port Phillip (23.7%) and the Mornington Peninsula (21.7%).[41]

From 2009 to 2018 the number of people in Australia receiving Medicare-subsidised mental health services almost doubled from 5.7% to 10.2%.[42]

Mental illness and substance use account for almost one-quarter of the non-fatal burden of disease in Australia, which is a measure of the number of years of 'healthy' life lost due to living with a disability.[43]

"The cost to the Australian economy of mental illness and suicide is, conservatively, in the order of $43 to $51 billion per year or around $2 billion to $2.5 billion in South-Eastern Melbourne."[44]

In 2017-18, 20% of the people who lived in the region had a mental illness and/or behavioural problems.[40]

Modifiable risk factors

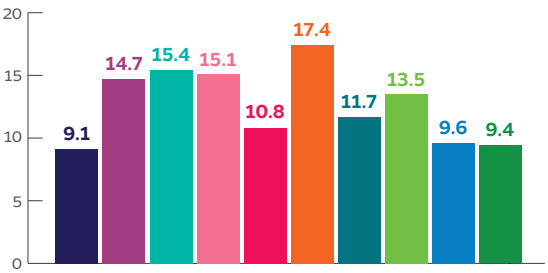
People living with mental illness can experience symptoms such as decreased motivation, lethargy and cognitive impairment. These symptoms can lead to behaviours that are not supportive of good physical health.

Modifiable risk factors are more common in people with mental illness in South-Eastern Melbourne.

- Limited or no physical activity plays a role in the development of chronic disease yet people experiencing mental illness are less likely to be active.[45]
- Just over 20% of people with a self-reported mental health condition smoke tobacco daily compared with 9.9% of people who do not report mental illness.[46]
- People are more likely to report harmful consumption of alcohol compared with the general population, with 15% of males and 10% of females consuming alcohol at risky levels.[47]
- Experience of a mental health problem may also be associated with a poorer-quality diet.[48]

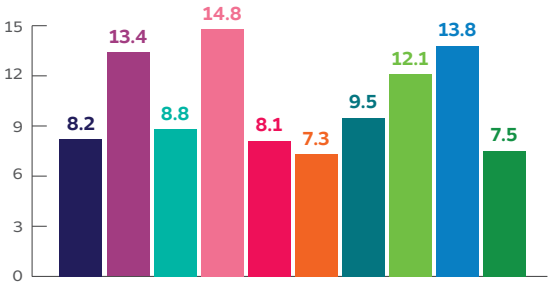
High or very high psychological distress

(ASR per 100)



Suicide Rate from 2013 to 2017

Deaths from suicide and self-inflicted injuries, persons aged 0 to 74 years (Average annual ASR per 100,000)



Co-occurring illness

Mental illness is associated with a higher prevalence of chronic conditions such as diabetes, cardiovascular disease and alcohol and other drugs (AOD) use.[49] People with mental illness have a lower life expectancy compared with the general population, with the main cause attributed to physical illness.[50] People with severe mental illness and a co-occurring physical illness can live up to 25 years less than the general population.[51]

Between 30% and 50% of people living with a disability have co-occurring mental illness, much higher than the 24% of the general population who are diagnosed with mental illness.[52]

Services to support mental health recovery

Like other health conditions, mental illness has different levels of severity ranging from mild to severe.[53]

The types of support and duration of support for people living with a mental illness will increase with the severity of the mental illness. As seen in Table 3, the service need, intervention and elements will increase with the increase in mental illness severity.

Table 3: Service need according to severity of mental illness

Intervention type	Early intervention	Mild mental illness	Moderate mental illness	Severe episodic mental illness	Severe persistent mental illness
Estimated population prevalence	23.1% of population	9% of population	4.6% of population	2% of population	1.1% of population
	Around 365,400 people	Around 142,000 people	Around 72,700 people	Around 49,000 people	
Service need	24% need some services	50% need some services	80% need some services	100% need some services	100% need some services
Service intervention required	Self-management	Low intensity care	Moderate intensity care	High intensity care	Complex care
Service elements	Self-help information and resources	• GP • Clinician-supported online treatment • Group therapy	Mix of GP and MBS-related psychological treatment	• Clinical care using a combination of GP care, psychiatrists, mental health nurses and allied health • Psychiatric care • Single care plan and care team	• Clinical care using a combination of GP care, psychiatrists, mental health nurses and allied health • Care coordinator • Inpatient services • Psychosocial supports • Single care plan and care team
Non-health supports • Income • Housing • Disability • Aged care services • Justice services • Prevention and early detection/intervention (outside of health) • Education and training • Employment services • Cultural services					

Source: Australian Government Department of Health, Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services, 2018 and Regional Plan Project Group Analysis.

Mental health service demand

- There has been a significant increase in mental health-related emergency department presentations, with public hospitals in South-Eastern Melbourne seeing year-on-year increases in patients with mental and behavioural disorders averaging more than 5% a year from 2013 to 2019.[54]
- Unplanned readmission for adult mental health patients is 14.5%.[55]
- Acute hospital admissions have increased at an annual rate of 2.4%.[56]
- A Victorian Auditor-General's Office report, Access to Mental Health Services, identifies a small increase in the number of people accessing public mental health services (around 2% per year), but only a marginal increase in the proportion of people receiving care (Table 4).[57]

Primary care providers and mental health professionals delivered more than 1.1 million services to people living in South-Eastern Melbourne in 2016-17[58] and in 2017-18 there were more than 32,000 admissions to hospital for mental health-related conditions.[59]

Barriers to mental health service access

The SEMPHN Needs Assessment Stakeholder Survey (2016), completed by service providers and their clients in the region, highlights several major obstacles to accessing services:[60]

- lack of affordable medical services (69%)
- lack of awareness of existing services (61%)
- lack of affordable transport (59%)
- shortage of allied health services (52%)
- gaps in health literacy (50%)
- distance to health care services (42%)
- lack of available after-hours appointments (35%)
- poor past experiences (35%)
- lack of available appointments (30%)
- shortage of culturally appropriate services (21%)
- shortage of GPs (19%)
- concerns related to privacy (19%)
- shortage of Aboriginal health workers (14%)
- lack of accommodation during treatment (14%)
- communication difficulties (e.g. experiences of people with hearing or intellectual disabilities) (11%).

The major challenges to providing services identified by service providers were:

- inadequate training (56.8%)
- inadequate staffing (52.9%)
- lack of standard guidelines on treatment (23.5%)
- language barriers (7.8%).

Table 4: Alternative indicators of mental health service

Consultation	2014-15	2015-16	2016-17	2017-18
Community service contacts (number)	2,058,909	1,935,262	1,675,772	2,407,730
Community service contacts (hours)	1,011,396	971,965	881,950	1,288,028
Total numbers of people accessing clinical mental health services	67,030	67,559	66,487	72 859
Proportion of population receiving clinical care	1.13%	1.12%	1.08%	1.16%

Source: Access to Mental Health Services, March 2019, Victorian Auditor-General's Office.

Suicide and self-harm

Suicide is the leading cause of death for people living in Australia aged 15–44 years and accounts for about one-third of deaths among people aged 15–24.[61] Despite ongoing efforts to make suicide prevention more effective, there has been no significant or sustained reduction in the death rate from suicide over the past decade.[62]

Between 2013 and 2017, more than 700 people died by suicide in South-Eastern Melbourne.[63] Port Phillip, Frankston, Cardinia and the Mornington Peninsula LGAs have higher-than-average rates of suicide deaths, attempts and/or ideation.[64,65]

For every death by suicide, as many as 30 people attempt suicide and are hospitalised due to intentional self-harm.[66] Sixty per cent of people who die by suicide have not disclosed their suicidal ideation previously.[67] Being exposed to the grief and shock of a suicide death can increase a person's suicide risk.

Up to 25% of people who attempt suicide will re-attempt, with the risk being significantly higher during the first three months following discharge from hospital after an attempt.[68] Half of those discharged from hospital after a suicide attempt do not attend follow-up treatment and responsibility and accountability for follow-up is unclear and inconsistent.[69]

Some individuals and groups may be more at risk of suicide than the general population (general population averages), including:[70]

- Aboriginal and Torres Strait Islander people, particularly young people (more than double that of the non-Indigenous population)
- people experiencing homelessness (twice the risk of the general population)
- men
- young people aged 12 to 25
- the LGBTQIA+ population.

People living in residential aged care facilities (RACF) are more than three times more likely to experience suicidal thoughts (46%) than the rate in older adults who are housebound but living in the community.[71]

Suicide and self-harm service demand

Port Philip has the highest length of stay in hospital for intentional self-harm (7.2 days, 1.6 times greater than SEMPHN average) and Frankston has high rates of hospitalisation for intentional self-harm (166 per 100,000 age standardised rate (ASR), 1.8 times greater than the SEMPHN average).[72]

Barriers to accessing suicide prevention services

There are several barriers to people accessing suicide prevention supports, including:

- stigma about suicide, which deters people from reaching out, having conversations and seeking help[73]
- some groups, such as older men, are reluctant to engage with health professionals[74]
- suicidal ideation or suicidality being treated as an acute issue with the person being taken to an emergency department (ED); however, this can cause more harm[75]
- "There are a large number of people presenting to EDs with depression and suicidal ideation at our access points, yet a large proportion are not able to access treatment and care."[76]

"My son wasn't deemed suicidal enough to be admitted to ED, despite his long history of mental health issues, so he was turned away. An hour later he took his own life."[77]

- Parent

Alcohol and other drugs (AOD)

Harm from drug use affects individuals, their families and the community more broadly. Risk factors for harm related to AOD include:[78]

- family history of addiction
- mental illness
- peer pressure, especially in young people
- lack of family involvement
- using alcohol and other drugs at an early age
- using a highly addictive drug such as cocaine or opioids
- living in areas of socioeconomic disadvantage where there are increased rates of unemployment, poor support systems and low rates of school retention
- a lack of housing.[79]

Up to 50% of people with severe mental health problems experience co-occurring substance abuse (dual diagnosis) and often need treatment or support for both issues.[80] The number of people with a dual mental health/AOD diagnosis is increasing; more than half of the people admitted to hospital for an AOD disorder also have a mental illness.[81] "Compared with the general population, people using specialist mental health services are 14 times more likely to use AOD services."[82]

AOD service demand

Bayside and Port Phillip had the highest number of hospital admissions for alcohol in 2016-17 at 119.3 per 10,000 people and 112.5 admissions per 10,000 people, respectively.[83]

There are high numbers of people living with AOD problems in psychosocially disadvantaged communities. Across the region in 2017-18, there were more than 450 alcohol-related ambulance callouts per 10,000 people.[84] Port Phillip and Frankston had the highest number of ambulance attendances for methamphetamines (11.2 per 10,000 people and 9.4 per 10,000 people, respectively).[85] Frankston and Cardinia had the highest rates of people requiring an ambulance for opiates (39.4 per 10,000 people and 31.8 per 10,000 people, respectively).[86]

Bayside and Port Phillip had the highest rates of admissions for opioids (27.5 admissions per 10,000 people for both LGAs).[87] The highest number of admissions for illicit drugs were in Port Phillip and Frankston, 70.2 admissions per 10,000 people and 62.7 admissions per 10,000 people, respectively.[88]

Barriers to AOD service access

Barriers to service access include:[89]

- location and access to services
- poor health literacy
- limited appointment availability
- challenges to service provision identified by stakeholders include inadequate training, staffing and treatment standards.

Community diversity

Health disparities are apparent within some population groups in the region. Age, language barriers, cultural differences and religious beliefs, stigma, discrimination, socioeconomic disadvantage and intergenerational trauma shape people's identities and experiences.

People who identify as Aboriginal and Torres Strait Islander, LGBTQIA+, culturally and linguistically diverse, and refugees and people seeking asylum experience poorer health outcomes compared with the general population.[90]

Diversity in age groups

The health and wellbeing of children, youth and older people who live in South-Eastern Melbourne are a priority for the Regional Plan partners. Risks to mental health begin before birth and can develop at different points in a person's life.

Children and young people

There are important links between children and young people's family systems and their mental health.[91] Risk factors include exposure to toxins during foetal development, poverty and social disadvantage, sexual, physical and emotional abuse or neglect, family conflict, academic failure, death of a family member, bullying, discrimination and marginalisation.[92]

Three quarters of all mental health problems manifest in people under the age of 25.[93] One in four Australians aged 16–24 years will experience mental health problems in any given year,[94] while 2.1% of Australian children and adolescents have a severe mental health problem and a further 3.5% have a moderate mental health problem.[95] Suicide remains the leading cause of death for young Australians.[96] One in 10 Australian adolescents (10.9%) have deliberately injured themselves and each year one in 40 (2.4%) attempt suicide.[97]

Mental illness in young people is "associated with impaired academic achievement, unemployment, poor social functioning and substance abuse".[98] In 2015, about 13% of Australians aged 4 to 11 years old experienced mental illness.[99]

Prevention and early intervention are important at this age to improve future outcomes. The complexity of services required by youth across various health and social disciplines demands effective and efficient collaboration and coordination of care by service providers.

Older people

"Between 2010 and 2050 it is estimated that the number of people aged 65 to 84 years will double and those aged 85 and over will quadruple."[100]

Older Australians are at an increased risk of mental illness due to a range of factors such as loss of independence, bereavement, change in socioeconomic status due to retirement or disability, loneliness and elder abuse.[101] Being socially isolated can negatively affect people's mental and physical health. Given 10% of people aged 60+ in Victoria experience chronic loneliness, this is of increasing concern.[102]

More than 50% of people in residential aged care facilities have depression, compared with 10-15% of adults of the same age living in the community.[103] Depression is three to four times more common in people with dementia compared with older people without dementia.[104] Substance use and co-occurring illness is also an issue.

Barriers to service access for older people include:

- unwillingness to disclose problems leading to delay in seeking professional help
- inability to access support provided online
- cognitive problems, including memory loss or dementia
- ageism and stereotyping by health professionals
- transport, mobility, hearing or language difficulties
- being a carer for a spouse or family members.

Alcohol problems ARE **3–4 times** MORE COMMON IN **older people with depression**[194]

Aboriginal and Torres Strait Islander people

"Aboriginal and Torres Strait Islander adults are almost three times more likely to experience high or very high levels of psychological distress than the general population".[105] Aboriginal and Torres Strait Islander people are hospitalised for mental health and behavioural disorders at almost twice the rate of non-Indigenous people and have more than twice the rate of suicide than that of other Australians, but have "lower than expected access to mental health services and professionals".[106]

The use of health services by Aboriginal and Torres Strait Islander people has increased, but access to healthcare is still very limited.

In 2011, almost 20% of the disease burden for Aboriginal and Torres Strait Islander people was caused by mental illness and AOD.[107]

In Australia, the rate of suicide for Aboriginal and Torres Strait people is 24 deaths per 100,000, compared with 11.2 per 100,000 for non-Indigenous people.[108] Factors that affect Aboriginal and Torres Strait Islander health include:[109]

- intergenerational trauma
- unemployment
- social and economic disadvantage
- cultural disconnection
- stressors such as substandard housing, poverty, physical ill health, trauma, abuse and loss.

Figure 4: Psychological distress in Aboriginal and Torres Strait Islander people (n.d)

Source: Productivity Commission Mental Health Draft Report Volume 1, p.5, 2020.

LGBTQIA+ people

Compared with the general population, LGBTQIA+ people are more likely to experience and be diagnosed with a mental illness.[110] Key health issues experienced by the LGBTQIA+ community are:

- homophobia and discrimination
- illicit drug use
- sexual health issues
- homelessness
- anxiety disorders
- depression: Gender diverse and transgender young people are more likely to experience significant depressive symptoms compared with cisgender young people[111]
- suicide attempts: Compared with the general population, LGBTQIA+ young people are five times more likely to attempt suicide and transgender adults are 11 times more likely to attempt suicide.[112]

Barriers to service access for LGBTQIA+ people include:[113]

- homophobia from health professionals
- delay seeking treatment due to expectations they will face discrimination or receive reduced quality of care
- reluctance to having their sexuality recorded in their medical history due to the fear that others may gain access to their records.

People from culturally and linguistically diverse (CALD) communities

In South-Eastern Melbourne, a large proportion of people from CALD backgrounds live in Greater Dandenong and Casey. Greater Dandenong has the greatest number of people (20,995) born overseas who speak English not well or not at all.[114]

Several factors contribute to increased risk of mental illness in CALD communities:[115]

- low proficiency in English
- low levels of health literacy
- disconnection from family
- racism and discrimination
- stress of migration and adjustment to new country
- limited opportunity to use occupational skills.

The health system is not designed to support the diverse needs of people from CALD backgrounds.[116] This is shown by mainstream services being under-utilised by the CALD community.[117]

Refugees and people seeking asylum

As well as the factors that increase the risk of mental illness in the CALD community, a range of factors can contribute to additional risk for refugees and people seeking asylum, including:[118]

- torture and trauma
- isolation
- fear of family persecution in their home country
- food insecurity
- unemployment
- legal issues
- financial stress
- uncertainty with visas and assessment waiting periods.

All these factors contribute to raised levels of psychological distress and suicide risk. Understanding the unique and specific needs of refugees is critical to providing appropriate treatment that supports their health and wellbeing. Mental health workers need to be culturally aware and practise cultural safety to minimise distress for people needing treatment for mental illness.[119]

Service utilisation and gaps

In South-Eastern Melbourne, 65% of people with a mental illness were provided with care by a GP, psychologist or psychiatrist,[120] yet 35% are not accessing mental health services.[121]

The region's key mental health service system strengths include good coverage of high-intensity residential rehabilitation and acute inpatient care and strong levels of mobile care for acute health-related and non-acute health outpatient care.[122]

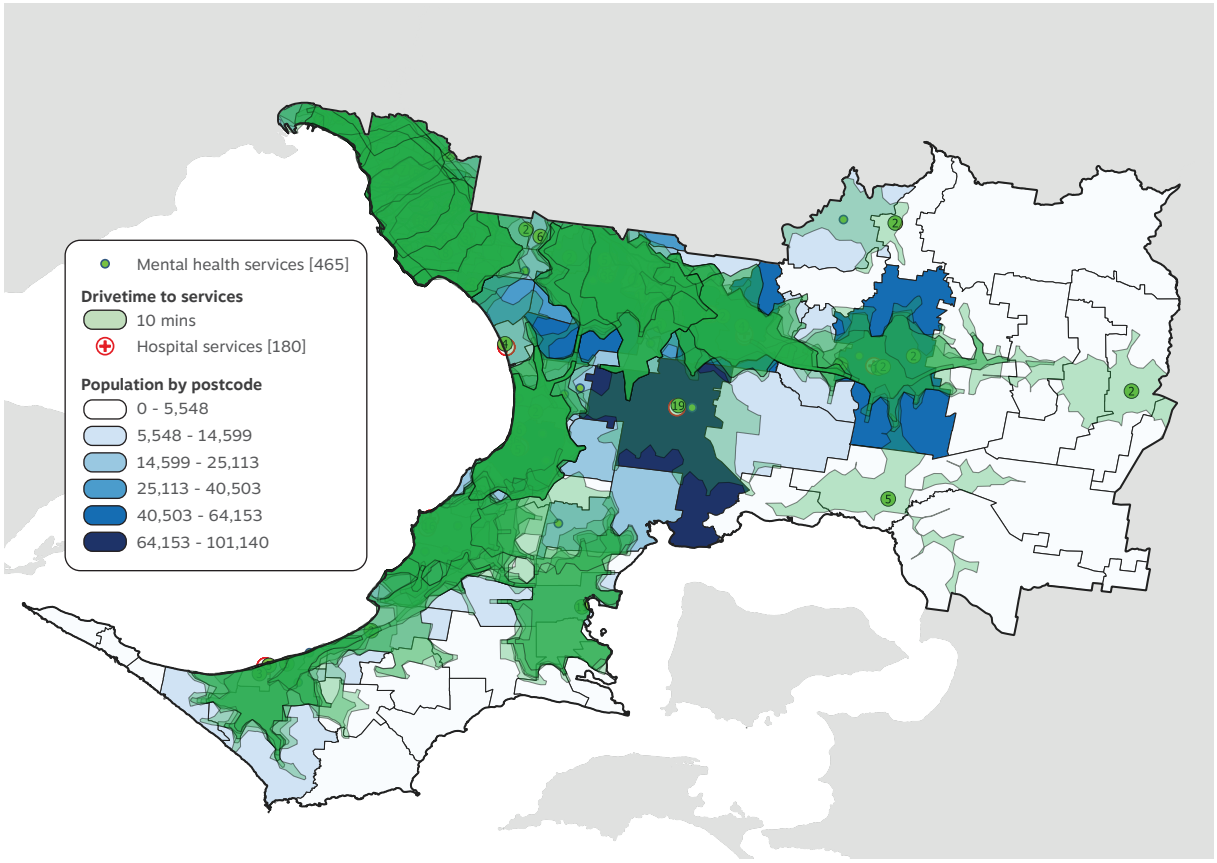
Service mapping of the region shows that most mental health services (Figure 5, below) are located in inner-city postcodes and are more evenly spread out among these. Further away from the CBD, they tend to cluster around the major suburban centres of Dandenong, Cranbourne, Pakenham and Frankston, with fewer services in the Mornington Peninsula and Cardinia. This aligns to South-Eastern Melbourne workforce data, which shows that mental health professionals are available in higher numbers and in greater capacity in LGAs that are closer to the CBD such as Glen Eira and Stonnington.

Areas of good access have higher socioeconomic status and larger commercial centres. There is limited access to bulk-billing services for some who require it (e.g. Health Care or Pension Card holders) in Mornington Peninsula, the northern areas of Cardinia, Casey and some areas of Frankston and Kingston. There is less access to after-hours general practice in the northern area of Cardinia, the southern area of Casey and some small areas of other LGAs.[123]

Service gaps include very low provision of acute and non-acute day care or day programs and limited options for inpatient care provided outside the hospital setting (particularly with 24-hour physician coverage).[124]

Figure 5 shows a risk stratification in blue (darker colouring highlights increased risk), service locations (green and red), and drivetime (showing where a person in a postcode can access a mental health service within a 10-minute drive). This shows the parts of the region where there is high risk of mental illness and service gaps, including parts of Cardinia and Casey.

Figure 5: Population risk, service locations and service access



Children and young people

There is a high percentage of young people accessing MBS-funded mental health services in Frankston (12.8%) and Mornington Peninsula (11.7%).[125] However, there is low use of mental health services in Greater Dandenong, despite data suggesting it is an area of high need (5% accessing MBS-funded mental health services).[126]

There is also evidence to suggest that young men aged 16–24 years are less likely to seek help for a mental health difficulty compared with young women.[127]

Service gaps for children and young people

Children (0-11 years):

- There are limited programs funded in primary care.
- There is a reliance on private providers and tertiary mental health services, with known gaps.
- There are limited after-hours services for children requiring psychological treatment.

Young people (12-25 years):

- There are service gaps for young people who exceed criteria for early intervention primary care services and do not meet admission criteria for tertiary services (missing middle).
- There are limited after-hours services for young people requiring psychological treatment.
- There are limited telehealth and digital health options.

Eating disorders

In South-Eastern Melbourne around 60,000 people live with an eating disorder.[128] Of these people:[129]

- 47% have binge eating disorder
- 12% have bulimia nervosa
- 3% have anorexia nervosa
- 38% have other eating disorders.

While the majority of those experiencing eating disorders are female (64%), the prevalence of eating disorders is increasing among males.[130]

Up to 97% of people experiencing an eating disorder have a co-occurring condition, most commonly depression, anxiety disorders, AOD or personality disorders.[131]

Alcohol and other drugs

In South-Eastern Melbourne, six out of 10 LGAs reported higher ambulance attendance rates due to alcohol than the Victorian average, with Port Phillip having high rates across all substances.[132]

There are no residential rehabilitation services in Frankston, Bayside, Glen Eira, Casey and Mornington Peninsula and only one residential rehabilitation service for young people in South-Eastern Melbourne (Dandenong).

Alongside insights from AOD service providers, this highlights several service-related issues, including:[133]

- "lack of accessible face-to-face intake and assessment services has proved problematic for clients seeking entry point into treatment"
- "lack of inpatient detox and rehab beds poses a risk as team are required to provide support to clients during high risk time for an extended period"
- long wait times to access services due to limited availability of services.

The workforce in South-Eastern Melbourne

The availability of a skilled mental health workforce to deliver a range of interventions and services across the region is critical to support people's mental health treatment needs. However, there can be challenges in recruiting and retaining mental health professionals.

These include an ageing workforce, employment instability with a move to more contract-based roles, gaps in workforce development, a lack of cultural representation, perceptions that a career in mental health is less prestigious than other health professions, and staff not wanting to work in regional areas (for example, Rosebud).[134]

The Regional Plan partners support the work being undertaken more broadly to build the peer workforce.

Table 5: Health workforce in South-Eastern Melbourne (2017-18)[135]

LGA	GPs (no.)	Psychiatrists (no.)	FTE (psychiatrists)	Psychologists (no.)	FTE (psychologists)	Mental health nurses (no.)	FTE (mental health nurses)	Mental health OTs (no.)	FTE (mental health OTs)
Bayside (C)	183	6	5.3	162	123.1	20	17.74	4	3.42
Cardinia (S)	82	1	0.2	35	30.8	46	40.34	4	3.11
Casey (C)	310	13	11.4	175	145.4	241	235.47	15	14.29
Frankston (C)	169	17	17.2	144	127.0	236	218.79	29	26.55
Glen Eira (C)	190	36	28.1	268	195.1	98	94.66	21	18.08
Greater Dandenong (C)	183	37	36.0	158	140.4	267	256.79	23	23.21
Kingston (C)	135	11	11.3	138	118.0	105	101.08	24	20.74
Mornington Peninsula (S)	208	10	11.7	138	110.3	77	64.55	6	6.21
Port Phillip (C)	147	10	8.6	154	130.7	49	43.66	7	7
Stonnington (C)	205	59	54.8	301	239.0	94	88.84	7	5.84
Total	**1812**	**200**	**167.4**	**1673**	**1359.9**	**1233**	**1161.92**	**140**	**128.45**

Note: FTE = full time equivalent hours. (C) = city; (S) = shire.

Part C:

Regional Plan Priorities

Gaining an understanding of the system and the needs of people living in South-Eastern Melbourne through primary, community and tertiary lenses has enabled the Regional Plan partners to define six key priorities.

Priority 1: Ensure services support the diverse needs of consumers.

Priority 2: Ensure services and activities are developed to maximise accessibility.

Priority 3: Ensure consumers' physical and mental health care needs are addressed.

Priority 4: Establish a systematic and coordinated approach to suicide prevention that is region-wide.

Priority 5: Expand workforce training and support to ensure a consistently competent and empowered workforce.

Priority 6: Strengthen partnerships and embed governance models that promote cross-sector and catchment collaboration and planning.

These priorities have been identified by the Regional Plan partners using data gathered from:

- The Fifth National Mental Health and Suicide Prevention Plan
- Regional Planning Project Group
- Joint population health needs assessment
- Consultations undertaken by the Regional Plan partners
- Royal Commission Interim Report
- Productivity Commission's Mental Health Draft Report
- Royal Commission submissions from Alfred Health, Monash Health, Peninsula Health and Victorian Primary Health Network Alliance (VPHNA)
- Integrated Atlas of Mental Health, Alcohol and other Drugs and Homelessness: South-Eastern Melbourne
- VAGO: Access to Mental Health Services
- Alfred Health, Monash Health, Peninsula Health and SEMPHN strategic plans.

An overview of each priority, including its context and background and why it is a priority, has been articulated in the following pages. These priorities and associated actions form the foundation of the implementation plan (Part D).

Strengthening partnerships, understanding community need, and using data to better inform use of available resources are the focuses of the Regional Plan partners. This approach will support the development of a Comprehensive Service Development Regional Plan, which will be delivered in June 2022.

Priority 1:

Ensure services support the diverse needs of consumers

Why is this a priority?

The needs of people affected by mental illness are multidimensional. Social determinants such as cultural, economic and the physical environment can affect mental health. AOD disorders often co-occur with mental illness (dual diagnosis). Deepening our understanding of consumers' needs and enhancing coordination between service providers are necessary to deliver more effective and holistic treatment that supports long-term recovery.

Many people experience both mental illness and addiction (dual diagnosis) and require treatment or support for both diagnoses.

In 2017

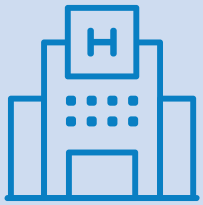
nearly 7000 people were classified as homeless in South-Eastern Melbourne

more than 57,000 of low-income households reported they were under financial stress from mortgage or rental expenses

People have a range of experiences, social influences and cultural factors that can affect the complexity of their mental illness. Language barriers, cultural differences, religious beliefs, stigma, discrimination, socioeconomic disadvantage and intergenerational trauma shape people's identities and experiences.

Social and health determinants such as discrimination, unemployment, homelessness, poverty and family breakdown can lead to harmful drug and alcohol use.[136] People facing these difficulties are at greater risk of poor health and early death. They also experience increased presentations to hospital, higher rates of homelessness, unemployment and violence, and an increased risk of suicide.[137]

Many people experience both mental illness and addiction (dual diagnosis) and require treatment or support for both diagnoses. The number of people with a dual diagnosis is increasing, affecting the need for specific dual diagnosis services and support.



More than half

of the people admitted to hospital for an

AOD condition

have a co-occurring

mental illness [143]

In 2017, nearly 7000 people were classified as homeless in South-Eastern Melbourne and more than 57,000 (or nearly 30%) of low-income households reported they were under financial stress from mortgage or rental expenses.[138] Across the region, more than 39,000 people were unemployed and high rates of gaming machine losses were reported.[139] Such factors can increase individual stress levels and contribute to substance abuse and the development of mental illness. COVID-19 is expected to have a significant detrimental impact on these factors.

The impact of substance abuse on individuals, families and the community can be devastating. This includes health harms such as: injuries; lung and other cancers; cardiovascular disease; liver cirrhosis; mental illness; road trauma; and social harms including violence, domestic and family violence, child protection issues and other crime.[140] There were 2845 alcohol-related family violence incidents reported in 2017 with higher-than-average rates in Mornington Peninsula, Frankston and Greater Dandenong.[141] Drug usage offences are also higher than the Victorian average of 7.8% in Greater Dandenong (12.6%) and Frankston (12%).[142]

More than half of the people admitted to hospital for an AOD condition have a co-occurring mental illness[143] and a large proportion of people who are admitted for a mental health condition also have an AOD condition. For example, at Alfred Health, 47% of inpatient mental health bed days are occupied by people who have a co-occurring mental illness and are AOD dependent.[144]

People with dual diagnosis often experience compounded stigma that reinforces differences in socioeconomic status, leading to increased stress, delays in seeking treatment and people leaving treatment.[145] Negative attitudes and discriminatory behaviours of health care professionals can result in people receiving less-than-optimal treatment, exacerbating poor mental and physical health.[146]

Actions

The Equally Well Consensus Statement advocates for the consideration of addiction and the harmful effects of drugs and alcohol on mental health and physical health during patient assessment and care planning.[147] However, existing models of care do not always provide integrative treatment for people with a dual diagnosis, meaning that a person's conditions are treated separately despite being experienced alongside one another. To create genuinely integrated care pathways, stronger partnerships between service providers are needed.

Priority	Actions	
Ensure services support the diverse needs of consumers	**1.1**	Develop a co-design and community consultation framework to identify ongoing consumer needs, based on the International Association of Public Participation Framework.
	1.2	Convene a mental health and AOD sector collaborative network. Develop a consistent and evidence-based approach to ensure service access and treatment across our catchment.
	1.3	We will establish an urgent care working group tasked with examining available data to identify opportunities for improvement.

Priority 2:

Ensure services and activities are developed to maximise accessibility

Why is this a priority?

People living with mental illness, their families and carers are negatively affected by service gaps and fragmentation in the mental health system in South-Eastern Melbourne.

A greater understanding of service gaps and accessibility challenges is needed to support a coordinated approach to service planning.

There are unmet needs for specific population groups in South-Eastern Melbourne:

people with an eating disorder

young people

people with an AOD disorder

people needing to access services after-hours

People face multiple barriers when trying to access services, including service gaps, inequalities in who can access services, non-inclusive eligibility criteria and insufficient services to meet demand. Other barriers include not knowing what services are available according to needs, how to access those services, and lack of knowledge of services that are available at low or no cost.

Services should be accessible, flexible and responsive to people, their families and carers.[148] However, effective service planning and efficient service delivery are limited by system fragmentation, a lack of service integration and privacy constraints that make it difficult to capture and learn from consumer journeys and health outcomes.

Using evidence to inform service planning can improve health outcomes, improve the experience of care and delivery of care, and reduce costs. Despite evidence-based guidelines being available, these are not always implemented into service planning and design.

A greater understanding of service gaps and accessibility challenges is needed to support a coordinated approach to service planning.

In 2016, nearly

60,000

people were living with an eating disorder but only

17% received treatment[149]

Unmet needs

There are unmet needs for specific population groups in South-Eastern Melbourne, including people with an eating disorder, young people, people with an AOD issue and people needing to access services after-hours.

People living with an eating disorder

In 2016, nearly 60,000 people were living with an eating disorder but only 17% received treatment.[149] Eating disorder-specific Medicare billable item numbers, added in 2019, will support general practitioners and allied health professionals to provide care and management to people living with an eating disorder.

Monash Health and Alfred Health have advocated for additional funding to support specialist eating disorder services that can provide the psychological model of care needed to reduce the impact and average time of illness.

Young people

Half of all mental illness emerges by the age of 14, with three-quarters emerging by the age of 25.[150] Yet there is an absence of integrated initiatives to support and optimise the development and wellbeing of children under 12.

There are several service gaps experienced by young people, including:

- limited programs funded in primary care for young people
- a reliance on private providers and tertiary mental health services for support
- limited primary care and community alternatives for children and young people after-hours, increasing Emergency Department (ED) presentations and demand on acute mental health services.

People with an AOD disorder

Several service gaps and inefficiencies exist within AOD services across South-Eastern Melbourne. These include:

- a lack of services that provide dual diagnosis interventions, despite the prevalence of dual diagnosis and other high-prevalence co-occurring concerns such as homelessness
- a shortage of pharmacotherapy prescribers with mental health experience
- a lack of mental health support detox programs
- a lack of lived experience AOD integration in mental e-health services.

Access to services after-hours

There is a known deficit of services available after-hours. This means that people may need to attend an Emergency Department for an urgent or non-urgent concern because their usual service is not available. People will also go without the services they need, or end up attending appointments at times detrimental to their employment.

“We have daily examples of children and adolescents who ‘fall through the cracks’ of the health system.” [151]

Actions

To increase access to treatment, the Regional Plan partners will work together to identify service gaps and develop a plan to address the needs of people requiring treatment for mental illness and AOD, especially after-hours.

Priority	Actions	
Ensure services and activities are developed to maximise accessibility	**2.1**	Develop a service accessibility plan that will be informed by 1.1 (consultation and co-design) and include a shared needs assessment to examine the level of need and barriers to access.
	2.2	Develop a consumer communication and marketing plan to increase awareness of available services in the region.
	2.3	We will use the learnings from 2.1 to develop a framework for joint regional service design and implementation to provide consumers with services that meet their needs (e.g. after-hours mental health clinic).

Priority 3:

Ensure consumers' physical and mental health care needs are addressed

Why is this a priority?

People living with a mental illness are more likely to experience co-occurring conditions, such as heart or lung diseases, which can reduce their life expectancy by up to 25 years.[152,153] This can be improved with appropriate and coordinated care and management, yet people living with mental illness are less likely to receive treatment for their physical health.[154]

In South-Eastern Melbourne, more than 50,000 people live with both a physical health and mental health condition.[155]

Compared with the general population, people living with mental illness are:

50% more likely to be diagnosed with cancer

six times more likely to die from cardiovascular disease

four times more likely to die from respiratory disease

In South-Eastern Melbourne, more than 50,000 people live with both a physical health and mental health condition.[155] Physical illness tends to worsen as mental illness becomes more severe.

Compared with the general population, people living with mental illness are:[156]

- 50% more likely to be diagnosed with cancer[157]
- six times more likely to die from cardiovascular disease
- four times more likely to die from respiratory disease.

It is estimated that the cost to the Australian economy of physical and mental illness is $15 billion a year,[158] or around $1 billion in South-Eastern Melbourne. Combining mental and physical health care is essential to providing quality care to consumers and should be considered a basic human right.[159]

People living with severe mental illness see health professionals twice as often as the general population but receive fewer physical health checks.[168]

It is estimated that the cost to the Australian economy of physical and mental illness is $15 billion a year, or around

$1 BILLION

in South-Eastern Melbourne

Factors contributing to poor physical health in people with mental illness

People living with mental illness are more likely to have health behaviours that increase their risk of physical illness,[160] including:

- increased rates of smoking
- harmful alcohol consumption
- reduced rates of physical activity
- a poor diet.

Medication side effects, such as weight gain and lethargy, can also affect a person's ability to stay physically healthy.[161]

People living with mental illness may experience discrimination and stigma from health professionals. This could be influenced by 'diagnostic overshadowing',[162] where a health professional treats the symptoms of mental illness but overlooks a consumer's physical health symptoms. Some mental health professionals do not consider physical health to fall into their scope of practice.[163]

Internalised feelings of shame and low self-esteem are also common for people with mental illness.[164] These feelings can lead to fears around being treated differently, dismissed or rejected and may deter people from seeking help, further exacerbating their mental and physical health issues.

In a fragmented health system, physical health care and mental health care are often provided by different health care providers. Unclear referral pathways and differing approaches to co-occurring mental and physical illnesses affect the delivery of coordinated care.

Improving systems, proactively screening and implementing care pathways will support prevention, early intervention and appropriate management of risk factors and physical health. Sector collaboration will improve consumer health and reduce the cost of health care to the economy.

Refining current funding and incentive mechanisms will enable health professionals to treat and/or refer consumers appropriately so their physical health and mental health needs are being equally met. Doing this will support the delivery of holistic and coordinated care for consumers receiving services for their mental health.[165]

"Improving the physical health of people living with mental illness and reducing early mortality" is one of the eight priorities defined in the Fifth Plan,[166] endorsed by State and Federal governments. A focus on the physical and mental health of Victorians is a desired outcome in Victoria's 10-Year Mental Health Plan.[167]

Being a relatively new area of focus for State and Federal governments, the sector should work towards developing a collaborative approach to improve the physical health of people living with mental illness.

Actions

Priority	Actions	
Ensure consumers physical and mental health care needs are addressed	**3.1**	We will create a regional community of practice that implements the Equally Well Framework across the region.

Priority 4:

Establish a systematic and coordinated approach to suicide prevention that is region-wide

Why is this a priority?

Between 2013 and 2017, more than 700 people died by suicide in South-Eastern Melbourne.[169] There is no single cause of suicide and no simple solution to prevent it. Taking action to reduce suicide rates needs to happen across sectors, levels of government and the community. Cross-sectoral action needs a systematic and coordinated approach.

On average, five immediate family members and up to 135 individuals are affected by a suicide.[170]

Suicide can affect anyone, but some groups are at increased risk, including:

Aboriginal and Torres Strait Islander people, particularly young people

people experiencing homelessness

men

young people aged 12 to 25

Every suicide has a vast ripple-effect on communities. On average, five immediate family members and up to 135 individuals are affected by a suicide.[170]

While some people may be experiencing a mental illness, for others suicidality may be related to situational distress. Co-occurring stressors can further increase distress.

Suicide can affect anyone, but some groups are at increased risk, including:[171]

- Aboriginal and Torres Strait Islander people, particularly young people (more than double that of other Australians)
- people experiencing homelessness (twice the risk of the general population)
- men
- young people aged 12 to 25.

Between 2013 and 2017,

more than 700 people DIED BY suicide in South-Eastern Melbourne[59]

Place-based suicide prevention

Suicide prevention approaches need to be tailored to the local community service and system context. A place-based approach recognises that people and places are interrelated, and that the places where people live and spend their time affect their health and wellbeing.[172]

SEMPHN and the Victorian Government are working together on place-based suicide prevention trials across the local government areas of Greater Dandenong, Frankston and Mornington Peninsula. Multi-component systems approaches are considered to be the most effective in reducing suicide and suicide attempts. Key elements of these trials have scope to be applied to suicide prevention approaches in communities across South-Eastern Melbourne.

"…. this trial is the first I've seen that is working to bring the community together to create a consistent and comprehensive approach to suicide prevention"

– Collaborator on a place-based trial

Lessons from the place-based suicide prevention trials

The value of lived experience input

People with a lived experience of suicide are key contributors as experts in designing, developing, implementing and evaluating suicide prevention activities.

- People who have been through suicidal crisis are best placed to tell us how to support others in crisis.
- Those bereaved through suicide can share what is useful and not useful following a death by suicide.
- People who have cared for a loved one through suicidal crisis can provide key knowledge of what helped them support their loved one.

The need for support after a suicidal event

The days and weeks following a suicide attempt are a period of increased risk and it is crucial that people are cared for during this time. Best practice after-care combines clinical and psychosocial support, including:

- immediate and assertive follow-up
- ongoing collaborative risk management and safety planning
- encouragement and motivation to follow treatment recommendations
- problem-solving support and linkages to address stressors such as housing, finances and relationships.

The Victorian Suicide Prevention Framework supports after-care through the Hospital Outreach Post Suicidal Event (HOPE) trials, running at multiple sites across Victoria (including Alfred Health and Peninsula Health). Complementary to this, Casey Hospital and Dandenong Hospital (Monash Health) are implementing The Way Back Service, a Beyond Blue model.

A recommendation of the Victorian Royal Commission into Victoria's Mental Health System will see the Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen create, deliver and evaluate the first phase of a new youth assertive outreach and follow-up care service similar to the HOPE service model (for children and young people who have attempted suicide, have suicidal ideation or have intentionally self-harmed) in their catchment areas.[173]

Postvention is a response to, and is care for, people bereaved by suicide, such as those affected by the suicide of a family member, friend or a person in their social network. Postvention responses aim to mitigate the negative effects of exposure to suicide through a coordinated, targeted response for affected individuals and communities.

There are postvention protocols in Frankston, Mornington Peninsula, Casey, Cardinia and Greater Dandenong, but they only provide coverage for those aged 12 to 25 years living within the region, not for people of all ages.

The importance of timely access to local suicide trend information

Access to and analysis of suicide trend data is essential to inform local service delivery, identify gaps and educate about suicide. Data from the Coroners Court of Victoria and the Victorian Injury Surveillance Unit has helped to increase understanding of place-based risk factors.

However, the limited representation of gender and cultural identity in the coronial data underestimates the multi-layered social and cultural dynamics of those in CALD and LGBTIQA+ communities. Increased sharing of data between local organisations that work on suicide prevention and postvention initiatives will help to address these data gaps and provide a fuller picture of the profiles of those who die by suicide.

The Regional Plan partners have committed to the following activities in an effort to reduce the number of deaths by suicide in the region.

Actions

Priority	Actions	
Establish a systematic and coordinated approach to suicide prevention which is region-wide	**4.1**	Identify opportunities to deliver, fund or support community initiatives that will improve education and build capacity to identify and respond to people experiencing mental distress and may be vulnerable to suicide.
	4.2	We will convene a regional suicide prevention working group. It will undertake a comprehensive review of the suicide prevention landscape to gain a better understanding of the gap(s), build on the work from the place-based suicide prevention trials and provide recommendations to the Regional Plan partners to support the delivery of services that meet the needs of the community.
	4.3	Develop a framework to increase coordinated targeted responses to support people affected by suicide (including postvention and bereavement support).

Seeking urgent help

If you, or someone you know, is in immediate danger, please call 000, visit your nearest hospital emergency or use any of the crisis helplines.

Lifeline (13 11 14)
24/7 crisis support and suicide prevention services.

Suicide Call Back Service (1300 659 467)
24/7 telephone crisis support for people at risk of suicide, carers and bereaved, as well as online resources and information.

Kids Helpline (1800 55 1800)

24/7 telephone counselling for young people 5 to 25 years.

MensLine Australia (1300 78 99 78)
24/7 telephone and online support, information and referral service for men.

Beyond Blue (1300 22 4636)
24/7 telephone support service and online chat 4–10pm (AEST).

Priority 5:

Expand workforce training and support to ensure a consistently competent and empowered workforce

Why is this a priority?

People should be able to access appropriate support and treatment when and where they need it. This is only possible with a dedicated, skilled and sustainable mental health and suicide prevention workforce. A shortage of experienced mental health workers creates barriers to access and to the effectiveness of mental health services.

"I feel exhausted and burnt out. The workload is much too big and too high risk... everyone is off sick and is unwell. It feels unhealthy to work here." [186]

– Mental health worker

Mental health workforce shortage

Recruitment and retention of mental health clinicians are significant challenges for mental health services across South-Eastern Melbourne and has been exacerbated by COVID-19. The full extent of the workforce deficit across the catchment is not well understood. However, Monash Health reports that mental health services have been "eroded to such an extent in tertiary care that people who require a specialist therapeutic intervention and are considered too complex to be treated within a primary care context are left without treatment".[174]

Factors such as community stigma, perceptions of mental illness and the nature of working with people with mental illness[175] mean that working in mental health is not always seen as an attractive career option.

A range of peak bodies are advocating for the development of a suicide prevention workforce strategy to scope current and future needs.[176] Building a sustainable, competent and compassionate workforce is one of the proposed core focus areas of the National Suicide Prevention Implementation Strategy.

83%

of staff surveyed in Victoria's mental health workforce reported experiencing violence in the previous 12 months[177]

"Occupational violence is a risk faced by mental health staff on a daily basis. There is little doubt that exposure to occupational violence inhibits retention of mental health staff in the workplace." [187]

Exposure to occupational violence

High levels of occupational violence contribute to low staff morale and high turnover, which are major factors in the shortage of mental health workers. Eighty-three per cent of staff surveyed in Victoria's mental health workforce reported experiencing violence in the previous 12 months.[177] Prolonged exposure to risk, trauma and occupational violence and aggression has a significant impact on staff, consumers, carers and family members alike, particularly in crisis and acute services.[178]

The Victorian Mental Health Workforce Strategy contends that for mental health careers to be perceived as attractive and rewarding, it is essential worker safety and wellbeing are protected[179] while also demonstrating that occupational violence is perpetrated by only a minority of people with a diagnosis of mental illness. Where violence occurs, it is often in the context of drug use, distressing hallucinations, previous trauma or treatment that may not have been effective.[180]

Workforce capability

Education and early training for general practitioners does not adequately prepare them for the nature of mental health care needed in general practice.[181] Hospitals are also concerned about the increasing number of new graduates and candidates for junior positions with limited skills and experience working in the sector.[182]

The evolution of a crisis-driven model of care has diminished opportunities for supervision and professional development, making it difficult for junior staff to expand their skills and knowledge. The provision of additional learning opportunities under supervision and access to secondary consultation are critical to upskill mental health workers and grow the collective capability of the mental health workforce.

"The inclusion of specialist peer support workers as part of multidisciplinary teams is an important addition to clinical mental health services." [188]

Mental health workers with lived experience play an integral role in all aspects of the mental health system.[183] Workers with lived experience provide peer support, advocacy and support for consumer and carer engagement.[184] Despite their significant contribution, peer support workers with lived experience are not yet embedded into systems and services. The provision of standardised training and defined scope of practice is needed to support consistent inclusion of lived experience peer workers in systems and service models.

Mental health services must reflect the cultural diversity of our region. Cultural safety is considered fundamental to achieving the best health outcomes for Aboriginal and Torres Strait Islanders.[185] The high proportion of Aboriginal and Torres Strait Islanders seeking treatment for mental illness relative to the general population requires a mental health workforce that is trauma-informed and understands the significance of cultural safety as a foundation for treatment.

The health, safety and level of job satisfaction of the mental health workforce are key to facilitating increased workforce availability and capability. As such, the Regional Plan partners have committed to the following actions.

Actions

Priority	Actions	
Expand workforce training and support to ensure the availability of a consistently skilled, knowledgeable and supported workforce	**5.1**	Develop a consultation and co-design plan based on the International Association of Public Participation Framework. Activities will include consultation with the tertiary sector and general practitioners to understand workforce needs, including areas where training would increase workforce capability.
	5.2	Develop a regional workforce initiative plan, informed by 5.1, that will include: • a plan to address prioritised training gaps • an approach to developing partnerships to support training and skill development • defining initiatives to ensure the experiences of people with a lived experience are considered when developing training initiatives.

Priority 6:

Strengthen partnerships and embed governance models that promote cross-sector and catchment collaboration and planning

Why is this a priority?

Strengthening partnerships and establishing good governance are fundamental to supporting system improvement and service integration. Enhancing the alignment and coordination of mental health and suicide prevention services are acknowledged as central to maximising the effectiveness and efficiency of service systems.

Primary Health Networks and Local Hospital Networks provide the core architecture to support integration.

The Regional Plan acknowledges that when information sharing between organisations is limited, it can contribute to inefficient service provision and duplication. Establishing a formalised governance structure will support the sharing of information and data across the sector, as well as establishing a more efficient way to plan, program and deliver services.

Ideally, additional funding will be available to support effective Regional Plan partnerships and the work required to be undertaken. Variable and complex funding streams can be a barrier to service integration. It can increase the reporting burden and limit service innovation and incentives for integration.

Enabling organisations to have greater insight into the health needs of the community is integral to delivering care that is responsive and helpful.

A lack of integration...

LEADS TO

poor treatment continuity, difficulty in maintaining treatment, poorer treatment outcomes.[190]

An example of this is the Way Back Service, which has three sets of reporting requirements. Recommendations outlined in the Royal Commission into Victoria's Mental Health System's Final Report[189] (for release in January 2021) and the Productivity Commission – Mental Health Final Report[190] (for release in November 2020) support opportunities to increase integration.

Enabling organisations to have greater insight into the health needs of the community is integral to delivering care that is responsive and helpful. Establishing appropriate structures, such as the Mental Health and AOD Sector Collaborative Network, a regional community of practice, and a regional suicide prevention working group, will support partners to implement this Regional Plan and develop the Comprehensive Service Development Plan. These should include broader community and stakeholder engagement, agreed datasets and coordinated service delivery between Regional Plan partners. Consideration will be given to data governance and consumer privacy.

The partnership between the Regional Plan partners involves establishing collaborative ways of working underpinned by shared ownership, joint decision making and open communication to build effective and sustainable outcomes.[191]

The Regional Plan partners are committed to improved service planning, delivery and coordination with the aim of:

- improving the quality of care to patients through a consumer-centred approach
- addressing capacity and accessibility issues, including clear service eligibility
- improving the whole system.

Regional integration

At a regional level, "Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) provide the core architecture to support integration".[192] A move towards a more integrated approach will include:

- exploring approaches for shared planning and governance structures
- defining parameters for shared needs assessments, information sharing and service mapping
- identifying areas for coordinated service delivery (for example, where a PHN service would support a person soon to be discharged from a tertiary service).

This approach supports the development of joint needs assessments, service mapping and planning. This provides the Regional Plan partners with a greater understanding of the needs of the region, allowing organisations to "align health workforce skills, availability and location with the need for the mental health services".[193]

While there are examples of program-specific or ad-hoc cross-organisational governance structures in place, this is not system-wide or formalised. However, the Regional Plan Partners Steering Group provides a platform to support implementation of the Plan priorities.

Actions

The following actions set out the first steps towards an integrated system that allows for cross-organisational governance and data-sharing in the region.

Priority	Actions	
Strengthen partnerships and embed governance models to support cross-organisational working arrangements	**6.1**	Develop Memorandum of Understanding between Regional Plan partners to support plan implementation and subsequent regional planning activities.
	6.2	Develop and establish a formal process for information and data-sharing between the Regional Plan partners to support ongoing collaboration.
	6.3	Establish shared reporting and accountability arrangements to effectively measure the impact on health outcomes and consumer experience.

Part D:
Implementation

The Regional Plan provides an overarching set of priorities, with their associated actions, to respond to the needs of people living in South-Eastern Melbourne. These actions will guide the implementation phase of the Regional Plan and provide a framework for ongoing collaboration between the Regional Plan partners.

The implementation phase of the Regional Plan is due to begin in January 2021. For implementation to be successful, several key elements will be considered:

- governance arrangements
- ability to be responsive to changes in the system and the environment
- ongoing review and monitoring.

An overarching governance structure will be established to:

- embed the vision and principles of the Regional Plan
- ensure the progression of the Plan through the implementation plan
- measure success of the Plan
- facilitate collaboration between the Regional Plan partners and the community.

The governance structure will include a steering group and working groups. The steering group will have overarching responsibility for ensuring the successful implementation of the Plan. The steering group will include representation from:

- Alfred Health
- Monash Health
- Peninsula Health
- SEMPHN.

A phased approach to implementation will be undertaken due to the extent and complexity of the priorities and actions. This approach will allow the Regional Plan partners time to consult with key stakeholders, which will also support the development of the Comprehensive Service Development Plan (CDSP). This will supersede the Foundation Plan (this Regional Plan) in 2022. An outcomes framework will be developed for the CDSP.

The Plan's priorities and actions, as shown in Figure 6, will be monitored regularly to measure the effectiveness of the implementation plan. Identifying the approach to monitoring and evaluation of the priorities and actions in the Regional Plan will be an activity of the governance groups during the implementation phase.

Table 6 shows the implementation plan, including the Regional Plan priorities, actions and associated timeframes, which are organised in two timepoints – pre-Comprehensive Service Development Plan (1-2 years) and post Comprehensive Service Development Plan (more than two years).

Implementation plan

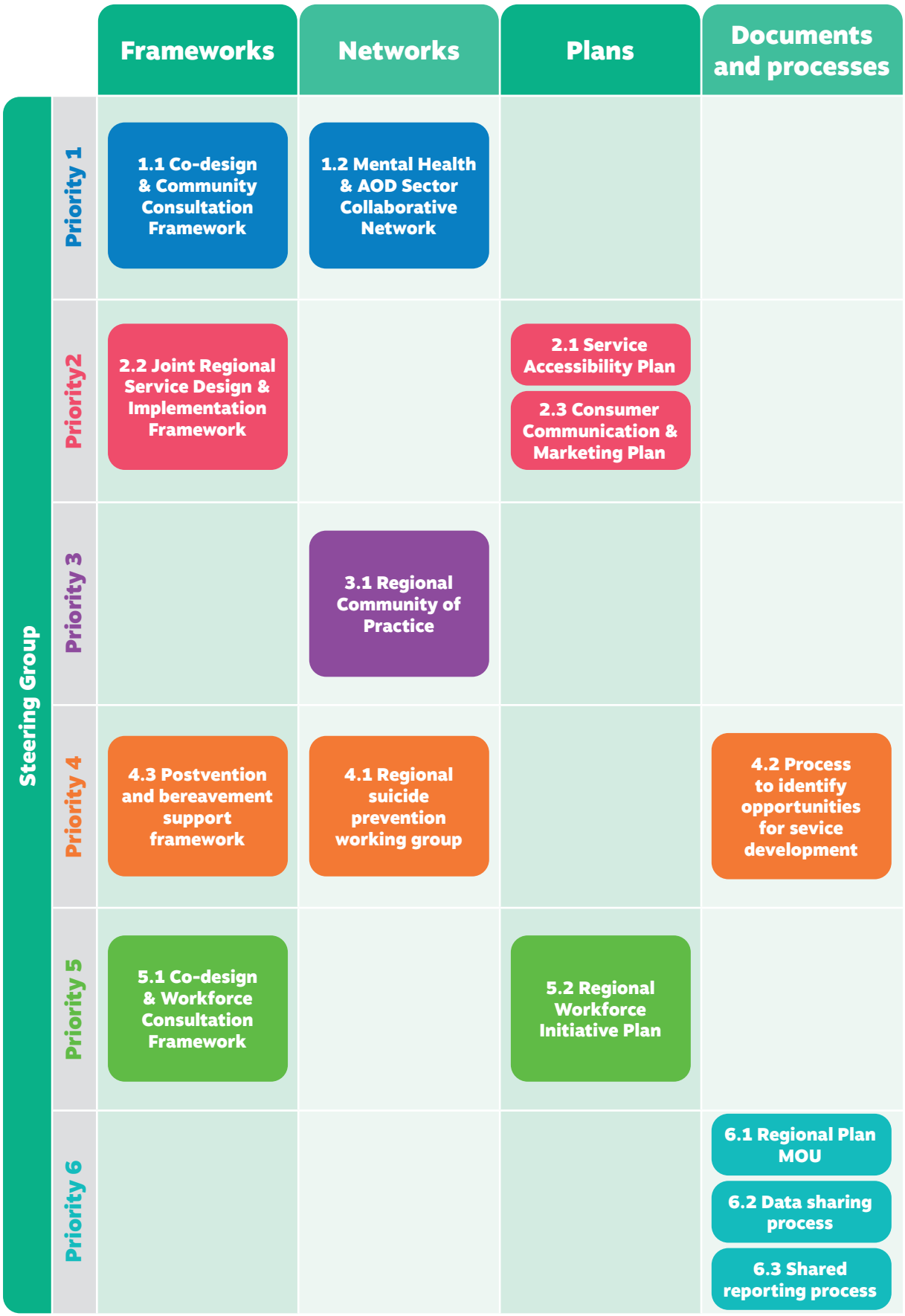


Figure 6: Overview of Regional Plan actions

PART D

Implementation plan

Priority #	Priority	Action #	Actions	Timeframe	
				Pre-comprehensive plan	Post comprehensive plan
1	Ensure services support the diverse needs of consumers	1.1	Develop a co-design and community consultation framework to identify ongoing consumer needs, based on the International Association of Public Participation Framework		
		1.2	Convene a mental health and AOD sector collaborative network. Develop a consistent and evidence-based approach to ensure service access and treatment across our catchment		
		1.3	We will establish an urgent care working group tasked with examining available data to identify opportunities for improvement		
2	Ensure services and activities are developed to maximise accessibility	2.1	Develop a service accessibility plan which will be informed by 1.1 (consultation and co-design) and include a shared needs assessment to examine the level of need and barriers to access		
		2.2	Develop a consumer communication and marketing plan to increase awareness of available services in the region		
		2.3	We will use the learnings from 2.1 to develop a framework for joint regional service design and implementation to provide consumers with services that meet their needs (e.g. after-hours mental health clinic)		
3	Ensure consumers physical and mental health care needs are addressed	3.1	We will create a regional community of practice that implements the Equally Well Framework across the region		
4	Establish a systematic and coordinated approach to suicide prevention which is region-wide	4.1	Identify opportunities to deliver, fund or support community initiatives that will improve education and build capacity to identify and respond to people experiencing mental distress and may be vulnerable to suicide		
		4.2	We will convene a Regional Suicide Prevention working group who will undertake a comprehensive review of the suicide prevention landscape to gain a better understanding of the gap(s), build on the work from the place-based suicide prevention trials and provide recommendations to Regional Plan partners to support the delivery services that meet the needs of the community		
		4.3	Develop a framework to increase coordinated targeted responses to support people impacted by suicide (including postvention and bereavement support)		

Implementation plan

Priority #	Priority	Action #	Actions	Timeframe	
				Pre-comprehensive plan	Post comprehensive plan
5	Expand workforce training and support to ensure the availability of consistently skilled, knowledgeable, and supported workforce	5.1	Develop a consultation and co-design plan based on the International Association of Public Participation Framework. Activities will include consultation with the tertiary sector and general practitioners to understand workforce needs, including areas where training would increase workforce capability		
		5.2	Develop a regional workforce initiative plan, informed by 5.1, which will include: • a plan to address prioritised training gaps • approach to developing partnerships to support training and skill development • define initiatives to ensure the experiences of people with a lived experience are considered when developing training initiatives		
6	Strengthen partnerships and embed governance models to support cross-organisational working arrangements	6.1	Develop Memorandum of Understanding between Regional Plan partners to support Regional Plan Implementation and subsequent Regional Planning activities		
		6.2	Develop and establish a formal process for information and data sharing between the Regional Plan partners to support ongoing collaboration		
		6.3	Establish shared reporting and accountability arrangements to effectively measure the impact on health outcomes and consumer experience		

Appendices

Appendix 1: Related policies, frameworks and strategies

Federal

- The Fifth Mental Health and Suicide Prevention Plan
- National Suicide Prevention Strategy
- National Aboriginal and Torres Strait Islander Health Plan 2013-2023
- National Drug Strategy 2017-2026
- The Living Is For Everyone (LIFE) Framework

Victorian

- Victoria's 10-Year Mental Health Plan
- Victoria's 10-Year Mental Health Plan: Mental Health Workforce Strategy
- Victorian suicide prevention strategy 2016-2025
- Balit Murrup: Aboriginal social and emotional wellbeing framework
- The Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037

Supporting policies and strategies

- Equally Well
- Royal Commission into Victoria's Mental Health System
- Productivity Commission — Mental Health Draft Report
- Victorian Auditor-General's Office (VAGO): Access to Mental Health Services, March 2019
- Victorian Auditor-General's Office (VAGO): Child and Youth Mental Health, June 2019

Appendix 2: Regional Plan – stakeholder consultation summary

Consultation	Methodology	Number of participants / respondents
Peninsula Carers Council forum	Focus group	25
AOD Consumer Forum – St Kilda	Focus group	15
AOD Consumer Forum – Frankston	Focus group	14
AOD Consumer Forum – Dandenong	Focus group	4
Carers' survey	Online survey	15
Frankston Mornington Peninsula Suicide Prevention Advisory Group	Focus group	13
Individuals involved in Dandenong place-based trial	One-on-one conversations	Unknown
GP survey	Online survey	5
Service provider survey	Online survey	16
Practice manager surveys	Hard copy surveys distributed at COP meeting	8
Total number of participants		**>115**

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