LOWER HUME
PRIMARY CARE PARTNERSHIP

Strengthening Supports for Mental Health across Lower Hume

2019

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Acknowledgements

Primary Care Partnerships are supported by the Victorian Government

The history, culture, diversity and value of all Aboriginal and Torres Strait Islander people are recognised, acknowledged and respected.

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1. Executive Summary

Lower Hume Primary Care Partnership (LHPCP) is a voluntary alliance of health and human service organisations operating within the local government areas (LGAs) of Mitchell and Murrindindi. Lower Hume PCP is one of 28 PCPs across Victoria funded by the Department of Health and Human Services (DHHS) since 2000.

Lower Hume PCP envisages healthy and resilient local communities whose health and wellbeing outcomes are improved through the collaborative and cooperative relationships of its members.

In December 2018, 3whitehorses were engaged to deliver a review of access to mental health services across Mitchell and Murrindindi shires to recommend ways to strengthen local mental health outcomes. The problem the LHPCP sought to address was:

- What mental health services are available locally?
- How are services accessed locally?
- How could acute mental health care be more accessible and connected to local community supports?
- Is there a suitable mental health workforce for Lower Hume?
- What could improve mental health outcomes?

Overseen by the LHPCP, project methodology included:

- A review of documentation provided by the Executive Officer of the LHPCP.
- An internet search for, and review of, policy documents.
- Consumer consultation in the form of reviewing reports from local consultation.
- Face to face meeting with funded service providers, federal and state funders and key influencers.
- Two workshops with the LHPCP Leadership Team to test assumptions and agree on a shared vision.
- Project documentation.

The project identified the LHPCP as an ideal platform to pilot a comprehensive Stepped Care model of Mental Health Service delivery that extends from the well population to chronic and complex client acuity needs.

This assessment is based upon:

- High levels of service integration and purpose in the LHPCP.
- Readiness to engage emerging stakeholders; seeking innovation to meet service delivery gaps and achieve better client outcomes.
- A need to more effectively respond to client and community expectations around the delivery of mental health services.
- The mental health service delivery model after the 2009 Black Saturday Bushfires.
- A willingness to align mental health scope of practice and competency frameworks across local agencies to provide better shared care of mental health clients and well populations.
- A willingness to pilot a common mental health risk assessment tool and language, to increase cross agency understanding of how clients are cared for.
- Readiness to share data to allow for evaluation of the new approach.

Stepped Care is an approach already being utilised across Lower Hume. It is a staged system response containing a hierarchy of interventions matched to the individual's needs, from the least intensive to the most intensive. The multiple levels within a stepped care approach are intended to provide an integrated spectrum of service interventions which allows the individual to transition up to higher intensity services or down to lower intensity services as their needs change.

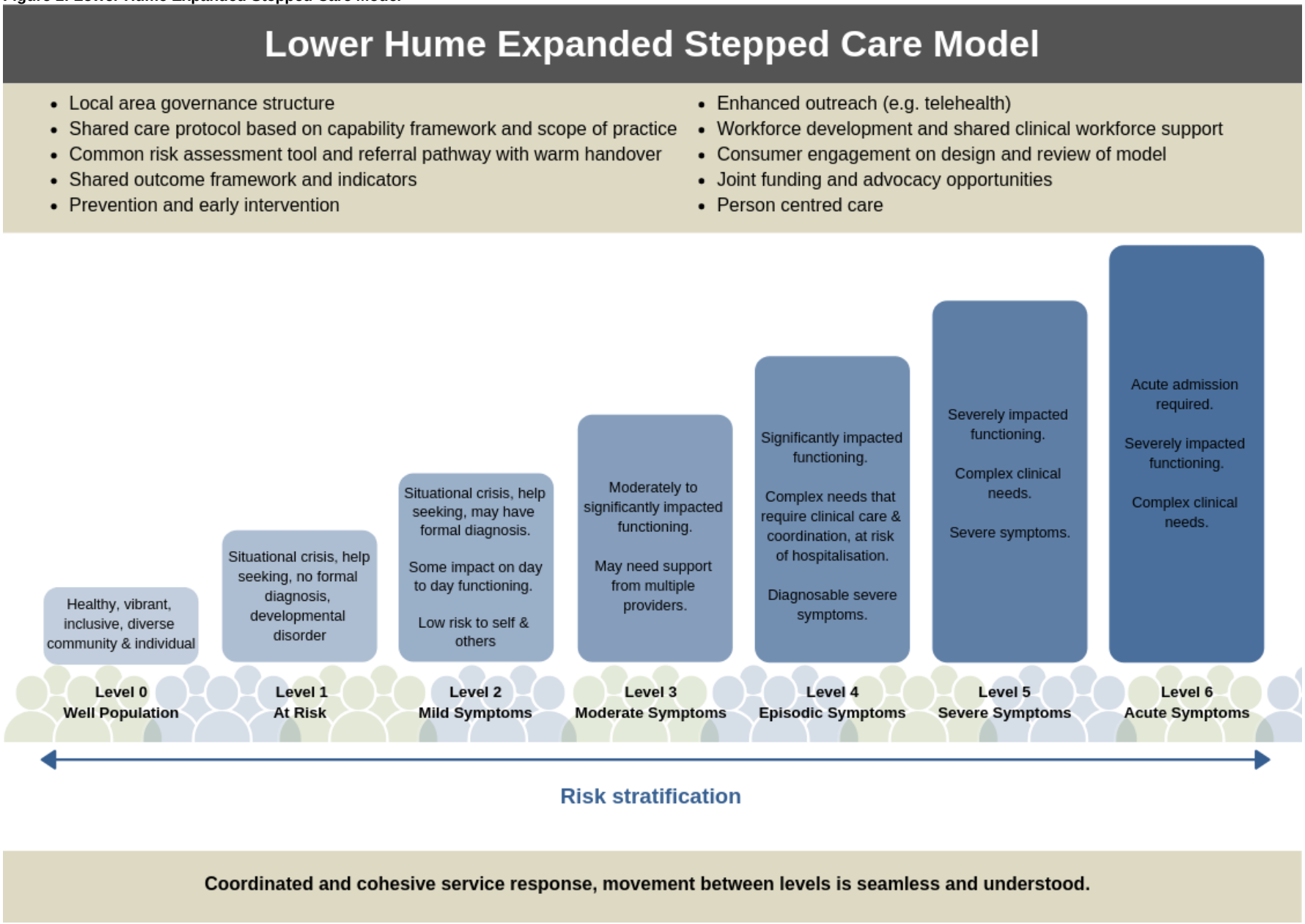
Funders and influencers consulted for this report are ready to consider new ways of delivering mental health services and have all stated that positive consideration is likely to be given to those applications and innovations that are client centred, place based, and enhanced by an integrated service delivery model/platform.

It is recommended that that the LHPCP adopt an Expanded Stepped Care model of Mental Health service delivery that extends from the well population to the chronic and complex clients acuity needs, recognising its established integration and potential to do more business together. The current Stepped Care Model has limitations in the expected breadth of service interventions. An enhanced model, including a common risk assessment and referral pathway would ensure connectivity across the entire service sector and drive stronger client outcomes through an integrated response system.

The suggested Expanded Stepped Care Model for Lower Hume can be found at the end of this Executive Summary and at Appendix 4.

The LHPCP will also need to develop a Terms of Reference and Communications Strategy that provides good governance and structured advocacy for its approach. The adoption of a capacity building methodology is also encouraged, with a documented and transparent commitment to long term plan to bring to life the LHCP Expanded Stepped Care Model.

Figure 1: Lower Hume Expanded Stepped Care Model



2. Project Methodology

The LHPCP commissioned a small project to review access to mental health services across Mitchell and Murrindindi Shires to inform opportunities to strengthen local responses that improve mental health outcomes. 3whitehorses were engaged to complete the project. Project methodology included review of existing consumer consultations, extensive stakeholder consultations (appendix 2) and a review of the policy and planning environment (appendix 3).

Initially the scope of the project was largely defined as a mapping and advocacy piece, focused on developing a joint model for Primary Health Network (PHN) Commissioning and making a submission to the Victorian Royal Commission into Mental Health. However, what quickly became apparent was the local agency maturation and appetite for an Integrated Mental Health Service delivery platform in Lower Hume. A robust and fulsome conversation at the LHPCP Leadership Team meeting in February 2019 determined that the project scope was varied to focus the report upon a proposal for an extension of the existing Stepped Care Model in Lower Hume. This decision was based on integration of the current service segments and a commitment by local agencies to working together.

3. Background - The Current Strategic Landscape and Policy Context

3.1 The Lower Hume Primary Care Partnership

Lower Hume Primary Care Partnership (PCP) is a voluntary alliance of health and human service organisations operating within the local government areas (LGAs) of Mitchell and Murrindindi. Lower Hume PCP is one of 28 PCPs across Victoria funded by the Department of Health and Human Services (DHHS) since 2000. Lower Hume PCP envisages healthy and resilient local communities whose health and wellbeing outcomes are improved through the collaborative and cooperative relationships of its members. Progress towards this vision is made through facilitating and enabling systems change across disease prevention and service system integration.

Lower Hume PCP members include Seymour Health (Chair), Yea & District Memorial Hospital, The Kilmore and District Hospital, Alexandra District Health, Nexus Primary Health, Mitchell Shire Council, Murrindindi Shire Council and FamilyCare (appendix 1). Members make up the governance committee for Lower Hume PCP, and an extensive number of additional partners are involved in relevant initiatives.

3.2 Mitchell Shire

Mitchell Shire is situated approximately 40 kilometres north of Melbourne along the Hume Freeway. The Shire includes urban, peri-urban and rural landscapes. Mitchell Shire is one of the fastest growing LGAs in Victoria. The majority of this growth is occurring in the southern end of the Shire where communities interface with metropolitan Melbourne.

3.3 Murrindindi Shire

Murrindindi Shire covers a large geographical area with a small and dispersed population. The southern border of Murrindindi Shire is approximately 60 km from Melbourne. The population is not set to increase dramatically over the next 10 years and is likely to continue ageing."

Figure 2: Lower Hume Catchment[1]

3.4 Mental Health Data Review

LHPCP have already collated and reported the primary data regarding mental health indicators in the Lower Hume PCP Population Health Profile (Domain 1 Report). This report provides the key data from which we have drawn our recommendations.

Good mental health is fundamental to the wellbeing of individuals, their families and the population as a whole. Mental health problems and mental illness are major causes of poor health in Victoria. Mental disorders including anxiety, depression, and substance misuse, are estimated to affect almost half of Australians aged 16–85 during their lifetime. Mental health problems and mental illness include a range of cognitive, emotional and behavioural disorders. The Kessler 10 (K10) Psychological Distress Scale was designed to monitor population prevalence and trends in nonspecific psychological distress.

In Lower Hume, the proportion of adults reporting high or very high psychological distress based on the K10 scale increased from 2011 to 2014. By comparison 13% of Victorian adults experienced high or very high psychological distress in 2014. The Goulburn and Ovens Murray region experienced the same rate as the state average whilst Mitchell (15%) and Murrindindi (16%) had higher rates of psychological distress.

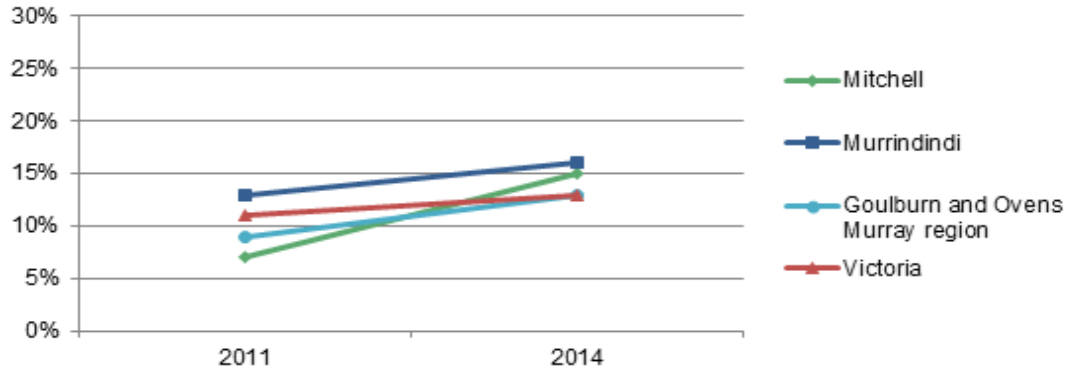
[1] Lower Hume Primary Care Partnership Website (text and maps).

Table 1: Proportion of adults reporting high or very high psychological distress 2011 and 2014

Mitchell		Murrindindi		Goulburn and Ovens Murray region		Victoria		Indigenous Victorians
2011	2014	2011	2014	2011	2014	2011	2014	2012/13
7%	15%	13%	16%	9%	13%	11%	13%	32%

Source: Victorian Population Health Survey, 2011 and 2014. Source: ABS, Australian Aboriginal and Torres Strait Islander Health Survey, 2014.

Figure 3: Proportion of adults reporting high or very high psychological distress 2011 and 2014



Source: Victorian Population Health Survey, 2011 and 2014.

3.5 Additional Indicators

3.5.1 Depression and Anxiety

Mental health includes emotional, psychological and social well-being, and it affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make choices. Wellbeing, or positive mental health, improves our quality of life in many ways including: better physical health; faster recovery from illness; fewer limitations in daily life; higher educational attainment; greater likelihood of employment and earnings; and better relationships.

Lifetime prevalence of depression and anxiety increased from 20% in 2011 to 24% in 2014 throughout Victoria. Murrindindi (25%), Mitchell (27%) and the Goulburn and Ovens Murray region (28%) had above state average rates of depression and anxiety in 2014.

Table 2: Lifetime prevalence of depression/anxiety and accessing professional help 2011, 2014

	Mitchell		Murrindindi		Goulburn and Ovens Murray region		Victoria	
	2011	2014	2011	2014	2011	2014	2011	2014
Lifetime prevalence of depression or anxiety	23%	27%	19%	25%	21%	28%	20%	24%
Sought professional help for a mental health related problem	15%	16%	16%	15%	12%	15%	12%	16%

Source: Victorian Population Health Survey, 2011, 2014

3.5.2 Suicide Rate

Suicide and self-harm are signs of serious emotional distress. There are about 500 suicides each year in Victoria. This represents only a small proportion of self-harming in the community and the related health and wellbeing burden of suicide and self-harm.

The average annual age standardised rate (ASR) for avoidable deaths from suicide and self-inflicted injuries of people aged 0-74 years of age was higher than state average across Murrindindi shire at 17 per 100,000 population in 2010-14. The rate in Mitchell shire was similar to state average of 10 per 100,000 population.

Table 3: Avoidable deaths from suicide and self-inflicted injuries persons aged 0-74 years average annual ASR per 100,000

Mitchell		Murrindindi		Victoria	
2009-12	2010-14	2009-12	2010-14	2009-12	2010-14
11	11	26	17	10	10

Source: Public Health Information Development Unit, 2017.

The Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP) provides a model of multidisciplinary care where mental healthcare is delivered as part of an integrated approach to health where medical, psychiatric and lifestyle interventions are combined into one action plan. The ccCHiP model includes psychiatry, dietetics, cardiology, sleep specialists, nursing, dentistry, exercise physiology and endocrinology that are co-located and linked through information systems to provide screening, detection, interventions and ongoing monitoring. In regional areas such a model should provide impetus to strengthen integrated care which does not separate out mental health from physical health.
Summary:

- Adults living in Mitchell and Murrindindi shires were slightly more likely to experience high or very high psychological distress
- Adults in Murrindindi and Mitchell shire were slightly more likely than the state average to have experienced depression or anxiety in 2014
- Adults living in rural regions were more likely to be diagnosed with depression or anxiety in addition to a higher proportion of females than males across the state.

4. Federal Government

4.1 Fifth National Mental Health and Suicide Prevention Plan

The Fifth Plan seeks to establish a national approach for collaborative government effort from 2017 to 2022 across eight targeted priority areas:

1. Achieving integrated regional planning and service delivery.
2. Effective suicide prevention.
3. Coordinated treatment and supports for people with severe and complex mental illness.
4. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.
5. Improving the physical health of people living with mental illness and reducing early mortality.
6. Reducing stigma and discrimination.
7. Making safety and quality central to mental health service delivery.
8. Ensuring that the enablers of effective system performance and system improvement are in place.

4.2 Primary Health Networks

PHNs were established by the Commonwealth Government with the key objectives of increasing 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. The second Murray PHN Strategic Plan, outlines a vision or Murray PHN to contribute to Better Health, Better Care and Better Systems across our region, through five distinct focus areas. Those areas are difference, better, happen, together and stronger[2].

The Lower Hume area is served by the Murray and the Eastern Metropolitan PHN. Both fund slightly different Stepped Care models for Community Mental Health Services in Lower Hume. Whilst similar, the primary difference in the two models is the requirement for a formal diagnosis to access mental health services in the Murray model.

PHNs report an expectation that future commissioning will be used for integrated responses. The integrated platform in Lower Hume is ready to pilot an expanded Stepped Care model, and part of this is different ways of governing and funding work packages. It is timely to consider how to further enhance partnerships with the PHNs and agreements on how to ensure boundaries do not impede access to care. This advancement could be attached to a change whereby only one PHN supports the Lower Hume area.

4.3 NDIS

The NDIS is designed to work alongside existing government service systems, including health, education, housing and mental health specific treatment services. People with mental health issues often require support from a range of sources such as community, family, friends, local or private mental health services and other mainstream systems. The NDIS works closely and in partnership with these other support systems and does not replace them. Health and mental health systems will work with participants when they need clinical intervention or medical treatment. They deal with psychiatric conditions and mental illness. This includes: all medical and clinical services such as general practitioners, mental health treatment by psychiatrists or psychologists, care while admitted in hospital, in-patient and residential care, rehabilitation, medications and pharmaceuticals. The health system is also responsible for other health related services such as dental care, dieticians, physiotherapists, palliative care and nursing care. Individuals and families sometimes also have a role in funding medical and clinical services, such as out of pocket expenses or gap payments. The NDIS does not cover these costs. Helping participants access the right parts of the service system when they need them can be part of a participant's plan if required[3].

Psychosocial Mental Health services traditionally funded by the Victorian Department of Health and Human Services will not always be available under the NDIS model. This presents a gap in the service system that the LHPCP Stepped Care model could attend to, supported by PHN commissioning.

[2] Murray PHN Strategic Plan 2018 - 21
[3] Psychosocial Disability, recovery and the NDIS, NDIS.org.au 2019

5. State Government

5.1 Victorian State - Mental Health Act 2014 and the 2019 Royal Commission on Mental Health

Victoria's Mental Health Act 2014 (the Act) is a key element of the government's mental health reform agenda, and places individuals and families at the centre of mental health treatment and care. The Act involves significant changes to compulsory assessment and treatment of people living with mental illness. It ensures that people living with mental illness and subject to compulsory treatment are supported to make or participate in decisions about their treatment and care. The Act also recognises the important role of families and carers in supporting the recovery of people living with mental illness. The key domains of the Act are:

- Recovery framework – establishing a recovery-oriented framework and embedding supported decision making;
- Compulsory treatment orders – minimising the duration of compulsory treatment;
- Safeguards – increasing safeguards to protect the rights and dignity of people with mental illness; and
- Oversight and service improvement – enhancing oversight and encouraging service improvement.[4]

The Victorian State Government broadly funds all acute mental health services in the Lower Hume and community based services linked to the acute service provider (GV Health)[5].

Recognition of shortcomings in the mental health system in Victoria has seen the establishment of a Royal Commission into Mental Health, to be completed by October 2020. The Royal Commission is seen as high-profile exposure for service and system deficits as well as a vehicle to improve the way Victoria addresses mental health. The LHPCP are well positioned to provide submissions about improvements through integration, place based innovation and an expanded Stepped Care model.

5.2 Statewide Design, Service and Infrastructure Plan for Victoria's Health System (2017-2037)

The Victorian government recognised that the current health system delivers some of the highest standards of care and outcomes when compared with similar systems internationally. But our health system is under growing pressure— from unprecedented population growth and ageing, from the rise in chronic disease, from more people surviving what were previously fatal conditions, from the rising costs of care and technology, and from community expectations for better, more convenient and personalised services.

The Victorian Government is responding to these pressures by delivering lasting changes to the health system, focusing on five priority areas that will chart our path forward over the coming 20 years:

1. Building a proactive system that promotes health and anticipates demand
2. Creating a safety and quality-led system
3. Integrating care across the health and social service system
4. Strengthening regional and rural health services
5. Investing in the future—the next generation of healthcare.

[4] Victoria's Specialist Mental Health Workforce Framework. Clinical Mental Health Implementation Plan 2014 - 17. Pg. 6
[5] See service map at Appendix 5

This statewide plan will guide workforce development, capacity building and infrastructure investment to ensure everyone in Victoria has access to the care they need, when and where they need it, regardless of where they live. The plan will support joined-up planning across health services, local government, community health services, Primary Health Networks, Aboriginal community-controlled health services and other service sectors. It will guide strategic planning by public health services, and support work with the private sector on innovative ways to provide care and respond to demand. The plan links to broader government planning, including the work of Regional and Metropolitan Partnerships, to ensure a unified approach to the health and wellbeing, environmental, housing, employment, education and transport needs of local communities. It provides the pathway towards our health system of the future.[6]

5.3 Community Health Taskforce

Victoria's has established a Community Health Task Force, with a defined Terms of Reference. The impact and influence of this newly established group could be supportive of better mental health outcomes in Lower Hume.

6. Key findings from Consultations

Significant issues that have also been raised as part of this report are state/federal imposed service boundaries, outcome frameworks and the need to ensure that they are meaningful to the local population.

6.1 Boundaries

Administrative government boundaries have an impact on the way acute mental health services are delivered in the Lower Hume, particularly for those requiring hospitalisation (a Shepparton based response). Currently any person from Lower Hume requiring an acute admission must have that admission conducted by Goulburn Valley Health. So, while initial treatment may be assessed by Ambulance Victoria staff and/or Emergency Department/Urgent Care Centre staff, if admission is required that client is transferred to GV Health in Shepparton. This may cause significant dislocation for the client and their family.

The acute system is under significant pressure across Victoria and this results in mental health bed wait times in the metro area that may extend to 72 hours. Access to GV Health beds has been considerably quicker (24 hours). While the dislocation for acute clients to GV Health is potentially traumatic it may represent a better outcome than remaining within a metro hospital awaiting a bed allocation.

Without a state-wide bed demand management strategy, it is unclear if inpatient health outcomes and wait times would be better served by admission to a metropolitan based mental health service (aligned to the way the Victorian Health System refers all other patients from the Lower Hume). What is clear is that vocal community influencers in Lower Hume believe that their community would be better served by admission to a metropolitan hospital for treatment, or even in a local health service.

[6] Vic Health.vic.gov.au

The administrative government boundaries for mental health service referrals are now relaxed for the 10 Year Anniversary of the 2009 Black Saturday Bushfires. It is possible that a more significant Victorian State Government administrative boundary change could occur.

In Lower Hume two PHNs (Murray, Eastern Metropolitan) have responsibility for commissioning mental health community-based services, and work closely with local services and the LHPCP. There is also a plan to improve the ways that local Department of Health and Human Services (DHHS) and the PHNs work together as there is no governance between the State and Federal funding bodies regarding how services are funded and the associated outcomes frameworks. Better alignment between the state and federal funders should result in a better connected funded service system. In Lower Hume, the PCP could be used as a platform for this approach.

6.2 Community expectations

The Lower Hume area is home to diverse communities with differing needs and expectations regarding mental health services. What is clear is the tension between the high-volume visible health service based mental health care that parts of the community expect and the contemporary way best practice mental health services should be delivered. In light of such a discrepancy, clients and communities should be part of a co-design development which advocates for the most effective mental health services in the Lower Hume. Indeed, some LHPCP partners such as local government are already well positioned to take a lead in this space.

The community also expected to be able to access mental health services locally, and at places they trust. Indeed, advice from the Eastern Metropolitan Primary Health Network was that clients remain more engaged with services when they can access what they need at the same place. Within a designed Scope of Practice, supported by credentialed and trained staff, consideration should be given to using common community access points, such as community/neighbourhood houses as the service delivery place for most Lower Hume mental health services.

6.3 Client centred links between acute and community based mental health services

The lack of a governed warm handover framework between the acute and community based mental health systems was criticised during consultation. Local communities are concerned that patients are being sent home without support services being in place. True or not, this perception is damaging to the reputation of mental health services in the Lower Hume.

The West Hume Partnership is exploring a Step Down Mental Health Acuity model to be based from Seymour and supported by GV Health. Ideally, this approach would be expanded to provide further stepped governance between acute mental health, community mental health and well population; an Expanded Stepped Care model.

6.4 Outcomes Framework

Aligned to the mental health indicators, and based on a common risk assessment and triage, an outcomes framework should be developed and promoted with clear and measurable advice about:

- What services are delivered.
- How many services are delivered.
- Where services are delivered.
- Does the service achieve its objectives?
- Are people better?

Doing so will provide a sound clinical base for the LHPCP Expanded Stepped Care Model, consistency of practice, a framework for a peer supported workforce and the basis of a communications/advocacy to the community about how mental health services are delivered locally to them.

6.5 Workforce

The ability to recruit and retain suitable credentialed staff to support each part of a Stepped Care Mental Health Service Delivery model is foundational to its success. This need can be addressed by:

- Defining capability statements for each part of the Stepped Care model and recruiting accordingly.
- Ideally, having people in roles that allow them to operate at the "top" of their scope of practice and using formal peer supported roles where appropriate.
- Working with the Regional Partnership and State Government's workforce strategies.
- Encouraging "growing your own'' opportunities (training, secondments and placements).
- Base services in metropolitan fringe areas, paying travel time, and using Telehealth.
- Enhancing and promoting the liveability of the Mitchell and Murrindindi Shires.

The LHPCP members will need to target resources to address workforce issues to support an Expanded Stepped Care Model. The ability to recruit and retain a suitably credited workforce is a critical issue.

6.6 Small Rural Health Services and community expectations

A review of recent community consultation works and listening to current consultation confirms that parts of the community believe that the provision of mental health services at small rural health services has diminished over recent years. This is mostly because the funding model and renewed Scope of Practice at the Yea, Alexandra, Kilmore, and Seymour Health Services has seen all acute admissions occur elsewhere, at GV Health or a metropolitan health service. Indeed, it seems that this concern has strongly influenced the commissioning of this report.

None of the health services want to deliver mental health services outside a best practice Scope of Practice and Capability Framework. All health services are open to improving the way this can occur as part of an integrated, peer supported model, including a "West Hume" model that could see some sub-acute mental health services provided for inpatients at

Seymour. Using the LHPCP Expanded Stepped Care model this work can be progressed in partnership and on an evidence informed and peer supported basis.

Additionally, the voice and experience of the practitioner is essential. A critical part of this education will be for mental health practitioners to ensure that they understand why changes to the model of care are being made, how it benefits clients and the impact their comment about the changes may have. Foundational to this will be the development of a first class LHPCP Expanded Stepped Care model that enjoys the confidence of practitioners.

6.7 Rural Ambulance Victoria

Noting that this report has not included direct consultation with Rural Ambulance Victoria, comment is made that some sections of the community may see Ambulance transport to a metropolitan based health service for mental health issues as confirmation that GV Health is a geographically less appropriate option. This premise has not been tested.

6.8 Telehealth

Without exception, consultation included positive responses to Telehealth. This option should be part of the LHPCP Stepped Care model both supporting client services and for practitioner peer support. Funding models and service delivery protocols will need to be refined. Various State based models for telehealth are in use, and could be a framework for the expansion of Telehealth in Victoria.

6.9 Comorbidity

Patients with comorbidities are not always accepted for treatment at mental health services (eg a patient may need to be sober to be assessed by a mental health service). Local practitioners are looking for solutions to this problem that can be formalised and tested for effectiveness.

The LHPCP Expanded Stepped Care model can provide a framework for piloting different ways of managing comorbidity and evaluating same. Examples such as the “No Wrong Door” approach can be considered. Managing comorbidity in a structured and sequenced way may also make more sense to patients and the community and give greater confidence to the LHPCP Extended Stepped Care model and the provision of mental health services generally.

Integration of physical and mental health care service response will improve health outcomes in Lower Hume. Advocating for improved administrative boundary alignment in Lower Hume will progress this issue.

6.10 Common risk assessment, triage and response framework

Mental Health risk assessments are not consistently applied across the Lower Hume. The application of a consistent risk assessment, triage and response framework will support the application of the LHPCP Expanded Stepped Care model. Additional benefits will include:

- The use of common language.
- Assessed access to the correct part of the Expanded Stepped Care Model.
- Cross sector capacity building.
- Community education and understanding about systems responses to mental health.

6.11 Supports tailored for different age groups and backgrounds

It is important that mental health services are provided equitably where and when they are needed. Population groups which may experience higher needs include youth, older people, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse (CALD) backgrounds as well as those who are harder to engage through traditional service delivery models. The size of communities and attached funding means that the LHPCP will need to be very inventive and draw deeply on a full and broad model of integration to serve its variable populations well. This could include:

- Inviting specialist agencies/services into the LHPCP Extended Stepped Care Model
- Using a diverse or multiple community consultation methods to hear and advocate for best mental health service delivery (including to the Well Population) in Lower Hume.

6.12 Mental health bed demand strategy

There is not a Victorian state-wide acute bed demand management strategy, making it difficult to assess if mental health beds are more accessible at GV Health than the Northern and Maroondah Health services. The loud community influencers in the Lower Hume state that their communities would be better served if they could access acute mental health beds either at their local health services or at the Northern or Maroondah Health services. While scope of practice considerations makes clear that managing acuity in small health services is not possible under the current capability frameworks, there doesn't seem to be a reliable way to determine if acute patients get quicker and better access to an acute mental health service at GV Health, or at a metropolitan location.

This issue will be important to understand when it comes time to work with the community about what an effective local mental health service looks like. Possible changes to Victorian State Government mental health administrative boundaries may make this a moot point.

7. Local context and a case for change

Mental health and wellbeing remain one of the biggest challenges for community members and service providers across Lower Hume. Awareness and availability of mental health services across the catchment is variable depending on where you live. Arbitrary service boundaries imposed by funding bodies further complicates and limits access for much needed service responses. Such inequities may prevent early intervention and often result in the exacerbation of mental illnesses as well as the broader impacts upon a person's (and their family's) life. A mental health service map for Lower Hume has been developed (appendix 5).

Primary Health Networks (PHNs) across Australia have been tasked with reforming community mental health services to provide support within a Stepped Care Model which aims to improve outcomes for people with mental health issues. The Stepped Care model is based on a person-centred approach, aiming to increase early intervention and prevention of mental health issues, thus providing the right care, in the right place, at the right time.

Stepped Care is centred on a staged system response containing a hierarchy of interventions matched to the individual's needs, from the least intensive to the most

intensive. The multiple levels within a stepped care approach are intended to provide an integrated spectrum of service interventions which allows the individual to transition up to higher intensity services or down to lower intensity services as their needs change.

Good mental health is fundamental to the wellbeing of individuals, their families, and the population as a whole. Mental health disorders including anxiety, depression and substance misuse are estimated to affect almost half of Australian population aged 16-85.
The prevalence of adults reporting high or very high psychological distress was higher than the state average (13%) in 2014 in the Mitchell (15%) and Murrindindi (16%) Shires, and rates of suicide are higher in regional Victoria and amongst the Aboriginal population.

There is a strong sense in parts of the Lower Hume that the provision of mental health services locally is poor, mostly in relation to local visibility and accessibility and the breadth of local services. This premise was tested through consultation and found to be an important issue with limited data available to explore more fulsomely. Regardless of the ready availability of current data, the view is supported by local government, agencies, the establishment of a Royal Commission into Mental Health and the current focus of state and federal governments. Communities and agencies in the Lower Hume seek a methodology to contribute to the co-design of local mental health service delivery.

The LHPCP discussed these issues at length in February 2019, and determined that the best response to improve local mental health outcomes is an Expanded Stepped Care model, with supporting long term governance and advocacy. Insufficient resourcing will be a critical barrier to this approach.

Equally challenging is the community education required to make sure that the broad population understand the way the LHPCP Expanded Stepped Care model works and why it is a good solution for them. A comprehensive Stepped Care model includes support to the Well Population, and should also have a defined, governed and supported role for local government and bodies such as community houses.

Using the LHPCP Expanded Stepped Care model as a framework, the LHPCP can oversight co-design work with the strategic goal of having a well informed and engaged community who are part of the Expanded Stepped Care Model (eg consider things like what can be in done in the well population, what is the role of community access points such as community houses).

8. Recommendation

The Lower Hume Primary Care Partnership (LHPCP) is an ideal platform to pilot an Expanded Stepped Care model of Mental Health Service delivery that extends from the well population to chronic and complex client acuity needs.

9. Next Steps

Set out below are actions that support recommendations, should they be adopted.

9.1.Expanded Stepped Care Model

a) Robustly work with LHPCP and key stakeholders to understand what an Expanded Stepped Care Model will look like and achieve full buy in for same. This is needed to ensure that funders, partners and community hear consistently of the support of the model. This is likely to need some conversations about what contemporary mental health service delivery is and how the Expanded model will work in practice.
b) Determine how the LHPCP will govern this work, engage and support partners, and commit to a long-term change agenda. An Executive led Capacity Building approach is suggested.
c) Refine the Expanded Stepped Care model business case quickly so it can be used for next round commissioning or other funding opportunities. This should include agreeing sequencing, required resources, activity mapping and priorities. Further refinement of the model will occur over time.
d) Promote an integrated approach, get support from community, Boards, agencies, local influencers and include it in all plans across the Lower Hume.
e) Include the Expanded Stepped Care Model and the supporting governance and intent around an integrated platform in the LHPCP submission to the Royal Commission into Mental Health in Victoria. Present this idea as a solution/innovation.
f) Promote this idea across the sector. Find critical friends to support the approach. Be transparent and foster a culture of shared learning.

9.2 Boundaries

a) Decide where the LHPCP believes the boundaries should be and advocate for same, including in the LHPCP submission to the Royal Commission into Mental Health.
b) Talk to the community about what they want and why. Co-design a solution that is informed by best practice, safety and workforce availability.
c) Consider including state and federal funders on the LHPCP.

9.3 Co-Design

a) Carefully establish why and how the LHPCP will undertake co-design work with the community and action same.

9.4 Outcomes Framework

a) Based on the mental health indicators, develop and use an outcome framework for each level of the LHPCP Expanded Stepped Care Model.

9.5 Workforce

a) Develop and deploy Scope of Practice and Capacity Frameworks matched to the Extended Stepped Care model.
b) Use governed Peer Supported models of care where possible.
c) Use Telehealth for practitioners and clients.

APPENDIX 1 – LHPCP Core Membership

Seymour Health (Chair)

Yea and District Memorial Hospital

The Kilmore and District Hospital

Alexandra District Health

Nexus Primary Health

Mitchell Shire Council

Murrindindi Shire Council

FamilyCare

APPENDIX 2 – LHPCP Stakeholders and Report Consultation List

- Chris McDonnell, CEO, Seymour Health
- Suzanne Miller, CEO, Nexus Primary Health
- Sue Race, CEO, The Kilmore & District Hospital
- Jo Wilson (and Rebecca Siriani), Community Strengthening, Mitchell Shire Council
- Lorina Gray, Manager, Yea & District Memorial Hospital
- Craig Lloyd, CEO, Murrindindi Shire Council
- Angela Armstrong, Director of Service Development, FamilyCare
- Debbie Rogers, CEO, Alexandra District Health
- Rebecca Southurst, EO, Lower Hume Primary Care Partnership
- Duncan Smart, Senior Program Advisor, Programs and Performance, South and East
- Mental Health Branch, Department of Health and Human Services
- Christie Ware, Well Ways
- Melinda Lawley, CEO, The Bridge
- Joshua Freeman, Director Mental Health Division, GV Health
- Caroline McDowell, Community Care and Mental Health, GV Health
- Pam Ewer, Community Care and Mental Health, GV Health
- Larissa Seymour, Mental Health & AOD, Eastern Melbourne PHN
- Emma Newton, Mental Health & AOD, Eastern Melbourne PHN
- Jason Minter, Director Regional, Murray PHN
- Tony Triado, Manager Population Health & Community Wellbeing, Goulburn Area, East Division, Department of Health and Human Service
- Neil Duggan, Team Leader, Agency Performance & System Support, Goulburn Area, East Division, Department of Health and Human Services

APPENDIX 3 - All documents reviewed to inform this report

- Australian Commission on Safety and Quality in Health Care. (2018). National Safety and Quality Health Service Standards User Guide for Health Services Providing Care for People with Mental Health Issues. Sydney: ACSQHC.
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- Regional Development Victoria. (2018). Discussion Paper: Strengthening Resilience in Regional Victoria: Framework for Productive, Inclusive and Resilient Future. RDV.
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- Senate Community Affairs Committee. (2018). Accessibility and Quality of Mental Health Services in Rural and Remote Australia. Canberra: Commonwealth of Australia.
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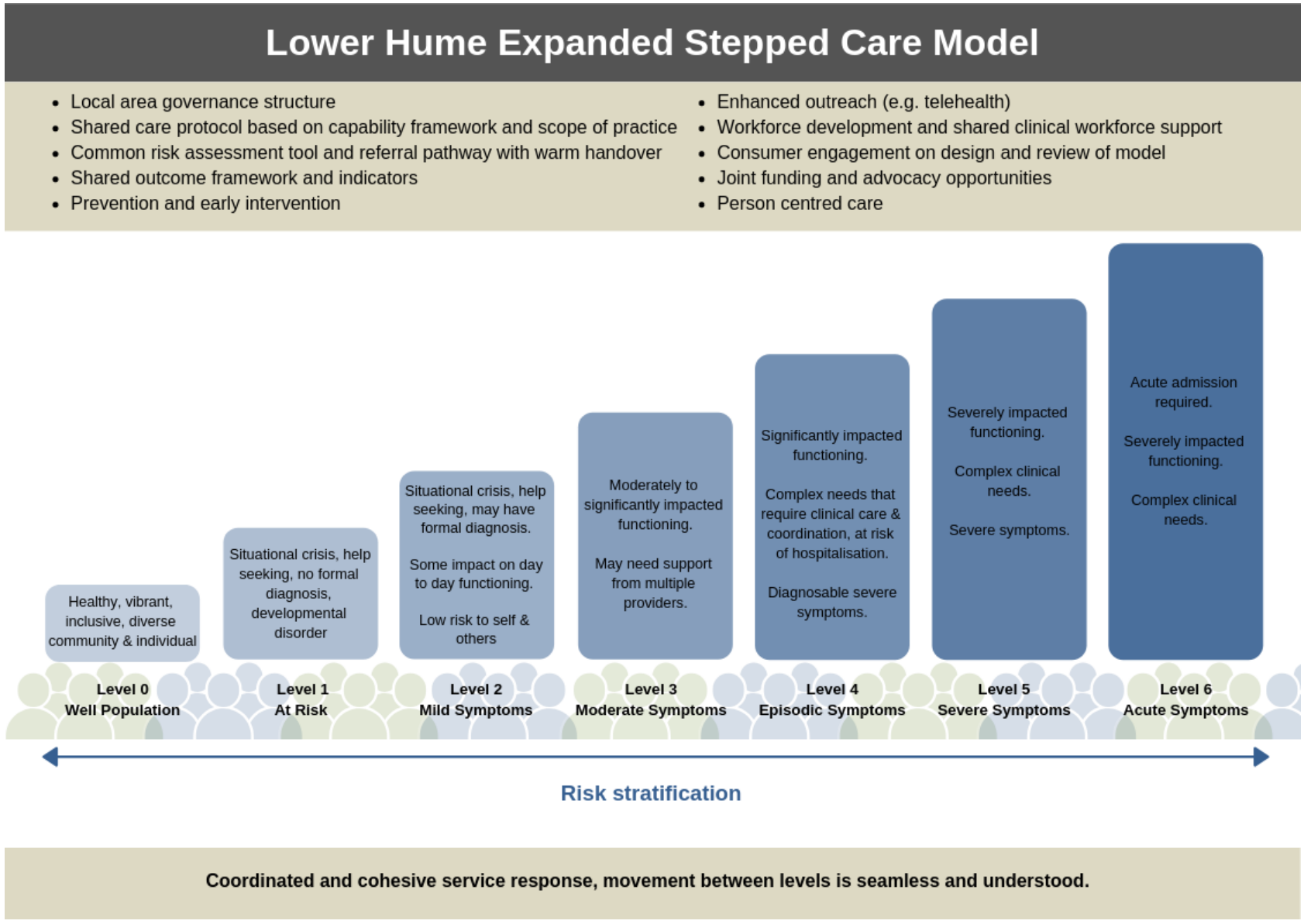
APPENDIX 4 - LHPCP Expanded Stepped Care Model



APPENDIX 5 - LHPCP Service Map