In-meeting survey results 18.06.2020

Preparing collaboratively for a potential surge

In light of the current COVID-19 impacts on service provision and on our consumers and their families, today's discussion aims are two-fold:

- To support sharing amongst our members, in particular focusing on what leaders have found useful in supporting their staff and in continuing to provide a quality service to people who experience mental ill-health and co-occurring issues.
- The Eastern Melbourne Primary Health care Collaborative (EMPHCC) have formed a MH and AOD working group with the aim of identifying changes to and gaps in service provision during the COVID-19 period, and potential collaborative solutions moving forward, including preparation for any potential surge in service/ system demand. This group is interested in hearing from our EMHSCA members about their experience at this time.

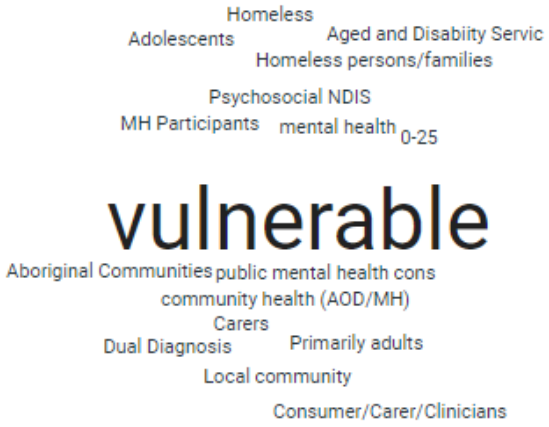
The Survey

A live Slido poll **#m234** was conducted during our meeting today and included the following questions:

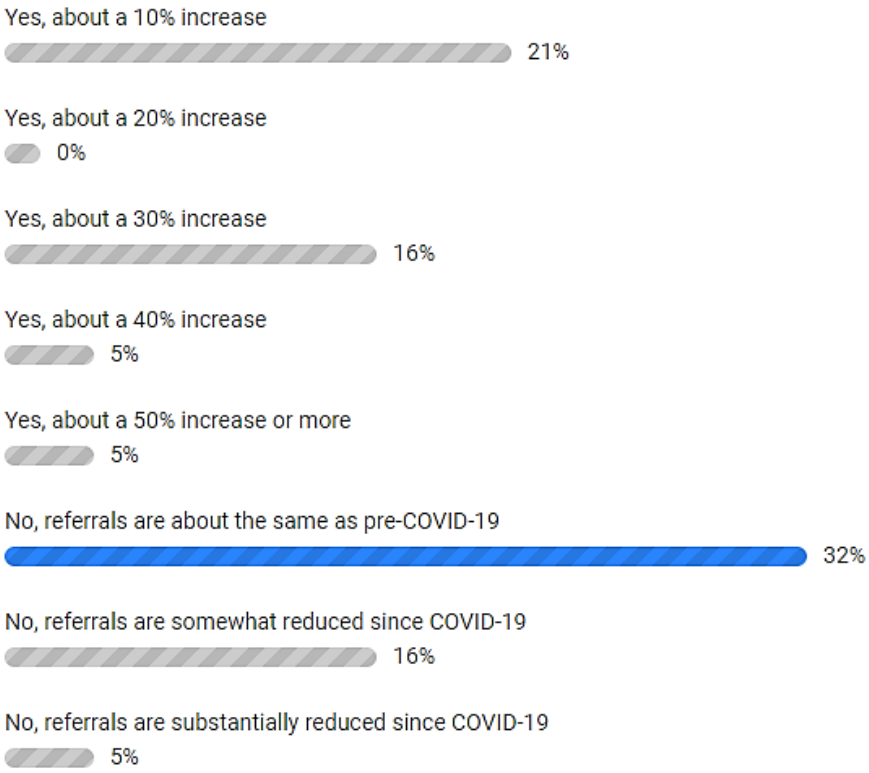
0: Which organisation/s do you represent?

- Eastern Health Child and Youth Mental Health Service
- YSAS
- EMPHN
- DHHS
- Each
- Uniting Prahran
- EACH
- Eastern Health
- Community health services in Yarra ranges
- Maroondah City Council
- Community legal assistance
- Access Health and Community
- Neami National
- Eastern Health
- Homelessness services in the East Region
- AOD

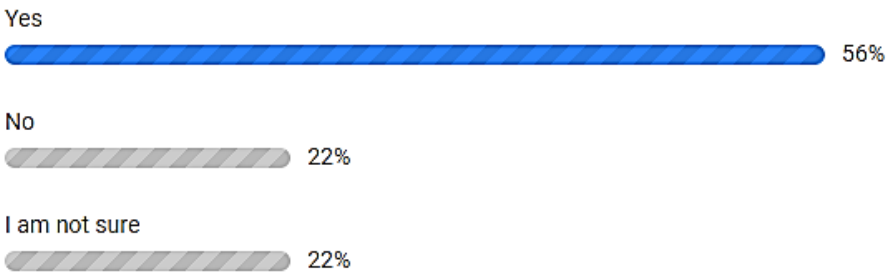
1. Who is your target population?



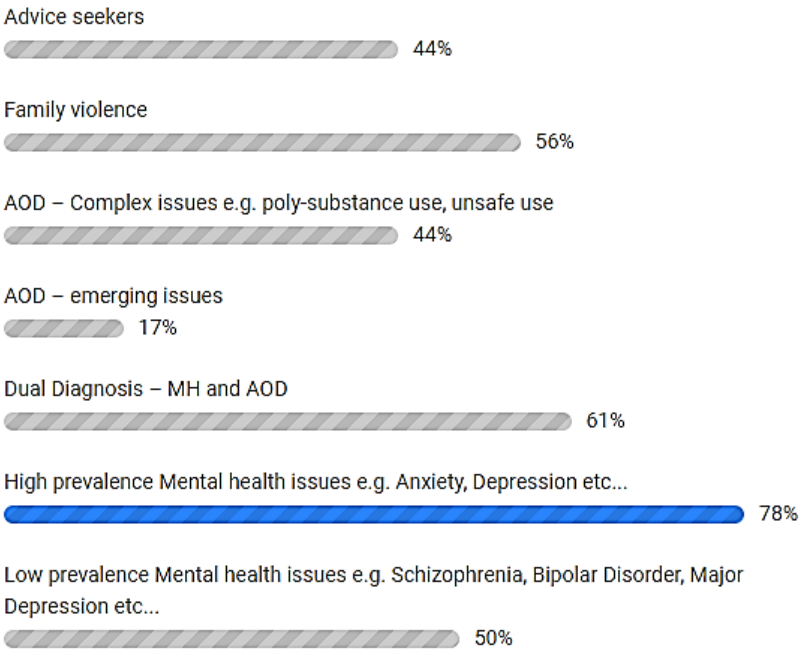
2. Have you seen an increase in referrals? (Percentage increase and “no we have seen a reduction”; “no about the same as usual”)



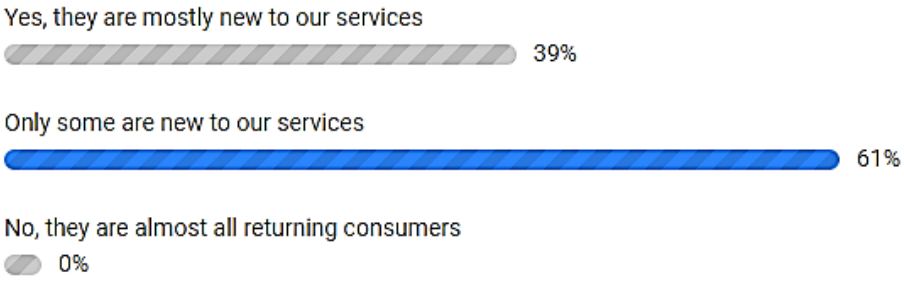
3. Have you seen an increase in complexity of presentations?



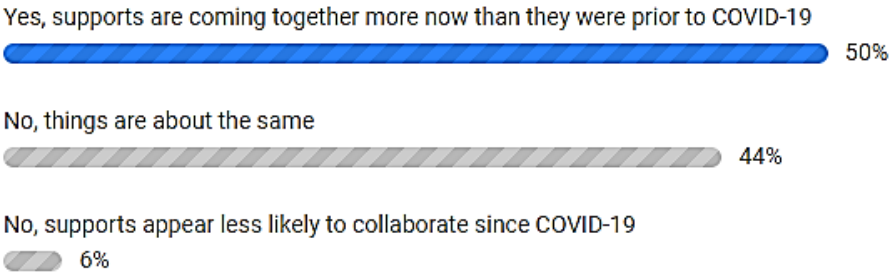
4. What type of presentations are you seeing?



5. Are these new consumers to your service?



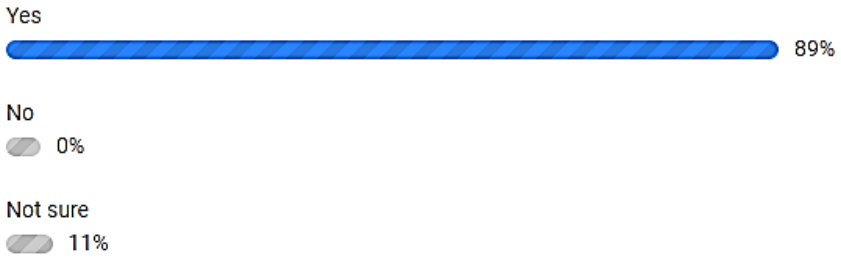
6. Have you had improved representation of cross-sector partners and advisors at meetings (care planning, service planning etc…)?



7. How do we improve our collaborative practice going forward?

- Utilise telehealth to encourage collaborative care planning and interventions, especially including GPs as part of care planning
- Needs to be built in and monitored as a core activity for all services.
- Continue with No wrong Door
- Share resources that agencies have developed to respond effectively to COVID (e.g. a resource to help clients engage via telehealth) Share information and data regarding changes in referrals (eg increased demand/complexity) Encourage shared care during COVID (e.g. telehealth/telephone conference care team meetings, particularly with GPs)
- Keep telehealth practices current, and staff skilled in its use, as this improves collaborative care planning.
- AOD is always looking at ways to improve collaboratively practice.
- Across the sector carer support seems to have large gaps.

8. Have you done anything specific to prepare (actions taken) for increased demand in service provision?



9. What strategies to manage a surge in demand have worked in the past?

- Triage of referrals, intra-program support, Brief interventions, Inter-agency referral,
- High levels of stress/anxiety for families during covid due to increased carer burden, and not being able to visit inpatient units. large gap left at EH by the demise of the COPES Carer peer Support programs MHCSS carer services did work very well for families. Much lost from carer respite, support, peer support. Carer Gateway just not filling the gaps for Mental health carer, and very much aimed towards carers of people with physical and intellectual disability. It is not evident how Carer Gateway will meet needs of MH carers even when running at full speed.
- Brief Intervention/ Single session work Supporting people through to longer term options such as NDIS where appropriate Tightened up waiting list processes. Closer working relationships with our providers. Consider all service/ response options- including non clinical options, telehealth/ group options - including lifeline and beyond blue.

- Forward planning in response to staff recruitment to deal with increased client numbers.as the physical resources are already available. The biggest issue has been people power as such
- Increased communication and collaboration between teams
- Increased knowledge of what other organisations are able to assist with and capacity to do so.
- Providing single-session consults (instead of a full intake/assessment) for clients with situational/less acute needs Providing high priority appointments for clients with higher needs (eg. suicidal risk) Attempting to redeploy staff into mental health/AOD/intake roles - but this is limited by resourcing/funding
- priority referrals / early intervention and joined up assessment across different services / renewed focus on collaborative discharge planning / reconsidering where resources are located in the service system and rationalising to meet the demand pressure points
- Use of purchase accommodation (eg. motels)
- Continue with collaboratively practice, support and shard experience

Questions and Comments

A series of questions were posted in Slido as each aspect of the survey was discussed.

Question

Eastern health: If we are seeing more people in services impacted by high prevalence mental illness (anxiety / depression) how is this impacting service delivery?

Comments

- We have seen increase in suicidal ideation presentations... we had a quiet period for a few weeks and now a marked increase.
- Neami: Our experience is that there was an initial been a drop off and recently it is starting to increase. Risk issues are magnified for people with increased mental health symptoms not feeling safe to access appropriate supports due to 'Covid risk'
- EMPHN Referral and Access Team have seen a 50%-60% reduction in referrals during COVID-19 (March-May). Starting to climb again- but not yet at original numbers. Key areas of need include suicidal ideation, employment/ homelessness/ family (and parenting) issues. Particularly in select parts of our sector - e.g. outer east
- Maroondah Council: reported a Drop in referrals. Possibly due to fear of COVID/assumption that services ceased.
  General calls from community seeking support because of COVID have been low - anticipate surge in Sept post Job Keeper.
- agree, we have seen how phone call back systems have impacted ability to access, and also reduced ability to access for those who need interpreters.
- Co-occurring mental health and AOD presentations have increased. Also well reported in media.
- Legal services has seen increase in people needing tenancy and employment law advice and this may surge in future as job keeper ends.
- Eastern Health DD and SEWB: There is need for increased support to Aboriginal people/communities given raised fear of dangers of contracting COVID19 and potential threat to life.

- Access H & CS: On the positive side - easier to organise care team meetings via telehealth etc (especially with GPs, psychiatrists) - saves time in travel. On the negative side - the lack of face to face contact amongst staff, services and teams has the potential to increase "silos" (less contact bw staff/teams)
- DHHS Aboriginal outcomes and engagement: At an individual client level, less engagement to address individual issues or challenges. There are various homelessness and housing supports being delivered to key organisations such as Launch - additional funding has also been announced.
- Mind Australia Homelessness: Homelessness services in the Eastern Region are collaborating more thanks to the Homelessness Emergency Accommodation Response Team (HEART).
- Inspiro: Telehealth in the Yarra Ranges is good but connectivity is poor.

Conclusion

Most EMHSCA member agencies have seen an increase in complexity of presentations with COVID 19. Although referrals have been about the same for 1/3rd of agencies, and reduced for about 1/5th of agencies, there has been a surge in referrals for just less than half of agencies. High prevalence disorders such as anxiety and depression have been most commonly reported. Dual Diagnosis is on the increase also, with substance use concerns featuring at present. Family violence is reported more frequently at this time.

New consumers who have not been contacting services prior to COVID 19 were identified by all, with 40% of respondents reporting mostly new consumers.

It is encouraging to see that the crisis has brought services together to work more collaboratively. Fifty per cent of EMHSCA respondents reported an improvement, and 44% reporting no noticeable effect. Suggestions for further imptovement included the use of tele-health to involve G.Ps and other providers, building in collaborative work as core business, taking a 'no wrong door approach, sharing resources and data, and improving support for carers to remain involved.

It seems that all EMHSCA member agencies are actively preparing for a potential surge in referrals at this time. Some strategies include brief interventions, increased cross-sector collaborations and partnerships, online engagement with consumers, strengthening of prioritisation processes, planning for rapid staff recruitment if required, and redeployment of staff to high need areas.

The sharing of resources via EMHSCA could support a joined up response across the region and reduce duplication of effort. Sharing of data regarding changes in the demand and complexity of referrals can also assist members to plan and respond.