Royal Commission into
Victoria's Mental Health System

Formal submission cover sheet

Make a formal submission to the Royal Commission into Victoria's mental health system

The terms of reference for the Royal Commission ask us to consider some important themes relating to Victoria's mental health system. In line with this, please consider the questions below. Your responses, including the insights, views and suggestions you share, will help us to prepare our reports.

This is not the only way you can contribute. You may prefer to provide brief comments here instead, or as well. The brief comments cover some of the same questions, but they may be more convenient and quicker for you to complete.

For individuals

Written submissions made online or by post, may be published on the Commission's website or referred to in the Commission's reports, at the discretion of the Commission. However, that is subject to any request for anonymity or confidentiality that you make. That said, we strongly encourage you to allow your submission to be public - this will help to ensure the Commission's work is transparent and that the community is fully informed.'

Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commission's reports, subject to any preferences you have nominated.

For organisations

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Because of the importance of transparency and openness for the Commission's work, organisations will need to show compelling reasons for their submissions to remain confidential.

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them. If you would like to contribute and require assistance to be able to do so, please contact the Royal Commission on 1800 00 11 34.

Your information	
Title	Mr
First name	Brian
Surname	Kennedy
Email Address	[redacted]
Preferred Contact Number	[redacted]
Postcode	3690
Preferred method of contact	☒ Email ☐ Telephone
Gender	[redacted]
Age	[redacted]
Do you identify as a member of any of the following groups? Please select all that apply	[redacted]
Type of submission	☐ Individual ☒ Organisation Please state which organisation: **Albury Wodonga Health: North East and Border Mental Health Services.** Please state your position at the organisation: **Operations Director Adult Mental Health** Please state whether you have authority from that organisation to make this submission on its behalf: ☒ Yes ☐ No ☐ Group

	How many people does your submission represent? I have consulted and accepted written material from multiple individuals within the organisation, selected written contributions are listed as appendix at the end of table. Question 11 on Dual Diagnosis was prepared for me by Dual Diagnosis Clinical Nurse Consultant.
Personal information about others	Does your submission include information which would allow another individual who has experienced mental illness to be identified? ☒ Yes ☐ No
	If yes, are you authorised to provide that information on their behalf, on the basis set out in the document ☒ Yes ☐ No
	Prior to publication, does the submission require redaction to de-identify individuals, apart from the author, to which the submission refers ☐ Yes ☒ No
Please indicate which of the following best represents you or the organisation/body you represent. Please select all that apply	☐ Person living with mental illness ☐ Engagement with mental health services in the past five years ☐ Carer / family member / friend of someone living with mental illness ☐ Support worker ☐ Individual service provider ☐ Individual advocate ☒ Service provider organisation; Please specify type of provider: __Public Mental Health Service ☐ Peak body or advocacy group ☐ Researcher, academic, commentator ☐ Government agency ☐ Interested member of the public ☐ Other; Please specify:
Please select the main Terms of Reference topics that are covered in your brief comments. Please select all that apply	☒ Access to Victoria's mental health services ☒ Navigation of Victoria's mental health services ☐ Best practice treatment and care models that are safe and person-centred ☒ Family and carer support needs ☒ Suicide prevention ☒ Mental illness prevention ☒ Mental health workforce ☒ Pathways and interfaces between Victoria's mental health services and other services ☒ Infrastructure, governance, accountability, funding, commissioning and information-sharing arrangements ☐ Data collection and research strategies to advance and monitor reforms ☐ Aboriginal and Torres Islander communities ☒ People living with mental illness and other co-occurring illnesses, disabilities, multiple or dual disabilities ☒ Rural and regional communities

	☐ People in contact, or at greater risk of contact, with the forensic mental health system and the justice system ☐ People living with both mental illness and problematic drug and alcohol use

For individuals only

Please identify whether this submission is to be treated as public, anonymous or restricted

While you can request anonymity or confidentiality below, we strongly encourage your formal submission to be public - this will help to ensure the Commission's work is transparent and the community is fully informed

Please tick one box	
☒ Public	My submission may be published or referred to in any public document prepared by the Royal Commission. There is no need to anonymise this submission.
☐ Anonymous	My submission may only be published or referred to in any public document prepared by the Royal Commission if it is anonymised (i.e. all information identifying or which could reasonably be expected to identify the author is redacted). If you do not specify the information which you would like to be removed, reasonable efforts will be made to remove all personal information (such as your name, address and other contact details) and other information which could reasonably be expected to identify you.
☐ Restricted	My submission is confidential. My submission and its contents must not be published or referred to in any public document prepared by the Royal Commission. Please include a short explanation as to why you would like your submission restricted.

Please note:

- This cover sheet is required for all formal submissions, whether in writing or by audio or video file. Written submissions made online or by post, may be published on the Commission's website (at the discretion of the Commission) subject to your nominated preferences.
- Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commissions reports subject to any preferences nominated.
- While the Commission will take into account your preference, the Commission may redact any part of any submission for privacy, legal or other reasons.

Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

Executive Summary

Albury Wodonga Health (**AWH**) welcomes the opportunity to provide a written submission to the Royal Commission into Victoria's Mental Health System. AWH is unique in being the first and only Australian cross-border health service which includes cross-jurisdictional delivery of mental health services between Victoria and New South Wales. The New South Wales (NSW) part of AWH's mental health service, although funded by NSW, is delivered under Victorian governance through an intergovernmental agreement. As such, our submission refers to services provided to our cross-border catchment region and makes reference to the unique local arrangements in which AWH exists.

Our consumers, their families and communities, and our staff, are optimistic that the Commission will deliver recommendations that will see a significant re-shaping of the mental health service system. We are hopeful that the Commission's determinations will result in a service system that recognises the strengths that exist within rural and regional mental health care and ameliorates the challenges faced by rural and regional consumers seeking mental health care.

Key suggestions

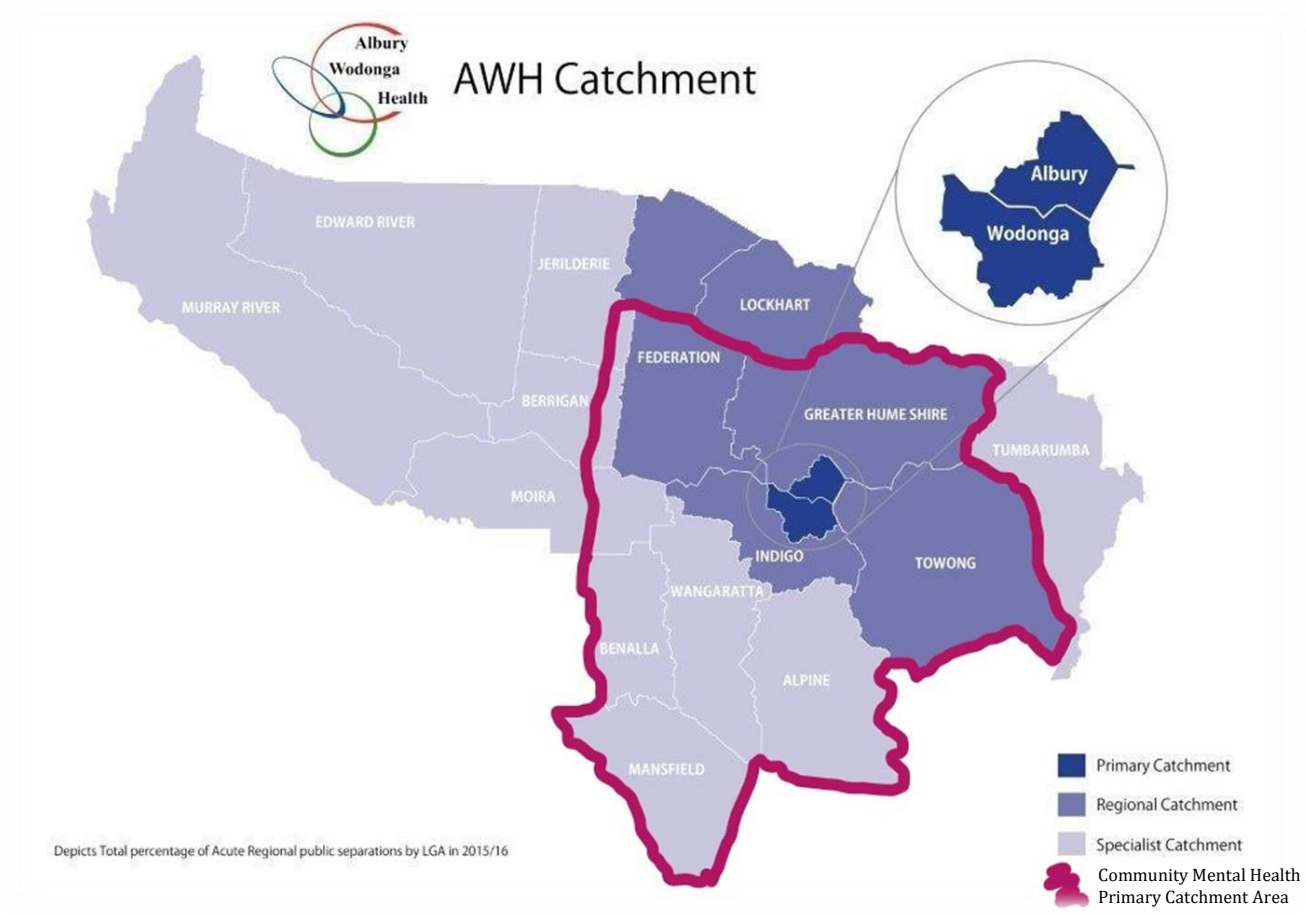
AWH encourages the Royal Commission to consider the following suggestions amongst others made in this submission:

- It is suggested investment in preventative programs, incorporating specialist infant mental health care into perinatal mental health, is required. In particular, long term preventative programs such as increasing supports around perinatal mental health, parental bonding and infant welfare are sound investments for the emotional wellbeing of future populations.
- It is suggested that regional mental health services be funded to deliver assertive outreach service models that see mental health clinicians embedded within rural communities delivering primary and secondary care consultations and engaging in community capacity building.
- It is suggested that increased numbers of mental health Nurse Practitioner positions be funded across the rural catchments to assertively engage with communities that are isolated by geography and culture to enable and provide early intervention.
- It is suggested the Commission consider the implementation of an "Advanced Practice Mental Health Practitioner" course, where candidates undergo an accredited training program to become eligible for certain formal mental health delegations, with a view of relieving psychiatrists of some of their current workload. Such delegations would require review or amendment to the *Mental Health Act 2014* (Vic).

An introduction to AWH

AWH is the clinical mental health service provider for North-East Victoria and Southern NSW, delivering a range of acute, subacute and community mental health services across 12 sites in Albury, Wodonga, Wangaratta and Beechworth with outreach sites located at Yarrawonga, Corryong, Benalla and Mansfield in Victoria. Our catchment region is pictured below (figure 1) with acute inpatient mental health services provided to this entire region via two acute inpatient units located at Albury and Wangaratta respectively. This catchment region has a population estimated at 250,000 people. The pink line illustrates the primary catchment region for our community mental health services. Last year AWH had over 1100 mental health admissions and delivered over 50,000 service hours of community contacts. We employ approximately 280 equivalent full time (**EFT**) staff across the disciplines of nursing, medical, allied health, peer workers, consumers and carers.

Figure 1: AWH Catchment Region including illustration of primary catchment region for Community Mental Health services.



Population health data identifies that many of the Local Government Areas (**LGA**) supported by AWH have an ageing population, whilst in the Wodonga LGA there is an over representation of the population under 24 years of age. The smaller rural communities we serve are typified by high rates of volunteer engagement in communities, low rates of higher education qualifications, high rates of socioeconomic disadvantage, higher rates of people at risk of alcohol-related harm on a single occasion of drinking, and high rates of avoidable deaths. Our larger urbanised centers show greater socioeconomic advantage and higher rates of higher education qualifications, but a greater percentage of social housing and family violence when compared with other Victorian communities (Victorian DHHS Population Health Data 2016).

Like all other regional mental health services, AWH is challenged to provide responsive, timely and effective mental health services consequent to the large geographical area served, the isolation of some of the communities within our catchment region, the difficulties faced in recruitment and retention of psychiatrists and other mental health clinicians and the co-morbid health needs of rural and regional people. In addition to this, AWH faces the unique challenges of delivering services in a cross-state context and in particular, under the requirements of two state Mental Health Acts that do not sufficiently align to enable clinicians to deliver best care. AWH will welcome with enthusiasm any recommendations made by the Commission that harmonise mental health legislation.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Mental health care in Northeast Victoria has a long history prior to Albury Wodonga Health providing services to the border regions. The Beechworth Mayday Hills Mental Hospital operated until 1995 when it was decommissioned. It was one of Victoria's three largest institutions of mental health care and had been in operation for 128 years with the resident patients receiving the treatment of the day. Built in an Italianate style, it boasted recreational facilities that included a theatre, kiosk, tennis courts, a cricket ground and quaint pavilion with majestic established native and exotic trees. There is an oak lined curved avenue, well-tended flowering gardens, shrubberies with walks and resting benches. As pleasing and tranquil as the surrounds could possibly be, the inescapable reality remained that the treatment of people who were living with a mental illness remained controversial, as it interfaces with the most basic of human rights.

The human rights reforms of the 1980s brought fundamental shifts in mental health treatment and care which were expressed in the *Mental Health Act 1986* (Vic). This legislative reform supported care through the deinstitutionalisation process with emphasis on community based care well into the new millennium. However, it could be argued, it was too paternalistic for a contemporary mental health Act, because it included "substituted decision making" for those who met certain legal criteria.

The *Mental Health Act 2014* (Vic) was drafted in the wake of Australia ratifying the United Nations Convention on the Rights of Persons with Disabilities in 2008, and duly introduced "assisted decision making", acknowledging that a person's capacity or ability to make decisions may fluctuate at times. The introduction of advance statements to communicate preferences, such as treatment preferences, along with nominated persons and other safeguards, has afforded increased human rights into the mental health treatment and care currently provided.

Mental health reform and progression can be viewed through the evolution of human rights. However, misconceptions, negative stereotyping with labelling, marginalising and self-stigma remain significant problems.

Community acceptance of mental health does appear to be improving. We see high profile individuals and champions disclosing substance use problems, episodes of depression and anxiety, and we hear of bullying and the unfair marginalisation of particular groups within society. In essence, many people with such lived experiences are coming out, sharing their stories, and disclosing their challenges with their mental health. This all fosters an inter-relatedness and contributes to the palatability, acceptance and compassion for those living with mental illness or mental health concerns, and enables or liberates us to better embrace our own mental health, perhaps allowing us to accept and seek support if and when we require it.

It is anticipated that with ongoing community education, a focus on human rights evolution and reforms, that fear of difference, prejudice and lack of acceptance will, by and large, soften as more people identify, show increased understanding and empathise with those living with mental illness.

Mental health public awareness education is currently undertaken through Albury Wodonga Health (**AWH**) North East and Border Mental Health Service (**NEBMHS**) Primary Mental Health Service. It is delivered by a small number of staff members who also provide clinical services within the rural catchment, and so availability for presentations is limited. To expand on the work currently undertaken would require increased staff availability, duly accredited and assigned to the role. It would be advantageous for this preventative mental health promotion to be available equitably across the whole of catchment. Activity already undertaken within schools includes Mental Health First Aid for youth, aimed at improving knowledge of mental illness, and strategies for appropriate first interventions until appropriate professional help is available or there is resolution of crisis. Mental Health First Aid Australia website identifies that Youth Mental Health First Aid is associated with decreased stigma.

Suggestions

- Recommend increased resources for education and Mental Health First Aid training so to enhance early identification, seek appropriate intervention, improve mental health literacy and resultantly reduce stigma including for self-stigma.
- Provide increased focus on the rights of people with disabilities through media campaigns and secondary education. Also on the evolution of human rights as is seen through mental health reforms. The goal is to ensure that people with disabilities, including for mental illness have the same rights as everybody else and that they are respected by others.
- Provide adequate staffing resources for tertiary services to facilitate engagement and offer support to those with the most need, who may not seek services out. Currently staff resources in acute mental health services are almost exhausted responding to those in the community seeking assistance. Those living with a diagnosis of mental illness who may not seek or receive timely assistance, at times, may show erratic behavior in public. The consequences of such shortfall in support or service provision available to those in such circumstances undoubtedly adds to negative stereotyping and the perpetuation of the very stigma we wish to eradicate.
- Further promote mental health education in schools, along with existing physical education. This could be incorporated under the general banner of a holistic health program and include nutrition and other relevant health education.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

The NEBMHS have long served to provide innovative modes of early intervention (identifying and responding to mental health where signs first appear), and primary prevention (building community resilience and improving mental health literacy, thereby reducing stigma). However, some of these services now need further support or development. Some examples are outlined below.

Early Motherhood and Perinatal Emotional Wellbeing Services

This might be best exampled through the Perinatal Emotional Health Program (**PEHP**) initiated locally around two decades ago, now taken up state-wide and reflected in the Centre of Perinatal Excellence model of care. The roots of the **PEHP** are in adult clinical mental health services, with a primary focus on the parent. Optimum perinatal mental health care must incorporate both parental and infant mental health. Therefore, an upskilling and building on the PEHP workforce to foster expertise in providing specialist infant mental health care is an essential element of future mental health care planning. Attachment 1 is a brochure which provides further detail about the PEHP.

Suggestion

- It is suggested investment in such preventative programs, incorporating specialist infant mental health care into perinatal mental health, is required. In particular, long term preventative programs such as increasing supports around perinatal mental health, parental bonding and infant welfare are sound investments for the emotional wellbeing of future populations.

We should continue and build on the PEHP model which holds much long term promise for mentally healthy communities.

Older Persons Mental Health Services

Older Persons Mental Health Services incorporating Cognitive Dementia and Memory Service (**CDAMS**) have cultivated primary care relationships over many years, providing general practitioners (**GPs**) and referred persons with comprehensive assessment and treatment interventions and plans.

The demand for services however, appears to be increasing* e.g. CDAMS year to date contact hours are 1,044, which is 30% over the target of 803 hours with numbers of referrals steadily rising:

- 2016: 212 CDAMS referrals;
- 2017: 219 CDAMS referrals;
- 2018: 264 CDAMS referrals.

(*See page 2- https://www2.health.vic.gov.au/Api/downloadmedia/%7BE891501C-2721-4E9F-A5E9-27F78E16BE38%7D regarding aging population).

The flow on from increased referral activity will herald a rising need for mental health and risk assessments, mental health case work, assessment admissions, clinical liaison, housing / accommodation including extended supported residential care, financial advocacy, family support and family counselling for older persons.

Historical rural context and collaborative approach

A decade or so ago, outreach workers would attend each town in the catchment at least fortnightly, providing therapy, meeting, consulting, supporting, educating, and building trust and credibility with local GPs, community health centres, counsellors, local police and ambulance services and the local community (all of whom would act as referral sources).

The following example is entirely fictitious. However, it serves to portray the positive practise of a collaborative approach in a rural context. Any similarities to actual people or events is purely coincidental.

> *The local policeman in a remote community might explain to the visiting mental health worker that Mick, who lived just outside of town, had been absent from the footy club and was only rarely coming into town for groceries. It had been noted his sheep were looking uncharacteristically in need of dagging and those who had seen him, felt he wasn't his usual self. The policemen may go on to explain that Mick's wife had passed away last year and that the community were worried about him as he wasn't answering his phone calls. At such an exchange, it may occur that the clinician and the policeman together conduct a welfare check to the residence, perhaps to find that all was going reasonably well, considering the situation, and a GP appointment may have been encouraged or arranged. Conversely, it may have also turned out that Mick was living with acute depression, malnourished and required hospitalisation; or somewhere in between.*

In response to the increased demand for services over the last decade, front footed consultative and collaborative approaches to service delivery, such as that illustrated above, and referral acceptance have been replaced by centralised triage systems. Although these are efficient, they do not provide the unique local responses through cultured relationships previously fostered and available to service the communities.

Suggestions

- Rural mental health services require adequate staff resourcing to offer optimal engagement to all stakeholders within the areas of the designated catchment. Those living in outlying towns do not have mental health clinicians readily at hand, and responses can be resultantly delayed. Time spent by mental health clinicians in rural towns is now mostly spent in primary consultation with

registered clients, leaving no time for collaborative networking, secondary consultation or capacity building with local health care professionals and emergency service liaisons.

- Clear instruction to the public as to where to get the appropriate assistance required and ensure services are resourced adequately to respond.
- We have seen much public promotion and prevention around cardiovascular health in the last half century, yet for mental health it seems a case of providing response once it manifests. We need to drum the message that mental health is a part of general holistic health and seek to further promote preventative strategies.

3. What is already working well and what can be done better to prevent suicide?

What is working well

Clinical services provide interventions on a daily basis, via the Crisis Assessment and Treatment Team (**CATT**) response, the HOPE Initiative, Youth and Early Intervention Service and case management to intervene and prevent suicide. Primary Mental Health Services extend educational programs, engaging communities around the catchment with the constant theme around prevention, support and recovery – "early in life, early in illness and early in episode", in close partnership with community and suicide prevention networks.

Responding to rural community needs

Rural communities differ from urban populations in respect to suicide prevention strategies. Innovative approaches toward engagement should be explored. The following describes such an approach which has worked very well for those regional communities in scope.

Locally, a male mental health nurse practitioner (**NP**) currently working in the primary mental health space has spent many years cultivating rural relationships, that is, through providing educational handouts at cattle sales, and generally doing the hard yards of engagement. This clinician accepts referrals from many unlikely sources, and assertively follows up with this difficult to engage cohort (who may be men working off the land, may be unlikely to seek mental health services through self-reliance, may not be engaged with a GP, may have difficulty articulating their feelings or show degrees of rural stoicism, and may have had some catastrophic reaction to loss or predicament). This is a cohort vulnerable to ending their life - Perceval et al (2018). The emotionally mature NP who is familiar with the cohort, shares common interests around farming, is sensitive to rural issues, and is able to engage and accurately empathise. It is through this engagement that a therapeutic intervention becomes possible. That is, rapport is established, emotional support is provided, and medication may be discussed, including as a trial initially (to be reviewed in the ensuing weeks or months). It is important for local responses to be tuned to local communities and individual needs if they are to maximise their credibility and be able to engage meaningfully.

Perceval M, Ross V, Kolves K, Reddy P, De Leo D. Social Factors and Australian farmer suicide: a qualitative study. *BMC Public Health.* 2018 18:1367 https://doi.org/10.1186/s12889-018-6287-7

Suggestions:

- Increased mental health NP positions be funded across the rural catchments to assertively engage with communities that are isolated by geography and culture to enable and provide early intervention.
- The mental health workforce provide flexible engagement strategies so as to remain accessible to all persons and shape services as acceptable to all the populations within the respective catchments.

Primary Prevention

The aim of the Primary Mental Health Team is to establish and strengthen service networks in partnership with rural communities to identify and respond to mental health problems, including for suicide prevention. Much of the work undertaken is providing Mental Health First Aid training and supporting suicide prevention networks and community response services. Education is primarily provided to communities, schools and organisations. It is understood such primary prevention activity is beneficial in raising community awareness, improving understanding of mental illness, and developing an understanding of what to do should mental health problems (including crisis) arise.

The main activities undertaken by the Primary Mental Health Team include:

- Providing community education to support services / business and community members to understand mental health problems better, so that individuals can be supported to get early access to the most appropriate services;
- Participate in and provide advice to local government health and wellbeing committees;
- Participate in health promotion groups through Primary Care Partnerships to keep Mental Health Problems visible and part of the current planning for population health;
- Establish and support the Wangaratta Suicide Prevention Network;
- Act as a member of the steering committee of the Benalla Suicide Prevention Place Based Trial;
- Support the Albury Suicide Prevention Network;
- Attend community events as mental health support or as guest speakers i.e. at CWA events, "Look over the Farm Gate" event etc.;
- Provide individual support and arrange referral pathways for people who are identified through education or community events as requiring treatment, enabling connection to the most appropriate mental health service indicated.

Through these networks, links are developed with organisations that will facilitate training to community members with attendance free of charge. A snapshot of the programs delivered is as follows:

Standard Mental Health First Aid (MHFA)

- 2019: Albury, Wodonga, Yackandandah, Myrtleford
- 2018: Albury, Wodonga, Whitfield, Benalla

Youth MHFA

- 2019: Chiltern, Wangaratta
- 2018: Beechworth, Mansfield, Wangaratta, Myrtleford, Tallangatta

Teen MHFA

- Annually: Myrtleford P12, Marian College Myrtleford, Mt Beauty, Bright, Benalla P12

Suicidal Person MHFA

- 2019: Wangaratta x 3
- 2018: Benalla x 2, Tallangatta, Wangaratta

Applied Suicide Intervention Skills Training

- 2019: Shepparton, Wangaratta
- 2018: Albury, Benalla

The benefits of increased mental health literacy and basic mental health first aid training including for suicide are consistently fed back by participants.

Normalising the experience of mental health problems and people being able to talk to family and friends about what they have learnt tells us that by providing community education we are targeting not only an increase in skills for the general public, but also addressing stigma.

HOPE Initiative

The HOPE Initiative offers service and allows support to people who may not have met the criteria for traditional Adult Mental Health Services, and so facilitates a greater uptake of people for intervention.

The introduction of the HOPE Initiative has provided a flexible, non-clinical approach to intervening in predicament suicide which typically manifests secondary to a significant event or cumulative stress. A commonality in attempting to or ending one's life is disconnectedness in its many forms. In the HOPE Initiative, the disconnectedness is not secondary to identified mental illness and the interventions are resultantly not medical. Service provided through the HOPE Initiative is predominantly emotional support, family therapy, evidence based psychological therapies, that is, through cognitive behavioural therapy and counselling support which seek to reconnect and restore psychosocial functioning facilitating emotional adjustment. Practical support is offered and may include occupational, housing, or assistance around social engagement / connection.

Opportunities to do more

Suicide and intoxication

We have seen a number of persons attempting to end their life whilst intoxicated, and when assessed, often after the effects of intoxication have passed, the person denies any ongoing suicidal intent, thoughts or plans. On examination, when the effects of a substance have dissipated, the person presents as not showing signs of depression and does not appear to have a mental illness. It frequently occurs that persons in this situation refuse any ongoing support or counselling options that are offered to them, only to, down the track in the context of further intoxication, attempt and possibly end their life. This group of vulnerable people remain a concern. It seems the intoxication allows for some release of strong negative emotions which evokes reckless and lethal behaviours.

It cannot be overemphasised how critically important the engagement opportunity is at these assessment points, which literally have the potential to be lifesaving. Such presentations highlight the need for all health workers to understand and be adept in taking a motivational styled approach for all persons presenting with Alcohol and Other Drug (**AOD**) morbidity and critically those with suicidality.

It also raises the issue of AOD co-morbidity and how much of mental health work is steeped in dual diagnosis (which is further discussed in response to Question 11). Where a window of opportunity presents with a person becoming contemplative around their substance consumption, any process of referral, wait times and new faces complicates the process to the extent that the "moment of engagement" is potentially lost. It is therefore recommended that all healthcare professionals working in acute care centres receive education around motivational interviewing, to enable intervention to be readily available. In effect, this would mean that whichever part of the service is entered, as far as AOD is concerned, skilled staff are there to facilitate a motivational approach – offering a "no wrong door" approach (as it is termed). All mental health professionals should be proficient in motivational change or "dual diagnosis capable".

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Inter-service collaboration

Responding to complex needs requires an integrated approach between multiple agencies relevant to the needs of the person with respect to identifying and responding to physical, social and emotional care objectives. Assembling and co-ordinating relevant agencies, and accessing resources can be difficult and can impede timely outcomes. Emergency housing programs struggle with demand, and access to AOD services and mental health services requires improved co-ordination to integrate treatment approaches.

Suggestion

- That a new professional role of "Service Navigator" be considered to assist with advocacy, supports and care co-ordination for people with complex needs.

Cross-border mental health service

The AWH NEBMHS are the first cross border mental health service in the country. The interstate MOU identifies NSW AWH catchment as a Victorian service under Victorian governance. However, NSW legislation and industrial requirements apply.

As people, subject to Mental Health orders and schedules, cross the Victoria-New South Wales border mostly for admissions, legal considerations arise. State mental health legislation cannot be progressed in a neighbouring state. It can however, under corresponding orders, serve to transport a person if the destination is the most appropriate in the circumstances. This translates for example, to a person who may be placed on an assessment order in a Victorian ED would preferably be admitted to the NSW inpatient unit (perhaps for proximity to family). Where this occurs however, they must undergo a further parallel assessment process. This involves a second ED visit and interview as the criteria for a NSW Form 1 are required to be met and needs completion prior to a formal admission occurring. Whilst this may satisfy those parts of the respective Mental Health Acts, it does not satisfy the overarching principles of the Mental Health Acts that indicate a person should be cared for in the least restrictive, least intrusive manner. Multiple assessments as a requirement for interstate inpatient admission can be frustrating and may feel intrusive.

AWH NEBMHS currently seek "Cross Border" advice to provide clarity on what the best practice might be in relevant circumstances.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Rural and remote communities

Options and access for mental health service and community management (i.e. out of hospital care), reduce with area remoteness. Many rural communities experience increased economic problems with high unemployment, social disadvantage and are subject to the vagaries of agricultural trends (for example, the dairy industry predicament). Farming communities, especially male farmers, strongly identify with their role as a farmer, resultantly if the farm fails (even secondary to external factors) the failure is personalised as "I failed", there is the high likelihood of any risk increasing where there is reduced help seeking. (Perceval, Kolves, Reddy & De Leo; Farmer suicides: a qualitative study from Australia (2017), *Occupational Medicine* 67; 383-388).

Suggestions

- Improving access to care can be achieved by increasing workforce availability in rural and remote locations. Currently, secondary to demand, services are becoming centralised. Mental health provision should be tailored as far as possible to being acceptable to the community serviced, or "fitting in" as exampled in response to question 3- *Responding to Rural Community Needs.*
- Continuing to promote and expand education to provide understanding and acceptance of mental health, aimed at reducing self-stigma and rural stoicism.
- Building capacity with local primary healthcare providers (predominantly GPs and counsellors) is sound and practical, given the relationships already exist and may not be as stigmatised as the visiting mental health speciality services.
- The use of telehealth as a service medium to access remote community is suggested to be used, to assist with consumer travel or where the distance and response times are prohibitive. AWH NEBMHS have made some initial piloting in the Mansfield district and remain keen to progress into other areas of operation. It is worth noting that the Office of the Chief Psychiatrist has provided clarification that persons may be remotely assessed by audio-visual medium, which allows for a reduction in the use of overly intrusive transportation under section 351 of *Mental Health Act 2014* (Vic) for rural and remote Victorians.

6. What are the needs of family members and carers and what can be done better to support them?

Regional child and adolescent beds

When a child or adolescent who resides in the AWH catchment region requires a specialist mental health admission, the current options are to transfer them to Box Hill, Victoria or Orange, New South Wales. The admission catchment for AWH NEBMHS extends out past Barham in the west, which is a 7-hour road trip to Box Hill via Albury (or 4 hour trip direct from Barham) or a 7-hour road trip to Orange.

Whilst measures are taken to care for children and younger adolescents locally wherever possible, there are times when an admission, especially to manage risk, is required. The added burden of a child being cared for or treated so remotely from family, home and supports is troublesome and presents multiple challenges for families to manage (for example, running a farm or business with one parent away from home, caring for siblings, taking time from work, logistics of travelling and staying close to the child or adolescent).

Regional child and adolescent inpatient wings / units would go some way to alleviating unreasonable travel expectations, and providing improved access for families and supports given the extraordinary distances required to travel for admission currently required.

Carers supports - as identified by lived experience workforce

The Mental Health Carer Support Fund provided by the Department of Health and Human Services (**DHHS**) has been used very effectively within the guidelines provided to assist carers in their role. An increase in allocation is suggested which will afford assistance to more carers.

For carers It is desirable for the mental health service to be responsive and intervene early, that they are easily accessed 24/7, and that the pathway into the mental health service is easy to find. A single point of entry is desirable and is something AWH NEBMHS is working towards.

Many carers experience significant distress; supported counselling for carers should be more available.

Young carers

Better identification and recognition for young carers / nominated persons is warranted. This includes students who are caring for parents/siblings with a mental illness. Funding to ensure young students have school uniforms, attend school camps (as respite care), and have access to other necessities (such as food), is required. We should ensure that young carers are actively supported with psychological, emotional and physical wellbeing checks and their needs are met where possible.

Grandparents as carers

Better recognition of grandparents caring for their grandchildren is called for when the parent is mentally unwell. Grandparents can be left to raise their grandchild/children with no financial support from the parent. The creation of Centrelink benefits for this cohort would greatly assist the financial struggle and give recognition to their role.

A carer's perspective – Lived experience workforce response

Carers, particularly long term carers, frequently experience significant stress and worry in their caring role. There are issues around perceived lack of service being provided to the consumer, and issues with bed availability when needed. Carer's provide feedback to the effect that they believe the situation needs to get to crisis point before help arrives.

The need is for more timely intervention before crisis emerges.

Case workers have large caseloads, meaning that they are unable to take on new clients unless it is a crisis. The time they have to spend with clients and supporting family members is limited. Family members are considered a key part of recovery for consumers, and accordingly, they need the skills to be able to support the consumer during periods of being unwell.

The roll out of the National Disability Insurance Scheme (**NDIS**) has been a massive hurdle for families as well. While there have been some success stories, the lived experience workforce hear of people who have 'slipped through the cracks'. When a diagnosis is not considered 'lifelong' it leaves family to fill the gap that has been left by community services no longer being available. The engagement from these services is now non-existent for people without packages, with only some follow up from public mental health services. Some improvements have been made, with some of our public mental health consumers being able to access community support through government funding, but the success of this is yet to be gauged.

Services for carers such as psychology can be provided through a GP mental health plan. The problem with this is that there is often large waiting lists to access the support needed. If more services could be provided by the public mental health system, it would be a more holistic approach to supporting carers. Carers often fight to get the services their loved one needs and often put themselves last. Programs such as Dialectical Behaviour Therapy need to be more readily available for consumers, because this starts the process of recovery and inevitably assists the carer.

Funding such as the Carer Support Fund has been a massive help to carers in their role. When things become difficult for carers, especially when the person they are caring for is unwell, this funding reduces the pressure. Practical help like fuel vouchers or assistance paying bills is very beneficial. Sometimes carers are unable to work due to their caring role, and this funding is essential. Being in a regional area, services are limited compared to major cities, and the role of a carer is often more isolating in these areas. More funding for carers to access community services for themselves would reduce the pressure upon carers, and the risk of burnout.

Overall, the issues described above are a result of a lack of funding and resources. It is evident that more staff are needed in mental health services for people in crisis, as well as people who are at risk of crisis. Early intervention can assist families to get the support that they need, before it reaches crisis point. More training is needed in family sensitive practices for staff, so they are more family aware and can take a holistic approach

in the consumer's care. Once again, this comes back to the funding provided. More staff, that are well trained, will ensure better services are provided to consumers and their carers.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

The mental health workforce is difficult to recruit into for all professional disciplines. For this regional area, it has been challenging to obtain suitably experienced skilled healthcare professionals. The issue of living away from extended family and area of origin may be an influencing factor.

We know that many undergraduate students, particularly nursing students who had not previously considered the mental health field as an option, when introduced to the workplace via a mental health placement, elect to take up the specialty. This has been one way of attracting / recruiting staff, albeit junior staff.

Psychiatrist recruitment to rural services also remains an ongoing issue. The possibility of local training and development of the existing and a new medical workforce is attractive, however the stringent criteria for supervision and accreditation disadvantages NEBMHS from establishing an accredited Psychiatrist Training Program. This may also affect other regional services.

The need to have multiple experienced and accredited Fellows of Royal Australian New Zealand College of Psychiatrists available for supervision of trainee psychiatric registrars in each specialty area creates an obstacle for the service to gain accreditation for training. Whilst audio-visual linkage is an accepted medium for supervision, sourcing available experts is problematic.

Suggestions to make psychiatrists more available for rural services

- Incentives be made available for accredited psychiatrist supervisors to provide specialist supervision to rural and remote psychiatric trainee program participants.
- Review possibilities for rural psychiatrist traineeships, and consider facilitating or rotating intensive residential training weeks centrally to simulate specialist scenarios.
- That the implementation of an "Advanced Practice Mental Health Practitioner" course, where candidates might undergo an accredited training program to become eligible for certain formal mental health delegations, with a view of relieving psychiatrists of some of their current workload, be considered. Such delegations would require review or amendment to the *Mental Health Act 2014* (Vic).

Suggestions to increase nursing and allied health workforce

- Offering career advice at career planning days held by educational institutions may be another way to encourage prospective work force.
- The reintroduction of specialist undergraduate programs for nursing students, perhaps also for occupational therapy, social work and psychology students wishing to work in the field needs to be considered. Perhaps if educational facilities were agreeable, this could be coupled with incentives such as discounted fees or contracted tenure in public health.

The Crisis Assessment Treatment Team overnight on-call function deters many staff from working in front end services. Increased resourcing at this end of the service to enable active shifts 24/7 would provide incentive for clinicians to return to this aspect of mental health service provision. This would also ensure timely responses by fresh energetic clinicians to crisis presentations.

It is fair to say the service system is under pressure. Experienced clinicians are in short supply, and so meeting the demand for service to the level of sophistication anticipated presents challenges. The inability to attract

adequate numbers of suitably experienced clinicians into the roles adds to the complexity of providing specialty services.

Suggestions to attract workers generally

- In years past, overseas recruitment programs were successful in bringing workforce into the country. This may be an option to obtain experienced mental healthcare professionals.
- Ongoing training and upskilling needs to be further developed and implemented for regional areas. Regions are disadvantaged with regards to educational opportunities available. Robust training calendars with local venues should be promoted to maintain a skilled and informed workforce.
- Workforce incentives such as temporary accommodation assistance or a relocation subsidy may be helpful.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

The implementation of the Early Intervention Psychosocial Support Response Service (**EIPSRS**) is providing a welcome alternative for those who may be currently waiting, not accepted or are yet to apply for an NDIS package of care. Support workers from Mind Australia provide up to 12 months support and assistance with focussed recovery goals which include resilience building, community engagement, and support to find and maintain housing.

Mind Australia (in partnership with AWH) have commenced operations. There is increasing referral activity and enthusiastic participation. Evaluation of the success of such programs should inform future planning.

Suggestions

- Social inclusion, including meaningful employment, should be embedded in recovery practice. Furthering supported employment approaches and improving employment options will enhance recovery.
- Appropriate housing remains an ongoing issue for people with mental health problems. It is hoped that through the Royal Commission enquiry and recommendation, timely access to appropriate accommodation will be improved.
- Increasing the rate of benefits for those on Disability Support Pensions would reduce poverty levels and inequity. Opportunity is vital for recovery.
- That innovative recovery programs such as EIPSRS retain funding and have capacity to grow as demand increases.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

One in five Australians has a mental illness or disorder and 45% of us will experience a mental health condition in our lifetime (https://dhhs.vic.gov.au/mental-health).

According to the AWH Annual Report 2018, the population of the catchment area is approximately 250,000 people. This equates to approximately 50,000 individuals with mental illness or disorder in the primary catchment area designated to AWH NEBMHS.

AWH NEBMHS have, at any given time, capacity across all mental health programs to provide service up to 1,100 individuals at an absolute maximum (which is only 2.2% of the estimated 50,000 individuals in the catchment living with an identifiable mental illness or disorder). It is arguable that carrying a case loading of 1,100 clients impedes the responsiveness of the service system to acute demand or to intervene early for people whose mental health might be deteriorating. It follows that the 97.8% of people with mental illness or disorder are in receipt of primary or private care, or are not receiving care at all.

It is clear that primary health, particularly local GPs, continue with the maintenance prescribing and symptom monitoring (not to mention carer's for the latter) for the majority of people living with a mental illness or a mental disorder.

The public mental health service system as is currently resourced and structured, is struggling to meet the increasing demand, some of which takes the focus from those most in need. The mental health system needs to find collaborative pathways to share care, if it is to remain effective and responsive.

Suggestions

- To further a model of care that enables comprehensive support for people experiencing mental illness through timely responses by specialist mental health services.
- If people were agreeable, to promote shared-care arrangements with their primary care provider (GPs) whilst experiencing an active phase of mental illness.

  That in the shared care arrangement specialist mental health services would provide the risk management, psychiatrist consultation, home visiting, hospitalisation or step up care where required. Along with the above, provide treatment recommendations, monitoring of treatment efficacy and toleration, facilitating joint consultations in primary care and exiting when risk issues and acute symptoms have abated, where maintenance therapy is appropriately indicated and where the person is agreeable for the GP to provide the primary ongoing care. It is thought such a model will, over time, assist to build capacity in primary care, significantly enhance working relationships and improve communications between mental health services and primary care service providers. Ultimately this would increase the complexity of presentations effectively managed in the primary care setting and thus further enable tertiary services the ability to respond swiftly to requests for service and assistance.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Rural mental health services are subject to unique differences, compared to their metropolitan counterparts. Specialist staff are less available at all tiers of the healthcare system, referral options are limited and large regions are covered. There is also a lack of infrastructure, including public transport and accessible internet. Where beds are not locally available, clients are forced to travel long distances as highlighted earlier in relation to child and adolescent beds.

The demand for public mental health response in rural communities appears to outweigh supply of available services. There is limited availability of alternative referral pathways which implicates the need for public mental health service responses, that is, in the [redacted] catchment there is [redacted] private psychiatrist (for face to face contact) [redacted]

Suggestions

- Audio Visual technology usage for clinical interventions is new, and many public mental health staff and consumers are not comfortable with the medium at this time. Clear central guidelines for usage should be standardised across the public mental health sector.

- Rural services lack the availability of private psychiatrists who are able to provide specialist consultation, ongoing monitoring and feedback regarding suitable management to GPs (other than those available through skype). This disadvantages rural populations and creates increased demand on public mental health services to pick up the need. This should be considered when determining any allocation of public staffing resources.
- Consider numbers of acute beds available on the understanding that approximately 50% of the catchment population is beyond the reach of providing home based CATT intensive support and monitoring. Inpatient care, although restrictive, becomes the obvious safe alternative where imminent risk might be present. The ratio of acute beds available to population needs to factor this in.
- Introduction of incentives and strategies that improve training and educative programs allowing for increased specialist mental health workforce representation and availability. Seek ways of establishing psychiatrist training programs to be available for rural services. Seek introduction and establishment of specialist mental health undergraduate training with tertiary education providers.
- Further a model of care to enable GPs to receive increased support and co-care arrangements with public mental health services, to allow them to manage more complex clients in the primary setting.
- Increase the availability of sub-acute mental health care including both bed based and community based sub-acute care. The deliberate insertion of intensive, goal oriented, time limited care aimed at supporting a person to continue to participate as they are best able to in their everyday life through stepped care models, would reduce the use of acute mental health inpatient units as the current 'one stop shop' for those people requiring 24/7 care in most regional areas and ensure these beds were more readily available for those people truly in need of acute psychiatric care.
- Encourage the Mental Health and Integrated Care sections of DHHS to work in collaboration so that funding models support mental and physical wellbeing and promote the integration of mental health and chronic care workforces to deliver holistic care.

11. Is there anything else you would like to share with the Royal Commission?

Dual Diagnosis

People with co-occurring substance use concerns are highly prevalent amongst people receiving treatment for mental health concerns. Deady et al in **Evidence Check Comorbid Mental Illness and Illicit Substance Use** estimate the prevalence at up to 71%.

There are significant harms and unwanted outcomes strongly associated with having co-occurring mental health-substance use disorders ('dual diagnosis). People presenting with dual diagnosis have significant variation in the combination of, and the severity of, their presenting disorders and consequently a wide range of treatment needs.

One cohort, people presenting with co-occurring Methamphetamine Use - Psychosis and aggression, have, for the past several years, posed particular management and treatment challenges to our acute mental health services. Other cohorts of people with co-occurring mental health- substance use disorders have posed less dramatic but still concerning challenges in providing effective treatment. One learning has been that people with either or both mental health and substance use concerns most often also have a range of other treatment-impacting needs and concerns. This recognition has given rise to a service focus on 'people with

dual diagnosis and other complex needs' (Arunogiri, S.,McKetin, R., Verdejo-Garcia, A., Lubman, D.I. (2018) **The Methamphetamine-Associated Psychosis Spectrum: a Clinically Focused Review**. Int J Ment Health Addiction; Deady,M., Barrett, E.L., Mills,K.L., Kay-Lambkin, F., Haber, P., Shand, F., Baker, A., Baillie, A., Christensen, H., Manns, L., Teesson, M. (2015) **Evidence Check Comorbid Mental Ilness and Illicit Substance Use**. **December 2014**. Sax Institute; Croton, G. (2008) **Australia's recognition of and response to dual diagnosis.** Chapter in Dual diagnosis: practice in context Peter Phillips, Olive McKeown and Tom Sandford. Blackwell. 2008)

Since 1998, NEBMHS has been working to develop service delivery to be more effective with people presenting with co-occurring mental health-substance use disorders. In 1998 Community Mental Health in Wangaratta used quality bonus funds to create one of Australia's first, cross-sector, dual diagnosis capacity building services. That service was absorbed into the Victorian Dual Diagnosis Initiative (**VDDI**) with the 2002 advent of the VDDI. From inception, that service was active on both a local and state-wide basis with organisational responsibilities for the then Substance Use Mental Health Network (**SUMHNet**) – a state-wide coalition of health care providers, consumers and carers with an interest in dual diagnosis. Wangaratta Community Mental Health was one of the first mental health services in Australia to institute routine screening for co-occurring substance use issues. NEBMHS was a central partner with Ovens & King Community Health Services in the development of the multi-agency, multi-sector No Wrong Door dual diagnosis protocol. The widely-used suite of Dual Diagnosis Capability Checklists for mental health or AOD workers or agencies to self-evaluate and plan to further develop their levels of dual diagnosis capability were developed in NEBMHS. The website Dual Diagnosis Australia and New Zealand (www.dualdiagnosis.org.au) was created by, and is still maintained by, NEBMHS.

A host of other initiatives and strategies have been developed by NEBMHS collaboratively with other local specialist mental health and AOD services towards better outcomes for people with co-occurring mental health-substance use concerns.

This work was augmented in 2003 with the creation of the Victorian Dual Diagnosis Initiative and considerably boosted in 2007 with the launch of Victoria's cross-sector dual diagnosis policy - Dual Diagnosis: Key Directions and Priorities for Service Development. That policy was built around how a cross-sector vision of Victorian Mental Health and AOD services would function when providing effective services to the various cohorts of people with dual diagnosis. The policy contained reportable Key Performance Indicators around services recognition (screening) of and provision of integrated treatment to people with dual diagnosis. The policy provided guidance to specialist AOD and MH services in collaborating around people with complex needs that transcended traditional service system boundaries. The policy had significant impact upon service delivery for several years, but its influence has now waned with the current day service demand in both mental health and AOD service systems.

Recent data (Victorian Auditor General **Access to Mental Health Services** March 2019) has graphically shown how underfunded Mental Health services are to achieve their tasks. In this context, it is understandable that the services have made little recent headway in building their capacity to provide integrated treatment to people presenting with dual diagnosis and other complex needs.

Suggestions re: responses to people with co-occurring mental health-substance use issues (dual diagnosis)

1. The Victorian Royal Commission into Victoria's Mental Health System includes Victorian AOD services in its recommendations for reform. In particular that it considers how the 2014 AOD sector recommissioning process impacted on the effectiveness of the AOD system in responding to people with co-occurring mental health concerns.
2. That the Royal Commission does not recommend placing Victorian AOD services under mental health auspice.

3. That the Royal Commission includes in its consideration and recommendations General Practice's provision of mental health and substance treatment services. In particular how the effectiveness of these services can be augmented and models for the provision of integrated mental health-AOD services in Primary Care be developed and funded
4. That the Royal Commission gives consideration to where, in Victoria's Mental Health and AOD systems, the various cohorts of people with dual diagnosis are best provided with treatment and care and to what models can be developed to meet the needs of those cohorts most likely to fall through the gaps and receive no services.
5. That the Victorian Royal Commission into Victoria's Mental Health System recommends to DHHS and other relevant bodies that:
    - DHHS be reformed so that mental health and AOD policy and planning bodies are enduringly braided together.
    - DHHS uses a multi-stakeholder, co-design process to update the 2007 Victorian Dual Diagnosis Policy, which includes implementation strategies and time-lined, reportable Key Performance Indicators
    - All Victorian mental health and substance treatment services be charged with developing their capacity to and providing ongoing reports on:
        - What percentage of current clients have co-occurring mental health-substance use concerns
        - What percentage of current clients don't have co-occurring mental health-substance use concerns
        - What percentage of current clients it is unknown whether they have co-occurring mental health-substance use concerns
    - Victorian Mental Health and AOD services be incentivised to further develop and report on their local development of a No Wrong Door service systems
    - That future DHHS reforms of mental health and AOD services no longer be narrow diagnosis-specific but be built around the recognition that the majority of people who present to either mental health or AOD services will have complex needs that transcend traditional service system boundaries.
    - Significant attention and resources be devoted to addressing how welcoming mental health and AOD services are – including physical layout, induction priorities and requirements and clinician and worker competencies in creating a welcoming, collaborative engagement with people.
    - Tertiary education providers be incentivised to build AOD education components into a diversity of undergraduate healthcare and medical courses.
    - Mental health and AOD services be tasked with conducting an annual agency 'dual diagnosis capability' self-audit. That each agency, from that audit develops and reports on an annual plan around its next steps in building dual diagnosis–capability / complexity- capability

Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☒ Yes ☐ No