Anxiety Recovery Centre Victoria

Anxiety Recovery Centre welcomes the opportunity to contribute to a better smarter mental health system

# Submission to the Victorian Mental Health Royal Commission

*"Providing support to individuals who struggle with their mental health everyday"*

The Anxiety Recovery Centre Victoria welcomes the opportunity to make this submission to the Victorian Mental Health Royal Commission. We believe the Royal Commission into Mental Health in response to the concerns from the community and health sector is timely.

## Background

ARCVic is funded by the Department of Health and Human Services to provide an information, support and referral service for people living with anxiety disorders including Obsessive Compulsive Disorder (OCD), Trichotillomania (TTM) and Hoarding. ARCVic is the only support service in Australia which specialises in and responds to the complexities of anxiety disorders with 30 years of specialist knowledge and experience providing a suite of services.

- ✓ Currently have 173 trained active volunteers delivering our helpline and support groups state-wide. It is estimated that our service reaches some 15,000 people a year with a helpline that operates 30 hours a week on a state budget of $330,000
- ✓ National organisations – SANE Australia, Beyond Blue, Mind Australia, Lifeline, NEAMI, EACH all refer to our helpline
- ✓ Complexity of helpline calls has dramatically increased due to crisis and lack of specialist supports and treatments
- ✓ Demand and requests for professional development from education services, workplaces and community groups have dramatically increased (Anxiety/OCD and new mums/VCE stress/unemployment/suicide awareness and intervention etc)

ARCVic's services provide a point of difference in that we can provide ongoing services with multiple points of entry. For example, someone might make an enquiry through our website or helpline, they can attend a seminar, a social group, a support group or a recovery program and through this integration of our services develop a network of support in an environment and framework that promotes and enhances resilience. In this way ARCVic assists individuals in understanding their condition, reducing the impact and learning to manage their anxiety through a variety of options (face to face, phone support, peer support and on-line contexts).

**ARCVic's purpose is to find and foster the inner strength and spark of hope that lies within each person with an anxiety disorder, and to provide a supportive and understanding community in which this strength and hope will flourish. In this way, a healing and recovery process is initiated, and many barriers, which could have interfered with successful professional treatment, are broken down. From this point, ARCVic can help to facilitate access and educate primary care and mental health services, and support people with mental illnesses to stick with sometimes long and difficult treatment programs.**

## Context

Anxiety disorders are Australia's most common psychiatric disorder; those living with a disorder are often severely impaired in their daily activities including their ability to attend school or work and maintain relationships with family and friends. Associated stigma and isolation compound an already distressing condition. It is of paramount importance that early intervention is the key and people living with anxiety disorders have adequate access to affordable and effective treatment services.

In Victoria the number of people suffering from anxiety disorders is estimated to be 1 in 4.

In young people 16-25 years up to 14% will experience an anxiety disorder. Although anxiety disorders are recognised as the most common mental disorders affecting Australians, Victorian government inquiries have uncovered several limitations in accessing appropriate services. People with anxiety disorders are disadvantaged in their access to specialised services in the public mental health sector, particularly in rural Victoria.

## Impacts of living with anxiety disorders, OCD, TTM and Hoarding

The condition of having a mental illness is intrinsically an isolating experience and feel a deep sense of difference and separateness from the rest of the community. Chronic and frightening symptoms reinforce this sense of alienation, which may eventually become entrenched by perpetuating avoidance behaviours and social isolation. Feelings of shame and worthlessness are common responses to the sense of being unacceptably different, and people will often expend enormous energy and effort in hiding their disorder from their work colleagues, employers, friends, family members, and even from health professionals who are involved in their care. Isolation is fertile ground for the growth of depression, desperation, anger and fear, and can insidiously affect a person's capacity to utilise beneficial treatments and health or welfare services.

The focus of clinical services on treatment, must be balanced by an equal emphasis on management of the social and emotional impact of psychiatric disorders upon people living with anxiety disorders and carers. The current mental health system does not provide this balance and ultimately fails to help many people with chronic mental illnesses. Without access to specialised support services and community networks, their needs for connection, understanding, acceptance, support and self-empowerment will not be met.

## Why the need to put in a Submission?

## Those living with anxiety disorders have less treatment and support options compared to those with depressive or psychotic disorders.

- ✓ Anxiety Disorders are the most prevalent mental health condition in Australia (Beyond Blue 2014)
- ✓ Obsessive Compulsive Disorder (OCD) considered one of the most disabling mental conditions (WHO)
- ✓ 1 in 4 (26.5%) of the population between the age of 16 – 24 years of age will suffer serious anxiety
- ✓ The 2007 National Survey of Mental Health stated 2.3 million people suffered from anxiety disorders
- ✓ Females are more likely than males to suffer anxiety disorders (17.9% compared with 10.8%)
- ✓ Primary health networks (PHNs) have a general lack of expertise and knowledge. Not a priority.
- ✓ Any expertise we do have lies in the private sector due to the structure of the clinical space
- ✓ No public inpatient programs for OCD in Victoria or Australia
- ✓ Public inpatient programs do not have the expertise to deal with OCD and people are turned away
- ✓ Lack of specific treatment programs. Despite suffering from severe impairment, only around 35% - 40% of OCD sufferers seek treatment, with less than 10% receiving evidence-based treatment. (Levy, McLean, Yadin, & Foa, 2013).

| Recommendation One: | |
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| • The urgent need to provide affordable specialist treatment programs and support services specifically for anxiety disorders, OCD, TTM, Hoarding<br>• Provide a flexible approach to service delivery (in home, skype therapy options etc)<br>• ARCVic to be set up as a specialist hub, secondary consultative service. (i.e. Spectrum / PANDA etc) | |
| Key points / Learnings<br>• People feel like they are educating their psychologist about their disorder - OCD TTM etc. | Rationale<br>Those suffering with anxiety disorders have less treatment and support options compared to those with depressive or psychotic disorders. That anxiety is far more than just a fleeting feeling or thought. For some it can be extremely debilitating and impact on their ability to engage with others, their ability to develop meaningful relationships and capacity to function daily. |

- Mental Health needs to have specialists like that of our health system.
- When someone suffering from an anxiety disorder decides to seek treatment from a psychologist or psychiatrist, despite Medicare rebates, it can be an expensive process and, in many cases, financially unsustainable over a long period of time.
- Reported costs to see a Psychiatrist $300-$500 is not sustainable for most families. Very difficult to find a Psychiatrist who bulk bills.
- Many people we speak to are housebound or so unwell they are unable to engage with services or access specialist services in their area, particularly rural Victoria. (Including large regional centres) These people will ring our helpline for regular support.
- Response from a past Chief Psychiatrist when ARCVic met to discuss the issues people faced. "if they need specialist treatment they need to be in private health"
- The need to create a system that provides equal access to specialised help and support.

- **The current Clinical space allows psychologists to pick and choose who they see. Need to provide Specialised Clinics/ incentives to specialise, to work with complex mental health. People living with OCD, TTM Hoarding are perceived to be" too hard too complex"**

- Many people have had terrible experiences with institutionalised stays and have terrible experiences with mental health professionals.

- No Peak Body Organisation advocating for specialist OCD services.
- There is no current / little Australian research around the number of people living with OCD (2%), Trichotillomania (2-4%), Dermatillomania (2-5%), Hoarding, Body Dysmorphia, PANDAS (Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus) which is linked to early onset OCD in children
- Urgent need for specialist clinical wisdom, clinical treatment programs and residential treatment options for children and adults (1 residential program for Adults in Australia- private health insurance needed)
- headtohealthgov.au website – Resources OCD (3) Tricho (0) Hoarding (0) PANDAS (0)
- Research states early intervention can dramatically reduce the debilitating impact of anxiety disorders.
- Higher suicide risk. Swedish research found Patients with OCD are 10 times more likely to die by suicide and attempted suicide five times higher than that of the general population. (Molecular Psychiatry 22,1626-1632c (2017)

**OCD & difficulty engaging in treatment**

Effects 2% of the population Victorians

Despite suffering from severe impairment, only around 35% - 40% of OCD sufferers seek treatment, with less than 10% receiving evidence-based treatment (Levy, McLean, Yadin, & Foa, 2013).
Many refuse to engage in treatment, and due to their debilitating symptoms, many tend to drop out of treatment early.
The most known effective treatment for OCD is a combination of Cognitive Behaviour Therapy (CBT) and SSRI (Rego, 2016; Vogel, et al., 2012).
Despite this, many OCD sufferers have limited access to CBT interventions due to a number of barriers, such as costs, living in a remote area, or difficulty leaving their home due to severe symptoms, particularly those involving contamination fears (Levy, McLean, Yadin, & Foa, 2013).
Cloe Khoury & Kate Bannister

**Trichotillomania**

**Unveiling Trichotillomania is essentially about bringing this disorder out and into the open.**

People with "tricho" are vigilant at maintaining their secret due to shame and guilt associated with the condition. Trichotillomania (hair pulling disorder) affects between 2-4% of the population and causes significant disability and distress.
Awareness of, and treatment for, trichotillomania is lacking in Australia.

People with trichotillomania repetitively and uncontrollably pull out hair from their scalp, eyelashes, and eyebrows to the point of hair loss. Due to the shame trichotillomania causes, sufferers experience high levels of social isolation; impaired vocational functioning; and report high rates of comorbid psychiatric disorders, like depression.

Treatment-seeking among people with trichotillomania is low. This is not only a result of the stigma associated with the disorder, but because of the limited public awareness of trichotillomania, including among health professionals.

There are currently no easily accessible, high-quality Australian resources for health professionals to gain knowledge about trichotillomania and its evidence-based treatments. The Anxiety Recovery Centre Victoria is the only Australian

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| • In relation to Hoarding there is growing concern that there are random services operating, cleaning up properties, other community services with no mental health background removing people's acquired stuff with no training and causing more harm not to mention the enormous cost the person who has a hoarding disorder. | mental health organisation that provides peer-support and resources for people with trichotillomania.<br><br>Due to lack of specific specialist support and treatments often people resort to look for other alternatives which leaves them vulnerable to scams and therapists who claim to have a "cure".<br><br>Hoarding<br>Some key points to acknowledge:<br>• High levels of stigma in the public, among health professionals, and shame among affected people results in no treatment seeking, delayed treatment seeking, enforced clean-outs (by family, friends, or council which increases risk of suicide) or other inappropriate treatments from poorly trained health/mental health professionals. CBT for HD is effective but it must feature a component of ERP – due to lack of specialise training/clinicians, people who do seek treatment for hoarding end up receiving supportive counselling (feels good to the client at the time, but does nothing to help them sort through their clutter & discard excessive possessions) or treatment for other anxiety/depression, which is not effective for hoarding specifically. Specialised CBT for HD takes longer than 10 sessions under Medicare – US research from experts like Gail Steketee & Randy Frost suggests at least 36 sessions for a significant reduction in hoarding severity. People with HD often cannot afford this because they are on DSP, unemployed, have chronic illness – all because of or exacerbated by the hoarding.<br>• Severe cases of hoarding can result in squalor and public health risks like pest infestation, building faults, and fire. This affects the individual, anyone living in the household (pets, children, elderly) and their neighbours. Other risks to the individual are falls (from trip hazards) and illness (from mould, lack of nutrition bc cannot cook meals, infection/poor hygiene when utilities break and cannot be fixed). This is a chronic and highly complex mental illness – the public and private systems are simply ill equipped to support people with hoarding.<br>-<br>A 2009 study by the Metropolitan Fire Brigade reported 48 hoarding-related fire incidents had occurred in the past 10 years, and even though those fires represented 0.25% of all residential fires in that period they accounted for 24% of preventable fire deaths: https://web.cs.wpi.edu/~rek/Projects/MFB_D09.pdf<br>A 2015 study by the MFB reported that between 2012-2015, the MFB had attended a hoarding-related fire or incident every 6.7 days (that's at least once a week): https://web.wpi.edu/Pubs/E-project/Available/E-project-050515-001501/unrestricted/MFB_Final_IQP_Report.pdf<br>MFB requests for local and state govt support/funding to address hoarding and squalor typically go unanswered despite the mortality (and risks to emergency services workers & general public) associated with hoarding. |
| ARCVic Case Study | Background<br>[redacted] is a [redacted]-year-old man, who had been refusing to go to school since he was [redacted] and suicidal, housebound for the last 2 years and was unable to access shared areas of the home when other family members were present. His parents desperate for help took him to their local public hospital and told "take him home and love him. he is too hard to treat".<br><br>ARCVic on receipt of ILC funding was connected with ARCVic's Companion Program by his parents after years of isolation and lack of Obsessive-Compulsive Disorder (OCD) specialist support in mainstream and mental health services. In desperation [redacted] parents reached out to ARCVic for support. [redacted] has OCD and his distressing thoughts are related to contamination, with his parents being the primary source of |

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| | this contamination, which impacts on the whole family's ability to function. On receipt of ILC Funding ARCVic was able to offer [redacted] and his family the following support.<br><br>Objectives<br>➢ The initial phase of support for [redacted] involved linking him into acute services with specialist OCD knowledge and expertise where he had an inpatient stay for a short period to work on his symptoms.<br>➢ To refer and connect [redacted] to an OCD specialist, regular support person to assist him on his journey to recovery<br>➢ Establish rapport with [redacted] with the hopes of connecting him to other services and supports.<br>➢ To reduce his isolation and bring some normality back to his life<br><br>Outcomes<br>✓ ARCVic provided Companion Support to JJ during his period as an inpatient to enable [redacted] and his volunteer to build rapport and get to know one another.<br>✓ [redacted] parents were also offered support through the Companion Program and were assigned a separate volunteer to provide support.<br>✓ ARCVic provided further training and support to carers and volunteers through a seminar on Exposure and Response Prevention in order to skill [redacted] parents and the companion volunteers in how best to support him once he returned home.<br>✓ Following discharge home [redacted] continued to be supported by his Companion Volunteer and ARCVic.<br>✓ Currently [redacted] is involved in one of ARC Vic's program The Beginners Mind Body Boot Camp.<br>✓ With additional support from his companion he has also re-engaged with a mainstream service attending a local gym for personal training twice a week.<br>✓ [redacted] mother has indicated that this is the best they have seen [redacted] for years and are so grateful for the support provided through the Companion Program and ARCVic.<br>✓ [redacted] self-esteem and confidence have risen and his ability to manage his OCD symptoms continues to improve. Going from being housebound to being able to leave the house up to six times a week.<br>18 months on…<br>[redacted] is still accessing a mainstream local gym for personal training twice a week. Has missed one session in all that time due to being unwell. He still sees his OCD specialist for regular support.<br>Parents are extremely grateful to ARCVic "Words cannot describe our gratitude you have given my son a purpose to live I now have hope for him. Thank you"<br><br>Also, to note: [redacted] younger brother 10 years old also recently diagnosed with OCD. |
| Further Ideas<br><br>ARCVic can provide some initial gaps if provided adequate funds.<br>(Have requested this for over 10 years.)<br>• Mentor Program<br>• Training loved ones in Exposure Response Therapy ERT<br>• Companion Program<br>• Expansion of the Helpline to provide | ARCVic has a long history of providing mental health community support services (MHCSS) and mutual support and self-help (MSSH) to assist individuals with obsessive compulsive disorder and anxiety across Victoria. Over the last 30 years we have fostered extensive growth in the scale and scope of our helpline. Given the maturity, efficiency and effectiveness of this service, ARCVic are in a strong position to leverage existing organisational and volunteer structures to achieve magnitude increases in service provision at low marginal cost.<br><br>Please note Helpline is only open Mon-Fri 10-4pm. Needs to be 10-10pm<br><br>Initiatives to improve engagement in treatment<br>Prior studies have implemented technological interventions to overcome barriers associated with engaging in, and continuing treatment, particularly for those who |

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| support with reassurance ERT homework etc | live in remote areas or struggle to leave their home. This includes phone calls, videoconferencing and other technological mediums. These types of interventions are known to reduce wait lists, travel time, and improve access.<br>In addition to this, it has been recommended standard OCD treatment should involve between-session homework assignments and therapist-assisted out of office in exposure-based tasks to enhance compliance (Rego, 2016). Furthermore, outpatient treatment that is provided in non-restricted settings, and is perceived as safe for the patient, can be sufficient, and that home-based treatments should be implemented for those with severe symptoms (Rego, 2016). Treatment protocols have also suggested delivering at least two sessions per week (Rego, 2016). Other interventions that have been used effectively are technological interventions, such as phone calls, which can be an effective way to overcome some of the barriers associated with engaging in treatment for OCD sufferers, and to provide additional care to compliment face-to-face interventions.<br><br>**Treatment involving outbound phone calls– previous findings**<br>Previous studies have demonstrated success in administering support for OCD suffers via cell phones and other technological mediums, in conjunction with face to face contact and counselling (Taylor et al., 2003; Lovell et al., 2006; Wootton et al., in press). One study by Vogel et al (2012) administered therapy sessions over teleconference and phone calls with promising results. All patients in their study rated the format of treatment as acceptable, and the quality of the working alliance as high. Further, all patients were highly improved which was marked by no longer meeting the diagnostic criteria of OCD. It was concluded that "the innovative treatment format shows promise as a method of delivery that may make treatment accessible for patients with poor access to specialty clinics" (Vogel, et al., 2012, p. 158). This notion would also apply to those who cannot afford treatment, or struggle to leave their homes due to severe impairment, which is common amongst OCD sufferers (Levy, McLean, Yadin, & Foa, 2013). |

**Recommendation Two:**

- **De stigmatisation- Increase Community awareness of anxiety and its impacts.**
- **Provide Community education to ensure that people seek assistance before their anxiety develops into an anxiety disorder and to a crisis point.**

| **Key Points / Learnings** | **Rationale** |
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| • To have a better informed and accepting community<br>• Education required for Health and Mental Health Professionals<br>• The need to have more understanding and compassionate workplaces.<br>• The need to have a more informed and sensitive education system, which | Gaining access to the right care at the right time remains a key issue for Victorians affected by mental illness. Whilst there remains considerate stigma in our community about mental health illness, many people do not engage in help seeking behaviours. This delays access to treatment, thereby risking exacerbating their illness.<br><br>Our services respond directly to individuals in one off conversations and ongoing care. We provide support and information not just for service users but also families and friends, and the wider community. This extended support enhances the reach of our services, encourages early intervention, reduces stigma and ultimately supports the broad community through increased understanding and empathy for people experiencing anxiety disorders.<br><br>Specialist MSSH organisations have an important focus on early intervention and prevention in their provision of support and a recovery-based approach to consumers and carers. Through this early intervention MSSH services have the capacity to reduce the impact of mental illness. Ready access to MSSH services and the ongoing relationship with consumers and carers over time increases the likelihood of early |

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| includes educating parents and teachers. | identification of mental illness and/or of an episode and/or escalation. This enables timely establishment of supports and interventions, given MSSH services specialist knowledge of the broader mental health service system. |
| **Example**<br><br>• ARCVic historically has provided many community education workshops. Reaching thousands of people living with anxiety but also providing a platform for loved ones and community to understand the impacts of anxiety.<br>• ARCVic over the past two years has developed an Anxiety Toolkit for classrooms through a Local Learning and Employment Network that reaches 32 schools (hard copies provided to all these schools). To date, these resources have been downloaded over 250 times. | ARCVic has periodically been able to provide limited early intervention by way of communication with parents through workshops, seminars and information. This provision is scant due to lack of funding and, once parents have identified that their child may have OCD, there are limited services available due to a lack of health professionals trained to work in this area. There are currently no group programs in Victoria for young people with OCD and some families travel to Brisbane to undertake the FOCUS program at Pathways.<br><br>**In the last 12 months ARCVic had developed 115 community education sessions to over 3000 people and provided 13,000 training hours. This is above and beyond our normal day to day positions.** |
| **Further Ideas**<br><br>•Train the Trainer programs for Well-being Programs / Community Workshops to equip Well-being Officers and School Psychologists<br>•Expand the capacity of our Helpline to support school refusal /separation anxiety / parental anxiety | |

**Recommendation Three:**

- **To think more creatively to deliver mental health services.**
- **To take a holistic approach to deliver mental health services, not solely a clinical approach.**
- **To recognise community and self-help services as a vital component in the process of support and recovery.**

| **Key points / Learnings** | **Rationale** |
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| • Community support and self-help services are not an alternative to professional or medical help, but rather a vital component in the process of recovery.<br><br>• Partnerships between ARCVic and primary care and mental health services are based on recognition of the importance of a combined approach to recovery that makes both partners stronger and provides a powerful force for effectively helping people with a mental illness and their carers when services are unable to respond.<br><br>• ARCVic over the years has developed very close partnerships with Swinburne University, Deakin University, Flinders University.<br><br>• ARCVic has a great reputation and has become a valuable training ground for our volunteers who then have become the future clinicians / mental health workers for Headspace / SANE / NEAMI / EACH / Suicide Line etc | There is a lack of specialist services for specific anxiety disorders such as OCD, Trichotillomania (TTM) and Hoarding. Another gap is also PTSD.<br><br>**Trichotillomania (TTM)**<br>Currently there are no treatments for (TTM) in Australia. People living with TTM continually express to ARCVic their frustration at the lack of specialist knowledge of TTM, and feel that rather than getting any treatment, they are educating their therapists as to their condition. In response to this ARCVic has provided support groups for the last 9 years and for the last 7 years run a 3-day intensive retreat.<br><br>**Obsessive Compulsive Disorder (OCD)**<br>There are 2 on-line OCD Treatment options available, however not everyone is able /well enough to use a computer to access treatment.<br><br>We regularly come across adults in their thirties, forties or fifties who have suffered all their lives in silence, just starting to receive a diagnosis of OCD. Treatment is then at a stage where recovery is so much more difficult due to the chronicity and co-morbidity of their illness, that could have been relieved if earlier intervention was available to them.<br><br>It is imperative that information and training is available for parents, teachers and health professionals for early detection, diagnosis and treatment of young people with OCD.<br><br>Most children and adolescents only receive treatment for OCD when the severity of their symptoms means that they are no longer able to function normally (e.g. disruptive behaviour/school refusal/suicidality/etc). When children's symptoms go unrecognised and therefore untreated, other difficulties emerge such as social disengagement, withdrawal from education and family disruption. Without intervention these young people are in danger of becoming marginalised in our society.<br><br>**Hoarding**<br>Hoarding Disorder is a complex and chronic psychiatric disorder, which places affected individuals and the public at risk of associated environmental hazards (e.g., fire, pest infestations). People with this condition, and their families, require a highly sensitive, long-term, multi-pronged and multi-system approach to supporting their de-cluttering efforts and psychosocial recovery. Such an approach has been recognised and clearly outlined in the Victorian Department of Health document, "Hoarding and Squalor: A Practical Resource for Service Providers". https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/hoarding-and-squalor<br><br>Unfortunately, the siloing and under-resourcing of the mental health and other relevant systems, means that the individual clinicians working with people who hoard, simply cannot implement the recommendations outlined in this best practice document.<br><br>**The need to look beyond clinical and medical intervention**<br><br>We believe we need to look beyond clinical and medical interventions and see the value of a holistic approach to mental health. Factors such as diet, nutrition, lifestyle and exercise all play a pivotal role in one's wellbeing, however, are difficult to maintain when someone is feeling incredibly unwell.<br>For example-:<br>A person on antidepressants who drinks 6-12 cups of coffee and consumes sugary snacks, biscuits, cakes etc is almost counteracting any effects the medications may be providing. |

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| | **Not everyone:**<br>✓ Wishes to take medication<br>✓ Is able to engage with clinical services due to financial costs, past experiences, degree of wellness, ability to travel etc.<br>✓ Many people have seen many psychologists/psychiatrists over the years (this would be an interesting research project and statistic)<br>✓ Responds to evidence-based treatments<br>✓ Feels the medication is working and needs more. |
| **Example of how ARCVic has provided a gap in the system**.<br><br>ARCVic has provided:<br>• Specific Support Groups<br>• Retreats<br>• Recovery Programs<br>(Have provided with no additional funding support)<br><br>**Further Ideas**<br><br>• To bring the Body Focussed Repetitive Disorders (BFRD) Treatment plan from America to Australia for TTM<br>• Train other health and mental health professionals including GPS<br>• Train parents and carers in Exposure Therapy to support loved ones for OCD<br>• Expand the capacity of our Helpline / Support Line | ARCVic is ideally positioned to offer recovery programs, support and treatment services. We already have existing complimentary services and ongoing support resources, established networks and relationships within the sector, connections to educational universities and a presence and commitment throughout many areas of regional Victoria.<br><br>**Retreats**<br>ARCVic has for 7 seven years been delivering an intensive 3-day retreat. Immersive peer-support retreats may be used as adjuncts to traditional treatments. We have in the past had people from all over Australia attend due to a lack of other supports available.<br>Attachment: a copy of the research paper based on our ARCVic Retreat findings and comparing the retreat outcomes to those of other Trichotillomania international treatment studies.<br>The research found that:<br>• The 3-day intensive peer-support retreat with a structured program provided the equivalent benefit to participants as 10-12 sessions of CBT<br>• Feelings of social acceptance and belonging endured 12 months after the retreat<br>• An immersive peer-support retreat provides therapeutic experiences not available through traditional delivery methods.<br><br>The model we have developed for these retreats could be replicated for other anxiety disorders if funding was available. We have over the years had request for similar retreats to be held for conditions such as OCD, PTSD and Anxiety.<br><br>**The Mentor Program - Pilot**<br>We would like to extend the support services of our Helpline to provide ongoing mentoring to people living with anxiety disorders during their recovery, in particular as an adjunct to one on one clinical intervention, and as an option for people who are too disabled by their condition to attend therapy. It is widely documented that there are high attrition rates during therapeutic interventions, in particular for hard to treat disorders such as OCD. Previous studies that have involved phone contact between therapy sessions for OCD have been found to significantly reduce the dropout rate during therapy, increased completion of exposure tasks and therefore a reduction in OCD symptoms and level of disability (Kenwright, Marks, Graham, Franses & Mataix-Cols, 2005).<br><br>**ARCVIc Recovery Program Pilot ILC Project**-<br><br>Psychosocial education and skills development programs delivered in a group-based setting tailored to the specific need of participants for 4-6-week period.<br>Affordable support utilising the Medicare Rebate |

**Recommendation Four:**

- **Prioritise early intervention strategies for mental health**

| **Key Points/ Learnings** | **Rationale** |
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| • ARCVic regularly provides community education workshops to all members of the community including regional and rural communities on request.<br>• Large requests from Schools primary and secondary<br>• Could provide much more in this space if provided funding.<br>• An opportunity exists to investigate the impacts of transitioning from middle school to secondary and identify a best practice approach to mental health awareness.<br>• LGA requests large Community education workshops for parents talking about children's anxiety. Over 250 people in attendance, running for 4 years now. | ARCVic has been involved in providing community education workshops for young people, parents and teachers in order to identify early signs of anxiety. From our experience key areas of concern are:<br>• Separation anxiety in early schooling<br>• Increase in school absenteeism and school refusal due to anxiety<br>• Transition from middle school to secondary<br>• Year 9 as a highly volatile time for many students<br>• VCE stress and pressure to perform<br>• Tertiary Study and the dropout rate<br><br>High prevalence mental health issues that often emerge during adolescence, such as depression and anxiety, have cognitive, emotional, behavioural and physical symptoms that can significantly impact on young people's capacity to learn and engage at a classroom level.<br><br>More education and awareness programs are required in order to identify early signs of anxiety, and to assist teaching staff to consider the needs of highly anxious students in their classrooms.<br><br>ARCVic has been working very closely with BGKLLEN (Local Learning Network) for the past 2 years developed a school package and an app for secondary students to use.<br><br>**ARCVic fully supports their Submission to the Royal Commission with regards to mental health and young people. Together we have been in discussions with the Department of Education.** |

**Recommendation Five:**

**Urgent need to address mental health concerns for those not covered by the NDIS**

- **That Specialist MSSH sector be adequately funded to provide an important range of services that supports the wellbeing of the whole Victorian community.**
- **To be acknowledged as a fundamental part of the mental health sector.**

| **Key Points / Learnings** | **Rationale** |
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| • The focus of the NDIS on permanent disability flags the need for renewed focus on mutual support self-help, prevention and early intervention. These areas will not be funded through the NDIS and are an important stage in the continuum of firstly limiting the need for services and secondly reducing the impact of mental illness.<br><br>• Particularly with the people living with OCD TTM Hoarding need specialised support | We know that out of the 184,000 Victorians with severe mental illness, only around 15,000 or 8 per cent will be eligible for the National Disability Insurance Scheme (NDIS) when it is fully rolled out. This leaves many tens of thousands of Victorians without access to the care they need.<br><br>The current changing environment – transition to NDIS, recommissioning of the PDRSS sector and commitment to a new national Mental Health Plan while providing opportunities for better coordination should take account of the important and inclusive role of mutual support self-help models in reducing stigma and thereby providing an effective access channel to services.<br><br>The Specialist MSSH Network organisations all play a considerable role in raising awareness and reducing stigma in their area of expertise.<br><br>Specialist MSSH Network organisation are keenly aware of the need to recognise the broad continuum of the mental health experience and the need for wide ranging services to respond to the diverse experiences of people with mental illness, with emphasis on those NOT covered by the NDIS. We note also the need for a focus on prevention and early intervention to reduce the impact of mental illness in the community.<br><br>The investment into the NDIS means there has been no or very little opportunity for growth funding or new funding opportunities.<br><br>(Fact: Last increase for ARCVic 12 years ago) |
| Example of how ARCVic has provided a service in this space. | ARCVic ILC Project 2018<br>Attached Report |

**Recommendation Six:**

**Urgent need to address Medicare reform**

- **Increase number of sessions per calendar year for complex mental health conditions**
- **Equal access to psychological supports (i.e. people that are housebound)**

| **Key Points / Learnings** | **Rationale** |
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| • 10 sessions per calendar year is not enough when experiencing complex mental health. (OCD TTM Hoarding etc)<br><br>• Need clarification around Medicare criteria for group therapy.<br><br>• Medicare requires a Psychiatrist to visit if someone is | We know that more many people financial hardship can be a barrier to accessing appropriate help.<br><br>For people living with complex mental health anxiety disorders, OCD TTM Hoarding can be chronic sometimes life-long assistance. The current system does not encourage or support someone to seek appropriate support due to the financial impact.<br>ARCVic has in the past provided Recovery Programs (group therapy) Under Medicare you need 6 participants for it to be a group. If people drop out sometimes due to people being so unwell and if the number falls below 6 it is no longer a group therapy session. Costs increases then for the remaining participants which can be very hard to predict and cause distress and financial hardship.<br><br>**We strongly feel that other participants should not be penalised because other people are so unwell.** |

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| housebound in order to make a referral so they can receive skype therapy. This is clearly problematic firstly where do you find a home visiting Psychiatrist and secondly, it's a requirement that within the first four sessions that person needs to visit the clinic. This is not realistic if that person has been housebound for long periods of time. (Example -one caller housebound for 8 years no support) | Many other providers no longer run group therapy sessions as the co-ordination, administration and delivery is time consuming due to the recruiting and screening process which becomes labour intensive and expensive. |

**Recommendation Seven**

- **That we see the urgency of Suicide Intervention like we see the importance of CPR.**
- **Mandatory Suicide Intervention Training for all mental health and health professionals.**

**Key points / Learnings**

- That we see Suicide Intervention like we see the importance of CPR
- It should be compulsory at the tertiary course level and as CPR renew every 2 years.
- We have 173 volunteers from the clinical and health space. They speak of being sent out on placements and that no-one has had the opportunity for intervention training.

**Rationale**

ARCVic is currently very active in the suicide intervention space, regularly running the LivingWorks safeTALK (suicide awareness) and ASIST (suicide intervention) programs to the public and in a wide breadth of community services (community health, AOD services, helplines, family services, family violence/sexual assault services etc).

Many current suicide prevention strategies involve training up general community members to look after each other and start conversations about suicide. This is important and wonderful work, however, there seems to be a significant problem with a lack of training and ability of mental health professionals in being able to engage clients in suicide intervention. When a general community member starts up a conversation about suicide with another community member, it would be common for them to encourage the person to seek help from a mental health professional. Suicide intervention training is not mandatory for psychologists, social workers, counsellors, psychiatrists, GPs or any other mental health professionals and therefore they often respond inappropriately.

We regularly speak with people on our helpline and support groups who feel like they have told their health and or mental health professional and have been shut down or given inappropriate responses that reinforce the stigma around suicide.
Some inappropriate responses have included:

- One GPs response "Don't say that word (suicide), if you say that word, I will have to do something about it, and you will get me into trouble"
- Another GP response "Perhaps you need to speak to your Priest about this"
- Clinical response "Don't die just stay with me" … that was all that was said
- Another clinical response – "My clients would never do that to me (i.e. Kill themselves)"
- Client arriving at an appointment with a government agency – "Sorry I'm late, I just tried to kill myself". Response from case worker – "Well, you're here now, let's get on with it", and NO discussion about suicide.

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| | Many people that we speak to indicate that no one has asked them directly about suicide or gone through a suicide intervention process with them. Others indicate that if suicide is mentioned, they are immediately asked whether they have a suicide plan – if the answer is no, they are deemed to have "no intent" or be "low risk" and the conversation goes no further. From our nearly 10 years of running suicide intervention programs, we know all too well that this response is not good enough and that a suicide intervention process with a thorough safety framework still needs to be completed.<br>.<br>We are also astounded at the lack of awareness of important services such as SuicideLine and Suicide Call Back Service. We are astounded at the many mental health services, community health workers, psychologists, counsellors who have not heard of these two lines. It is also shocking to speak to families who have supported a loved one through chronic suicidality over many years who have not been made aware of these crucial numbers. |

| **Recommendation Eight**<br>• **To maintain and value our mental health workforce including our volunteers** | |
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| **Key points / Learnings**<br>• It has been difficult to provide increases in salaries due to rising operational costs.<br>• Future provisions need to allocate in order to address this need and to ensure that our workforce and volunteers are being appropriate renumerated for their enormous contributions they make to our community increases just don't cover it. | **Rationale**<br>• To provide adequate funding to renumerate our mental health workforce. It can be difficult to maintain and attract the right candidate.<br>• Staff morale can be challenging when we are not able to provide increases due to lack of funds.<br>• ARCVic is fortunate that we have managed to provide consistency with very skilled and trained staff. Our experience is that our staff always go above and beyond because of our organisational culture and the nature of what we do. However, we have lost 3 staff due to renumeration in the last 10 years. Attracting new candidates have been difficult.<br>• Our volunteers change and save lives every day. We recognise that volunteers need specialised training, support and supervision. It is estimated that our 173 volunteers equate to<br>• To consider the rising costs of operational costs and other associated costs in running a service. |

**Recommendations**

ARCVic remains committed to working collaboratively to achieve a comprehensive, robust, and sustainable mental health system for all Victorians. We support consumers, carers and families being placed at the centre of mental health planning and service delivery. This includes acknowledgement of the variety of needs that people identify for themselves, and the importance that choice plays in helping them to access the most appropriate services.

Of interest to ARCVic is the impact of mental illness on peoples' ability to cope with day to day functioning. Their ability to engage with the clinical sector interventions regularly, and the capacity of people to make informed decisions about their health and wellbeing is challenged and compromised. Equally concerning is the capability of the clinical sector to deal appropriately with the complex prevalence of mental illness with people living with OCD, TTM and Hoarding. We see a real opportunity to address some of these concerns.

Health care policies, service developments and treatment advances aimed at recovery, normalisation and de stigmatisation may benefit consumers in many ways, and yet, the essential fact of the mental disorder cannot be ameliorated.

ARCVic is a community created to respond directly and explicitly to this need, and contains the key components required for effective expiation of this need – that is, the joining of a group of people with a common condition and needs, whose purpose is to draw upon the support, caring, resources and skills of all group members, for the benefit of all – thus providing a model and an experience of a unified community, engendering inclusion and empowerment. ARCVic over a span of 30 years has engaged with local communities to inform this submission and we base our recommendations on responses and feedback received through our helpline, our support groups and 30 years of experience in this field of providing information, support and referral.