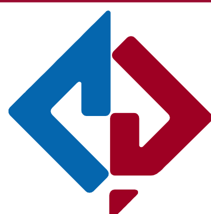

Submission to the Royal Commission into Victoria's Mental Health System

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Introduction

Who we are

The Australian Association of Social Workers (AASW) is the professional body representing more than 3,000 members in Victoria and 12,000 social workers throughout Australia.

We set the benchmark for professional education and practice in social work and have a strong voice on matters of social inclusion, social justice, human rights and issues that impact upon the quality of life of all Australians. Social workers are key partners in the mental health sector and, given our commitment to improving the health and wellbeing of all Australians, we welcome the opportunity to contribute to the Royal Commission.

The social work profession

Social work is a tertiary-qualified profession recognised nationally and internationally. The AASW is the key professional body representing social workers in Australia and is responsible for the accreditation of social work university programs.

The social work profession is committed to maximising the wellbeing of individuals and society. We consider that individual and societal wellbeing is underpinned by socially inclusive communities that emphasise principles of social justice and respect for human dignity and human rights, including the right to freedom from intimidation and exclusion. Drawing on theories of social work, social sciences, psychology, humanities and Indigenous knowledge, social workers focus on the interface between the individual and the environment and recognise the impact of social, economic and cultural factors on the health and wellbeing of individuals and communities. Accordingly, social workers maintain a dual focus in both assisting with and improving human wellbeing; and addressing any external issues (known as systemic or structural issues) that may impact on wellbeing, such as inequality, injustice and discrimination.

The AASW is the assessing authority, on behalf of the Federal Government, for social workers interested in providing mental health interventions through Medicare Australia.

Mental health: a human rights issue

Mental health is an integral and essential component of health. The World Health Organization (WHO) constitution states: ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. An important consequence of this definition is that mental health is considered more than just the absence of mental disorders or disabilities.

‘Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.’[1]

This statement from WHO captures the bio-psychosocial dimensions of good mental health (also known as the Social Determinants of Health). It goes on to also identify the multiple factors that can compromise a person’s mental health: specific psychological, personality and biological factors; socio-economic – inadequate income and education; social environmental – rapid social change; gender or

[1] https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

racial discrimination; risks of violence, and personal – unhealthy lifestyle, physical ill health.

Mental health needs to be understood within a human rights framework. Unless people can be confident in the security and freedom that flow from political and civil rights, it will be difficult for them to realize the state of wellbeing in the WHO definition. Similarly, people also need to be confident that their basic needs for nutrition, shelter, safety and security will be met before they can attain that state of well-being and can contribute to their community and the economy. It is no co-incidence that the elements named in the International Covenant of Economic Social, and Cultural Rights feature so strongly in the determinants of mental health.

Taking a human rights approach to mental health provides valuable insights into how we can address the contributing factors to ill-health and strengthen the factors that promote mental health. It directs attention to the needs of disadvantaged groups and to the interaction between discrimination and marginalization on mental health. It demonstrates the importance of many principles that underpin the service system such as equality of access to services and the need for standards and accountability in the delivery of services.

Social work and mental health

Social workers are present throughout the mental health field. The settings and fields of social work mental health practice include, but are not limited to: public mental health; adult mental health; private practice; community teams; child and adolescent mental health teams; and primary mental health care. Social workers provide a range of supports including direct services, assessment, therapeutic supports, case management and care coordination, advocacy, community development, research and policy. Furthermore, social workers encounter and work with mental health in other settings outside of the mental health sector for example family supports, family violence, child protection, housing, alcohol and other drugs and aged care.

Social workers are trained to understand and assess that the mental ill-health experienced by individuals, families, groups and communities are not caused or determined by a single factor. There may be intrinsic personal factors, combined with familial, psychological, economic, health, educational, employment, legal or other societal issues that contribute and pose obstacles to people achieving positive mental health and wellbeing. In their commitment to human rights and social justice, professional social workers collaboratively advocate for the rights of consumers against the discrimination, reduced opportunities and abuse they can experience.

Through therapeutic interventions and the mobilisation of services and supports, mental health social workers enhance the person's social functioning, promote recovery and resilience and aim to reduce stigma. Social workers practice in specialist mental health and generalist settings across the age and illness spectrum in numerous roles including: clinical mental health social worker, caseworker, case manager, family support worker, drug and alcohol counsellor, child and family counsellor, rehabilitation worker, crisis counsellor and therapist.

Mental Health in Victoria

The Victorian mental health system is in urgent need of reform. This has been significantly impacted by recent policy changes. With the introduction of the NDIS, and as it progressively rolled out across the state, approximately $70mil was withdrawn from what had been seen as the bench-mark mental health system in Australia, due to its well-developed community based system and the qualified

workforce that had been built up over decades.

In the six years since the NDIS first began operation in Victoria that system has been dismantled to the point that it is lagging far behind other states.

This is not to say that the system had previously been ideal or working to the high standards we believe people living with mental illness and their families deserve. There was clearly inadequate investment across the system to keep up with population growth and demand, and there were many gaps – for instance, aged mental health- and inefficiencies in service delivery.

Our members, however have indicated that Victoria used to have a robust mental health system which was easier to enter earlier in episode and was resourced to provide therapeutic supports to a wider spectrum of mental illness. This breadth included consumers beginning to deteriorate, consumers in crisis and consumers who have stabilized and need ongoing therapeutic supports due to the chronic or persistent nature of their mental health needs.

AASW Members identified three areas in which the decision to withdraw funds to pay for the NDIS has negatively impacted on mental health consumers and workers:

- Loss of a skilled cohort of mental health specialists with the loss of mental health jobs, and increasing burnout rate and turnover in the remaining workforce.
- Removal of key organisations, day programs, networks and supports that provided an easy access into the mental health system and provided psychosocial support to consumers in recovery.
- An underfunded, overburdened system that is increasingly focused on crisis triage rather than supporting recovery, creating a revolving door wherein consumers are rotated through the health system, the community and the justice system.

We commend the Victorian government for its commitment to reform and believe the Royal Commission provides a once in a lifetime opportunity to significantly improve the health and wellbeing of all Victorians.

AASW Submission

Summary of our submission

Our submission was developed in extensive collaboration with our members who have significant experience in the field and the see the impacts of the current system every day.

It is beyond debate that Victoria is currently facing a significant mental health crisis. The Australian Bureau of Statistics (ABS) estimates that approximately 45% of Australians have experienced a mental health disorder in their lifetime, with the most recent data identifying that 20% of Australians are currently experiencing some form of mental health issues in the last year.[2 3] The daily impacts are significant and affect the lives of every individual, group and community across Australia.

As social workers, we are on the frontlines of service delivery and see the devastating impacts.

It is the position of the AASW that in order address our current mental health challenges, the Victorian government needs to ensure a person centred, rights based, multifaceted and systemic approach to service delivery. Central to this is strengthening the participation and collaboration of people with mental illness, carers and family to policy development, practice, and research.

We believe that as social workers we play an important part in assuring that every person is provided the supports they need to reach their full potential.

Our submission highlights the following major points:

- Substantial investment is required to raise the capacity of the system to meet need;
- Psychosocial rehabilitation and community-based services should be reintroduced as part of an integrated system;
- Mental Health Workforce Strategy should be revisited to provide a comprehensive response to loss of expertise and experience, with a greater focus on peer workforce;
- There should be a whole of life approach to services and mental health supports;
- Assertive outreach particularly for hard to reach people needs to be reintroduced;
- There should be a focus on developing an integrated service system to meet mental health needs of people across sectors;
- Whole of community approach addressing stigma and discrimination is needed;
- A central coordinating body that is able to independently monitor and provide oversight for the sector should be established.

AASW responses to the Royal Commission Terms of Reference.

1. How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.

Meaningful change towards a Recovery Model

The current mental health system is crisis driven and does not address the full psychosocial needs of people living with a mental illness. The AASW renews its call for a greater focus on early intervention, recovery, community and human-rights based approach to effectively support individuals, groups and communities. There needs to be a fundamental shift from the highly individualized medical model of mental health towards a recovery-oriented approach that is person-centred, trauma informed, and provides a continuum of supports across the lifecycle when and where people need it. Despite a mandate to deliver mental health services from a recovery model[4], the mental health service system in Victoria has progressively moved to a medical model that is not sufficient to meet the needs of people with mental illness, and their families, loved ones and carers.

The dominance of a medical model has meant:

- Consumers are not receiving a holistic, person-centred and integrated approach to mental health care;
- The focus of care is still largely based on diagnosis and symptoms, rather than on a consumer's past and present situation and experiences (including trauma experiences) and the impact of these on their current functioning and quality of life;
- A focus on pharmacological interventions, rather than utilising a broad range of psychosocial interventions;
- A limited trauma-informed care approach;
- Poor recognition and response by clinicians of significant social issues impacting on consumers, such as past abuse/trauma, elder abuse, substance use and addictions, grief/loss/bereavement, financial stress, family conflict, discrimination/exploitation, sexual assault, risk to children, forensic issues, intergenerational conflict, and issues relating to cultural diversity and the migration/refugee/asylum experience.
- Loss of assertive outreach to enable connection with hard to reach people – such as those in rural and regional areas, homeless, youth,
- Consumers becoming bored and agitated in acute settings due to a lack of availability of therapeutic counselling or group programs.

A significant step the government could take is to support the cultural shift that is needed within the sector to fully recognize the complexity and varied dimensions of mental health.

Early intervention

Mental health is a complex issue and there isn't a single determining cause. What we do know is that

[4] https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

prevention and early intervention are key in order to address poor mental health and its devastating impacts.[5] The current system requires a high level of crisis before someone can be admitted to a mental health service to receive support. Consumers are no longer receiving the therapeutic work needed to effectively reintegrate into the community and be supported longer-term to enable them to participate meaningfully in their community. Therefore, care has become episodic rather than a continuation. A crisis focus has removed the flexibility of a step-up or step-down approach which supports consumers over the longer-term and provides support following discharge and transition. This results in a revolving door service, with consumers being stabilized, discharged with little or no community support, re-deterioration of the consumer's mental health, leading to a state of crisis, readmission, followed by stabilization and discharge again without support.

This revolving crisis door also has an impact on workers. AASW members identified that there has been a drastic reduction in a wholistic and therapeutic approach to services that puts someone on a trajectory out of services. Instead, members are experiencing a greater emphasis on short term crisis interventions. The focus on crisis is resulting in professional burn-out as workers are becoming increasingly aware of how their work is no longer providing long term results. This is compounding the loss of skilled and experienced mental health workers already caused by the de-funding of services.

The sector currently doesn't have the capacity or funding to do the supportive or preventative work that is desperately needed. Members reported that we had transitioned from a 'no wrong door' approach, to a highly segmented system which is extremely difficult to enter if you don't fit the specific deficit based requirements of existing services.

Prevention or early intervention strategies need to also consider the broader structural and systemic issues which impact on mental health, including ways of building resilience and developing healthier societies.

A whole of person approach

There is strong evidence that the economic and social determinants of health impact significantly on the incidence and severity of mental health.[6] The AASW recognises the value of community resources such as Men's Sheds, Neighbourhood Houses, Community hubs and Social Firms that assist many people in developing or maintaining a role with a sense of belonging in their communities. These can be especially important in areas of economic downturn (e.g. where there has been closure of major industries) and in rural areas. Such initiatives can also give people an opportunity to informally discuss concerns they have, which if left unaddressed can develop into more serious mental health issues or impact on domestic environments.

Promoting non-stigmatising engagement in activities which address both emotional and physical wellbeing has been shown to be effective at all levels of community. Initiatives such as 'Act, Belong, Connect'[7] and '5 ways to Well Being'[8] are evidenced based programs developed in the UK and used in some Victorian services as broader community development programs. These promote community engagement and are shown to have some effectiveness countering the incidence of mental health issues.

Provisions addressing the social and emotional well-being and countering stigma in the community,

[5] https://ebmh.bmj.com/content/21/4/182
[6] World Health Organisation (2014). 'Mental health: strengthening our response'. August 2014

must also take account of specific cultural needs. For example, members have raised significant concerns about the lack of appropriate services for refugees and people seeking asylum. While recognising the needs of Asylum Seekers and refugee populations are primarily the domain of the federal government, there are many initiatives that can be supported at a local state level. Local Asylum Seeker welcome centres are recognised and supported by many local communities with little or no funding. These centres offer a safe space and providing people with support and a sense of belonging. While many of these people have a significant trauma history and the uncertainty of their status weighs heavily on their well-being, they often have great resilience. Maintaining hope of being able in future to be a productive member of their new society is central to what these centres can offer. Links are established locally, and this is another (often volunteer) workforce that requires support/education to know how to better support a person and when to refer to a specialist mental health service.

Integrated service system to meet mental health needs of people across sectors

Mental health impacts every aspect of Victoria's health and social support system. The service delivery system is currently highly siloed leading to a poorly coordinated approach to mental health service delivery. Members report that new programs are continually being added to an already complex network of services, rather than being explicitly designed to build on existing structures with a focus on collaboration and coordination. This is leading to more fragmentation, with increased demands for coordination of service delivery to clients due to the expanded number of services, ultimately resulting in a less coordinated infrastructure for community-based care

There needs to be a central coordinating body that is able to independently monitor and provide oversight for the sector. The AASW supports Mental Health Victoria's recommendation to establish an independent Mental Health and Wellbeing Commission to provide system leadership for mental health and addiction, implementation support for system transformation. [9] The Mental Health and Wellbeing Commission would provide a significant leadership function and provide an important accountability mechanism for consumers.

2. How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages.

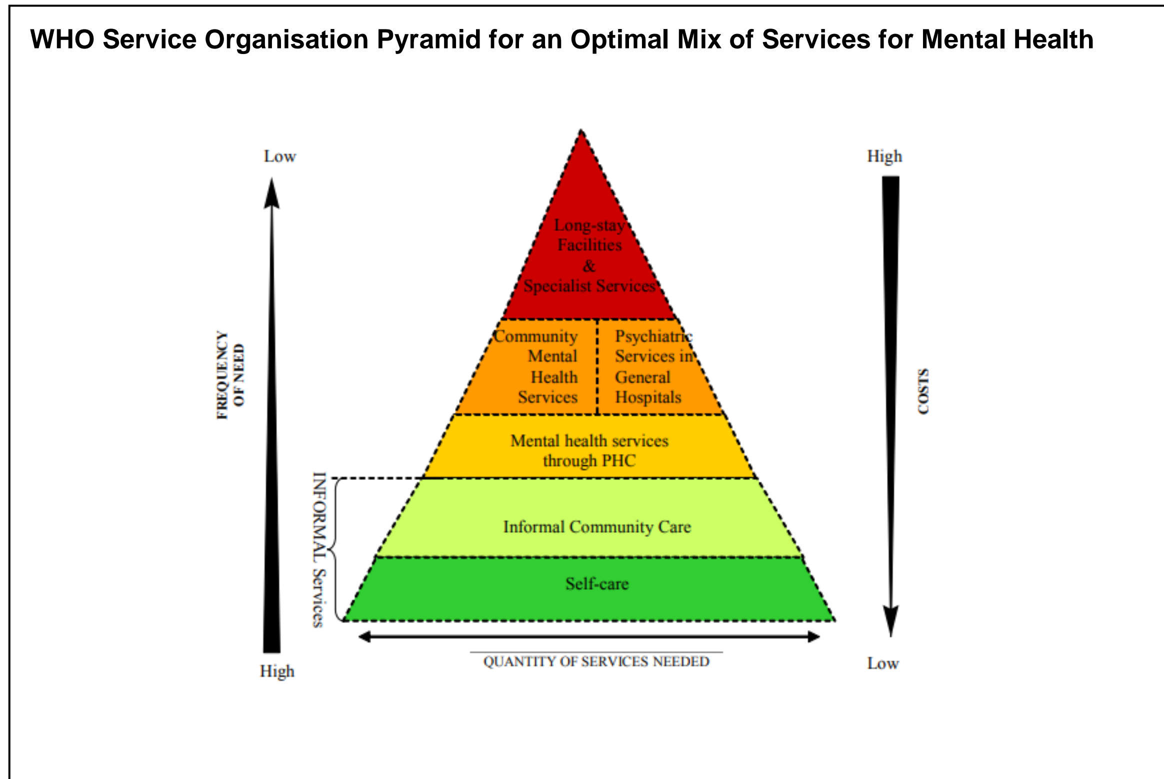
Community based supports

As identified previously, the system has seen a shift towards a medicalized model of mental health services as community-based services and support have been defunded. There is resounding agreement internationally that community based services are an essential component of effectively meeting peoples' mental health needs, as captured in the World Health Organisation (WHO) 'Service Organisation Pyramid for an Optimal Mix of Services for Mental Health'.[10]

[9] https://gallery.mailchimp.com/bef3d4502de8e4da07df417fc/files/10575dc8-c867-4350-8e9d-844148223410/MHV_VHA_Joint_Submission.pdf
[10] https://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf

As Community Mental Health Australia state, "The WHO model identifies no single type of service can meet an entire population's mental health needs. The various levels of care work in partnership — with support, supervision, collaboration, information sharing, and education taking place throughout the system. The model also promotes the involvement of people with lived experience of mental illness in their own recovery and that self-care continues at all levels, which in turn promotes and encourages recovery and better mental health."[11]

WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health



The model also emphasises the pivotal role that community mental health services have in the mental health service delivery system. This is currently an area that is several lacking in Victoria. Without appropriate community services there is a significant risk that individuals are unable to transition away from tertiary services.

Community-based activities such as ERMHA breakfasts, Day programs for mental health consumers, and even the physical space of community mental health organisations, provided both formal and informal avenues for consumers to be connected in the community and to receive social support from others engaged with services. These organisations provided a space where consumers felt comfortable and welcomed, and for many it provided a sense of social inclusion, community and purpose. With the defunding of key community organisations, consumers living with mental health issues have lost a sense of community that isn't being addressed in the individualized funding model and are at increased risk of isolation.

Commonwealth funded programs such as Partners in Recovery, Personal Helpers and Mentors (PHaMs) and Day to Day Living, also played important roles in assisting people to connect to services, create communities and contributed to recovery. These programs have had their funding withdrawn and transferred to the NDIS, and their loss is contributing to the loss of support for people.

[11] https://cmha.org.au/wp-content/uploads/2017/05/cmha-taking-our-place.pdf

The prevalence of market-based incentives are unlikely to replicate this organic and community-based offering supported by block funded organisations.

AASW members identified a general loss of recovery oriented supported services - services that provided support and maintenance over the medium-to-long term to provide assistance to consumers in their recovery. These services were key in ensuring consumers stayed engaged with therapeutic services, were able to attend their specialist appointments, and crucially prevented deterioration or non-adherence to treatment which might result in an emergency department presentation, or worse.

Our members also reported that the current system is overburdened. Waitlists are long and services do not have the staffing to keep up with demands. Triage mental health hotlines are particularly overburdened leaving a very vulnerable group without supports. Members gave several examples where consumers were asked to leave a message and be called back, with the wait being several hours. These are critical hours when wait times can be the difference between life and death.

Furthermore, the current funding and commissioning model of a collection of discrete compartmentalised items of service creates difficulties for people who need a comprehensive coherent response to their evolving and complex needs. Our members have reported needing to devote a significant amount of time to assisting vulnerable people through liaison and advocacy with community and health services to ensure that people receive the full range of appropriate community supports. Even when those supports are in place, social workers know how important it is that that they cohere into a unified, comprehensive “wraparound” service. There are particular issues in multiple system intersections, such as those between the mental health sector and child protection, the NDIA, family violence services or the family court.

Social workers and case managers in mental health are key not just to effective care coordination, but also the networking and interlinking of services to provide interconnected and comprehensive mental health services. Without the presence of adequate support to navigate a sometimes impenetrable system, it is not surprising that services are becoming more segmented and difficult to engage.

Mental Health Workforce

To deliver improved mental health outcomes, it is essential that a targeted approach to developing a capable and supported workforce is a priority. Mental health service delivery is fragmented across each sector, workforce groups and across States and Territories.

People deserve highly skilled and knowledgeable professionals with a rights-based and collaborative focus.

Counselling is a poorly understood concept resulting in a great variety of practices that can come under that banner, with not all based on the best evidence available. We also know that the first engagement with mental health services needs to be positive to assure ongoing support. With a fragmented and poorly regulated workforce this can be difficult.

For social workers, the AASW regulates our mental health workforce through the provision of Accredited Mental Health Social Work (AMHSWs) status. [12] AMHSWs are members of the AASW and meet the highest standards in professional recognition. They are subject to the same accreditation requirements as both their registered and unregistered allied health counterparts, such as psychologists and speech pathologists, in adhering to professional and ethical standards, maintaining

[12] https://www.aasw.asn.au/practitioner-resources/accredited-mental-health-social-workers

continuing professional development and engaging in professional supervision.

Members noted that as mental health services are being restructured and become more crisis focused, the key role of social workers and their role in multidisciplinary teams is being diluted. Instead, position titles are 'case managers' or 'clinicians' or 'practitioners' which are perceived to be generic titles that can be held by a wide range of professional groups – psychologists, occupational therapists, community development workers.

As social workers are increasingly employed in generic positions such as this, there is a fear that the social work focus on structural, systemic, wholistic, and psychosocial supports is being lost. This removes the truly 'multidisciplinary team' where there are a variety of positions each with a specific focus, to generic teams of multidisciplinary background, who all perform the same role and lose the specialized focus of their discipline.

Workforce: Rural and remote areas

The size of the specialist mental health workforce declines in a direct relationship with distance from a major centre. Even when calculated as Effective Full-time Equivalent positions per 100,00 people, the numbers of professional mental health staff decrease markedly as remoteness increases, leading the Royal Flying Doctor Service (RFDS) to report a crisis in mental health in rural communities. While operating as a general practitioner service, it reports having conducted 24,000 mental health consultations last year.

This demonstrates the importance of a well-respected GP service as the gateway to appropriate mental health services. Despite the low numbers of specialist personnel, the continuing trust in GPs presents a significant opportunity to provide appropriate services. The federal government has created the Better Access program which is designed to improve accessibility to community based, mental health care. Because it is accessed through a visit to a GP it is ideally placed to respond to people's reluctance to initiate contact with a specialist mental health service.

AASW members have identified that the difficulties being experienced in metropolitan areas of Melbourne and in major regional centres is compounded in rural and remote areas by distance and lack of staff to meet demand.

The loss of assertive outreach supports has impacted the capacity to provide preventative and early interventions, or to respond in a timely manner. Assertive outreach models are also beneficial for people with multiple and complex social and economic disadvantage. Acute response outreach services are significantly underfunded and understaffed in regional areas. Technology is not adequately filling this gap, as many still prefer face-to-face models of practice.

One case cited to us involved of a consumer living rurally who previously had support receiving medication and attending appointments. It was not just difficult for this client to self-coordinate due to cognitive impairment, but their medication made them extremely drowsy and unable to drive the distances needed. This patient was deemed to be not eligible for the NDIS, and now has no services to help him get to his appointments or pick up his medications. His only option would be to drive dangerously whilst on anti-psychotics, or be left to deteriorate.

Members said this was emblematic of a system that refuses to recognize that some mental health clients will always require mental health and residential support throughout their life. For some, recovery will never be an absence of support but instead will be defined by what they can accomplish with continued support. The system no longer has funding for those clients who will require ongoing

support and stability.

Peer workforce

The AASW strongly supports the formal development of the lived experience workforce within the Victorian clinical and nonclinical mental health system. Systematic development and implementation of the lived experience workforce as a discipline with a diversity of roles and career structure requires careful planning and dedicated resourcing.

Establishment of funded peer support workers alongside the existing adult and youth system advocate Consumer and Carer Consultants positions would be highly desirable. Most importantly this workforce development needs to provide for both consumer and carer positions a point requiring emphasis as often the assumption is that the lived experience workforce relates only to that of the consumer. In such an important developmental system reform it cannot be underestimated the need to factor in senior clinical and lived experience mentor and supervisory roles within employing organisations as critical to a well-considered establishment process.

There are significant roles and opportunities at all levels for the Lived Experience workforce, including in community agencies to combat the stigma of mental illness and to foster hope, encourage social inclusion and recovery at a grass roots level.

3. How to best support the needs of family members and carers of people living with mental illness.

AASW members related that carers and families were often uninvited, excluded or not well involved in the care, discharge, treatment or safety planning of their loved ones. Many highlighted that in their experiences dealing with families in grief following suicide, families wonder why they were not included sooner, when they could have provided key supports. Other members said families felt unsupported or not taken seriously by professionals when raising their concerns about their family member who may be mentally unwell and contemplating suicide, but are not yet severe enough for triage or crisis services.

The AASW and its members supports the advocacy of Carers Victoria in calling for carers and families to be taken seriously, respected for their importance in community care, and where applicable and feasible, be involved in the care planning of those they support[13]. The AASW emphasizes the *Carers' Recognition Act 2012* (Vic) s. 9 (b) principle –

"A person in a care relationship should, if appropriate, have his or her views considered in the assessment, planning, delivery, management and review of services affecting him or her and the care relationship"

This feedback and advocacy by Carer's Victoria would indicate that such principles and guidelines are not being upheld to the standard expected. Social workers have identified they are key in finding and involving families and carers, and ensuring that principles such as those identified above are well-explored.

Members report that carers are currently not well supported, requiring better respite services and

[13] Carers Victoria, April 2019, 'Carers Victoria Submission - Productivity Commission Inquiry into Mental Health', https://www.pc.gov.au/__data/assets/pdf_file/0013/241213/sub461-mental-health.pdf

further financial support. The increased focused on a medical model and indivualised treatment and support, and the inadequate resourcing of mental health carer support and respite, has resulted in a decreased focus on recognition of families and collaboration with them. The AASW supports Carers Victoria's call to provide services for carer respite, transport, emergency support, and to advocate for flexible workplaces that make concessions for the variable demands of many care roles.

The AASW emphasizes the Centre for Excellence in Child and Family Welfare's calls for prevention and early intervention[14], which includes further supporting parents and vulnerable families.

The AASW acknowledges the first thousand days are a critical developmental period for mental health and encourages the commission to make strong recommendations that support families to provide a safe and stable early life – particular where parents have been in care previously or intergenerational trauma and disadvantage continues to impact family functioning.

4. How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health.

The AASW recommends that any discussion about improving mental health outcomes needs a wholistic consideration of individual, family and community needs.

In particular, members emphasised a need for a more integrated system in hospitals. Multidisciplinary teams in hospitals often don't contain a mental health professional as these are seen as to be separate – the hospital medical model being for physical ailments not psychological ones.

The current segmentation of the mental health system in Victoria, the lack of services to meet demand, and the missing interconnection between services does not allow for wrap around support for complex consumers. The AASW recommends an increase in direct funding for programs to meet the needs of those experiencing serious mental illness, regardless of whether they do or do not meet the eligibility requirements of the NDIS. The AASW recommends the creation of a Partners in Recovery (PiR)[15] style service at the state level to co-ordinate services for consumers with complex needs and promote the interaction and interconnectivity of mental health services. The AASW recommends the removal of competitive processes for tender and individual customers which, in the spirit of creating competition, serve to silo and segment the service system and prevent the sharing of information or delivery of co-ordinated care.

While beyond the scope of the Commission, we want to highlight that many consumers with a mental illness are unable to work or struggle to find sustainable work, leaving them reliant upon Newstart and the Disability Support Pension to survive. These payments are, as has been advocated for by the AASW and ACOSS previously, far below what is necessary to live comfortably. It is unnecessarily difficult for those on these support payments to meet their needs, let alone attempt to afford transport to services and treatment options.

[14] Centre for Excellence in Child and Family Welfare Inc., April 2019, 'Submission: The Social and Economic Benefits of Improving Mental Health'.

[15] https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir

Noteworthy Programs

The AASW would like to draw the Commission's attention to several programs already in place that are providing effective supports

- Partners in Recovery (PiR) is a model that has worked extremely well.[16] Whilst this was a commonwealth program, a similar model could be re-introduced at a state level to cover the gap left by PiR. Currently, PiR is due to end on 30 June 2019 – and there are many who used to receive their services who have been deemed ineligible for NDIS or have yet to be assessed. A state-level reintroduction of a program similar to PiR could assist in these gaps and could work towards a goal of a more co-ordinated and integrated service system than currently exists.
- Wellways[17] and their families teams were highlighted by members for their emphasis on relational recovery rather than treating only using individualized models.
- Wellways Doorway program[18] was also identified, as being an important model supporting people into secure housing, which lead to better employment outcomes, and improvements in mental health and wellbeing.
- The Prahran Mission Engagement Hub was suggested as a possible structure that reflects this drop-in engagement model, which allows people to engage at the stage they are at – transitioning from just drop-in to regular classes.
- Open Dialogue models were suggested, opening dialogue up with community and social networks to create spaces for care decision making. Allows the creation of a team which can provide care early, with consent and input from the consumer and those around them, creating a safety net that exists before a person deteriorates to the point of ED presentation.
- St Vincent Mental Health Café – the safe haven café - was a good place for possible consumers to enter who need mid-level assistance but have not yet escalated to needing crisis support. "The Safe Haven Café has peer support workers and volunteers with a lived experience of mental health issues, who will work alongside mental health professionals to provide a safe, therapeutic space for people needing it. The Safe Haven Café doesn't replace clinical mental health interventions, but enables people to explore what options may be available to support them, and identify relevant local services."
- Foundation House – Foundation house has extremely long waiting lists due to the demand for trauma-informed services. Foundation house has partially begun to address this by forming waitlist groups based on the reason for presentation, allowing for a semi-formal response to exist prior to properly engaging with the service, and allows those on the waitlist to provide peer support to one another. Observation has been that some lower needs people are then no longer needing the service provided and are able to stabilise before being seen by foundation house, reducing the waitlist.

[16] https://www.sprc.unsw.edu.au/media/SPRCFile/PIR_Evaluation_final_report.pdf
[17] https://www.wellways.org/
[18] https://www.wellways.org/our-services/doorway

5. How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

Trauma, inequality, poverty, homelessness, drug and alcohol use, family violence and other forms of abuse contribute to a person's mental health. Any attempt to reduce the prevalence of mental health issues has to take into consideration the related comorbidities and social conditions. This includes systems that can appreciate the complex and intersectional set histories and circumstances that contribute to its existence.

The AASW supports the call from VCOSS calling on the government to address comorbid alcohol and drug use:

> "Rates of co-occurring substance use and mental illness are high, particularly among the most marginalised members of the community, including people experiencing homelessness and people in the justice system. For some people, addictions develop as a result of attempts to self-medicate the symptoms of mental illness or trauma. Use of alcohol and other drugs can also lead to or exacerbate some mental illnesses.
>
> However, people can recover from co-occurring mental health and substance use disorders, if they are able to access integrated treatment options. VCOSS members report that program funding restrictions and strict eligibility guidelines mean that often people are turned away from both mental health and AOD services. Instead of the 'no wrong door' approach that is recommended to increase engagement with services, too often people find themselves facing a 'no right door' scenario.
>
> The Commission should examine strategies that encourage services to undertake universal screening at all entry points for mental health and substance use problems, to identify co-occurring issues. Increased funding for care coordination and workforce development around comorbidity practices are also important."

Homelessness is intrinsically linked to mental health, and whilst there is a lack of affordable and suitable housing options for those living with a mental illness, there will be no positive outcome for these consumers. The AASW recommends an immediate increase in investment in social housing and supported living options for those living with a mental illness, such as Community Care Units, with clear transitional methods to prevent exit to homelessness.

Members identified that the housing situation has become particularly dire, compounded by the intersection of disadvantage caused by the interaction of mental health issues and unstable housing. Members highlighted the negative feedback loop that can quickly dominate a consumer's life when mental health begins to impact housing tenure, leading to further stress, anxiety, sleeplessness and instability, leading to further deterioration in mental health, leading to further issues in securing stable tenure, etc.

Supported accommodation such as Community Care Units were identified as helping this particular cohort, however noted that their stays had been similarly shortened with a higher turnover, and are difficult to enter. Many consumers have been at the end of their CCU stay, with no supportive living or transitional arrangement in place. Members noted that the Supported Residential Services as they stand are insufficient as they were sometimes "little more than boarding houses", with no therapeutic work to manage and improve consumer outcomes. The increase of consumers in crisis across the sector as noted above has resulted in what members identify as a 'growth of complexity' in the

consumers taking residence in SRSs, who may not be equipped or funded to deal with so many consumers with high and complex needs. It has also resulted in a perceived 'scope creep' for CCUs, leading them to have a dual diagnosis or developmental disability focus, reducing the amount of beds for the broader range of MH consumers who experience housing instability.

Members identified that the residential mental health support currently being delivered to youth demographics, such as the programs by NEAMI and Mind Australia, are successful. These programs give 12-24 months to build capacity and strengths until they are capable of supported or independent living. These contain therapeutic interventions with a clear structure. Members suggested similar models be rolled out to adults.

6. Any other matters

There needs to be a greater focus on how to better support specific groups and how the mental health system engages with other services including the interface with aged care and disability.

Aboriginal and Torres Strait Islander peoples

The mental health system is deeply failing Aboriginal and Torres Strait Islander peoples. The disproportionate rates, including youth suicide, are a national emergency that needs immediate state and federal action.

The AASW strongly supports the recommendations from National Aboriginal Community Controlled Health Organisation (NACCHO) and other peak groups[19] calling on governments to:

- Provide secure and long-term funding to Aboriginal community controlled health services to expand their mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drugs services, using best-practice trauma-informed approaches
- Increase funding for Aboriginal community controlled health services to employ staff to deliver mental health and social and emotional wellbeing services,
- Increase the delivery of training to Aboriginal health practitioners to establish and/or consolidate skills development in mental health care and support, including suicide prevention
- Commit to developing a comprehensive strategy to build resilience and facilitate healing from intergenerational trauma, designed and delivered in collaboration with Aboriginal and Torres Strait Islander communities

Older Australians and Mental Health

Older persons' mental health is a neglected area in national and state strategic planning efforts. Although many older people are on average living longer and healthier lives, for individuals with a mental health condition there will be rising demand for both mental health and aged care services by virtue of this demographically expanding cohort.

The current composition of the aged care workforce at all levels does not adequately provide services that consider the full range of psychosocial needs of older Australians. There is significant research and literature demonstrating the importance of addressing the mental health needs of aged care residents as they have a direct impact on all other aspects of their physical and emotional wellbeing, including care needs. Comprehensive enhanced assessments and supports will not only improve the

[19]https://www.naccho.org.au/health-bodies-declare-aboriginal-youth-suicide-an-urgent-national-priority/

quality of life of residents, but also that of their families and reduce work pressures on care staff. Improving the skills of the aged care workforce is essential to address issues related to the increased longevity of Australia's ageing population.

Furthermore, the loss and grief of older persons and their families associated with the transition into aged care services and dementia is not adequately assessed or supported by the existing aged care workforce. This is a highly complex area were individuals and their families are grieving the loss of independence, family and identity that significantly impacts adjusting, coping and wellbeing. The aged care workforce needs access to training to adequately identify and address the range of issues experienced by older people and their families, for example the significant mental health and grief and loss issues. Greater emphasis on a comprehensive approach to service delivery and education and training of direct service staff is an important factor in meeting the future challenges of the sector. The current workforce is hampered and undermined by a lack of service integration leading to poorer outcomes for consumers. Older people with complex needs greatly benefit from coordinated interventions from appropriate agencies and workers

The recognition of mental health needs in aged care outside of dementia still hasn't been properly recognized. The very medical model that dominates aged care in both community and residential facilities was identified as missing the need for psychosocial and mental health supports. The focus is entirely on physical co-morbidity, and there is an over-attribution of difficult behaviours to the BPS of dementia.

Members identified that mental health pilot programs, new models of treatment or innovative approaches are rarely tendered towards the elderly, instead being predominantly youth focused. This means innovation is focused on young people, research and development doesn't include the aging population, and there is no progression in the way mental health is treated in an aging population.

Lesbian, Gay, Bisexual, Trans and Gender Diverse, And Intersex (LGBTI) People

The AASW strongly support the recent Joint Statement from Health Organizations that call on the Royal Commission into Victoria's Mental Health System to consider LGBTI Mental Health.[20] As the statement points out:

> "All lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) people deserve to live happy and healthy lives, and to enjoy the benefits of a mental health system that is respectful, safe, affirming and supportive. The life experiences of LGBTI people are diverse and the majority of LGBTI Victorians are happy and content. However, a range of mental health outcomes are known to be associated with experiences of marginalisation, discrimination, stigma, violence and abuse."

The AASW calls on the Commission to engage in extensive consultation with community-controlled LGBTI organizations, experts in LGBTI health and consumers who have significant appreciation of the limitations and opportunities to improve the mental health of LGBTI Victorians.

The National Disability Insurance Scheme

As stated previously, we have significant concerns about how the Victorian mental health system has

[20]https://thorneharbour.org/news-events/news/leading-health-organisations-call-on-the-royal-commission-into-victorias-mental-health-system-to-consider-lgbti-mental-health/

been impacted by the implementation of the NDIS. It is self-evident to say that the NDIS is a disability support scheme and not a mental health system; and yet it would seem that governments believed the Scheme would meet the needs of people with mental illness and psychosocial disability, evidenced by the transfer of funds from valuable community mental health supports to the NDIS. Adequate care coordination is not provided under NDIS, which can be sorely needed where there is continuing impairment or lack of capacity to self-manage services. NDIS will offer 'support co-ordination' at approximately 1 to 2 hours per week, however this is generally little more than a rostering of services and doesn't properly integrate services into a wholistic wrap-around care team. For complex consumers, such little time would not allow for the high degree of co-ordination required or to work with the consumer and recognize further areas for strength, psychosocial intervention, and reviewing the need for services as the recovery journey progresses.

The interface between NDIS and other segments of the community support and health system have not been well developed to date, and particularly with the mental health sector. People being discharged from hospital have had to wait unacceptable periods for their eligibility of NDIS supports to be assessed, and the connection between the two systems for people with complex needs have not been effective. Notwithstanding short-term interventions put in place by the Department of Health and Human Services to overcome these gaps, the long-term arrangements needed for better integration need to be addressed.

Members experience of their interaction with NDIS was that there is "No room in the NDIS for recovery".

Conclusion

The AASW welcomes the opportunity to make this submission and continue working towards towards improving the health and wellbeing of Victorians, and all Australians.

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