Your contribution

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

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

Partnerships with media outlets – the manner in which the media reports violent incidents, court cases where mental illness is used as a means of defence, & behaviour that is attributed to mental illness leads to & supports the existence of stigma & discrimination. This needs to be addressed collectively and collaboratively in a similar manner that the negative reporting of suicide was some years ago. Main stream mental health service providers & the (local) media outlets should engage in regular dialogue that supports the development of appropriate reporting, & through review the good & not so good reports as a means of education, learning and quality improvement. Media and social media platforms can often contribute to or heighten a perception that mentally ill people are incapable or violent, whereas in fact people who are mentally ill are overwhelmingly the victims rather than perpetrators of violence. (ANROWS Examination of the burden of disease of intimate partner violence against women, November 2016).

There is a need for clarity of language and meaning to improve the understanding of what is meant by "mental health and wellbeing" and "mental illness". The term mental health is used by community, media and politicians to describe both interchangeably, and is generally given a negative connotation. Media can and should be an active partner in promoting mental wellbeing and reducing stigma.

DHHS, & (in particular) state funded mental health service agencies, should have positive mental health promotional activities that include service users, as part of their funding agreements/service outcomes. Regular open days at mental health service centres (including hospital settings) and community engagement events available to everyone & anyone could be organised to inform the public about services, how services function and allow the public to view facilities to gain an understanding of what goes on behind closed doors.

Social media & prime time television could be used more extensively for positive promotion.

Shifting the focus from individual pathology and labelling can positively impact both stigma and communities' wider capacity to engage in finding collective answers.

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

Prevention & Recovery Care Services – most of these services seemed to be working well, particularly when the focus is primarily on step-up from community as they should be. The use of these facilities is to be encouraged in an attempt to avoid the need for hospitalisation, focusing on least restrictive practice and options.

The **telephone triage entry point** to area mental health services currently operates as a "gatekeeping" process, rather than a "gateway" process that should provide the opportunity for people seeking help to at least engage in an assessment of their needs. The Victorian State-wide Mental Health Triage Scale document gives clear guidance through a tiered rating approach, ranging down from the most urgent, that allows the opportunity to prioritise response times, but not

exclude people at the first hurdle. Unfortunately, referrers need to jump an ever increasing number of hurdles, even those with a professional background, for an assessment to be offered. The focus is on the most acute cases & those that favour a crisis driven response. People need to be judged as or prove that they are "sick enough" to gain a response or entry to the system. The current response & management of referrals through the triage system prevents early intervention & early treatment because those with emerging issues rather than well-established diagnoses don't get past a phone call (this is particularly evident for young people; adolescents, young adults). But even those with well-established diagnoses have to wait until they are acutely unwell before being "allowed back" into the system. This is another reason why emergency departments are overwhelmed with people presenting with mental health issues because there is no alternative for people seeking mental health support. The mental health telephone triage system is no longer fit for purpose. An alternative could be to establish mental health service hubs with free access 7 days per week.

The disconnect between area mental health services & alcohol & other drugs (AOD) treatment services is another major issue in the prevention of mental illness, & works against people receiving early mental health intervention. The main problem is that AOD services in Victoria are "out sourced" to not-for-profit or non-government agencies. Both mental health & AOD services should come under the direct governance of DHHS & be aligned in service delivery. The entry point to receive assessment for Victorian AOD services is out sourced to the Australian Community Support Organisation (ACSO) which by design places an immediate barrier for people wishing to address their AOD issues, & if there is a co-existing mental health disorder, this process can also delay access to mental health assessment. The current structure does not allow for both AOD entry & mental health triage points to work together. They are complete silos. This contributes to frequent disputes between the services about which issue is the primary – AOD or mental ill-health. Meanwhile the client, relatives or referrer are often left to manage on their own. Frequently, there is no proactive effort on the part of the two services to work together in the best interest of the client. The onus is often on the client to be the proactive one, which in times of high levels of distress or illness do not have the capacity to follow through.

Take the service to the people – there is no incentive for area mental health services to provide outreach & take the service to the people. In rural areas this in part is due to the capacity & willingness of psychiatrists to work outside the major population centres. It is also a result of the necessity for maximising psychiatrists' time. A change in the funding model could help change this situation by financially incentivising outreach work. However, more can be done by the non-medical workforce providing more services that are not centre based. Early intervention, earlier treatment options would be enhanced if more services were provided in people's homes, at GP clinics, community health agencies, schools, headspace centres, Centrelink offices, etc.

Older persons' mental health requires greater investment with an aging population, particularly for mental health assessment. For far too long the investment has not kept pace with demand. This has possibly been due to the expectation of the Victorian government that the Federal government would look after the needs of older people. But this is clearly not the case when it comes to mental health. People aged between 65 and 75 years may not demonstrate the physical signs of aging, or dementia, and therefore not qualify for some commonwealth funded assistance. But this cohort can have significant mental health issues which the State government services are responsible for responding too and providing service for.

Access to **Child & Adolescent Mental Health Services** is far too restrictive & often assessment is denied due to there not being evidence of mental illness. The criterion has shifted & the onus put onto the referrer to demonstrate that behaviours are due to mental illness. The introduction of the

CAPA system in some CAMHS services has led to a great deal of frustration, & falsifies the true waitlists (in both times & numbers) & outcomes.

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

The trial of **HOPE** program in Benalla & Wangaratta appears to be working well with people receiving appropriate & timely responses post suicide attempt or intentions. However, this is only a trial without any guarantee of future funding.

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

Cross Border Issues

People who live along or close to a Victorian border (NSW and SA) can find it difficult to navigate mental health services and receive timely, appropriate and equitable responses. These issues can occur wherever there is a border crossing or "twin towns", but it is particularly evident in the Albury Wodonga communities, due in part to the larger population straddling the border at this point. A cross-border environment creates specific and complex barriers to integrated and effective approaches to treatment and recovery. The differences in state and federal legislative, policy and funding environments makes it very difficult to align work and program development, to measure outcomes, for clients to have equitable choice of services and service delivery, and can in fact rule some people ineligible for services they need.

Albury Wodonga Health (AWH) is a Victorian Health Service Entity aligned with the Victorian Department of Health and Human Services (DHHS). AWH is the only cross border health service in Australia, and along with other health specialty services, is responsible for the delivery of public mental health services in southern NSW and northeast Victoria with a catchment population of approximately 225,000 people. This demographic is vastly different from other border towns and locations. In addition, Albury Wodonga is a Commonwealth Government "preferred place" of resettlement for refugees or new migrant arrivals, particularly for people of Congolese and Bhutanese origins.

The area mental health service, known as North East & Border Mental Health Services (NEBMHS), is a specialist directorate of AWH and operates on both sides of the Vic/NSW border. This service is the result of a staged amalgamation of services that existed in the region at the time of creation of AWH. The NSW component was previously administered by Murrumbidgee Local Health District (MLHD), and the Victorian component was made up of services originally auspiced through Wodonga Regional Health Service, Northeast Health Wangaratta, and Beechworth Health Service.

NEBMHS operates under both Victoria and NSW mental health Acts, and the 2 Legislations are quite different in design, and therefore interpretation and implementation. Residents of the region can receive quite different responses for the same mental health issue, and particularly if they happen to be on the opposite side of the border to their normal place of residence when needing to urgently engage with services or support. This is highlighted more so if people require acute inpatient services. (AWH operates 2 acute mental health units, one at Albury Base Hospital and the other at Wangaratta Hospital, Northeast Health Wangaratta.)

The current service model has different access and entry processes for each side of the border, and both rely heavily on people presenting to an emergency department for assessment, particularly for

acute and out of hours presentations. Each side of the border has a telephone “triage” line, but access to services is reliant on the referred person attending the service, rather than the service going to the people.

There are many elements of the current service structure that leads to confusion for the community, other agencies and professionals alike. In turn this leads to difficulty in navigating the system, and for some, receiving a timely response. The service name (NEBMHS) is misunderstood, and because AWH mental health services extend so far south into Victoria, this also can cause confusion in the general public. The name of this service could be changed to something like, Albury Wodonga Health Area Mental Health Service.

There are differences in clinical practice within the one/same service, which can lead to different clinical outcomes, depending on which side of the border people access services through. This is not the fault of clinicians, but rather a consequence of legislation and historical policy and planning that leads to operational and procedural differences. For example, people subject to either mental health Act face different processes and potentially different clinical outcomes, particularly when it comes to time frames of compulsory orders. If a Victorian resident (and vice-versa) is admitted to the Albury acute unit under the NSW Act and requires compulsory community treatment in Victoria from point of discharge, the person must see a Victorian based psychiatrist at point of discharge to take over care and the administration of treatment under the Victorian Act. This is a clumsy process and can delay discharge.

The general public of the region do not see a border when they require services of any type. It is one community for them, without a border. In addition, people requiring acute medical services or hospital admission, usually attend the Albury Campus of AWH because this is where the AWH acute and specialist services are located. The current mental health facilities (condition, standard and availability) vary greatly between Victoria and NSW. The 2 acute inpatient units are vastly different in design, and also function differently, partly due to design features. This lends itself to differences in the way the units are managed and differences in client experiences. There are no acute Mothers and Babies or adolescent beds in the AWH mental health service. People requiring this type and level of care are referred to Melbourne or Sydney (usually depending on residential address) which is not only disruptive for clients, but for their families and friends also. Referral back to local services for follow-up can be fraught due to communication/handover issues, and establishment of a timely response by local services.

Recruitment and retention of medical staff is a major issue for the service. The psychiatry medical workforce can be employed under different Awards or contract conditions depending on which state they were originally employed in, and align with different Chief Psychiatrists and State policy. On the NSW side most are employed on a fly-in/fly-out basis (usually from Sydney) and have little, if any, capacity for in-put into service development or improvement.

Employment conditions for non-medical staff are also different depending on which side of the border is considered to be the staff member’s primary location of work. This is not helpful in establishing a collegiate workforce as staff are doing the same work within the same service, for the same employer, but under different Awards and employment conditions. This arrangement can lead to differences in service provision and clinical practice, and potentially undermine service development or changes in service design that would provide an equitable response to and experiences for clients and their families. For example, differences in roster practices and hours of service availability.

There are lingering issues related to alignment or allegiances to MLHD or DHHS. There is an agreement between AWH and MLHD for access to acute mental health beds at Albury when the Wagga Wagga facility is at capacity. At times this has disadvantaged AWH clients and their families by not being able to access a local mental health bed when needed.

Brief Case Example

A woman was referred to Gateway Health Wangaratta, with her husband, for relationship counselling in March 2019. The woman had a history of depression and she was having difficulties accepting her

husband wanting to separate from the marriage. After a few joint sessions with the counsellor the woman presented to an appointment quite distressed and expressing the wish to die with marked suicidal thinking. The counsellor appropriately contacted mental health telephone triage but her call went to a message bank. She tried a little later in the day with the same result. The counsellor finally made direct contact with a triage clinician 2 days later. (During this time a safety plan was in place)

When connection with tirage was established the counsellor explained the situation and was initially met with "what do you expect us to do". Eventually, possibly following a supporting referral from the woman's GP, triage accepted the referral and a mental health assessment took place a few days later. However, there was no ongoing follow up or treatment offered by the clinical mental health services – "there is nothing more we can do", and the counsellor had to chase the mental health service for this information.

At an appointment with the counsellor in June there was a similar presentation and again the counsellor made a referral for the woman to mental health triage. On this occasion further assessment was not offered. The counsellor felt she was not believed and was basically dismissed by the triage worker. (The counsellor is a very experienced and credentialed social worker with many years of practice experience).

A week ago the woman made a well-planned suicide attempt, [redacted] which she took at a time believing her husband would not return home for many hours. Fortunately for her, her husband returned earlier than expected and acted on a safety plan the counsellor had discussed with the couple and he called an ambulance. The woman required urgent medical treatment and spent some time in a general medical ward before being detained under the Mental Health Act. When the woman was medically stable she underwent a mental health assessment, with an outcome plan for transfer to the acute mental health unit. However, there were no beds at the AWH Wangaratta acute mental health unit at that time so she was transferred to the AWH Albury unit, quite a distance away from her usual social supports. To be admitted to the Albury unit required the woman to be discharged from the Victorian MHA order and a NSW MHA order be initiated.

This case highlights several issues. The triage system blocks referrals rather than prioritising them for timely assessment. Once an assessment does occur there is no guarantee anything will come of it for the client; even information or advice. Risk assessment is slap-dash and supporting information not taken seriously, if considered at all. The acceptance of referrals through telephone triage is a very subjective process. In this case there was a strong inference that the woman was "not sick enough" or "there is no crisis". This type of outcome makes all those involved (outside the "system") feel frustrated, abandoned and asking themselves "what's the point".

This case also highlights a lack of client centred practice, and had the mental health service been more responsive to the referral it most likely would have prevented the suicide attempt, avoided the need for hospitalisation and potential harm that this can inflict (hence following least restrictive practices), or the use and restrictions of the Mental Health Act(s).

Unfortunately, this example is not an isolated one.

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

Availability & access to services is the biggest issue in rural & remote communities. As stated earlier, services need to go to the people as much as possible. Cost or lack of reliable transport can be an inhibitor to attend appointments at centres many kilometres away. This could be overcome to some extent with greater uptake of technology such as Skype & telemedicine facilities. There is reluctance by some to use this technology, but also, in some locations connectivity remains an issue.

There was a missed opportunity for the direction of videoconferencing in mental health when the

Victorian Mental Health Act 2014 was introduced. This has been a feature of the South Australian MHA for many years & has positively influenced the use of technology in that state for many years. Perhaps a policy or guideline review could achieve this in Victoria. General Practitioners in rural settings require greater support from the mental health service system in their efforts to support people with mental health issues, in particular through secondary consultations with psychiatrists. This also could be done via the use of technology & financial reimbursement.

The introduction of the NDIS & the inclusion of mental health under the scheme has left many rural & remote people without the psychosocial supports they require & previously experienced. This will lead to many experiencing poorer mental health outcomes & needs to be addressed urgently at a State/Federal level. Some people with NDIA funded support packages have the bulk of their funds taken up by agency travel expenses due to distances support people need to travel to get to where the client is located.

People living in rural areas have higher rates of self-harm and suicide and less access to services than their metropolitan counterparts. Isolation, geography, poor internet access, under employment, insecure housing, climate change vulnerability, local towns losing population and general services all impact mental health and wellbeing in different ways to metropolitan areas. The lack of social connections, education and training & employment opportunities in some rural communities is leading to poorer mental health outcomes.

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

Families and/or carers need to be listened too; they need to be heard & taken seriously. They also need to be included in the planning & decision making processes (as far as possible & particularly if consent has been given from the client), & be part of the solution. This would be a huge step in them feeling supported.

When their relative or the person they are caring for is unwell or showing signs of becoming unwell, the service system needs to be proactive & respond to requests for help or assessment. The system needs to be responsive to its community.

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

Greater and ongoing attention to workforce is required to both support mental health and to treat mental illness. Rural regions experience considerable disadvantage in recruiting health specialists. Innovative models have been developed to address workforce shortages in general practice and dentistry – similar attention needs to be paid to the clinical and community based mental health workforce in both the public and private sectors. The non-mental health workforce increasingly needs skills in working with people who are experiencing or recovering from mental illness. In rural regions there is limited opportunity to develop the knowledge and skills required.

Investment in culturally appropriate, competent and trauma informed workforce for Aboriginal and Torres Strait Islander people, and for rural refugee and resettlement communities is imperative. A number of population cohorts have inherent cultural issues and stigma around mental illness which can impact their ability and or/willingness to seek help. These groups often also suffer the impacts of racism, misunderstanding and even fear directed at them which in turn lowers their trust of the broader service system. Lack of interpreters in rural areas heightens this issue for some language groups.

Lack of wage parity and employment conditions in state based Enterprise Bargaining Agreements impacts workforce recruitment, retention and service delivery.

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

Ensuring mental health and wellbeing to allow full and productive participation in the workforce, in community, in schools and within families is a role for of all of government, all sectors, all employers and all communities; and should be reflected in all policies and funding. The wellbeing of people needs to be at the centre of sustainable public policy and decision making. Active promotion of psychological safety and mental wellbeing in workplaces is needed across the board. Return to work programs reflecting psychological safety and active prevention of harm in workplaces are key to improving participation. Employment and work environments must aim to be accountable for supporting good mental health for all staff.

Misunderstanding and stigma around mental illness negatively impacts employment, education and community participation. Insecure or intolerant employment conditions can lead to homelessness and isolation, further reducing access to opportunity and services; increasing vulnerability and the risk of entering the justice system.

Broad multi-sector partnerships need to be supported to ensure that mental health and response to mental illness is collaborative, that there are shared priorities and actions that lead to measurable outcomes over time. Partners can and should actively address risk factors and interconnected issues such as homelessness, isolation, chronic illness, substance misuse, addiction, crime and family violence.

Fund other sectors (housing, education, health, police and justice, transport, education etc) to include mental health and wellbeing as their core business. Most people having problems with their mental health are not clients of the mental health 'system'. Their mental health needs should therefore be able to be addressed in the places they do access. Develop shared actions, priorities and wellbeing outcomes indicators across sectors.

To ensure a positive focus on mental health and wellbeing, there must be an increased focus on streamlined and longer term funding for prevention and early intervention – before people become unwell or incapacitated. Increase funding and focus on community mental health especially in rural and regional areas, and clear and supported roles and relationships between mental health clinical treatment services, the broader health system and other sectors and settings.

Planning and developments in cities, towns and suburbs should focus on what is required to ensure health and wellbeing. Liveability - green spaces, transport, walkability, food security, services, community connection and accessible and affordable recreation options need to be given as much importance as return on investment for developers.

People with lifelong mental illness are able to participate in workforce and community with appropriate levels of support. Community members are expressing concern regarding the adequacy of and barriers to navigating the NDIS in supporting their ability to participate.

A national system of outcome measurement for *all* funded mental health and mental illness services

and systems is needed – with outcomes and effectiveness measured by consumers as well as providers across a range of domains.
9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?
The current alignment of clinical mental health services with *the* major health service provider in each region of Victoria allows for major differences in policy and service delivery in each region. Policy development is at the direction and satisfaction of local health Boards, which can work for general health, but not always for mental health. This means that the mental health service consumer experience can vary greatly from region to region across Victoria. There is no uniformity across the state, al-be-it there can be similarities, which means the quality of service, service response and therefore client outcomes will depend on where a person lives. This is not just simply a metropolitan Vs rural setting issue. A recommendation for change in structure of this type would not cost money. It will take government policy change and direction, but could be achieved relatively quickly. In some other Australian States there is uniformity and commonality of consumer experience because the State health authority has direct governance or policy setting responsibility over mental health service provision.
11. Is there anything else you would like to share with the Royal Commission?

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