Royal Commission into Victoria's Mental Health System

City of Greater Dandenong Submission to the Royal Commission into Victoria's Mental Health System

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Background and Preamble:

The City of Greater Dandenong is the most diverse municipality in Australia with 64 per cent of its 160,000 residents born overseas representing 157 countries with over 200 spoken languages. The low socio-economic profile of the municipality carries a number of developmental challenges, particularly in relation to mental health programming. These challenges can be categorised across the following themes and/or cohorts:

1. Homelessness and high numbers of people at risk of homelessness because of significant overcrowding due to lack of adequate affordable and social housing stock.
2. High levels of youth disengagement coupled with high levels of unemployment.
3. Interlinked comorbidity risk factors directly linked to mental health such as homelessness, disability, impacts of alcohol and other drugs use, forensics, social isolation, etc.
4. High levels of family violence, gender-based violence and violence in public places.
5. Lack of equity and access for women and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) people.
6. Lack of cultural and linguistic lens applied to mental health programming.
7. Lack of adequate mental health resourcing and focus on generalised family, youth and community care services creating additional complexities in an already disjointed clinical mental health service system.
8. High levels of gambling losses and gambling related harm.
9. An ageing population with interlinked complexities borne by low indices of human development in relation to education, employment and standard of living.
10. Unmet needs of people seeking asylum and refugees. City of Greater Dandenong is home to 25 per cent of total people seeking asylum in Victoria.

Within these parameters, whilst mental health must be looked at from a population perspective, at the City of Greater Dandenong, it is necessary to embed a linguistic and cultural lens in mental health programming. Targeted programs must be designed for certain culturally and linguistically diverse (CALD) communities. This will require significant focus to be placed on the training of service providers so that they are aware of the specific needs of certain segments of CALD communities. Unless service providers are aware and able to tailor their services to specific needs, raising community awareness may be counterproductive and create distrust among clients because the programs and services offered do not match with what is discussed in community awareness sessions. Unless service provision is mindful of intersectionality of clients' complex background issues, establishing community connections will continue to be a challenge. The City of Greater Dandenong therefore recommends the development and implementation of a targeted five-year mental health pilot project in the municipality with a comprehensive approach that addresses the ten themes mentioned above. Such a project will provide a benchmark for an Australia-wide adoption of a mental health program model for culturally diverse communities.

Specific suggestions and recommendations are as follows:

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

Approaches to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination must begin with open discussions in mainstream media and politics about the topic of mental health and the different types of issues faced by people. These conversations must embed a linguistic and cultural lens in mental health programming to enable such honest conversations to flow into culturally and linguistically diverse communities.

Certain clinical terminologies of mental health in the English language already carry negative connotations and stigma and have been stereotyped (eg. psycho, lunacy, schiz, madness, etc). When these same terminologies are used with linguistically diverse segments of our community, with an aim to translate them into other languages where such words may not exist, there will be challenges in creating meaningful discussion. Similar lessons can also be drawn from how the use of clinical language in social settings created significant stigma and discrimination around LGBTQI inclusion.

Lack of awareness, stigma and discrimination may be the result of inadequate discussion on the kinds of mental health issues/illnesses that exist and how each of the factors/categories affect different people in different ways. Enabling such conversations require testimonials and input into tailored programming from people who have suffered from mental health and such testimonials must have a good mix of the population to demonstrate the diversity of people (from prominent public personalities to members of the general public). It should also highlight that although mental health can affect anyone from any social spectrum, there can be a disproportionate impact of mental health across people who identify with an intersectionality of a complex combination of issues such as disability, race, gender identity, sexuality, the impact of socio-economic conditions, etc.

To improve community understanding of mental illness and reduce stigma and discrimination, the City of Greater Dandenong recommends:

- Multi-modal reinforcing messages across different media and social media platforms, eg, TV, radio, the Internet, billboards, transport interchanges, railway and bus stops, and related vehicles such as buses, trains, trams.
- Community awareness campaigns in multiple languages and formats; use of multi-language resources such as radio stations, social media pages and community groups. Within CALD and other communities, not everyone starts from the same place in understanding mental health literacy. For some of our communities, the topic of 'mental health' is completely foreign and alien. Some languages do not have a direct translation for certain English words, or the closest equivalents translate to words like "crazy" or "mad" which carry negative connotations.
- More campaigns in media to educate people on self-help seeking behaviour, with less focus on 'mental illness' and more focus on 'mental wellness'.
- Training for service providers and particular general practitioners (GP) who are often the first port of call for a person with mental health issues. The current GP training in understanding the mental health system is limited to referring patients to private psychologists on the Mental Health Care Plan (MHCP).

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?**

- Mental health program needs to be designed with focus on a 'housing first', particularly for persons who are homeless or at-risk of homelessness. There is adequate evidence that with or without interlinkages between homelessness, family violence, drug/alcohol issues, and other social challenges; chronic homelessness and mental health are interlinked. A housing first model can be the starting point to addressing the current siloed service system where different service sectors are

not able to coordinate client care and referrals well. The system that is applied by Child Protection Services, with housing the child first and then providing wrap around services, should also be applied for treating mental health issues as well, especially to the cohort of people who are homeless or at risk of homelessness. Evidence suggests that homeless children and their mothers face increased levels of mental health issues, which necessitates the need for wraparound services based on the housing first model. Lack of appropriate housing results in mental health issues being insufficiently managed, including other problems such as leaving treatment early, not following treatment plans or ineffectively engaging with mental health services. A housing first model would cover account for significant accommodation savings through reduced use of shelter/emergency services, hospitalisations and programming expenditure.

- Resources and funding must be increased for generalised youth, family, elderly and community care services where trust and connections have already been established. This will ensure streamlining of services as these services have the capacity to ensure seamless referral pathways to the clinical system across the continuum – mental health – drug and alcohol – disability and dual diagnosis services. Currently, these services often work separately in silos and a community member often needs to access more than one service. Asking the community member to move themselves between the service systems is fraught with issues, with multiple barriers such as language, cognitive capacity resulting in the inability for individuals to appropriately advocate for themselves.
- NDIS is rigid and does not allow for all mental health issues to be addressed from within its system.
- Improvement in the number of sessions awarded on MHCP - 12 sessions per calendar year is grossly inadequate and leaves community members out of the private system and onto the expansive and unacceptably long waiting lists of the public system. (An example: What if a similar system was used in anti-biotic prescriptions? Required dosage is 2 tabs daily for 5 days, but the system rations that as one tablet per day for 5 days, and then if problem persists, one tablet per day for 5 days but only after a waiting period of 2 weeks. Would that system work?)
- Program initiatives that specialise on early intervention with people who are at risk of developing a mental health concern should be expanded – for example Paying Attention to Self (PATS) program and CHAMPS Peer Support program target children and young people who have a parent/carer with a mental health issue. These two initiatives provide early intervention to this vulnerable cohort through the development of positive coping and self-help seeking behaviour.
- The service 'Headspace' requires further resourcing and expanded targets as it is a clinical model and works with low to no risk mental health clients but excludes the majority of at-risk youth. The current service system has significant waiting lists and periods, which only exacerbates and increases the risk factors. For example, Headspace marketing infers it is the number one provider for youth mental health concerns – however the demand outweighs the service availability and waiting lists are an unacceptable 6-8 weeks.
- Home and Community Care support (HACC) – where there is a diagnosed mental health illness. This service provides intensive on the ground support to individuals and families within their homes and their communities which reduces pressure on the public health system.
- Soft engagement method which provides psycho-social support such as art therapy or other mediums such as film, building or physical activity.
- Over-arching Commonwealth or State-based strategies should be developed that focus on supporting individuals that present with an intersectionality of complex issues and diverse backgrounds. For example, LGBTQI people are often included as one group among many in mental health policy frameworks but their intersectionality is often overlooked.
- Localised primary prevention approaches require pre and post intervention activities are having some impact but are band aid approaches. Most of the focus and resources seem to be targeted towards secondary and tertiary prevention space (mid- to down-stream) because of the urgency of need. However, such urgency can be greatly reduced by doing more primary prevention (upstream) work which looks at building mental health literacy and creating more supportive environments that are conducive to people seeking support and asking for help.

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

- Men's health issues must be targeted more comprehensively. The highest rate of suicide completion is amongst young men, and is increasing at an alarming rate. There are limited campaigns directly addressing this issue and two specific cohorts amongst males attempting suicide must be targetted, that is, young males aged 10-25 years and those aged 45-60 years.
- Suicide rates among homeless people and people at risk of homelessness are nearly twice the rate from general averages, which again reinforces the need for mental health programming to be designed from a Housing-First approach.
- Increased awareness and breaking down of stigma towards LGBTQI groups as heteronormative and homophobic behaviours and attitudes remain.
- Increased access to support and specialised services eg; Headspace, Monash Health, Non-government Support Services such as YSAS and Brosnan, and, government Youth Services.
- Medicare coverage of psychology or counselling expenses – requires expansion and further refinement of number of sessions available in a calendar year.
- Increase of mental health literacy in schools – requirement for schools to embed mental health literacy and positive self-help seeking in curriculums. Similar to what has been done with the work on respectful relationships in secondary schools. Opportunities for community hubs within primary schools to also undertake mental health literacy with families / parents attached to the school.
- Expansion of national and state social media campaigns eg: R U Ok?, Movember, Support your mate initiatives.

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.

- Housing first model with wrap around services.
- Appropriate funding to address the siloed service system. Mental health, or, mental illness is often a comorbid risk factor within disability, drug and alcohol, homelessness, and forensics. Yet – the service system works in silos and does not promote a 'no wrong door' approach – leaving community members without the right supports and limited access.
- Greater investment in capacity building of community leaders and cultural groups in order to build mental health literacy in a culturally appropriate and sensitive way that accounts for beliefs from different countries of origin.
- Greater investment in the promotion of the GP setting as the entry point for mental health supports. Also clear communication of the fact that people have the right to choose an alternative GP if they do not like/feel comfortable telling their story to their usual GP. Many migrants see a GP from within their community, and due to fears of stigma they would not openly discuss mental health with them. However, they also don't know that they are able to choose another GP if needed. This piece of information might make them more likely to seek support elsewhere.
- Cease use of 12-month funding opportunities – reduction of funding in mental health do not allow for the sustained, established services that need to be on the ground to help support recovery. A community member whom suffers from mental health concerns, including generalised diagnosis, typically are not able to finalise their treatments within 12-month timeframes. The ins and outs of services within localities further disjoints and isolates system access to the most vulnerable.
- There is a historical debate between forensic services and clinical mental health services that needs to be addressed and worked on. For example; a young person exhibiting aggressive behaviour, or engagement in criminal activity is excluded from receiving clinical mental health services for treatment and labelled as "forensic client". There are limited services within forensic field, and limited number of private providers or generalised Non-Government Organisation (NGO) and mandated services that work therapeutically with this cohort. The official forensic services that are available are only in the prison system- therefore a young person needs to continue to offend in the community in order to receive treatment. If there was a bridge between forensic and clinical mental health this would reduce the opportunity of further offending as the young person is able to receive the appropriate supports in the community.

- More funding to implement localised programs which target local communities. This eliminates the need to consider transport costs which is a significant barrier to accessing services.
- Acute services – discharge occurs quickly with no post follow up – or if there is – it is a referral to a CCT team where each case team carries loads of 50 clients per EFT. This is untenable and unrealistic for case managers to adequately assess and manage chronic mental health concerns.
- Focus needs to be on increasing social/cultural connection – and the avoidance of disconnection. Working collaboratively across the service system- in particular dual diagnosis that helps target vulnerable community members, i.e. rough sleepers and their access to mental health services.
- Role of frontline workers eg; social workers, nurses, GP's, to identify early warning signs and be thoroughly knowledgeable of the service system in order to effectively connect individuals with the right supports.
- Mainstream health providers must address rigid gender norms and other drivers of discrimination, stigma, violence, and abuse in their services delivery and prevention activities. These factors contribute to higher rates of mental ill-health in LGBTQI people.
- There are barriers relating to culture and cultural health belief models that have been mentioned above. This restricts people's likelihood of independently seeking services/supports.

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

- The system has not looked at addressing homelessness and mental health through a housing first model.
- Socio–economic disadvantages linked to disengagement, unemployment and social isolation are some drivers of poorer mental health outcomes. Other drivers are cultural beliefs and stigma, toxic masculinity and rigid gender roles/patriarchal households.
- Poor mental health literacy and understanding of Australian healthcare system.
- Lack of mental health literacy. Invest in mental health literacy through funding provided to community and cultural groups themselves.
- The Royal Commission must recognise LGBTQI people as an 'at greater risk' group, acknowledging and addressing gaps in mental research and data on LGBTQI experiences and much higher rates of mental illness. Mainstream health providers must address rigid gender norms and other drivers of discrimination, stigma, violence, and abuse in their services delivery and prevention activities. These factors contribute to higher rates of mental ill-health in LGBTQI people and women and children experiencing family violence. LGBTQI people disproportionately face negative health stressors and negative health events compared with the general population and this is related to the stress of being a stigmatised minority group. Homophobic and transphobic environments also exacerbate the drivers to poorer mental health.
- LGBTQI people also experience increased rates of bullying, exclusion, and devaluation as children and adolescents. This can very well continue into adult life. More efforts to develop programs such as Safe Schools can address this.

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

- Carer support is limited– supporting people who care for people with mental health illness is an urgent area of funding required. Burn out of carers not only impacts on the individual and their families, but also provides greater pressure on an already overworked system when there is failure or breakdown of care in the home. Carer support programs that provide access to their own individualised and group supports is a must.
- Increase in respite funding and respite services that offer emergency, short and long term respite options.
- Offer free mental health first aid to carers – carers need to be considered in the same vein as first responders as they are often the ones bearing the brunt of an episode or trigger event.
- Many carers and family members themselves have limited mental health literacy and probably don't know how they can support their affected family member effectively.

- Greater support for people experiencing a tough time through Employee Assistance Programs or workplace mental health programs, ensuring this includes options for family members and carers to also receive support.

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

- Greater promotion of the peer support workforce through appropriate channels (eg. through mental health services, Local Hospital Networks (LHNs), Primary Health Networks (PHNs), Community health etc) and pathways into the profession. Also increasing the appeal of joining the mental health peer support workforce through increased profiling, as well as professionalization and standardisation of the discipline to ensure greater/more appropriate remuneration and career growth opportunities. Also including people living with mental illness in awareness campaigning, rather than actors/actresses portraying themselves as someone living with mental illness.
- Good and supportive supervision.
- Variation to working hours.
- Peer support - Peer support workforce is not a professionalised discipline. Therefore it is not standardised or regulated which results in poor salary and conditions. As a result there are very few incentives to seek a career in this profession. Additionally, within the mental health profession there are still archaic hierarchical structures that place peer support workers at the bottom of the pecking order and psychiatrists at the top. The peer support workforce is therefore less likely to feel valued and supported in their employment.
- Mental health first aid mandatory training for all police, ambulance and first responder services. Specialist services available immediately to first responders to help combat their own Post Traumatic Stress Disorder (PTSD) that is work related and induced. This can also apply for sectors of employment that experiences vicarious trauma.
- Flattening of the mental health workforce, raising the profile of peer support workers and allied health professionals (eg. Occupational Therapy, Social Work, Counselling) and encouraging psychiatry services to share the spotlight with linked personnel are possible solutions.
- There is a need for greater investment in both the tertiary education and training sectors (eg. TAFE) and through regulatory bodies such as Australian Health Practitioner Regulatory Agency (AHPRA) to professionalise the degree. Also greater investment in social marketing of employment/participation opportunities, as well as capacity building of mental health services and periphery services/sectors to direct and refer current/ex-clients into employment pathways.

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?

- Addressing the stigma and discrimination associated with mental health, especially in relation to employment. In relation to continued employment, certain mental health conditions may need to be protected through legislation.
- Increased work and understanding with employees and employers around issues of mental health.
- Increased support to maintain or improve access to mental health services at work settings, eg; counselling, psycho-social programs.
- Accessible and affordable recreation and leisure opportunities.
- Heterosexist discrimination can lead to social isolation and economic disadvantage. Addressing this discrimination will help improve the social and economic participation of LGBTQI people.

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?

- Housing first model to address homelessness.

- Seamless service pathways and entry for both cohorts: 1. those community members considered to have low to moderate mental health concerns and good connections to supports and 2. vulnerable community members whom require significant outreach and supports – including forensic clients.
- Models of treatment and care must be informed by evidence, best-practice health promotion, and a commitment to the principles of justice, equity, and diversity.
- Reduction in 'drop-in' funding that sees services exist for 12-month pilots – 2 year minimum funding requirements to help embed good practice and provide in-depth evaluation.
- Support and build upon the mixed model of mental health service delivery that provides access to community-controlled, specialist LGBTQI services in addition to mainstream services to ensure a 'no wrong door' approach.
- Prioritise community-controlled mental health services and build capacity to meet demand.
- Ensure mainstream services are safe and inclusive for LGBTQI and other marginalised communities through adequate training and workforce development.
- Addressing cultural and religious barriers through greater engagement of cultural associations/faith based settings and community leaders. Also ensuring greater and more effective use of interpreters.
- Greater funding for non-clinical staff within mental health organisations who are responsible for building partnerships with interface and periphery sectors/services. Greater collaboration is needed between the health/mental health services and sectors such as settlement, housing, Alcohol and Other Drug, family violence, justice etc. Currently funding agreements are largely tied to clinical hours of service. Which means staff cannot be pulled "offline" easily to prioritise greater networking and partnership building.

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

- Capacity building with staff already within the system regarding the peeling back of hierarchies and breaking down of power structures that dictate psychiatry is at the top and peer support is at the bottom. Greater sharing of professional kudos is needed. This sentiment should also be built into training of the new mental health workforce, eg through tertiary and certificate level training programs.
- Ensure people have a greater access and pathways into the NDIS. Ensure the NDIS has greater responsiveness to the community – there are known localised stories of members waiting up to one year for approvals on plans and quotes – leaving them without adequate supported needs such as respite and facilities/ equipment (appropriate bedding, wheelchairs, shower, commodes).
- Prevention and early intervention initiatives that are both localised and State wide.
- Continue media campaigns like R U Ok? But make it more often and use the platform to create change and community awareness.

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

Victoria is home to the most culturally diverse municipalities within Australia. Focus needs to be given and highlighted that there are a multitude of communities whereby a culturally sensitive social approach is necessary to mental health programming. Mental health campaigns and early intervention initiatives need to be targeted to these cohorts to allow for mental health literacy to be developed, and in turn realise greater access to the service system.

Ensure involvement of "carers" and "consumers" in the decision making and planning regarding the implementation of the commission's findings. Perhaps in a number of co-design working groups that are adequately funded so that people can be remunerated for their time and supported to participate meaningfully.