2019 Submission - Royal Commission into Victoria's Mental Health System

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
No response

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?
"Theme 1 Greater resourcing of trauma-specific and other social support services can help prevent the onset of serious and disabling mental ill health. Increased holistic support available to children and adolescents who have experienced childhood adversity is crucial. Childhood adversity, particularly sexual and physical abuse, is strongly associated with mental ill health in adulthood. Consequently, there is a need for better approaches to identify childhood adversity in schools, youth programs and residual programs such as child protection, in order to link in young people to effective trauma-specific support. Effective trauma-specific counselling/therapy generally require far more sessions than are currently available through Better Access to Mental Health and Headspace programs. There is a need for more investment into trauma-specific support that is able to meet with young people for extended periods of time to prevent the development of serious mental ill-health, especially those in the personality disorder cluster. Beyond childhood adversity there are other social factors that can increase the risk of mental ill-health such as poverty, social exclusion, unemployment, loss, and family violence and breakdown. These phenomena have been found to increase the risk for serious mood disorders and suicidal ideation. Effective counselling and support around these experiences can help prevent the emergence of mental ill health. While the Better Access to Mental Health Program provides subsidised counselling, there is often a substantial gap between the cost of the counselling and the Medicare rebate. This makes accessing this support prohibitive for middle to lower income earners. An initiative to address these costs barriers, or another scheme designed to provide counselling to low-income earners, would be of great benefit in terms of preventing mental ill health. For those people with moderate to complex psychosocial presentations who do access the Better Access to Mental Health Program there is substantial evidence of repeat annual use of the service, which suggests that limiting this group to eight psychotherapy-based sessions annually, is ineffective. Both reducing the cost of this service and broadening its scope from psychotherapy-based interventions to broader psychosocial interventions is likely to increase its effectiveness. References: (1) Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. International Review of Psychiatry, 26(4), 392?407. https://doi.org/10.3109/09540261.2014.928270 (2) Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Giles, W. H. (2005). The enduring effects of abuse and related adverse experiences in childhood. European Archives of Psychiatry and Clinical Neuroscience, 256(3), 174?186. https://doi.org/10.1007/s00406-005-0624-4 (3) Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., van der Kolk, B. (2005). Complex trauma in children and adolescents. Psychiatric Annals, 35(5), 390?398. (4) Royal Commission

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

"Theme 2 Substantial work is required to improve the way in which the mental health service system responds to people in acute psychiatric crisis who are at risk of suicide. A serious lack of support exists for people currently experiencing acute psychiatric distress in the community, often proving a burden to Emergency Departments. This is particularly the case amongst middle to lower income earners who cannot afford to see private psychiatry/psychology/counselling practitioners. A responsive, 24-hour support service is needed in the community staffed by a range of disciplines including peer workers. This support could involve intensive outreach into the home such as Open Dialogue, more effective telephone counselling, face to face support located in the community, or more short-term residential programs such as PARCS. It is important that choice is available in the kinds of support people can access when they are becoming distressed. At present most publicly available support relies on medical models of treatment that are often not fully responsive to the needs of consumers. Involving a range of professionals in these teams could broaden the choices available to consumers. Specifically, the option of peer support, ideally within peer-led programs, should be expanded as there is growing evidence supporting the efficacy of peer support. Inpatient psychiatric services that are currently the main public response to acute suicidality are in urgent need of reform. Many consumers who stay in these services find experience them as extremely unhelpful or at times more harmful due to a range of factors. The current inpatient system is designed to serve almost all types of consumers in psychiatric crises ranging from consumers who are suffering from psychosis as a result of methamphetamine and other drug use, consumers with forensic histories, and consumers who are experience acute distress related to past or current trauma. These groups have very distinct needs and current inpatient units are largely reactive to behaviourally disruptive high-risk consumers - often those who have been using methamphetamine and other substances that can cause consumers to exhibit challenging behaviours and can pose a risk to staff and other patients. Responses to this consumer group tends to focus on restrictive measures such as restraint, both mechanical and medical, and seclusion. The needs of other consumers, particularly those with trauma histories, are often neglected in these settings and these consumers can also be subject to restrictive practices that can be deeply retraumatising. This is coupled with the fact sexual violence by consumers, and occasionally staff, regularly occurs on inpatient wards. Consequently, inpatient units are often experienced as unsafe, especially by trauma survivors, and are not therapeutically helpful for people experiencing suicidality. The development of women's only wards/corridors in some inpatient units is a positive step to address unique needs of women in these spaces. A step further would involve separate wards for consumers with serious AOD issues (particularly methamphetamine) that would enable consumers specific support for their AOD issues and would help create environments with less difficult behaviour to manage in other wards. The work being done as part of Safe Wards with a focus on minimising restraint and seclusion is also promising. Ideally this would be extended and provided with more resourcing so that psychiatric inpatient staff have are trained to use a range of responses to distress that do not involve restrictive practices. Currently there is a serious lack of psychosocial support available to consumers in inpatient units. Treatment is highly medicalised and not responsive to the self-defined needs of consumers. A

greater focus on psychosocial options, including links to appropriate community resources and peer support would increase the ability for consumers to have their needs met both within these spaces and as they integrate with the community. The ageing of the Australian population is an opportunity to better understand and respond to the mental health treatment and support needs of older Australians. Older men and members of the older LGBTI community are sub-populations of the elderly that are vulnerable to depression and suicide. Improving the assessment skills of clinicians and support staff with respect to the assessment of depression and suicidality of older Australians, especially those engaged with the My Aged Care platform, would begin the process of refining effective treatment and support approaches to these groups. References (1) Brophy, L., Roper, C. E., Hamilton, B. E., Tellez, J. J., & McSherry, B. M. (2016). Consumers and their supporters perspectives on poor practice and the use of seclusion and restraint in mental health settings: Results from Australian focus groups. International Journal of Mental Health Systems, 10(6), 1?10. http://dx.doi.org.ezp.lib.unimelb.edu.au/10.1186/s13033-016-0038-x (2) Gooding, P., McSherry, B., Roper, C., & Grey, F. (2018). Alternative to Coercion in Mental Health Settings: A Literature Review. Melbourne: Melbourne Social Equity Institute. (3) McKenna, B., McEvedy, S., Kelly, K., Long, B., Anderson, J., Dalzell, E., Furness, T. (2017). Association of methamphetamine use and restrictive interventions in an acute adult inpatient mental health unit: A retrospective cohort study. International Journal of Mental Health Nursing, 26(1), 49?55. https://doi.org/10.1111/inm.12283 (4) Mental Health Complaints Commissioner. (2017). The right to be safe: ensuring sexual safety in acute mental health inpatient units: sexual safety project report. Melbourne, Australia: Victorian Government. (5) Canetto, S. S. (2017). Suicide: Why Are Older Men So Vulnerable? Men and Masculinities, 20(1), 49?70. https://doi.org/10.1177/1097184X15613832 (6) Shiloh D. Erdley, Donald D. Anklam & Christina C. Reardon (2014) Breaking Barriers and Building Bridges: Understanding the Pervasive Needs of Older LGBT Adults and the Value of Social Work in Health Care, Journal of Gerontological Social Work, 57:2-4, 362-385, DOI: 10.1080/01634372.2013.871381 (7) Sasson, I., & Umberson, D. J. (2014) Education of workers in aged care to assess depression and anxiety and the impact of widowhood Widowhood and depression: new light on gender differences, selection, and psychological adjustment The journals of gerontology. Series B, Psychological sciences and social sciences, 69(1), 135?145. doi:10.1093/geronb/gbt058 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3894126/ (8) Timothy H. Monk, Marissa K. Pfoff, and Joette R. Zarotney, Depression in the Spousally Bereaved Elderly: Correlations with Subjective Sleep Measures, Depression Research and Treatment, vol. 2013, Article ID 409538, 4 pages, 2013. https://doi.org/10.1155/2013/409538. https://www.hindawi.com/journals/drt/2013/409538/ "

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.

"Theme 3 There is a lack of professionals, particularly social workers, with service navigation skills available to individuals with mental illness, their families and carers in what may be described as a piecemeal service system comprising state and federally funded services. Pathways in and around the system, which consists of state, federal and privately-funded services, are difficult to identify and navigate for consumers and their families. The introduction of a stepped care model of service that is understood and supported by service providers and where individuals with mental illness their families and carers are providers are able to access expert service navigation and therapeutic case management may assist in alleviating these issues. Entry points at crisis, in prevention and in management are challenging to identify and access. The complexity

of a system dealing with people with substantial co-morbidities and co-occurring issues is also a significant challenge for system navigation. Mental health is commonly associated with co-existing issues such as homelessness, drug and alcohol use, domestic violence and participation in the child protection system. While services in the mental health system may be focused on mental health, they cannot do so holistically and comprehensively if the system is unable to accommodate or manage the complexity of co-existing issues. Navigation within a system, which by its nature consists of clients with complex combination of issues, is undermined by interactions between system boundaries and the resistance of individual services to work with these co-morbidities and complexities. Limited access to a convincing clinical mental health system. If access is obtained to the clinical mental health services system it over-relies on high levels of coercive use of seclusion and community treatment orders instead of positive treatment, rehabilitation and planned and supported discharge planning and linkage to community-based support services. Lack of access to an enhanced case management model that emphasises a therapeutic link with the person living with mental illness, their carers and family. Lack of culturally competent services to address the significant health disparities between the health status of non-Aboriginal Australians and that of Aboriginal and Torres Strait Islander peoples. Lack of support for multiple and complex needs style initiatives that increase the physical and social health to people living with severe and enduring mental illnesses. Such initiatives would benefit from considering housing that is underpinned by intentional community principles so that social isolation is reduced and access to pro-social activities is increased and leading a connected meaningful life becomes possible. Theme 4 The recommissioning of the Psychiatric Disability Rehabilitation Support sector, the introduction of the NDIS, and the channelling of the Community Managed Mental Health funding through the NDIS has resulted in one of the biggest barriers to accessing mental health care in Victoria. Victoria went from having a vibrant non-government mental health sector that was able to deliver a range of recovery focused programs to consumers to a system where almost all non-government support comes through NDIS packages, which largely, at present, provide basic instrumental support to consumers such as housing cleaning and shopping. The focus on recovery is absent from this service model. In addition, it is very difficult for consumers to access appropriate NDIS packages due to issues with NDIA planners lack of understanding of psychosocial disability, the focus on permanent disability which excludes a large proportion of consumers, and the difficulty navigating the NDIS pathway when consumers are grappling with complex issues such as AOD, homelessness etc. It is important to reconsider the funding of Community Managed Mental Health Services to ensure that consumers who cannot or do not want to access the NDIS are able to utilise a range of recovery focused programs. Theme 5 There is a missing middle within our mental health system. There are a number of options for higher income earners and there is limited support available for people who are acutely unwell but there is a shortage of services for people on middle/lower incomes who are experiencing mild to moderate mental health issues that cannot be effectively met by the Better Mental Health Outcomes program of limited sessions. References (1) Donovan, J. Hampson, R. Connolly, M. Service Navigation Navigators In the Workforce: an ethical framework for practice Asia Pacific Journal of Health Management 2018; 13(2): i36 doi:10.24083/apjhm.2017.0036 (2) McCreary B (2016) Developmental Disabilities and Intentional Communities: Creating Lives with Meaning. J Ment Disord Treat 2:131. doi:10.4172/2471-271X.1000131 (3) Commonwealth of Australia 2017. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Canberra: Department of the Prime Minister and Cabinet) (4) Smith-Merry, J., Hancock, N., Gilroy, J., Llewellyn, G., Yen, I., & Bresnan, A. (2018). Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Sydney, Australia: University of Sydney. (5) Meadows, G. N., Enticott, J. C., Inder, B., Russell, G. M., & Gurr, R.

(2015). Better access to mental health care and the failure of the Medicare principle of universality. The Medical Journal of Australia, 202(4), 190?194. https://doi.org/10.5694/mja14.00330 "

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

"Theme 6 Strengthening disenfranchised communities Families with pre-school children residing in these communities that are known by child and family welfare agencies would benefit from customised Headstart style programs which are proven to enhance academic and social adjustment and reduce rates of adult psychopathology Few employment opportunities for young people in rural and some regional areas is corelated with higher suicide rates. Improving access to robust employment opportunities for young people either though relocation or government, corporate and philanthropic intervention to create educational and employment opportunities in disadvantaged communities. Low morale communities require community development strategies to increase citizen morale and improve contributions to and participation in civil society which are correlated with improved levels of pro-social behaviour. In communities with high rates of offending behaviour often results in people living with mental illness having contact with the criminal justice system ? once this occurs, especially for lower tariff drug related and property offences, the results are usually negative for the person living with mental illness and result in poorer individual and social outcomes References (1) Wilkinson, D. & Gunnell, D. (2000). Youth Suicide Trends in Australian Metropolitan and Non-Metropolitan Areas, 1988?1997. Australian and New Zealand Journal of Psychiatry, 34(5), 822-828. (2) Putnam, R. (2000). Bowling Alone: The Collapse and Revival of American Community. New York: Simon & Schuster. (3) Tew, J. (2011). Social Approaches to Mental Distress. London: Red Globe Press (4) Morris, P., Connors, M., Friedman-Krauss, A., Charles McCoy, D., Weiland, C., Feller, A., Page, L., Bloom, H. & Yoshikawa, H. (2018). New Findings on Impact Variation From the Head Start Impact Study: Informing the Scale-Up of Early Childhood Programs. AERA Open, https://doi.org/10.1177/2332858418769287 "

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

"Theme 7 Reconceptualising the service system as an individual and family centred system so that family members and carers are legitimate targets of treatment support in their own right Increasing efforts to include carers and families in treatment and support planning for the person in their affected by mental illness Targeted support programs for carers and families, which include brokerage funds to purchase ad-hoc and ongoing support. There are a number of demonstration projects that have shown the efficacy of these relatively low-cost programs. Recognition of the children of the mentally ill person as requiring specialist support in their own right, especially targeting those young persons who are often their carers of younger siblings when their mentally ill parent is acutely unwell. Inclusion of carers and family members in system design, implementation and evaluation measures to build responsive service system that is responsive to the needs of family members and carers It is important that interventions designed to respond to carers and families remain trauma-informed and responsive to the wishes of the individual experiencing mental health issues. While many family systems are protective for people in distress, there are families that are a source of abuse, violence, or conflict that can harmful to the person experience mental ill-health. The wishes of family members need to therefore be taken into consideration alongside the psychosocial history of consumers and their explicit wishes. Increasingly heavy workloads result in services becoming fragmented and only focused on the

family member receiving care. As a result other vulnerable members of the family, in particular children, slip through the cracks' without their needs being responded to. This is an urgent issue with small children being asked to take on caring roles of their unwell parent or being left without care or supervision. Family members are frequently asked to support elderly parents who demonstrating cognitive and physical decline and becoming increasingly unable to cope independently in the community without knowledge of available services or how to navigate them. In addition, the gap between service provision in the community and the mental health service system does not include continuing supported care in the community to strengthen the capacity of the older person to live independently as long as is possible. Theme 8 Statutory Child Protection Services need staff specialisation to respond appropriately to parents with mental illness so that notification and re-notification rates can be reduced Families where the main caregiver, usually a woman, has a mental illness that may or may not coexist with a substance misuse disorder and poverty are the subject of high notification and re-notification rates to statutory child protection services. Each time this occurs the family and its members are likely to experience this as traumatic. In the case of repeated investigation re-traumatisation may occur. Reducing this experience for these families requires a specialised response form the statutory child protection services in the first instance and the broader child welfare service system in the second. Building greater competence in inter-sectoral collaboration and the mental health service system is imperative if the lives of families in these highly adverse states can be improved. References: (1) Slade, M., Pinfold, V., Rapaport, J., Bellringer, S., Banerjee, S., Kuipers, E., & Huxley, P. (2007). Best practice when service users do not consent to sharing information with carers. The British Journal of Psychiatry, 190(2), 148?155. https://doi.org/10.1192/bjp.bp.106.024935 (2) Arney, F. Lange, R. & Zuffery, C (2010). Responding to parents with complex needs who are involved with stautory child protection services. In F. Arney & D. Scott (Eds). Working with Vulnerable Families: A partnership approach (1st Ed). Cambridge: Cambridge University Press. (3) Tsantefski, M. Gruenert, S. & Campbell, L. (2013). Working with Substance-Affected Parents and their Children. Sydney: Allen and Unwin. "

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

"Theme 9 Developing employment pathways for social work students on placement and recent graduates of Social Work entry-to-practice degrees Final field education placement destinations of social work students are more often than not gateways to base grade employment in these services. The creation of student units in clinical and support services is a proven method for supporting greater uptake of student placements in other sectors that can be transplanted to the mental health clinical and support service settings. The creation of entry-level roles to allow social work graduates who have not completed placements in mental health services to obtain entry to the field would create opportunities to expand the mental health workforce. Theme 10 Building workforce capability, support and knowledge for practice Stronger clinical supervision practices in clinical and support services for staff and peer support workers Stronger leadership development programs that emphasize the importance of developing a sustaining a high morale, for staff with clinical backgrounds to prepare them for team leader and management roles Creation of joint academic appointments for social work in all clinical services, and similarly for allied health, to build knowledge for practice especially in the areas of effective models of community-based support individuals living with mental illness, their families and carers. Better access to research and evaluation opportunities for social workers employed in clinical and support services Theme 11 Building and supporting the peer workforce is essential to having an effective mental health system. To do this it is important for peer workers to be appropriately

training and supported, and for workplaces to be developed so that they can best utilise peer work. Investment in a range of training options for peer workers needs to be occur. Peer workers enter the profession from a range of backgrounds and education histories, and consequently the profession would benefit from a diverse choice of education options beyond Cert IV in Mental Health Peer work (although this should continue to further developed and offered to new peer workers). It would be good to partner with universities to develop further training aimed at tertiary qualified peer workers or peer workers who are moving into leadership positions, such as Graduate certificate or Graduate Diploma courses. Government subsidies to obtain this training would help to make the pathway into peer workforce careers more attractive. The work that is currently being done as part of the Consumer Perspective Supervision Project is well done and should be expanded and resourced so that all peer workers have access to appropriate consumer specific supervision. In addition to this it is worth investigating what else is needed to support peer workers to thrive in their careers. For peer work to become a key plank of mental health service delivery work needs to be done with other mental health professionals and organisational structures to enable peer workers to be effectively incorporated into organisations. This could involve training focused on educating MH staff about the role of peer work, peer work ethics and values, and how peer work can work alongside other professions. This could also involve building in more pathways to leadership amongst peer workers and ensuring that new projects/policies are meaningfully co-produced with peer workers. The introduction of an advocacy service to support workplace issues experienced by peer workers would also be an option to better support this workforce. References (1) Bogo, M. & McKnight, K. (2006). Clinical supervision in social work. The Clinical Supervisor, 24:1-2, 49-67, DOI: 10.1300/J001v24n01_04 (2) Scottish Recovery Network (2011). Experts by Experience: Guidelines to support the development of Peer Worker roles in the mental health sector, www.scottishrecovery.net (3) Gothard, S., & Austin, M. J. (2013). Leadership succession planning: Implications for nonprofit human service organizations. Administration in Social Work, 37(3), 272-285 (4) Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: a qualitative investigation. BMC psychiatry, 11, 68. doi:10.1186/1471-244X-11-68) (5) Victorian Mental Illness Awareness Council, Centre for Psychiatric Nursing, & Department of Health and Human Services. (2018). Consumer perspective supervision: A framework for supporting the consumer workforce. Melbourne, Australia: Department of Health and Human Services. "

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?

"Theme 12 Improving the psychosocial environments of people living with a mental illness Better access to comprehensive treatment, rehabilitation and support services, including stable housing, to improve the mental and physical health status of people with living with mental illness to enable them to experience meaningful and sustainable participation in employment participation Specifically designed employment programs that are connected to the treatment and support service system so that people living with mental illness and employers have responsive expertise and support appropriate to supporting people in employment Investment in support that prevents the decline of mental health or relapse will maintain the ability for people to remain in work/education rather than having to rebuild this after acute mental health crises. References (1) Tew, J. (2011). Social Approaches to Mental Distress. London: Red Globe Press "

Thinking about what Victorias mental health system should ideally look like, tell us what

areas and reform ideas you would like the Royal Commission to prioritise for change?
"Theme 13 Designing a more effective mental health treatment and support service system Use of service navigation principles to assist people living with mental illness their families and carers to have appropriate access to federal and state funded services Targeted support programs for family members and carers Improving the physical health status of people living with mental illness through supported access to primary care especially GP services Ensuring stronger linkages between the mental health clinical and the primary health care system so that physical and mental health status of people living with mental illness can be improved Developing a range of more effective responses to acute psychiatric crises in the community is essential in order to prevent hospitalisation or suicide. This range should allow for a choice of response to meet consumer defined need and should include peer run services. Reform the Mental Health Act so that involuntary treatment is used at a much lower rate than today. Consumers should have many more options available to them when in acute distress which should reduce the reliance on involuntary treatment when consumers do not want to utilise traditional medical treatment responses. Work to substantially improve inpatient facilities by ensuring that seclusion, restraint, and involuntary treatment are used minimally. Develop specific wards for specific client groups- notably women and consumers with serious AOD issues. Increase psychosocial and peer run supports in these settings. Rebuild the Community Managed Mental Health Sector so that there are a range of recovery focused programs available to consumers including peer run programs. This sector should not be funded through the NDIS so that it is available to all consumers, not just those who have NDIS plans. Develop low or no cost counselling/support programs for middle/lower income earners with mild to moderate distress. Deliver mental health services in a way that is holistic. This would ensure that co-existing issues such as AOD, homelessness, family violence etc are incorporated into models of care rather than delivered in a siloed approach. Deliver mental health services in a way that is trauma-informed. This would involve building systems to ensure that consumers are encouraged to disclose their trauma histories, that they would be able to access trauma-specific support if desired, and that the ways in which services are delivered do not re-traumatise consumers. Ensure that meaningful co-production is involved at every level of mental health service delivery, policy, and research. This would involve the development of the peer workforce to effectively participate in co-production and the development of the mental health workforce more broadly to effectively use co-production. References (1) Pevalin, D., Reeves, A., Baker, E. & Bentley, R. (2017). The impact of persistent poor housing conditions on mental health: A longitudinal population-based study. Preventive Medicine, 105, 304-310. (2) Leucht, S., Burkard, T., Henderson, J., Maj, M., & Sartorius, N. (2007). Physical illness and schizophrenia: a review of the literature. Acta Psychiatrica Scandinavica. 116(5), 317-33. (3) Colton, C., & Manderscheid, (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease, 3(2). (4) Harris, B., Duggan, M., Batterham, P., Bartlem, K., Clinton-McHarg, T., Dunbar, J., et al. (2018). Australia's Mental Health and Physical Health Tracker. (5) De Hert, M., Correll, C., Bobes, J., Cetkovich?Bakmas, M., Cohen, D., Asai, I., et al.(2011). Physical illness in patients with severe mental disorders. Prevalence, impact of medications and disparities in health care. World Psychiatry, 10(1), 52-77. (6) Brophy, L., Roper, C. E., Hamilton, B. E., Tellez, J. J., & McSherry, B. M. (2016). Consumers and their supporters perspectives on poor practice and the use of seclusion and restraint in mental health settings: Results from Australian focus groups. International Journal of Mental Health Systems, 10(6), 1?10. http://dx.doi.org.ezp.lib.unimelb.edu.au/10.1186/s13033-016-0038-x (7) Clark, C., Young, M. S., Jackson, E., Graeber, C., Mazelis, R., Kammerer, N., & Huntington, N. (2007). Consumer Perceptions of Integrated Trauma-Informed Services Among Women with Co-Occurring Disorders.

The Journal of Behavioral Health Services & Research, 35(1), 71?90. https://doi.org/10.1007/s11414-007-9076-0 (8) Gooding, P., McSherry, B., Roper, C., & Grey, F. (2018). Alternative to Coercion in Mental Health Settings: A Literature Review. Melbourne: Melbourne Social Equity Institute. (9) Reeves, E. (2015). A Synthesis of the Literature on Trauma-Informed Care. Issues in Mental Health Nursing, 36(9), 698?709. https://doi.org/10.3109/01612840.2015.1025319 (10)Roper, C., Grey, F., & Cadogen, E. (2018). Co-production - Putting principles into practice in mental health contexts. Centre for Psychiatric Nursing: University of Melbourne. (11)Smith-Merry, J., Hancock, N., Gilroy, J., Llewellyn, G., Yen, I., & Bresnan, A. (2018). Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Sydney, Australia: University of Sydney. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"'- Planning for the future workforce and ensuring that all professions are operating at the top of their respective scopes of practice in the current service system. - Reforming funding structures for mental health services eliminating the unhelpful plethora of services that are confusing for people living with mental illness, their carers and families. This Royal Commission offers us an opportunity to substantially reform the mental health system, rather than adjusting a system that is fundamentally broken. There has been inquiry after inquiry into the Australian mental health system since deinstitutionalisation, with not substantive change resulting from each inquiry. What is needed is a wave of reform of a similar scale to deinstitutionalisation that deeply considers and reforms root and branch the mental health service system. Without such an in-depth reform any changes made will likely fail to address the deep systemic issues that currently inhibit our current system of provision. "

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

This submission has been co-authored by academic staff engaged in teaching and research (some with practice backgrounds) in mental health. Staff members from the Department of Social Work are able to provide further examples of research to support the claims made throughout this submission and are willing to cooperate with the Commission in sharing this research.