Royal Commission into Victoria's Mental Health System

Outline of questions we ask as part of the Formal Submission process

We have been asked to consider some important themes relating to Victoria's mental health system.

The 11 questions set out in the formal submission cover those themes. There is no word limit and you can contribute as many times as you like. Attachments are also accepted.

You do not have to respond to all the questions. You can also make a Brief Comment submission if you wish.

To help us focus on the areas that matter most to the Victorian community, the Royal Commission encourages you to put forward any areas or ideas that you consider should be explored further.

You can request anonymity or confidentiality when filling in the cover page, which also allows us to capture details about your age, gender etc.

These are the questions that you will be asked:

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

Mental Health remains one of the most highly stigmatised health condition in Australia, particularly within certain demographic groups. Significant work is still required to educate the broader community and reduce the stigma associated with mental health conditions, not only to benefit the integration of people with existing mental health conditions but also to support the early recognition of emerging mental health conditions.

Sitting alongside this issue is that of mental health literacy. While there has been much work in the area of health literacy over recent years, incorporating mental health literacy into these developments is essential to better equip people to overcome barriers and discrimination and in order to aid with prevention, early intervention, management and recovery. Literacy and awareness in relation to the issue of suicide should be particularly prioritised.

The earlier that inclusive and positive attitudes to mental health form, the better. Ideally, Australian citizens would benefit from a baseline level of understanding of the role that positive mental health plays in overall health and wellbeing. In this scenario, common symptoms of poor mental health would be as recognisable as common symptoms of poor physical health. This could be achieved in part by a more substantive and ongoing commitment to running mental health education programs in primary and secondary school classrooms.

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?

Similar to 1, prevention of mental illness can best be achieved when individuals possess good mental health literacy, and are aware of the general and specific health and lifestyle factors that signal both positive and negative mental health trajectories. When this occurs individuals are thus more able to take their own personal actions to positively manage their individual mental health.

It is also useful to consider life periods where one is subject to normal or abnormal levels of stress (or trauma) from a proactive mental health prevention perspective. This might include times such as an older

person transitioning into residential age care after the loss of a loved one, a young person changing schools after parental unemployment, the death of a primary caregiver etc. Proactively resourcing mental health supports to assist with these common but challenging life events present good opportunities for prevention. Currently, the majority of mental health support is directed towards managing acute episodes where individuals are already identifiably unwell.

Early treatment and support is also furthered by adopting a tailored approach for individuals across the lifespan. EACH's experience is that children, young people, adults, and older adults look (and respond) to services that have been designed with their specific life-stage (and cultural) needs in mind, that are identifiably "for them", and that do not turn people away for associated issues such as co-occurrence of alcohol or drug problems. Models of service such as headspace have enjoyed strong community support for some of these reasons. Unfortunately, similar levels of resourcing are still required for both children's and older person's mental health in the community. Ultimately, early intervention is often limited by the lack of supports in the local community including informal and professional supports. General practitioners and primary health workers such as Community Health staff are skilled in working with mental health conditions and are an essential front-line in responding to mental health issues in their local communities. In addition, Community Health Services are able to mobilise and build community capacity for better managing mental health at the community level through the provision of mental health first aid training and other mental health responses to a variety of community groups such as Men's Sheds, Church groups, Sporting clubs, etc.

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

Systematic and effective approaches for suicide prevention have not been widely understood nor implemented. However, there is early indication that this situation is changing and needs to be continued. EACH has been part of joined-up cross-sectoral suicide prevention service responses across local communities. The knowledge sharing and care planning in these type of collaborative arrangements have shown some good early signs in identifying and responding to suicidal risk.

Data indicates that the majority of people exhibiting suicidal risk do not necessarily come into contact with mental health specific services. Clearly, effective suicide response needs to incorporate non-mental health service sectors such as education, housing and employment, as well as families, peers and other loved ones. It is also well understood that certain groups are more likely to die from suicide, such as young men, Aboriginal and Torres Strait Islanders, GLBTIQ, refugees, or victims of crime and torture. Initiatives that effectively deal with specific drivers such as: shame, disempowerment, social rejection and isolation, lack of conformity to dominant cultural or gender expectations - may deliver better results.

Preventing suicide requires different methodology than simply crisis intervention, or even, from timely and effective mental health treatment responses in general. Where suicide risk is indicated, responsibility to respond is often referred to the acute public mental health sector. Due to excessive demand pressures, the model of care for tertiary mental health services is largely restricted to managing imminent clinical risk, rather than dealing effectively with the drivers causing that risk.

Programs that effectively address drivers for suicide need to build capacity "upstream" with key partners in community settings. This capacity could then be mobilised when community need is indicated. The use of peer workers to reduce the impacts of social isolation and stigma associated with suicide has also been shown to be of particular value. It is understood that individuals who have experienced a family member dying by suicide are at a higher statistical risk of dying by suicide – more proactive responses to this target group are required.

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.

Australia's mental health service systems predominantly assume that individuals who require treatment and support will be able to self-access treatment when required. This includes having the patience and stamina to navigate a system that is disjointed and fails to provide continuity to their care across different stages of their condition. Addressing this fragmentation and addressing how the system can best ensure care continuity for when consumer needs change and/or when care environments alter is essential.

Consumers who require long-term community assistance to manage the impacts of longstanding and enduring mental health conditions are underserviced with the cessation of previous Community Mental Health programs. Also associated with this is the integration of the mental health systems with other sectors (such as the criminal justice and AOD sectors, primary and dental health) and funding streams (such as NDIS and aged care funding); the ability of the system to enable seamless interfaces and connections is essential to ensuring quality outcomes. Moreover, addressing current access issues relating to a highly fragmented community mental health system and inadequate clinical supports (like psychiatry and pharmaceuticals) and the acute care provision in a preferred place of service is required.

Like physical health, mental health is a construct that may be experienced quite differently by different people. Interrupted domains such as quality of life, relationships, thoughts, feelings, daily living, and vocational engagement are uniquely impacted by a mental health experience. The implication of this is that mental health outcomes are pan-sectoral; a segmented, stand-alone sector approach to funding mental health outcomes is not likely to meet the needs of consumers. However, it is clear that fostering continuous and consumer-centred relationships between providers and consumers is essential in developing a system that is able to deliver quality mental health outcomes over time.

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

Whilst each individual's mental health journey is different, exposure to negative social determinants of health experience accelerate poorer mental health outcomes where risks are already present. This includes but is not limited to lack of family supports/family conflict, lack of cultural connectedness, unemployment or underemployment, experiences of trauma, housing instability, unaffordability and homelessness, substance abuse, excessive travel and food costs as a proportion of a personal budget, disability, social and economic exclusion, excessive/chronic pain, poor literacy, nutrition etc. Unfortunately, the recent decommissioning of community mental health programmes in Victoria has further exacerbated poor mental health outcomes in vulnerable communities that EACH serves. Lack of appropriate local services and "trusted safe spaces" can mean that effective windows for timely and appropriate intervention are missed, ironically resulting in higher degrees of unwellness and higher costs of treatment in the tertiary mental health system (hospitals).

The simultaneous interaction of many of these drivers (comorbidity or co-occurring conditions) is not uncommon in vulnerable communities. Although challenging for funders and services, integrated program planning, funding, delivery and accountability would mirror the aetiology and required treatment of mental illness in vulnerable communities.

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

Mental Health conditions do not just impact those living with the condition but also impact the families of those people. In particular, children who have parents living with mental health conditions can be

significantly impacted, often having to take on pseudo caring roles and being isolated through these additional responsibilities and/or the stigma related to having a parent with a mental health condition. It is essential that our system is able to recognise and be responsive to the needs of the children, and the broader families, of people living with mental health conditions. It is also essential that the system properly recognises the role carers have in supporting and improving the outcomes for people with mental health conditions and is able to adequately support and address the unique needs of these carers.

Whilst the intervention of professional support services is time limited, the support of family members in a consumer's recovery is lifelong. Engaged and supportive family members who enjoy the consent of their loved one need to be recognised as key stakeholders in the care planning process. Specific carer and family initiatives, models of practice, brokerage, and support specialists (e.g. family therapists, family conferencing and care planning, carer peer workers, family treatment approaches) could be further strengthened through targeted government intervention.

Ironically, two programs developed and conducted by EACH to address the needs of Parent Carers (COPES) and stigma for Primary School Aged Young People (SKIPS) have been conducted for over a decade without funding. Both programs have been evaluated and receive exceptionally favourable consumer support (and recognition) but neither fit into an existing funding line and are currently mooted for discontinuation due to budget reductions in the Community Health program which has cross-subsidised these services over the entire period.

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

Consumers, carers and family members who have their own lived experience of Mental Health and recovery make a highly valued contribution to the mental health service sector as a whole. EACH firmly believes that the professional peer mental health workforce requires better recognition, support and integration across all components of the system. Moreover, better access to targeted training and development opportunities could enable more robust and diverse career paths and opportunities within the sector. EACH's experience to date suggests that peer workers benefit from a flexible and committed workplace, regular support through a community of practice involving other peer workers, and peer worker supervision.

Respectful and competitive remuneration is needed to retain high quality individuals within the mental health workforce. Remuneration across the mental health workforce currently varies considerably, depending upon, inter alia, the type of experience, qualifications, discipline, and sub-sector that an individual employee works within. However, as a long term provider of mental health programs, EACH has noted that when qualified mental health staff leave the organisation, it is often due to the short-term nature of program operations/funding contracts. Furthermore, working for a sustained period of time in the mental health sector can expose individuals to greater workplace risks, including exposure to primary and secondary trauma. In particular, workers who deal with high acuity presentations (e.g. forensic mental health, dual diagnosis, anti-social behaviours) and simultaneously experience high through-put demands/internal organisational pressure are at greater risk. Greater consideration to employment stability and career development opportunities across the sector is necessary to assist the mental health workforce to proactive manage their own career and wellbeing in the industry.

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?

There is no doubt that social and economic inclusion serves as a positive recovery factor for many people. However, the specific nature of individual symptoms and pathology can pose very real barriers to participation. It is crucial that consumers who are significantly unwell have access to professional supports that promote participation in day-to-day activities and services where required. A "one-size fits all"

approach to service access, mutual obligation, and government entitlements for those individuals suffering from poor mental health does not appear to be indicated from a health perspective.

The high prevalence of mental health conditions suggests that roughly 1 in 5 people suffer from mental illness. Most people have a close friend or family member that has experienced these challenges if they have not done so themselves. This universality of experience presents opportunities for employers, communities, clubs and workplaces to mobilise and warmly welcome people who have had a mental health experience. Targeted community campaigns, employer and new business incentives, and local community grants are options that could be more consistently utilised across the Victorian community. Additionally, workplaces that promote a positive mental health achieve greater productivity and are more successful at attracting and retaining talented staff.

Ironically, as mentioned above, workplaces that themselves provide mental health services may experience greater risks than other work environments (i.e. exposure to stress, vicarious trauma/re-traumatisation, Occupational Violence and Aggression, insecure employment etc.). These risks could be addressed through the application of targeted measures to mitigate the clinical risks to staff as well as improving the job security, training and career pathways for the mental health workforce.

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?

To summarise, EACH recommends that priority consideration is given to:

- A transformational intersectoral approach to addressing the social determinants to poor mental health, in particular access to safe, affordable, appropriate and secure housing

- Strengthen the newly emerging focus on suicide prevention including more research into identifying and effectively addressing the drivers for suicide;

- Recognising the integrated and cumulative impact of multiple issues and health affecting experiences (e.g. substance use, experiences of state care, homelessness, unemployment, family violence, gambling addiction) in a person's overall mental health by providing longer term, integrated, cross-government linkages and accountability;

- Simplifying the burden that many consumers describe when having to navigate the complexity of many different programs and providers relevant to their mental health; consider leveraging off Victoria's unique network of Community Health Services which are located in every community across the State, to become the easily identifiable access point to every level of the sub-acute mental health system (GPS and hospitals are also challenged by lack of knowledge of eligibility criteria and referral pathways into many of the formal and informal community-based mental health resources);

- The short term nature of funding for many community mental health programs and the negative impact this has on workforce longevity in the industry as well as the continuity of care for service users' needs to be addressed through longer term funding contracts; consider alternatives to competition policy as the most effective means of resource allocation due to the damaging effect it has on sector collaboration, sector workforce development and consistency and security of support availability to consumers whose contact with the mental health system may be variable, but who need to know it will be there when they need it;

- The deficit based approach to locating functional impairment associated with mental health issues within an NDIS context (when consumers have asked services for many years to employ a recovery orientated approach);

- Sustained actions to further promote life-long mental health literacy, not just mental health awareness;

- More greatly adopt preventative and early interventions that are tailored to a "stages of life" approach (e.g. community based child mental health services, mental health services in schools, post-partum mental health services, mental health services in residential aged care)

- Greater investment in collaborative programs that combine both acute/crisis and community/earlier intervention approaches (e.g. Prevention and Recovery Centres, Homelessness Outreach Psychiatric Teams, Youth Early Psychosis Programs, Residential Recovery approaches, Police, Ambulance and Clinical Early Response etc.);

- Shift the dominant focus (and resources) of the mental health system from its current focus on providing crisis treatment services within the tertiary/acute mental health system, to a focus on community-based recovery models of intervention aimed at symptom management and keeping people well; these community-based approaches are evidence-based, effective, consumer-centred, wrap around and delivered in the more natural environment of the community rather than in the more expensive, clinical, hospital settings.

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

Conducting this commission into Victoria's mental health system is a useful first step. However, it is important that responses that aim to improve mental health in Victoria are regularly revisited through reviewed and updated action planning that is informed by robust evidence. In addition to a state-wide plan, local community or area-based planning will also be necessary to address the local mental health context within each region.

In addition to responding to the items detailed under question 9, EACH suggests the following items should be considered:

- Bring together consumers, policy makers and service providers in meaningful co-design processes to formulate robust system and practice improvements;

- Prioritise state wide policy and regional efforts to achieve more sectoral integration or at least better coordination of effort between sectors such as justice, housing, education, employment, child and family services and health in the Victorian context;

- Secure bi-partisan political support and accountability for a planned approach to achieving a more integrated, coherent and effective mental health system and system improvements over a longer timeframe;

- Investment in programs and funding to address new, emerging, and interdependent issues (e.g. cyberbullying, internet addiction, drug induced psychosis);

- Undertake ongoing mental health promotional campaigns for Victorians, across all ages, that are culturally inclusive and relevant to groups that may experience higher risks for mental illness (e.g. Aboriginal and Torres Strait Islanders, refugees, people identifying as GLBTIQ)

- The greater adoption of digital Health technologies to more efficiently assess, diagnose, treat, and support recovery from the effects of mental illness.

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

Yes, please find included some case studies that share the perspective of some of the community members that have used EACH's services.

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