Royal Commission into
Victoria's Mental Health System

Formal submission cover sheet

Make a formal submission to the Royal Commission into Victoria's mental health system

The terms of reference for the Royal Commission ask us to consider some important themes relating to Victoria's mental health system. In line with this, please consider the questions below. Your responses, including the insights, views and suggestions you share, will help us to prepare our reports.

This is not the only way you can contribute. You may prefer to provide brief comments here instead, or as well. The brief comments cover some of the same questions, but they may be more convenient and quicker for you to complete.

For individuals

Written submissions made online or by post, may be published on the Commission's website or referred to in the Commission's reports, at the discretion of the Commission. However that is subject to any request for anonymity or confidentiality that you make. That said, we strongly encourage you to allow your submission to be public - this will help to ensure the Commission's work is transparent and that the community is fully informed.'

Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commission's reports, subject to any preferences you have nominated.

For organisations

Written submissions made online or by post, may be published on the Commission's website or referred to in the Commission's reports, at the discretion of the Commission. However that is subject to any request for anonymity or confidentiality that you make. That said, we strongly encourage you to allow your submission to be public - this will help to ensure the Commission's work is transparent and that the community is fully informed.'

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Because of the importance of transparency and openness for the Commission's work, organisations will need to show compelling reasons for their submissions to remain confidential.

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. If you would like to contribute and require assistance to be able to do so, please contact the Royal Commission on 1800 00 11 34.

Your information	
Title	Chief Executive officer
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Surname	Rhode
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Preferred Contact Number	[redacted]
Postcode	3690
Preferred method of contact	☒ Email ☐ Telephone
Gender	[redacted]
Age	[redacted]
Do you identify as a member of any of the following groups? Please select all that apply	[redacted]
Type of submission	☐ Individual ☒ Organisation Please state which organisation: Gateway Health Please state your position at the organisation: CEO Please state whether you have authority from that organisation to make this submission on its behalf: ☒ Yes ☐ No ☐ Group How many people does your submission represent?

Personal information about others	Does your submission include information which would allow another individual who has experienced mental illness to be identified? ☐ Yes ☒ No
	If yes, are you authorised to provide that information on their behalf, on the basis set out in the document ☐ Yes ☐ No
	Prior to publication, does the submission require redaction to deidentify individuals, apart from the author, to which the submission refers ☐ Yes ☒ No
Please indicate which of the following best represents you or the organisation/body you represent. Please select all that apply	☐ Person living with mental illness ☐ Engagement with mental health services in the past five years ☐ Carer / family member / friend of someone living with mental illness ☐ Support worker ☐ Individual service provider ☐ Individual advocate ☒ Service provider organisation; Please specify type of provider: Community Health Service ☐ Peak body or advocacy group ☐ Researcher, academic, commentator ☐ Government agency ☐ Interested member of the public ☐ Other; Please specify:
Please select the main Terms of Reference topics that are covered in your brief comments. Please select all that apply	☒ Access to Victoria's mental health services ☒ Navigation of Victoria's mental health services ☒ Best practice treatment and care models that are safe and person-centred ☐ Family and carer support needs ☐ Suicide prevention ☒ Mental illness prevention ☒ Mental health workforce ☒ Pathways and interfaces between Victoria's mental health services and other services ☒ Infrastructure, governance, accountability, funding, commissioning and information-sharing arrangements ☐ Data collection and research strategies to advance and monitor reforms ☐ Aboriginal and Torres Islander communities ☒ People living with mental illness and other co-occurring illnesses, disabilities, multiple or dual disabilities ☒ Rural and regional communities ☐ People in contact, or at greater risk of contact, with the forensic mental health system and the justice system ☒ People living with both mental illness and problematic drug and alcohol

	use

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

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Submission to Royal Commission into Victoria's mental health system

July 2019

Gateway Health is a regional Victorian Registered Community Health Service in the North East of Victoria, providing a diverse range of services to our communities. We welcome the opportunity to contribute to the Royal Commission.

There are four broad messages and a number of recommendations Gateway Health would like to emphasise in the discussion to improve the mental health and wellbeing of Victorians:

1. **One of the greatest barriers to maintaining mental health and preventing mental illness is the stigma, judgment and perception surrounding mental illness. Stigma and discrimination is present in media, health professionals, government and non-government agencies, communities and within individuals and their families.**
2. **Mental health and wellbeing is not the absence of mental illness. Wellbeing is impacted both positively and negatively by social and broader environmental issues, most of which are outside the health sector.**
3. **The differences and issues between metropolitan and regional/rural areas and the impacts of state borders on access to care must be recognised and addressed. These issues relate to equitable service access, the complexity of the assessment and service system, integration across agencies and sectors, data and information sharing.**
4. **The workforce needed to address current and future service and treatment inequities, manage complex co-morbidities, address funding of psychosocial disability support and provide best practice care is currently inadequate, and issues are further compounded by rurality**.

In 2017 United Nations Special Rapporteur on the right to health, Dr. Dainius Pūras, called for a move away from the biomedical model and "excessive use of psychotropic medicines".

"The urgent need for a shift in approach should prioritize policy innovation at the population level, targeting social determinants…
The focus on treating individual conditions inevitably leads to policy arrangements, systems and services that create narrow, ineffective and potentially harmful outcomes… It paves the way for further medicalization of global mental health, distracting policymakers from addressing the main risk and protective factors affecting mental health for everyone.
…Paternalistic and excessively medicalized concepts must give way to participatory, psychosocial care and support in the community. Cost-effective and inclusive options with successful outcomes do exist and are being used around the world today - they just need to be scaled up and maintained."

Mental illness, stigma and discrimination

One of the greatest barriers to maintaining mental health and preventing mental illness is the stigma, judgment and perception surrounding mental illness. Stigma and discrimination is present in media, health professionals, government and non-government agencies, communities and within individuals and their families.

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

- The current mental health system can traumatise, stigmatise and de-skill people with mental health concerns or mental illness issues who access it. The same trauma and stigma can occur in all other areas of the health system throughout primary and acute care. People with mental illness often do not have their voices or concerns heard, are often treated in terms of their mental illness not as a person who may have concurrent physical illness. There is a lack of capacity in primary care to concurrently address chronic mental and physical illness.

- Stigma around mental illness can stop people seeking help early. This is an issue in rural communities, Aboriginal and Torres Strait Islander communities, refugee and multicultural communities and among trans and gender diverse people. Combined with a lack of services actually accessible and available at the times they are needed, particularly in rural areas – intervention and support can come far too late and have lifelong consequences.

- **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[1].

- There is a need for clarity of language and meaning to improve our understanding of what we mean 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 though responsible reporting, language and factual information can and should be an active partner in promoting mental wellbeing, positive recover, hope and reducing stigma.

- **Listen** People who have a mental illness are able to speak for themselves, articulate their needs and make decisions. At times they need treatment, at times they need specific support; they always need respect. The “Listening To Voices” theatre production is a key initiative supported by Gateway Health. It is a local, social impact and innovative project that has both infused purpose and pride in those involved, connected audiences with experience of trauma and stigma and inspired community consideration of “how can we all do better”.

[1]ANROWS Examination of the burden of disease of intimate partner violence against women, November 2016

- Listening To Voices is a great example of a how a small group of people (experts by experience) can change their own lives and that of many others - see https://vimeo.com/300229963/b28f6a771e This submission supports that of Listening To Voices which shares the perspective and clear voice of people with mental illness, their families and communities.

- **Ensuring 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.

- **Trauma** The impact of family violence, substance misuse, racism, insecure housing, parental incarceration, interrupted schooling, bullying and inequitable access to extracurricular opportunities all impact negatively on the mental health and wellbeing of children, some from before birth; and need to be addressed early, from both prevention and early intervention angles. Trauma informed practice and language is needed across all service delivery, all planning and program implementation, in all sectors.

- **Trans and gender diverse people** can find the process of questioning, defining, and affirming their gender identity to families, schoolmates, workmates and teammates difficult, overwhelming and distressing. This process can also be difficult for people around them such as partners, parents, siblings and friends.[2] This submission supports that of the Gender Service Community Reference Group.

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

Recommendations

1. **Recurrent funding for the Gateway Gender Service is needed as a matter of urgency. We have seen firsthand the incredible impact of this service on the lives and wellbeing of rural and regional trans and gender diverse young people, their families, friends and schools.**

2. **Provide funding for the maintenance and expansion of Listening To Voices. This innovative work reflects and celebrates lived experience of mental illness and is having a positive impact across Victoria.**

3. **Develop clear media guidelines, standards and training across all formats around public reporting on issues related to mental health and wellbeing and mental illness. E.g. Mindframe's work on suicide reporting[3]. Monitor implementation, breaches and impact over time.**

4. **Ensure that trauma informed principles and practice is an ongoing component across training and education curricula for all health and related disciplines. Ensure that the health and related workforce are able to listen to and respect the voices of those with lived experience of mental illness and their families and carers. Enable simple information sharing within and across providers and with clients to reduce compounding trauma through continually re-telling stories and repeating information.**

[2] Gateway Health Gender Service Community Reference Group
[3] https://mindframe.org.au/suicide/communicating-about-suicide

5. **Research, understand and address stigma and discrimination against those with mental illness in rates of housing, employment, return to work, educational access and attainment. Develop and fund support roles to allow people with or at risk of mental illness choice, control and equal opportunity.**
6. **Work with the Commonwealth to reduce Medicare complexity by adequately funding and simplifying access to bulk billed long consultations and multidisciplinary care across different disciplines for those with or at risk of mental illness.**

Prevent mental illness and pro-actively help people to get early treatment and support

Mental health and wellbeing is not the absence of mental illness. Wellbeing is impacted both positively and negatively by social and broader environmental issues, most of which are outside the health sector.

"We need the involvement of society as a whole to tackle the causes of the causes of social exclusion and its dramatic health consequences[4].

Mental health and wellbeing cannot be seen as a separate issue from the society and communities we live in, and the values and norms that underpin them.

Prevention and treatment should never be seen or funded as in competition, they should occur at the same time. Both are equally important if we are to reduce in any way the personal and social impact of mental health conditions, to reduce the risk of developing mental illness, and to improve recovery and ensure equal opportunity for people with mental illness. The current focus from media, government, treatment providers, media and therefore communities is primarily focused on treatment and measures designed to help people after they have become unwell.[5]

- **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. Local and state governments have a key role in building and planning liveable cities and regions that improve health and wellbeing.

- **Social exclusion** can a reality for people with mental illness, people with substance use issues, people in contact with the justice system, children impacted by protective services, minority populations, people with chronic illness, those in insecure housing and/or employment and people from low socio-economic backgrounds or postcodes. The result for these groups is increased morbidity and mortality, lower life expectancy, small or no prospects and hoplessness[1] and increased hospitalisation rates due to injury.[6].

[4]Marmot, M. Inclusion health: addressing the causes of the causes. The Lancet Volume 391, ISSUE 10117, P186-188, January 20, 2018 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32848-9/fulltext

[5] VicHealth and partners (2019) Focusing on prevention: A joint submission to the Productivity Commission Inquiry into mental health, Submission to the Productivity Commission into Mental Health

AIHW, Hospitalised injury and socioeconomic influence in Australia 2015–16, July 3, 2019

Addressing the issues leading to the exclusion of people and the ongoing intergenerational effects, i.e. the social determinants of health, is a role for all of government and all of society and requires long term funding, integration and new ways of thinking, funding and measuring outcomes.Many people having with problems with their mental health are not clients of the mental health 'system' and indeed may not be interacting or engaged at all with the health system more broadly. Mental health needs should therefore be able to be addressed in the places people already access. Developing and prioritising shared actions and wellbeing outcomes indicators across sectors can lead to collective action empowering some of the most disadvantaged community members to see hope, recovery and a way forward.

- Partnerships that include those who have lived experience, communities, diverse non-government organisations, private sector agencies and government departments across all sectors need to be funded to undertake long term work to actively address risk factors and interconnected issues such as homelessness, isolation, chronic illness, trauma, substance misuse, addiction, crime and family violence.
  Doing this locally and flexibly in response to community identified need with agreed monitoring and evaluation measures can have stronger impacts than short term treatment of prevention programs that may not reach into rural areas. For example – place based suicide prevention trials, local drug action teams.

- **Justice** People with mental illness are over-represented in the justice system and in prisons. Too often people with mental illness end up in courts or incarcerated, when their needs and issues could be more effectively be responded to elsewhere. Critical service gaps, not addressing the social determinants of health, and inadequately funding services that provide support directly impacts number of people with mental illness in the justice system.

- Those who are involved in the justice system experience poorer mental and physical health than the general community, and this often worsens when people leave prison. Gaps in services and lack of support for people returning to the community impacts on rates of recidivism and return to prison.

- **Prevention and early intervention** to ensure a positive focus on mental health and wellbeing, there must be an increased focus on and prioritisation of streamlined and long term funding for prevention and early intervention – before people become unwell or incapacitated. Clear and supported roles and relationships between mental health clinical treatment services, the broader health system and other sectors and settings would help to improve access to treatment for those who need it and improve opportunities for undertaking broader activities and/or treatment or services to reduce risk.

- Broad multi-sector partnerships need to be supported with adequate and long term funding and research to ensure that response to and prevention of mental illness is collaborative, that there are shared priorities and actions that lead to measurable outcomes over time.

- **Complexity of access** is a major concern, particularly in rural areas. Emergency Departments as first point of access create bottlenecks and missed opportunity for effective care that could be provided in other settings.

- **Trans and gender diverse** There are few places to obtain care in Victoria where trans and gender diverse people feel safe and secure, with such services largely being provided by a small number of specialist general practice, community health and hospital services that are concentrated in Melbourne. The cost to rural and regional people of accessing services, especially medical gender affirmation services, play a major part in limiting service access. In some cases, these services can be regarded as life-saving healthcare because of the associated risks of depression, self-harm, and suicide that trans and gender diverse people can face[6].

- **Safe and secure housing** is fundamental to health and wellbeing of families and individuals. Supportive housing policies by governments with a focus on regional areas can impact mental health and wellbeing of vulnerable populations.[7]

- **Employment and work environments** must be accountable for supporting mental health and wellbeing for staff and clients.

- **Early intervention for children** - models and funding for assessment and are siloed and confusing, and services often are focused on children after they become unwell. The services, resources and information needs to be transparent to families and health professionals and streamlined with improved early access, multidisciplinary assessment, information and data sharing.

- **Rural and regional Victoria** has an aging and in parts, isolated population. Models of care, services and support for rural and regional older people and their carers and families with mental illness are inequitable and inadequate. Increasing rates of dementias, impacts of mental illness on chronic physical illness and vice versa, and the ongoing concerns raised by and about the capacity of the residential aged care sector caring for people with mental illness are accentuated in rural and regional areas.

- Funding, models and location of assessment, early intervention and treatment services are not equitable across rural and regional areas, many families and children have inadequate or no support available or accessible. Improved models linking education providers, allied health providers and services provided outside the health sector are needed.

[6] Development of Trans and Gender Diverse Services, Victoria: Final Report, 2018, p.7- 8
[7] Bentley, R et al (2016) Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis, Housing Studies, 31:2, 208-222, DOI:10.1080/02673037.2015.1070796

Recommendations

7. **The Commission include consideration of the social and environmental determinants of health in considering all future actions and recommendations to improve mental health and wellbeing of Victorians.**

8. **Develop and fund shared and robust outcome and impact measures/evaluation over time. Measures should include promotion of mental health and wellbeing and prevention of mental illness as core business across other sectors (housing, education, health, police and justice, transport, education etc). Outcome measures must capture meaningful client input to allow for improvement.**

9. **Increase funding and focus on developing community mental health hubs especially in rural and regional areas. Allow for flexible models, service design and delivery that reflect local population and need, so services can go to where people are rather than expecting those who are unwell or at risk of becoming unwell to travel. Recognise the impacts that little or no public transport has on rural people, the tyranny of distance and adequately reflect travel costs and impacts for rural providers in models and funding.**

10. **Investment in the active sustained promotion of mental health and wellbeing should be reflected in all polices and funding agreements. The wellbeing of people needs to be at the centre of sustainable public policy and decision making and all of government, all sectors, all employers and all communities have a role.**

11. **Adopt recommendations of the Development of Trans and Gender Diverse Services DHHS Report (2018) and fund current and expansion of 'spoke and hub' type model to support trans and gender diverse people in rural and regional areas. The model includes case intake and management systems, psychiatric assessment, education and training, family support, and advocacy. Funding must include the dedicated capital and recurrent expenditure necessary to sustain such development.**

12. **Increase the supply and options for social and affordable housing in regional and rural areas, aligned with appropriate support services for those with or at risk of mental illness.**

13. **Responses for people experiencing substance misuse, homelessness, family violence and both incarceration and release from prison should provide holistic, integrated wrap around support, that includes mental health services, psychosocial support, housing support, physical health care and other relevant social services. Remove the active and often entrenched disconnection and barriers between mental illness, substance misuse, family violence services and other social services. Information and data sharing, integration and funded organisational capacity (including workforce and information technology – software, hardware and support) for multidisciplinary care is needed.**

14. **A national review of the entire mental health 'system' is required – with a commitment from all jurisdictions to work towards a comprehensive national model which is able to be understood and easily accessed by clients and families, which provides a range of options across the spectrum of people's needs (including a range of peer-led services) and which promotes hope, positive wellbeing, and recovery.**

15. **Work with the federal government to improve integration of and learnings from headspace models.**

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

The differences and issues between metropolitan and regional/rural areas and the impacts of state borders on access to care must be recognised and addressed. These issues relate to equitable service access, the complexity of the assessment and service system, integration across agencies and sectors, data and information sharing.

- **People living in rural areas** have higher rates of self harm and suicide and less access to services than their metropolitan counterparts.[7,8] Isolation, geography, lack of transport, poor internet access, under employment, insecure housing, climate change vulnerability, local towns losing population and services all impact mental health and wellbeing in different ways to metropolitan areas.

- Funding and service design must reflect the particular issues around the lack of public transport in rural areas meaning that people cannot access traditional centre based services. Outreach and outpost services must have adequate funding to ensure equity, innovation, IT capacity, early intervention strategies and enable accessible options.

- **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.

- 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.

- 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

[7]Victorian Suicide Prevention Framework 2015-16
[8]National Rural Health Alliance 2017

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 metropolitan catchments and 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, Indian, Filipino and Bhutanese origins.

- The cross border acute and community mental health service through Albury Wodonga Health operates under both Victoria and NSW Mental Health Acts. The two 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.

- 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. For example, people subject to either Mental Health Act face different processes and potentially different clinical outcomes, particularly when it comes to time frames for compulsory orders. 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.

- **Community mental health and wellbeing service delivery** especially prevention and early intervention, is underfunded, under resourced and under recognised. Community health has a valuable part to play in the stepped care model of mental health support . Currently community mental health is siloed, operates differently in every state and territory, and is poorly monitored for cost, safety and efficacy. 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.

Recommendations

16. **Improve and prioritise relationships and agreements with NSW Ministry of Health to ensure a streamlined cross border system and model can be implemented and maintained by Albury Wodonga Health.**

17. **Increase Victoria's financial commitment to mental health service provision both acute and community based in the growing Albury Wodonga Health catchment.**

18. **Rural mental health as a specific area for investment in research: it would be useful to shift current patterns of investment from crisis driven e.g. post drought, flood, fire etc. to a more pro-active investment in research and innovation in enabling "resilient" rural communities. A sustained, integrated and aligned effort across and at all levels of government and service delivery is required.**

19. **Community mental health care should be integrated with multidisciplinary physical health care and social support services, and based in the community where people live, wherever and whenever possible.**

20. **Innovative models of community development and empowerment, workforce development and early intervention services need to be funded and evaluated over longer periods than 1-3 years if they are to show results. Funding periods for programs, services and innovation needs to be of a duration that allows for development, implementation, evaluation and improvement**.

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

The workforce needed to address current and future service and treatment inequities, manage complex co-morbidities, address funding of psychosocial disability support and provide best practice care is currently inadequate, and issues are further compounded by rurality.

- **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.

- The NDIS workforce is extremely limited in remote rural areas, with few providers appearing to offer psychosocial support services. NDIS Support Coordinators report market failure in remote communities of Northeast Victoria for people attempting to access psychosocial support services through the NDIS. The result is that people needing individual support are being required to compromise on the amount of service they are able to receive, regularly needing to use their allocated funds to pay for their own travel costs and/or that of support staff. People with complex mental health conditions in regional cities are also finding it difficult to find appropriately qualified staff to meet their needs, leading to underutilisation of packages and reduced opportunities to reach their stated goals.

- **Cross border** Lack of wage parity and employment conditions in state based Enterprise Bargaining Agreements impacts workforce recruitment, retention and service delivery. This is emphasised in catchments that abut or cross state borders.

- Recruitment and retention of medical staff to work is a major issue in regional areas and is compounded where the service sits across state borders, as in Albury Wodonga. 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.

- Cross border workforce recruitment and retention and 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.

- **Investment in culturally appropriate, competent and trauma informed workforce** for Aboriginal and Torres Strait Islander people, for rural refugee and resettlement communities and for trans and diverse gender people 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, ignorance, misunderstanding and even fear directed at them which in turn lowers their trust of the broader service system. Lack of and cost of qualified interpreters in rural areas heightens this issue for some language groups, including Auslan.

- **Psychosocial disability** people who were previously accessing support through federally funded psychosocial rehabilitation services (Partners in Recovery, Personal Helpers and Mentors and Day to Day Living programs) had access to a highly skilled workforce with strong capacity to support them in their recovery. Staff in these programs supported people with complex mental health conditions through offering assistance with appropriate education, referral, and coordination of intersecting services such acute treatment, rehabilitation, housing, physical health needs, employment and social connectedness. These services were adequately resourced to support people in their communities, including those living in more remote locations. With the introduction of the NDIS we have seen a decline in the qualified mental health workforce. The result is a very real and negative impact on people with a psychosocial disability who need to access qualified staff for appropriate support through the NDIS to achieve their stated goals.

- The support provided by the NDIS for people with a psychosocial disability is task oriented and practical, it is not recovery oriented psychosocial support. Our agency struggles to attract Disability Support Workers who have any or appropriate qualifications or experience or in working with people with psychosocial disability. Discussions with other service providers would indicate that this is a national trend. We fully expect to have further difficulties attracting and retaining well qualified staff in this period and into the future.

- We are concerned that people in the community with complex psychosocial and other needs will not receive recovery oriented psychosocial support through the current NDIS structure. We are also concerned about how and where people who require assertive outreach and assistance to connect with service options will access appropriate help and support, preventing exacerbations of their illness.

- **Peer workforce** Social participation and inclusion activities, connection and participation for people with significant mental illness and/or those at risk of mental illness requires additional support. A supported and consistent peer workforce can be valuable in enabling participation.

Recommendations

21. **Increase education and awareness of health care practitioners about mental health, particularly the primary health needs of people with mental illness.**

22. **Ensure community based psychosocial rehabilitation based on recovery oriented practice, with a skilled and supported workforce is available for those who need it, where they need it.**

23. **Investigate and address the workforce issues faced in recruitment in rural, regional and cross border areas. Develop career pathways, local professional development and networks, capacity funding to allow for strong and effective clinical supervision.**

24. **Invest in ongoing development, training and support to build a skilled and qualified Aboriginal and Torres Strait Islander workforce in acute and community health treatment and mental illness prevention.**

25. **Service providers and employers need funding and capacity to support and develop a peer workforce to enhance mental illness treatment and recovery, promote mental health and wellbeing, and participate in design, delivery and evaluation of culturally appropriate services and programs. Statewide guidelines should be developed, trialed and evaluated with the peer workforce, building on experience in other states eg. peer Work Hub in NSW http://peerworkhub.com.au/**