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

Organisation Name
N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Our current mental health system is very complex and can be difficult to navigate. This complexity can increase both stigma and discrimination not only from community members but also from organisations that don't have a good understand of the system and how to assist people to navigate through it. If our service system is not aligned, it makes sense that it will always be difficult to then increase awareness and understanding of community members. Our service system has many cogs that all move at different paces and funding requirements are often also be quite different between programs. For a person requiring services, depending on where and how they enter the system can determine their overall access to the services provided and their overall experiences of the services they have accessed. An example of this maybe that a person requires a primary service intervention for generalist counselling. They call a mental health service triage number only then to be referred back to an alternative service, or their GP which in turn may lead to either more phone calls and or a wait period of weeks to be able to get into that system. The person becomes frustrated and then does not follow up. Mental Health has become a broad term used at all levels of service system regardless of the situation of the individual. Generally, Mental Health depicts a vision of someone having a mental Illness or Mental Issue as opposed to being mentally well. If a person is grieving it's a mental health issue, if they are angry its mental health etc. Ideally, language should be consistent to talk about emotional health and wellbeing. Tertiary Mental Health services should be reflective of Mental Illness. Even consideration of changing the service name to be Psychiatric services as opposed to Mental Health Services. With all this in mind it then stands to reason that people accessing services around emotional wellbeing should influence a reduction in stigma and discrimination. A community misperception seems to exist that a person who attempts suicide or states suicidal thinking must be mentally ill. The reality is that at least 10% of people that attempt suicide may not have a mental illness. This leads to a level of community and carer dissatisfaction that tertiary mental health does not always fix a person who attempts suicide. The same holds true for clients with deliberate self-harming behaviours. Public awareness raising and education may impact on this and highlight other services and resources that may effectively address social, psychological, and interpersonal stressors that lead to suicidal ideation, and self-harming behaviours. Sectors of the rural community believe that an admission to a Mental Health inpatient unit will fix a mental illness or mental disorder and can become disgruntled when admissions are not an outcome of mental health assessment. Greater education around the resourcing and activities of recovery focussed, inclusive community mental health may address this misconception of illness or disorder requiring hospitalisation. Community Education, via media outlets and prevention early intervention' services to focus on what is mental illness, the prevalence, treatment, supports and what the community members can do to support people would assist and demystify community understanding and reduce stigma. "

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?

"Partnerships In the Northern Mallee, we pride ourselves in our ability to create and maintain collaborative partnerships between clinical Mental Health Services and other service providers. We develop and maintain many partnerships and networks through a variety of means to ensure that our service system is as fully informed as possible. Some of the ways that local partnerships are established and consolidated are; in addition to standard Memorandums of Understanding and service agreements, we facilitate interagency orientation and joint education sessions, sharing of staff members through secondments or shared employment contracts, facilitated case conference and case planning sessions for clients utilising multiple service providers and the development of new partnerships when applying for new funding. The limitation of these partnerships is that they are facilitated by clinicians and managers that are also required to manage high workloads within their own services and finding time can be difficult. Also some of these networks have limited membership do not extend to all areas of the health system such as disability. The marketization of current funding and individualised service provision under the NDIS is creating difficulties in maintaining inter-service collaboration and tailoring of services to meet the individual needs in a timely manner. This funding model creates a competitive market whereby services have to contend for available funding and often results in funding going to the biggest service with funding available to engage the best submission writer rather than what is best for the client. The complexity of the NDIS system impacts on partnering with Carers and Consumers, impeding their comprehension of the service availability and difficulty in navigating the service system are likely to prevent them getting the best possible outcomes. NDIS funding does not take on board the need for the organisational development and training needs of their staff and as such we have the most vulnerable people in our community being managed by the least skilled work force. Deinstitutionalization was meant to address this issue but in fact our current model has made this worse. Training There are many great examples of training that can be provided to improve the community's literacy around Mental Health and suicide prevention including Mental Health first Aid, Applied Suicide Intervention Skills Training (ASIST), Trauma Informed Care. The addition of MH POD, increased use of IT platforms for training and Training Clusters has greatly improved rural clinician's access to training. Specific issues for rural and remote include: There are extra costs for rural services and communities including transport costs, accommodation, time and extra staff costs required to access training in cities or larger regional centres. For example if a staff member wants to attend 2 days training in Melbourne from Mildura, in addition to registration fees, the staff member has to either drive 6 hours each way or pay $350 for a return flight, $150 for accommodation and $100 for transport meals etc. When our staff only receive $900 retention allowance for professional development, $600 is not very much and there should be consideration given to a rural loading. There are also extra costs to access trainers needing to travel from out of the area to provide local training is also an extra cost that services must find. The work force also employs positions that have state wide obligation. My Role as Senior Psychiatric nurse is an example. However no other funding is included for rural areas to meet the demands of the position. I.e. there is an expectation that I will attend meetings in Melbourne at least monthly. For me there is an extra cost of $450 return flight, $150 cost in Taxi and a 12 hour day for what is often a 1-2 hour meeting. use of teleconferencing is limited as there is no standard infrastructure that all services can or will use. GP's Mental Health Care plans have been a great strategy to ensure that GP's are included and involved into consumers care and access mental health treatment and support. Areas that require improvement are: Government support to financially incentivise and support GP's and private practitioners working in Victorian headspace centres who are unable to charge a gap fee. Increased accessibility to GP's. The Changes to Medicare funding and GP supervision has reduced the amount of GP's and increased the waiting time to

access GP's in rural remote areas. Changes to Medicare to enable people with complex mental health issues extended accessibility to private practitioners. Primary Care Providers There is plenty of evidence to show that early access to Primary Health Services improve client outcomes. However, access to these services is becoming more difficult as we move toward individualised services and the need for people to receive a diagnosis prior to receiving much needed services. Primary mental health services to provide services earlier improving the trajectory of the person's mental illness. (Prevention and earlier treatment). Additional and flexible funding needs to be increased to allow local access to local Primary Mental Health Services including psychosocial, housing, financial supports which can be delivered in groups as a more cost effective way. Programs where primary services are supported by tertiary services around interventions, supporting people with suicidal ideation such as the Beyond Blue The Way Back Support Service' Tertiary Mental Health Services The mainstreaming of mental health service has been a very positive move for Tertiary Mental Health Services in regards to access and the destigmatisation of mental illness however there is still a long way to go. Access to acute beds in our region is quite good with an average occupancy of 80% so we are able to provide therapeutic interventions in a safe environment but there could be improvements in the areas of; The integration of MH and AOD services would assist with integrated service provision and the navigation of the service system given that most of the clients we see have both mental health and Alcohol & Other Drug issues. Changes to current funding models in order to provide child & family friendly inpatient services for rural and remote communities. Currently Child, Youth and Peri-natal services are limited and community members are expected to travel long distances in order to access centralised services. Primary & Tertiary services need to have greater capacity to support the role that families and carers play in recovery with increase support to provide family inclusive interventions. Schools Victorian Government Anti-Bullying & Mental Health Initiative (VABMHI) - increased resources to improve the availability of mental health support for students and school capacity training welcome though service provision limited Rural and regional areas need to improve capacity of schools / education department of respond to mental health concerns, particularly around children and young people with specific diagnoses such as complex autism spectrum presentations and trauma presentations. Further investment in the SAFE minds and suicide risk continuum training (SRCT) for all schools Broadening principles of SAFE minds and SRCT for non-school based organisations/workplaces to assist with identification and early intervention "

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

"Several years ago a group led by the Mildura Base Hospital developed the Northern Mallee Suicide Postvention Communication Protocol. The purpose of the protocol is to provide a coordinated and effective response to suicide incidents. The core services that respond when there is a death in the local community are VicPol, headspace, Mallee District Aboriginal Services, Sunraysia Community Health, StandBy postvention services and the Murray PHN. These services are responsible for ensuring that the deceased family, carer and social network receive support following a death by suicide. This group provides suicide prevention and post vention support via Public forums, sporting clubs, responding to media reports with a focus on the Lived Experience. The group works closely with the Standby' providing support after suicide. Other supports available in the local community include: Current mental health services are available 24 hours per day for crisis responses. Community Training and Promotion programs include: ASIST, Mental Health First Aid, What do I say, what do I do' and RUOK day, suicide training to our local police amongst other activities. What else would assist our rural and remote communities would be oThe engagement of people with a lived experience in the training and programs provide valuable

learning experiences for both clinicians and community members in the training. oPublic awareness raising and education to highlight appropriate local services and resources that address social, psychological, and interpersonal stressors that can lead to suicidal ideation and self-harming behaviours. oDeveloping a collaborative approach to service delivery to improve outcomes for people affected by suicide. oGreater collaboration and engagement with local user groups to understand and support consumers, family and friends after someone has attempted suicide. oFunding for a local service to provide a specific Prevention, and Post Vention support within the local community to ensure a timely sustainable response. oFund local service promote and support increased access to Online and Web based The State of Mildura Rural City Report 2018 indicates that Mildura has dramatically less access to online services and resources with 21.1% of households having no internet access compared to state-wide average of 13%. oFurther access to longer term community base support services post tertiary mental health services crisis intervention. Disengagement is common at this time. oImproving skills and capacity for school based services. oLocal ready access to primary providers with a range of expertise to meet the needs of the individual, family or friends. Early intervention in emotional health and wellbeing leads to better outcomes. oLocally there are declining numbers of primary support services available for people to access leading to people accessing tertiary mental health services or not accessing services at all. oOther preventative services that need to be more readily accessed are financial counselling, relationship counselling, gambling or drug and alcohol oCapped service provision can also have an impact as often health and emotional wellbeing issues are not only dealing with a client but quite often more complex relationship and family issues. oLocally there is difficulty in accessing GP's in a timely manner if at all. oThe tertiary Mental Health services are often the initial access point as the primary mental health services are not availability or after hour's access is non-existent. oConsideration of a Sip of Hope' type program to promote early access and reduce stigma. (Please see link below) https://www.ozy.com/good-sht/the-chicago-coffeehouse-that-offers-a-shot-of-psychology/90125 "

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.

"Promoting good mental health will have a significant impact on reducing the incidence of death by suicide and suicidal behaviours. Having a coordinated approach to support people navigate and access the mental health, AOD and wider service system, would increase the appropriate access, at the appropriate time to the appropriate service. Providing a direct coordinated care will prevent people bouncing from one service to another increasing the likelihood of ineffective service provision and improve the experience of people. To have people experience good mental health we want to encourage early intervention. Schools are very adept at developing their students Intelligent Quotient (IQ) but not necessarily developing the EQ or Emotional Quotient. Although there are examples of schools that have taken on this type of approach, wider implementation within the school program should be considered. Over the years education and family systems have changed. Although access to university via mature age options is more readily available, there is a large focus on the academic result of year 12. Nuclear family structures are nowhere near the norm. For example, increasing incidents of single parent families may equate to various inconsistencies in child development and emotional growth. Therefore implementing standardised EQ programs which have a focus on the more fundamental life skills would be beneficial in developing lifelong skills. Promotion of sports, exercise, community groups involvement will reduce social isolation of people and lack of community connectedness, which are extremely important factors for developing and maintaining health and wellbeing. Initiatives to support

participation in sport, gym memberships etc. a tax deduction would lead to increase participation at all levels and be a great early intervention strategy. Investment in infrastructure is detrimental to the ongoing development of community and inclusion is sport and recreation. Currently in Sunraysia there are plans to develop a sporting precinct hub that will deliver a $36M facility to our community. (20 years ago this facility would have cost 10% of this cost). This is one of the major capital development s that has occurred in this a rural and remote area. This facility has been worked on by local community members for over 20 years and is central to bringing life to communities that are shrinking. Even though there has been significant funding obtained so that the project can be started ($17 M Commonwealth funding, $8M Local Government and $3 M from State funding) there remains an $8m short fall to have the project completely funded. It is difficult to understand how government can be serious in discussions around early intervention and prevention when there is not the required support for such a facility to be funded and built to the entire project scope, especially when we see so much capital investment in other less remote areas. Please review the link below to the Mildura Future ready project https://www.mildura.vic.gov.au/Council/Major-Projects/Mildura-Future-Ready Public transport in rural areas needs to be addressed. Mildura has a public transport system that caters for more urban base residents with limited or no access to nearby communities and rural remote areas. The 1990's reform to both Mental Health service and services for the intellectual disabled led to the closure of institutional care. The limited stake holder engagement, the Institutional closures led to people then placed to live more individually in the community. Social role valorisation was deemed a best practice principle, with vulnerable people given the right to be managed or supported in the community by mainstream services. This has contributed to poor support for both the consumers and the carers with a high level of vulnerability and an inadequate service system to support them. Staff have become less qualified so that we have the most vulnerable people being supported by the least trained staff without the specialised trained staff to provide adequate support Funding to service can often be fragmented, unsustained or too rigid to maintain consistency for consumers and their carers. For the more vulnerable people this has meant that the only type of institutional care available to them has been Gaol. In Mildura we have had many examples of people with intellectual disabilities that have severe behavioural disturbances. The community looks to Mental Health to provide a contained environment to manage their behaviours. Having a person with an intellectual disability housed in an acute inpatient unit that only has adult 12 beds to service 26,000 square km is not a viable option. As such the consumer then is charged for offenses and then placed in gaol. The Northern Mallee has over the past 10 years seen a huge reduction in services providing Social engagement and reducing isolation. Where there is now a tendency to provide individual support packages which is certainly a great advantage for some clients, the ability for group programs has diminished. Group programs offer so much and provide great opportunity for peer support and community inclusion in a safe and contained environment. This is also a point of respite for carers. The Northern Mallee now has a lack of support groups that have a focus on social activity and participation (i.e. not program driven) for isolated community members. The decrease in drop in type social support groups has served to isolate elements of the community (eg clients with chronic mental illness, or complex psychological disorder such as Borderline Personality Disorder). In the past having a safe venue where people could drop in on their own accord and have trained staff and peer led support to talk, be involve in a program or simply have a cuppa was invaluable. Quite often, the staff could recognise early warning signs and link people back to the service system and prevent relapse in what at time could be very severe. Here we had many examples of consumers who through their participation in these type of Psychiatric Disability Support Programs (PDRSS) have formed bonds and friendships that have lasted for years. It would Appear that at this stage the funding through

NDIS will not support the implementation of such programs. Although services can implement a group type program the individual funding rate changes so that having several consumers combining their resources does not attract a greater amount of funding for that service. Added to this the NDIS rollout of care packages for mentally unwell, may further weaken capacity for social connection. People with significant psychological disorder (BPD etc) will not qualify for the funding and thus further restricting service access and social connection opportunities. Current individual funding does not recognise sporadic and episodic nature of Mental Illness and as such having long term stable services that consumers and families can access quickly when needed are not available. The role out of the NDIS would seem to mirror the poor implementation of de institutionalisation in the 1990's. The impact of service provision has been remarkably understated and not enough infrastructure or service planning has been done to address the complicated issues of people experiencing psychiatric disorders. There is extreme anxiety currently experienced by consumers, Carers and service providers in the transition of care if and when accepted by the NDIS. Even for people when they have been approved the communication and implementation process is very poor, transition is not seamless and often the consumer experiences a gap in service provision. The system relies on the consumer and family having a good understanding of service availability in their community which more often not the case. The Organisation for Economic Co-operation and Development (OECD) of Australia highlights the point of how complicated the Australian Health Care system is to Navigate Health Care Quality Review. Below is a link to this information Australia should improve the integration of care across the patient pathway to prepare for a rise in chronic disease and make the health system less complex for patients https://www.oecd.org/australia/australia-s-health-system-is-too-complex-for-patients.htm Lack of access to stable and affordable accommodation impacting on consumer's ability to remain well, or on admission seeking presentations to acute mental health services. Malsow's Hierarchy of needs demonstrates the importance of stable housing as a base to being up to build stability in emotional health and wellbeing https://www.simplypsychology.org/maslow.html Access to trained Debriefing or critical incident management services is a large gap in the community. In Sunraysia we have made several efforts to address the service gap that exists by having clinicians trained to provide debriefing to community following a serious incident. Unfortunately the service has not been able to be sustainable as clinicians were providing the service on top of their normal duties and demand exceeded the ability to supply the service. "

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

"The lack of services and ability to be able to access them is a key factor in our local area. Other factors identified in the The State Of Mildura report 2018 by Rachael Williams January 2018 demonstrates several concerning statistics relevant to the Northern Mallee catchment area:- 1.41 1.1.5.1.A Deaths due to road traffic crashes, Road Crash Information System VicRoads Avoidable deaths from transport accidents, persons aged 0 to 74 years (per 100,000), 2010-2014, Public Health Information Development Unit (2017) (LGA) TL Mildura 6.8 compared to state average of 4.4 1.63 Workplace fatalities by sex, 1997 to 2015, WorkSafe Victoria (LGA) TL (results shown right are for females) Locally 27.3% compared to the State average of 4.6% 1.88 1.2.1.1.A Proportion of adults who report high or very high psychological distress, 2014, Victorian Population Health Survey DHHS (LGA) TL Locally 14% compared to state average of 12.6% 1.98 History of mental illness of parent, 2014, School Entrant Health Questionnaire 2014 (LGA) TL. Locally 10.2% . State average of 6.9% 1.99 Happy and Healthy Adolescents have good mental health, Rate of Hospital Admissions for Mental and Behavioural Disorders, Residents aged 10-19 Years

(per 10,000), 2013-16, Victorian Admitted Episodes Dataset (HOS data), 2017 (LGA) TL (results shown far right are for Regional Victoria) REVISED FROM Adolescents have good mental health, Psychiatric hospitalisations' for 10-17 year olds per 1,000 adolescents. Locally 37.7, State wide average of 31.3 1.100 Health Rate of Hospital Admissions for Mental and Behavioural Disorders (per 10,000), Residents aged under 19 Years, 2013-16, Victorian Admitted Episodes Dataset (HOSdata), 2017 (LGA) TL (Section 4.6 2012 Social Indicators Report) (results shown far right are for Regional Victoria) REVISED FROM Rate of Child and Adolescent Psychiatric Admissions (per 1,000 Residents Aged Under 19 Residents). Locally 20.3 State average 17 1.101 Health Rate* of Hospital Admissions for Mental and Behavioural Disorders (per 10,000), Residents aged 20 Years, 2013-16, Victorian Admitted Episodes Dataset (HOSdata), 2017 (LGA) TL (Section 4.5 2012 Social Indicators Report) (results shown far right are for Regional Victoria)REVISED FROM Rate of Adult Psychiatric Admissions between 2006 and 2012 (Per 1,000 Adult Residents). Locally 106.7 compared to state average of 100.9 1.102 Registered mental health clients (per 1,000 population), 2014-2015, Department of Health and Human Services (LGA) TL / R. Locally 24 compared to State average of 11.9 1.103 Estimated population with mental and behavioural problems (ASR per 100), 2011?13, Public Health Information Development Unit (2014) modelled estimates (LGA) TL. Locally 14.6 compared to the state average of 12.7 1.104 Estimated male population with mental and behavioural problems (ASR per 100), 2011?13, Public Health Information Development Unit (2014) modelled estimates (LGA) TL. Locally 12.4 compared to the state average of 10.8 1.105 Estimated female population with mental and behavioural problems (ASR per 100), 2011?13, Public Health Information Development Unit (2014) modelled estimates (LGA) TL Locally 16.8 compared to the state average of 14.6 1.107 Intentional injuries treated in hospital (per 1,000 population), 2014-2015, Victorian Admitted Episodes Dataset (VAED) and Victorian Emergency Minimum Dataset (VEMD) (LGA) TL / R. Locally 7.4 compared to the state average of 3 1.108 Hospitalisations for intentional self-harm injuries (rate per 100,000), 2011/12 to 2013/14, Victorian Injury Surveillance Unit (VISU), Monash University (LGA) TL. Locally 116.8 compared to the state average of 100.2 1.110 Hospitalisations for intentional self-harm injuries - % by age, 2011/12 to 2013/14, Victorian Injury Surveillance Unit (VISU), Monash University (LGA) TL (results shown right are for children aged 0-14 years). Locally 4.9% compared to the state average of 2.6% 1.111 Hospitalisation rates for intentional self-harm injuries (per 100,000) - children and young people, 2011/12 to 2013/14, Victorian Injury Surveillance Unit (VISU), Monash University (LGA) TL (results shown right are for young people aged 15-24 years). Locally 272.8 compared to the state average of 230 1.112 Hospitalisation rates for intentional self-harm injuries (per 100,000) - adults, 2011/12 to 2013/14, Victorian Injury Surveillance Unit (VISU), Monash University (LGA) TL (results shown right are for persons aged 25-64 years). Locally 142.7 compared to the state average of 115 To improve identified issues we need support to include:- Improve community engagement for people with a mental health illness. Support employment opportunities. Have access to local supported accommodation. Have services available to support vulnerable at risk families relocating to the rural areas for low cost housing Support foster care and specialist residential care options for children and adolescents who are experiencing mental health issues and who need out of home care and respite.. NDIS service changes causing insecurity & confusion. More supports for people that do not qualify for NDIS or more urgent needs before this can be put in place. Support transport opportunities Support rural and remote areas with poor mobile phone and internet connectivity Promote the recruitment and retention of GP's and specialist health practitioners. Many farming communities cannot access drought relief packages due to extensive criteria. The cultural awareness of Mental Health Tribunal to address the many specific needs CALD service users and their family/carers. Increase housing/ accommodation opportunities. Support a coordinated no wrong door policy to

facilitate direct referrals AOD Services. Increase specialist services in rural areas e.g. AOD specialised detox & rehabilitation services, IPU services and family therapist Support mental health education to primary support agencies Increased funding for sessions to see private counsellors. Early intervention and prevention actions need to be part of all service delivery. "

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

"Local supported accommodation for people severe and significant mental illness. This will take some of the burden and support the mental health of families and carers. Respite support for families and those who care for people with severe and significant mental illness. Re open psychosocial rehab drop centres to support both the individual with the mental illness and their family/carer. Current funding and clinical models in tertiary Mental Health services need to further reflect the increased complexity and time required to enable clinicians to be more inclusive of carers and families. The value family inclusive practice is recognised in the treatment, planning and future support during and following a crisis admission particular with referral to primary care providers. Continue and ongoing support for the carer support funding. Support for the provision of resources and education for adults and dependent children living with mental illness or mental disorder, Increase support for clinical staff to be trained in family intervention or family therapies. "

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

"Recruitment / Retention Specific to the Northern Mallee area is the discrimination against the employers of private health providers that provide public services. In the transition from public to private employer staff were reassured by the then liberal government that no staff would be worse off. This in fact has not been the case. Under the ATO provisions Ramsay Health Care employees are unable to access salary packaging. Apart from meaning the loss of income for those already employed it has meant that any potential employee coming to the Northern Mallee has to consider a reduction in conditions to do so. That, on top of costs of moving etc to a rural and remote location away from family and friends presents a very real barrier. This also does not include the cost to the local of economy with that money then not being spent locally through things like meal allowance. One simple solution that could have addressed this issue could have been to place a special clause in EBA with pay rate specifically to Ramsay Health Employees employed by the Mildura Base Hospital. Through the EBA, rural and remote workers get the same allowance for training as do metro staff. This however does not allow for the extra cost of travel and accommodation. For a staff member to access training in Melbourne it is a $450 plane flight, $100 - $150 transfer to and from the airport, potential accommodation cost if the training is more than 1 day and then the cost of the training on top. If the staff member chooses to drive instead of fly there is 14 hours travel time to be considered if driving to Melbourne and back. For employees that are keen to continue their staff development and study this is a very real barrier. Also considering how family friendly this process for those people who have children that can't afford these extra costs or child care costs on top of the costs already mentioned. Again this could be considered through the EBA via a .rural and remote loading. Attracting experienced Mental Health Workers is very difficult to rural/remote areas. Provision of allowances are required to better cover accommodation costs, relocation costs etc for mental health workers prepared to move to rural settings. If we were able to provide temporary accommodation in order for the clinician to move

and settle quickly into the area, this would reduce the need for agency/ locum staff and provide incentive for clinicians to move to the area. Staff moving to the area are required to take out at least a 12 month lease but then have a 6 month probationary period. Our inability to attract appropriate candidates for our positions leads to the organisation filling positions with new graduates and junior staff. Additional resources / funding are required to protect professional supervision time, especially for new and junior staff. This is especially relevant for services experiencing high workload and high overtime hours. Presently Clinical Supervision is voluntary. Although protected in the EBA for Mental Health clinicians it is not always taken up and seen as an extra burden for clinicians. Supervision is an important part continued professional development. Consideration could be given to mandating supervision the same as professional development. Nursing staff are required to get 20 Continued Professional Development (CPD) points per year to maintain their registration. Having a similar system for supervision hours would encourage clinicians to seek out supervision and ensure quality service provision. Changes to the training in workforce have dramatic effects in staff recruitment. To look to the future sometimes it is important to reflect on the past. Round the bend: a brief history of mental health nursing in Victoria, Australia 1848 to 1950's, shows us that our current mental Health system came about because of the need to provide specialist service to the people that experience mental illness. Certainly, our system has developed a lot since then but in particular, with Mental Health Nursing we have removed a speciality and training for a direct pathway to become a Mental Health Nurse. Instead we have a general nurse pathway and rely on post graduate qualifications for staff to enter the Mental Health work force. Round the Bend: A history of Psychiatric Nursing in Victoria is a one-hour documentary film that explores the development of psychiatric nursing from the early colonial beginnings in 1848, through to the post-institutional 1990s. The film commences with a montage of photos, film and narrative which documents the period until 1930s. The period from the 1930s to the present is described chronologically in oral histories provided by personal interviews with psychiatric nurses. The interviews include a number of key psychiatric nurse leaders who were instrumental in bringing about significant changes to nursing practice and education, and were also at the forefront of leading major reforms to service delivery in Victoria such as the community mental health movement. The oral histories provide a warts and all' account of the history of this unique area of nursing. At times confronting and challenging, the film also highlights the significant contribution of psychiatric nursing to the development of humanistic, person-centred philosophies of care in mental health. https://vimeo.com/136420528 Prior to the implementation of university base training when hospital based training was the fashion, students were employed by the hospital and all training was supported. The students were recognised under the EBA and had specific scopes of practice appropriate to their year level as a student with supervision. This meant that there were a lot of tasks that occurred in a client's care that did not require the attention of a qualified practitioner. The Student nurse however gaining valuable workplace experience as they progressed to complete their qualification. This led to a highly trained and more robust work force. For allied health staff, specialised masters or diploma level training courses need to be available people who wish to work in mental health and is offered in a way that rural and remote practitioners can access whilst they continue to live and work in their communities. The same goes for Family therapy training which is expensive and available only in major cities. Fully funded Developmental Psychiatry Course for CAMHS clinicians. Currently this is only partly funded and a great deal more expensive to offer in rural and remote centres. Rural and remote clinicians are disadvantaged and as such rural consumers who then do not have access to this skill base outside of the metro area. Their needs to be a wider range of scholarships for all rural remote clinicians including Nursing and Allied Health with the access to the scholarships decided on a local level to ensure flexibility to the local communities Creation of

Allied Health Educator positions within rural mental health services (currently the only profession that has dedicated educator funded positions is nursing) As mental health moves increasingly to therapy models for ongoing care, the focus is increasingly on counselling theories and their application - areas that allied health are specifically trained in over four years of university. Volunteers are a valuable resource to support consumers, carers and service providers. However, the workload usually falls back to the same people who then become burnt out. Funding is needed to support volunteer carer and consumer groups that is inclusive of support to agencies and for resource allocation to cover rent and other incidentals. "

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?

"Their needs to be a complete review the psychiatric disability support model. Changes have occurred across the system with very little stakeholder input and very little research to provide evidence based practice. Previously the Northern Mallee had a well-resourced PDRSS service that catered for the cyclic nature of Mental Illness which also provided outreach services to outlying rural and remote communities. The programs were consumer led with increasing peer support. The services were collaborative and worked in well with clinical services. This or a similar service needs to be refunded to improve the social and economic participation of people with a mental illness. Suitable training to enhance the understanding of mental health issues for the support staff in the health and welfare services. A greater range of supported employment and training opportunities needs to be established for consumers with mental health illness. These need to be tailored to or with local industry. There are currently limited opportunities for people with lived experience to gain employment within acute services. The expansion of lived experience workforce at all levels of the organisation, with recognition of the particular knowledge and skills they contribute. A multi-facet approach to care needs to be considered from individual to group type supports. Many people with more chronic and acute Mental Illness can find participation in programs difficult. "

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?

"The Murray Primary Health Care network (PHN) Primary Mental Health Program Guidelines February 2018 (Attachment 2). Outlines a comprehensive document of how to improve our Mental Health system with the implementation of the Stepped model of care. The full implementation would contribute to a coordinated service model. The Victorian Mental Health system needs to interface with the aligning states to support border communities. Interstate collaboration within consistent legislation and funding models need to be considered. One universal integrated mental health Information management, Electronic Medical Records and data collection system is paramount to promote a coordinated effective system across the country. "

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

"Develop a coordinated service to address the Mental health and AOD needs utilising stepped model of care addressing each of the five identified target areas. Immediate review of the way psychosocial support is delivered to mental health consumers is an urgent need. Move away from activity based funding of mental health services to a guaranteed block funding (for Community MH Services) model - allowing services to better target resources to meet consumer

and carer needs. Resource the development of specialised mental health frameworks to better meet needs of indigenous and CALD communities. Increase roll out of post-vention services to better support consumers transitioning from acute episode of care to community or self-management with a focus on reducing representation to acute services through capacity building and community and social linking of consumers and their carers. Promotion of health and wellbeing. "

Is there anything else you would like to share with the Royal Commission?
"I would like to share with you my journey with Mental Health Services so that you may gain some insights into what I have written in this submission. In 1985 as an 18 year old straight form school I entered the work force as a ""Prospective Student at Aradale Mental Hospital. I completed my Psychiatric Nurse training in 1989 and my Mental Retardation Nursing in 1991. From there I moved to Mildura and supported People with Intellectual disability to live independently in the community. I returned to psychiatry in 1994 and have subsequently worked in most areas of mental Health including inpatient, and community both as a clinician and manager. I currently work in management and educations as the Senior Psychiatric Nurse at Mildura Base Hospital. My 35 years of nursing has seen many changes in our service delivery and over all I believe the standard of care provided to consumers I vastly better than when I started my career. I do remain concerned that current funding models and lack of work force development investment will compromise the care needed for the most vulnerable people in out community. The inclusion of peer led workforce has been a major step forward and I think only really starting to take purchase in service delivery. Psychiatric Nursing was not my first career choice but has certainly become my passion. Not only do I work as a professional but also a user of the services. system through family circumstances. "