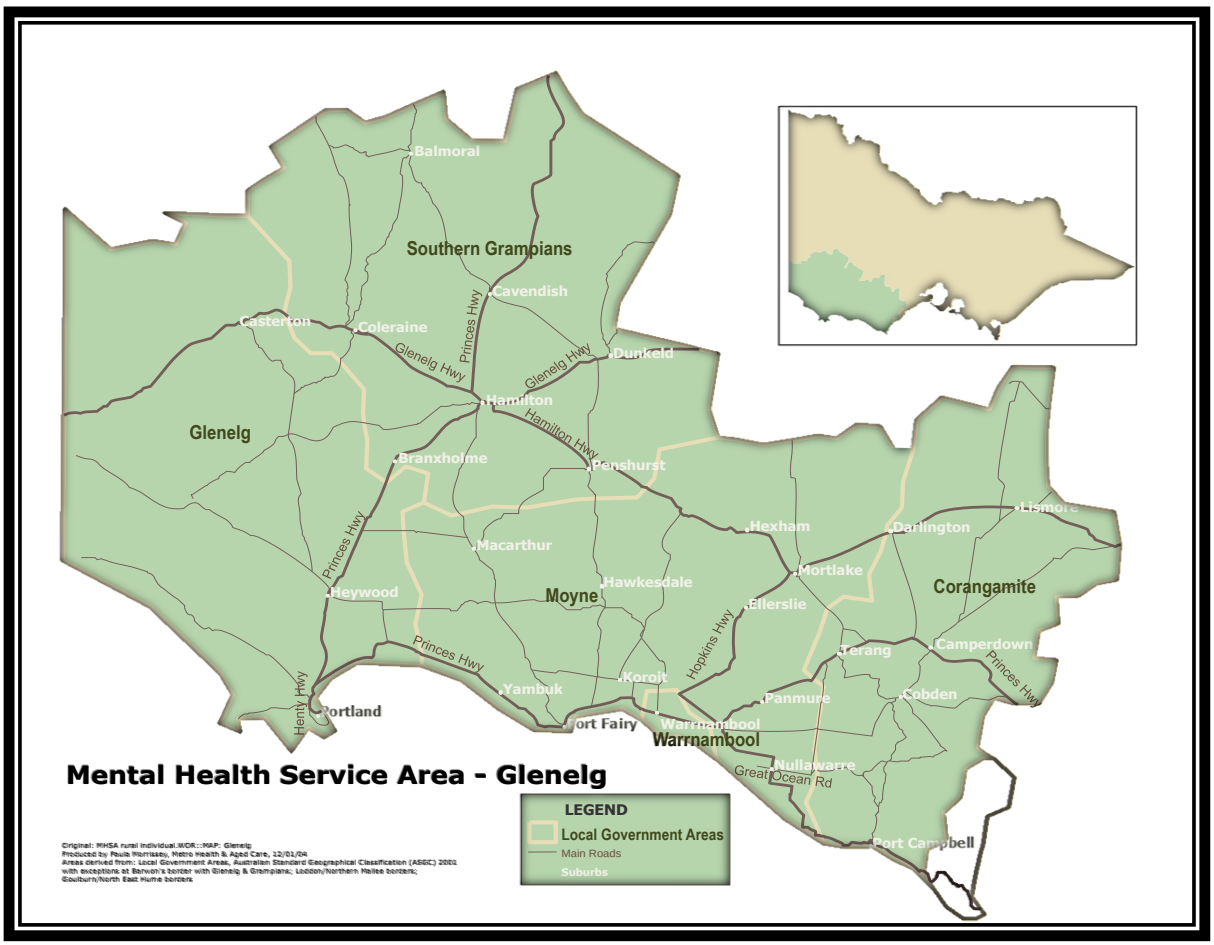
Royal Commission Submission

Overview of South West Healthcare Mental Health Services

South West Healthcare (**SWH**) is one of the smaller of eighteen designated Area Mental Health Services (**AMHS**) in Victoria. SWH Mental Health Services (**MHS**) covers the large South West Victoria geographical area, with a population of approximately 110,000, dispersed across 26,000 km^2. Demonstrated in the map below, SWH MHS covers the 'Glenelg' Catchment usually referred to as the South West Catchment, consisting of five Local Government Areas (**LGAs**); Warrnambool City, Moyne, Corangamite, Southern Grampians and Glenelg. SWH MHS aims to deliver excellence in regional and rural healthcare, through innovative and efficient local service solutions.[1]



[1] SWH MHS Strategic Plan 2018-2021.

SWH MHS has four community based offices, located in Warrnambool, Camperdown, Hamilton and Portland.

In addition to the Warrnambool adult mental health services, the head office based in Warrnambool houses:

- the aged persons mental health service, child and adolescent mental health service and the primary mental health service for the entire SWH MHS catchment (meaning staff in these services must travel across the entire catchment);
- the adult and aged bed-based services for the entire SWH MHS catchment; and
- associated leadership and support services.

The offices in Camperdown, Hamilton and Portland are smaller in size, and predominantly are staffed by adult mental health teams for their own 'catchments' (usually the corresponding LGA they are located within). Clinicians from the head office visit and work from the regional offices on a daily basis.

Primary Mental Health Team (PMHT) members (including psychologists, mental health social workers, mental health nurses and an occupational therapist) are located across all four community based offices and are also co-located at many of the participating general practitioner (GP) practices across the region. The PMHT support high prevalence presentations in the primary care sector (being mild to moderate mental health conditions), and aim to build and support the capacity of GP's to identify and intervene early in relation to mental health presentations. The PMHT is currently not funded directly by the Department of Health and Human Services (DHHS) (with direct funding having ceased in 2014). Recognising the integral role that the primary care sector/GP's play in the assessment and treatment of mild to moderate mental health conditions, SWH MHS continues to support the PMHT and its GP co-located service model using the community activity-based funding allocated to SWH MHS. SWH MHS recognises the critical importance of maintaining and supporting strong collaboration between primary care and specialist mental health services that additionally has early intervention opportunities and benefits for the broader community. The PMHT incorporates specifically funded programs within its broader team, including the Perinatal Emotional Health Program (PEHP), Farmer Community Support programs, Problem Gambling consultation support, and Psychological Therapy Services (PTS) (the latter being commissioned services via the Western Victoria Primary Health Network (WVPHN)).

SWH MHS has an Access Mental Health Team (**Access Team**) based in Warrnambool, which provides coverage for the region 24 hours per day. The Access Mental Health Team is effectively a triage team for SWH MHS. From 8.30 am to 4:30 pm business hours, the Child and Adolescent Mental Health Service (**CAMHS**), Aged Persons Mental Health Service, (**APMHS**), and the four Adult mental health services are responsible for managing access (triage) to their own services across the catchment. A handover period occurs from 4:30pm to 5:00pm each business day. However, after-hours access to the various mental health services offered by SWH MHS is managed centrally by the Access Team based in Warrnambool. Initial screening and assessments are often undertaken by the team in Warrnambool via telephone, or more recently, via tele-health video conferencing, as the service does not have the capacity or resources to have clinicians 'on call' across the entire regional area. Currently, although under review, the Access Team does not include mental health clinicians with identified expertise from APMHS or CAMHS.

In the South West catchment, there are:

- two EDs - Warrnambool Hospital (being the largest), and Hamilton Base Hospital; and
- six Urgent Care Centres (**UCCs**) – Portland, Port Fairy, Timboon, Camperdown, Heywood, and Terang. UCCs are the term used for unfunded emergency departments in small rural hospitals (which may have, for example, 5 acute beds and a UCC). UCCs are operated by highly skilled nursing staff rostered to acute care units in small hospitals, generally with visiting on-call GP's.

Community-based Mental Health Services

SWH MHS offers the following community-based mental health services, funded by DHHS. The number of staff employed to provide each service, expressed by the full time equivalent (**FTE**), appears in brackets. The teams are comprised of multi-disciplinary mental health clinicians, and some teams also include peer workers and administrative support officers (some staff are shared across more than one team).

- Adult MHS Continuing Care (Recovery and Wellness across four sites) (31 FTE);
- Access Mental Health Team (11 FTE);
- Aged Persons Mental Health Services (9.1 FTE);
- Child and Adolescent Mental Health Services (**CAMHS**) (9.6 FTE). SWH MHS does not run a child and youth mental health service (**CYMHS**) (which provides services for consumers up to age 25),

as it was found to be unsustainable due to the size of SWH MHS. SWH MHS has a CAMHS (which provides services for consumers aged 0-18 years);

- CAMHS in Schools Early Action Program (**CASEA**) (1.5 FTE);
- Autism Spectrum Disorder Assessment and Coordination (0.5 FTE);
- Primary Mental Health Team (**PMHT**) (7 FTE). The PMHT initiative is no longer funded by DHHS. Accordingly, SWH are currently considering ongoing viability of the PMHT, which will impact on the primary care sector significantly in the South West region;
- Perinatal Emotional Health Program (**PEHP**) (1.0 FTE);
- Early Intervention and Dual Diagnosis Team (1.8 FTE).

SWH MHS also employ staff and the leadership team in the following service-wide roles:

- Executive Director, Mental Health Services with SWH wide portfolio responsibilities (1.0 FTE);
- Clinical Director (**CD**), Mental Health Services/Authorised Psychiatrist (1.0 FTE);
- Associate Director (Operations and Performance) (1.0 FTE);
- Medical Workforce (including Psychiatrists and Psychiatrists in training) excluding CD (10.3 FTE);
- Executive Assistant supporting the above team plus Administration Services Officer (**ASO**) cover to Warrnambool teams as needed including data entry and reception (0.6 FTE);
- Quality Coordinator (0.8 FTE);
- Consumer Consultant (0.8 FTE);
- Carer Consultant (0.8 FTE);
- Senior Mental Health Nurse (1.0 FTE);
- Senior Psychologist (0.8 FTE);
- Psychiatric Nurse Consultant (1.0 FTE);
- Family Violence Advisor (0.5 FTE);
- NDIS Interface Worker (0.4 FTE);
- Commissioned Services – Farmer Health and Psychological Therapy Services (**PTS**) (3.1 FTE);
- Systems and Programs Administrator, which is a new role to support commissioned services and ICT systems specific to SWH MHS (1.0 FTE)

Bed-based services

All SWH MHS' bed-based services are located in Warrnambool. SWH MHS provides the following bed-based services:

- A Mental Health Acute Inpatient Unit (**MHAIU**) with fifteen beds (including three to four high dependency beds which are used for higher acuity consumers in a secure setting, and include one "swing" bed which can be used for low or high dependency). The MHAIU facility is 28 years old and has had minimal infrastructure changes during that time.

- An Extended Care Inpatient Unit (**ECIU**) with five beds. The facility in which the ECIU operates was built in 2009 as a Secure Extended Care Unit (**SECU**), though it has never operated as a SECU. ECIU is a therapeutic sub-acute unit, and accordingly, the secure design of the facility does not appropriately support a therapeutic recovery focussed milieu.

- A Prevention and Recovery Centre (**PARC**) with thirteen beds, ten of which were commissioned by the DHHS in 2018. Three beds remain unopen, awaiting funding or bed-based re-design.

SWH MHS is currently in negotiations with DHHS with the aim to:

- expand the number of acute beds from 15 to 20;

- open the three unopened PARC beds plus an additional two 'day places' for outpatients with 5 beds allocated for an extended PARC (to total 15 PARC beds). An extended PARC is a stay option for up to 6 months for those consumers who need it.

    - The above cannot be achieved without infrastructure, and funding is being sought through the Victorian Health and Human Services Building Authority (**VHHSBA**) in collaboration with DHHS for this purpose.

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?

What is already working well

The following programs and services offered by SWH MHS exemplify what is working well within Victoria's mental health system.

1 CAMHS and Schools Early Action (CASEA)

The CASEA program is a therapeutic prevention and early intervention program provided at SWH MHS, which:

- was implemented at SWH MHS in approximately 2017;
- is funded by DHHS for ongoing provision across a number of Victorian AMHS;
- is directed at children in their early primary school years who may be at risk of developing emotional and behavioural disorders;
- aims to enhance collaboration between CAMHS and the education sector;
- is innovative, in that it aims to intervene with children early, when behaviour problems are still amenable to intervention (which is in the majority of cases);
- is at the core of SWH MHS' early intervention initiatives; and
- because of the group-based format, and focus on schools with the highest need, has a broad and efficient reach to vulnerable children via their school environment.

CASEA is one of the few funded programs providing an opportunity for public mental health services to work in an early intervention space, however, unfortunately the program cannot reach every school in the catchment due to the limited funding available (which currently sits at 1.5 FTE clinicians or one school per term, for the SWH program).

2 Families Where a Parent has a Mental Illness (FaPMI)

FaPMI is a service development strategy that aims to build mental health clinician capacity to support the needs of children where their parent has a mental illness. FaPMI has been in place at SWH MHS since approximately 2009. SWH MHS has a single full time FaPMI Coordinator. The FaPMI program:

- has enabled improvements in systematic family focused mental health service delivery; and
- is increasingly leading to mental health clinicians identifying and addressing the needs of children of parents with mental illness, whilst also promoting parenting confidence, competence

and identity amongst consumers who are parents.

SWH MHS' own evaluation has demonstrated that peer support groups for adolescents have been effective in increasing young people's understanding of mental illness and treatment, building their own coping skills and providing social connection. While adult clinicians have been trained in facilitating these groups, no groups have eventuated within SWH MHS in recent years, as clinical crisis work means that clinicians do not have the time required to plan, implement and evaluate groups. As the skills required to run groups for young people are different to a general clinical skill set, the barriers to getting these groups operating regularly are immense and if available, would provide a valuable opportunity for early intervention in this vulnerable population group. SWH MHS are currently reviewing the delivery of the FaPMI program within the service to ensure the strategies can be embedded within the service and the broader sector within the catchment with our partner agencies.

There is robust evidence to support the positive impact on recovery of focusing on parenting roles.[2] Research also demonstrates the preventative impact of supporting children of parents with a mental illness in understanding their parent's condition and treatment, and improving their own social and emotional literacy and resource base.[3]

3 Mental Health and Police Response Initiative (MHaP)

The MHaP, which was launched in December 2017, sees an experienced mental health clinician allocated to a shift with a police officer. The mental health clinician is located at the Warrnambool police station for rostered shifts, and when not required for a MHaP response, undertakes AMHS administrative tasks. This supports individuals who are experiencing a mental health crisis to receive a mental health assessment in their home, rather than needing to come to the Emergency Department (**ED**) with police. The MHaP received ongoing funding from DHHS, following the successful Police, Ambulance and Clinician Early Response (**PACER**) trial in metropolitan and larger regional AMHS. The MHaP, which is based on PACER, operates through a partnership agreement

[2] J Nicholson, 'Supporting mothers living with mental illness in recovery' in N. Benders-Hadi & M. E. Barber (eds), *Motherhood, mental illness and recovery: Stories of Hope* (Springer, 2014) 3-17; J Nicholson, 'Parenting and recovery for parents with mental disorders' in B L Levin and M A Becker (eds) *A Public Health Perspective of Women's Mental Health* (Springer, 2010) 359-372; A Reupert, R Price-Robertson, & D Maybery, 'Parenting as a focus of recovery: A systematic review of current practice' 40(4) *Psychiatric Rehabilitation Journal* 361-370.

[3] Stiegenthaler, Munder & Egger, 'Effect of Preventive Interventions in Mentally Ill Parents on the Mental Health of the Offspring: Systematic Review and Meta-Analysis' (2012) 51(1) *American Academy of Child and Adolescent Psychiatry* 8-17.

between SWH MHS and Victoria Police. Ambulance Victoria and the Emergency Departments (ED's) via the South West Emergency Services Liaison Committee are kept informed about MHaP.

The MHaP partnership with the rostered MHaP Police member and the SWH Mental Health Clinician has meant that when Police first responders arrive at a 'disturbance', often at people's homes, if necessary, they call upon the MHaP as second responders to assess the need for crisis mental health assessment and treatment in a hospital setting. The MHaP clinician has access to the electronic clinical notes and therefore can quickly ascertain if the person is a current or past public mental health consumer, identify treatment and management plans that are in place and understand triggers and stressors along with strategies that are supportive of the person. MHaP clinicians are able to deescalate these kinds of situations and provide supportive interventions on site, negating the need for transport pursuant to section 351 of the *Mental Health Act*.

The MHaP has led to:

- a more efficient use of health and emergency services resources;
- a marked reduction in the number of ineligible consumers presenting to the ED for mental health assessment; and
- accordingly, has been a highly successful addition to the services provided by SWH MHS.

An evaluation of the MHaP program completed by SWH MHS in 2018 indicates that feedback from consumers, carers, police, ED staff and Mental Health clinicians, is positive.

However, the benefit of having MHaP respond in a timely way is prevented by the tyranny of distance in many cases. Currently, the MHaP program is only able to operate in Warrnambool and surrounding districts, and cannot reach the entire catchment due to:

- limited funding for both Mental Health Services and Victoria Police (and therefore limited resourcing);
- Only a few Police Stations operate 24 hours per day in the catchment;
- the broad geography covered by the SWH catchment; and
- a lack of critical mass in smaller communities, meaning resources could not be efficiently deployed.

Due to these limitations, this means that in Portland, for example, people experiencing mental health crisis who are attended by police are still required to be transported to the Portland Urgent Care Centre for assessment via telephone or video conferencing. Although secondary consultations (whereby the police or ambulance officers seek advice in relation to a particular person over the phone with the Access Team) are offered to all Police and Ambulance in the region, they are not consistently taken up by police or ambulance officers when they are in the throes of responding to a 'crisis' in the community or due to the lack of a robust relationships between non-Warrnambool based police and ambulance officers; and the MHaP clinicians and MH Access Team.

4 Perinatal Emotional Health Programs (PEHP)

The PEHP has been funded in an ongoing manner at SWH MHS since 2012, and provides home based early motherhood services for families experiencing emotional difficulties during pregnancy and after childbirth for the first year. The PEHP additionally supports practitioners including midwives, Maternal Child Health Nurses (**MHCN**), GPs, and family support workers, in their provision of services to women during the perinatal period.

SWH's PEHP has averaged over 10 referrals per month since its inception, equating to over 120 referrals per year to the program that is operated by two part-time staff (equated to 1.0 FTE). This occurs in the context of an average birth rate across the catchment's birthing hospitals of approximately 1,070 births per year, and reflects an average annual referral rate to the program of 12% of all births in the catchment's birthing hospitals. SWH notes the outcomes of the recent Victorian Parliamentary Inquiry into Perinatal Services (**the Parliamentary Inquiry**), which established that there is inadequate investment in addressing:

- the prevalence of mental illness (and associated risk factors such as family violence and bereavement) during the perinatal period; and
- its impact on the mother, the baby, the family, and the wider community.

The Parliamentary Inquiry determined that perinatal mental health services are in need of greater support from State and Federal governments. It recognised the value of the former joint investment by the State and Federal governments, including through:

- the National Perinatal Depression Initiative (**NPDI**). The NPDI was aimed at improving the prevention and early detection of antenatal and postnatal depression and providing support and

treatment for new and expectant mothers experiencing depression;

- the Perinatal Emotional Health Program (**PEHP**), which was established in 2010, and was jointly funded by the State (50%) and the Federal Government (50%).

The Parliamentary Inquiry found the subsequent withdrawal of Commonwealth funding from the PEHP in June 2015 adversely impacted perinatal mental health services in rural Victoria, noting that most PEHPs were forced to close, compounding the unavailability of other services such as Early Parenting Centres. Noting the vital role the PEHP played in South West Victoria, SWH MHS retained its program, and used funding from other programs to cover the funding deficit which resulted from the withdrawal of Commonwealth funding. Recommendation 3.8 of the Final Report from the Parliamentary Inquiry suggests that:

> "*The Victorian Government provide ongoing funding for the existing Perinatal Emotional Health Programs (PEHP), and fund the expansion of the program state-wide to be delivered as a key element of supporting women at risk of, or experiencing, mental health illness in the perinatal period."*[4]

5 Telehealth

In February 2018, SWH MHS commenced utilising video conferencing between the hours of 5PM-8.30AM (outside business hours for SWH MHS offices and non-bed based services) to facilitate face to face mental health assessment of consumers presenting to EDs or Urgent Care Centres in Regional and Rural areas that are distant from SWH MHS' Warrnambool campus (where clinicians are available to perform mental health assessments 24 hours a day). Telehealth assessments are being used for consumers presenting to the Western District Health Service and the Portland Base Hospital, and on occasion at smaller rural hospitals.

This initiative has gone some way to addressing the inequity with metropolitan areas, where consumers would receive face to face triage. Telehealth has reduced the need for consumers to be transported by ambulance to Warrnambool for assessment, unless it is deemed necessary for a probable inpatient admission. The same technology is being trialled by CAMHS to facilitate increased access to services for children and young people in rural locations when a CAMHS clinician

[4] Parliament Inquiry, Final Report, p 151.

is not in that area within business hours.

This technology is not used as a substitute for face to face contact (which is ultimately the best option), but as a way to improve service delivery (in comparison to telephone contact). An evaluation of the program completed in 2019 by SWH MHS, in conjunction with other AMHS, demonstrates that consumers view video conferencing as superior to a telephone call.[5] Clinicians are also more engaged in the face to face 'review' using video conferencing rather than a telephone call, because they can observe the consumer's behaviour, body language and other presenting symptoms. Feedback from medical and nursing staff from the hospital partners outside of Warrnambool is also very positive. They too report feeling better supported and more confident in managing the consumer's presenting issues, because they have support (albeit via video) in the UCC or Emergency Department from the AMHS in Warrnambool.

Ongoing relationship and capacity building forms a large part of the SWH MHS leadership group strategy when working with our service partners. In rural settings, developing strong relationships and collaborative partnerships is essential.

What can be done better to prevent mental illness and to support people to get early treatment and support?

Several other action plans have been published which make broad suggestions about prevention and treatment of mental illness, which SWH endorses, including:

- The Victorian Health Priorities Framework 2012-2022 – Rural and Regional Health Plan, finalised in 2011, set out that health promotion, disease prevention and the primary health sector must be a major focus for both the Victorian and Federal governments. Figure 3 in the Framework[6] identifies what health outcomes were expected to be for rural people in 2011/2, and what would change by 2022. When it comes to mental health, alcohol and other drug treatment, presentations are becoming more complex. Aged care services are also hard to access. The system is also not integrated or resourced well across a person's lifespan in rural and regional areas. The stepped care model, which talks about services being matched to individual need and severity, is used for commissioning and funding bodies for the provision of services across

[5] South West Mental Health Telehealth Project, Final Project Report, March 2019, p12-13.

[6] Victorian Government Department of Health, *Victorian Health Priorities Framework 2012-2022 – Rural and Regional Health Plan* (December 2011) 8-9.

Australia. However, using a stepped care model for mental health in rural and regional areas results in an inadequate level of care, given all of the services (or 'steps') are not readily available in rural and regional areas. In rural settings, there simply are not the services available to provide treatment to match the needs of individuals equally across the rural catchments, as may be expected in a metropolitan or larger regional setting.

- The World Health Organisation's Mental Health Action Plan 2013-2020 identified the necessity for a coordinated approach between health and social services. The Plan sets out four major objectives, being: *"more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research."*[7]

From a practical point of view, SWH MHS offers the following suggestions for improving prevention and early intervention initiatives (and recommends that appropriate funding be provided for each initiative):

1 A role should be funded to enable AMHS to be active in the early intervention space (and to implement initiatives like CASEA). Given the depth of knowledge that AMHS' hold in relation to issues within the community, and their ability to detect themes in referrals and presentations, AMHS could provide a flexible response focused on early intervention. For example, AMHS could provide direct services to schools with high referral rates, and direct services to communities 'recently' impacted by issues such as bushfires or milk pricing.

2 Persons (appropriately trained and supported) with lived experience and volunteers have a role to play in mental health prevention and psychosocial interventions, particularly in rural and regional areas where there is a shortage of clinically trained providers. This is especially so, the further away from major towns where consumers live. Lived experience workers (peer workers) are an existing potential workforce resource and many would already live amongst the smaller rural communities.

3 Sporting and other social clubs, who are the heart and soul of small communities, must be part of the broader mental health prevention space in addition to the primary mental health

[7] World Health Organisation's Mental Health Action Plan 2013-2020, p 5.

care sector and health and wellbeing promotion initiatives arising from local governments and partnerships between health services.

4 Legislative establishment of information sharing pathways (similar to the Family Violence Information Sharing Scheme) would support consumers and ensure treatment providers have the appropriate information to hand when making early treatment decisions.

5 The government should provide sufficient funding to ensure that every person in the region has timely access to the following:

(a) Primary Mental Health teams (PMHT clinicians), which are co-located with GPs and health services across Victoria; and

(b) Mental Health Nurse Initiative Programs (**MHNIP**) and similar programs with Mental Health Allied Health in primary care and non- Mental Health services. (e.g. rural hospitals)

(c) Commissioned services via PHNs (including Psychological Therapy Services, Suicide Prevention services, and Services and Treatment for Enduring and Persistent Mental Illness (**STEPMI**);

(d) Project management roles for collaborative projects, to ensure that pathways of care can be properly developed and implemented. With so many agencies involved in the core of mental health, and siloed funding anomalies, a fragmented system results. The funding of project management roles would ensure that service and catchment planning could be undertaken in conjunction with PHNs and non-governmental organisations to deliver services effectively to rural communities and not pull valuable clinicians away from core functions; and

(e) Ensure Medicare Better Access Services for psychological treatment for mild to moderate or high prevalence mental health disorders are consistently available across the region. Furthermore, SWH MHS would welcome a review of the cap of 10 sessions per annum, with a view to increasing access and support for persons with mental health disorders of mild to moderate severity in the private sector throughout an entire year, at the right frequency of sessions. Currently, when session caps are reached or when symptoms have become severe, public sector AMHS receive an increased number of

crisis referrals; both of which may have been prevented by increased support privately through the Medicare Better Access scheme. This is likely to reduce pressure on public mental health services to provide services to this vulnerable population, which is not usually core business for an AMHS.

The above initiatives would allow for a partnership approach to early mental health intervention and care. The initiatives would reduce stigma associated with mental health care, and ensure that care occurs in the person's community with support from significant others at the right time, and in the right place, without significant delays.

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

General drivers of poorer mental health outcomes

The World Health Organisation report on Social Determinants of Mental Health (2014)[8] recognises that mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live. The report highlights that social inequalities are associated with increased risk of many common mental disorders and that taking action to improve the conditions of daily life from before birth, during early childhood, at school age and adolescence, during family building and working ages, and at older ages provides opportunities to improve population mental health and to reduce the risk of those mental disorders that are associated with social inequalities. While comprehensive action across the life span is needed, scientific consensus is considerable that giving every child the best possible start will generate the greatest societal and mental health benefits.

Childhood adversity, such as maltreatment, poverty or neglect is highly correlated with adult presentation of mental disorder. Exposure to family violence and familial drug use and trauma can have similar patterns of correlation.

In adulthood, mental health problems have shown a correlation with poor educational attainment,

[8] p 43.

unemployment or underemployment, and high rates of debt. The 5 Local Governments in the South West catchment has recently focused on increasing year 12 attainment in the catchment, as it had one of the lowest rates in the State. This measure was intended to address the social determinants of poor mental health, including the problems associated with underemployment or unemployment. To the above social issues, adding the intersection of various forms of stigma and discrimination and a lack of culturally safe services means psychological distress in the population increases, as does vulnerability to serious mental disorders.

Psychological distress has an impact on day to day living. For example, in five LGAs (Warrnambool, Glenelg, Southern Grampians, Corangamite and Moyne) known as the "South West" of Victoria the proportion of adults reporting that they were unable to work, study or manage day to day activities due to psychological distress, for one day or more in the previous four weeks, was higher than that reported for rural Victoria as a whole. [9]

According to the Productivity Commission's 2019 Issues Paper on the Social and Economic Benefits of Improving Mental Health:[10]

> *"an improvement in an individual's mental health can provide flow-on benefits in terms of increased social and economic participation, engagement and connectedness, and productivity in employment. This can in turn enhance the wellbeing of the wider community, including through more rewarding relationships for family and friends; a lower burden on informal carers; a greater contribution to society through volunteering and working in community groups; increased output for the community from a more productive workforce; and an associated expansion in national income and living standards. These raise the capacity of the community to invest in interventions to improve mental health, thereby completing a positive reinforcing loop"*.

Increase in prevalence of mental health issues in rural areas

Within a rural context, there are diverse variables that impact on mental health and wellbeing, and cause an increased prevalence of (or perpetuation of) mental health issues. These communities do not have access to the same choice of mental health treatment services as people in metropolitan

[9] PHN Data 2018 <https://westvicphn.com.au/about-us/about-us/members-health-professionals>.

[10] p 3.

areas. In rural and remote areas, levels of isolation, and the impact of low access to services (including due to a lack of transport options) leads to high levels of psychological distress.

For instance:

- Rural infrastructure for social supports may be less established, resulting in a lack of childcare options, fewer community and social groups, fewer social services, limited sport and recreation opportunities and a smaller range of employment options;
- The culture in rural and regional communities (together, **'rural communities'**) strongly features traditional gender stereotypes, which can lead to homophobia, higher rates of gender based violence and increased social isolation for community members who are not accepted due to a perceived deviance from the social and cultural norms;
- Rural areas often experience environmental issues, natural disasters, and other extreme weather conditions, which can impact upon the mental health experienced by the population. For example:
    - global economic trends can impact primary producers, leading to financial uncertainty and stress;
    - climate change can impact the likelihood of natural disasters such as bushfires, which can lead to post traumatic stress disorder, adjustment disorder, anxiety and depression;
    - protracted periods of drought causing economic uncertainty, physical health impacts and increased stress have been shown to impact the rate of suicide in farming communities;
- Changes in farming practice and the fall in milk prices have resulted in significant economic flow on effects in rural communities;
- Rural communities have been experiencing economic downturn more broadly, over a number of years; and
- Rural communities may have waiting lists for public housing that are years long, or have limited access to temporary housing options.

Within rural communities, the issues particularly affect:

- Farmers and rural workers, where there may be stigma and fear associated with help seeking, or an inability to leave the farm or town easily (for example, during calving season), may present a barrier to accessing mental health services;
- Men in relation to suicide, given data indicates that men are at least three times more likely to die by suicide, than women;[11]
- Women, given comparative research indicates that women with depression who were not taking medications were more likely to come from rural areas.[12]

Challenges in delivering and accessing mental health services in rural areas

1 Limited access to appropriate stepped care

Stepped care is an evidence-based, staged system of care that includes a range of mental health interventions, from the least to the most intensive. As needs change, a person may access and leave the stepped continuum, and transition between services depending on their presenting needs and acuity. Members of the Victorian community, particularly those who live in rural and remote areas and long distances from larger cities with or without the means to pay privately, may not be able to access appropriate stepped care in their communities, further isolating them. For example:

- lack of access to appropriate and timely early intervention services in rural settings may lead to people experiencing an escalation of symptoms, resulting in increased risk of acute episodes requiring treatment (often compulsory treatment) at an AMHS;
- GPs are available in rural areas, they may be over-burdened or ill-equipped to discuss mental health issues or screen for possible illness;
- there may be a lack of alternative (private or public) service options for people with lower acuity, therefore diminishing the opportunity for early intervention; and

[11] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3

https://www.beyondblue.org.au/media/statistics

https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas

[12] Julie Byles, Ian Robinson, Richard Gibson, Lynne Parkinson & Deb Loxton, 'Depression Among Women In The Australian Longitudinal Study On Women's Health' <https://www.newcastle.edu.au/__data/assets/pdf_file/0011/34040/depression.pdf>.

- the location of service delivery may not be within the LGA or the broader catchment.

In the SWH MHS catchment in particular:

- There is a lack of appropriate and available services for those who require intensive support during an acute episode - for instance, adolescents need to travel to Melbourne for an inpatient stay, which has a detrimental impact on their recovery and places significant distress and financial burdens on their families. There is also just one Secure Extended Care Unit (**SECU**) bed allocated for the entire South West region when the need in this region is far higher;

- SWH MHS' Mental Health Acute Inpatient Unit (**MHAIU**) has limited capacity to care for people with high physical health needs due to aging infrastructure and staffing, and is generally not appropriate for older or vulnerable persons;

- in the experience of SWH, in smaller hospitals, consumers experiencing mental illness are often admitted to general (non-mental health) wards for overnight stays. Although general hospitals are not well-equipped to manage the needs of people with mental illness, this may occur because it may be the only option to keep the consumer safe if transporting the consumer to a mental health facility is not possible or is impracticable. The prevalence of this approach is evidenced by higher rates of hospitalisation for some small hospitals within the catchment for schizophrenia and delusional disorders, anxiety and stress disorders, bipolar and mood disorders, depressive disorders, drug and alcohol use and dementia than the overall regional Australian rates[13]

- supported accommodation options, for people with significant and complex needs, are seriously lacking;

- there is a lack of specialist and community-based mental health service providers, for consumers who do not meet the threshold for access to clinical mental health services;

- local private mental health providers are scarce and have wait lists;

- it is often necessary for SWH MHS to refer consumers to private Medicare Benefits Scheme (**MBS**) subsidised services for further care which SWH MHS does not have the capacity to provide

[13] Health Round Table Data. SWH is a participating agency in The Health Roundtable Limited.

(for example, psychological therapy). This is evidenced by the higher proportion of the Western Victorian Primary Health Network which access MBS subsidised mental health related services relative to that of Victoria. MBS subsidised mental health related services are provided by psychiatrists, GPs, psychologists and other allied health professionals. These services are provided in a range of settings, including hospitals, consulting rooms, home visits and online videoconferencing as defined in the Medicare Benefits Schedule. The proportion of the population in Western Victoria accessing MBS-subsidised services decreases, the more remote the area is, because the availability of MBS-subsidised services declines.

Consumers may find it is difficult to access treatment if they do not meet the criteria for inpatient treatment, but require a higher level of care that can be provided by a GP. There is also a financial impact associated with many of the existing private providers due to the gap between the rate charged by the provider, and the reimbursement which a consumer will receive from Medicare, which serves as a disincentive for many.

The inequities of living more regionally, even within the SWH MHS catchment, are highlighted in the following examples for older persons, but could equally be true for adults.

Mr A

Mr A lives in Warrnambool and is beginning to show signs of a relapse of his Depressive Disorder. His case manager is able to get an urgent review with the Aged Persons Mental Health Service in the Warrnambool community mental health office. The part time Psychiatrist adjusts the consumers' medication. The case manager is able to increase supportive home visits and family education and draw on other team members. A relapse is avoided.

Mr B

*Mr B lives in Casterton and is beginning to show signs of a relapse of his Depressive Disorder. His case manager is unable to schedule a review with the Aged Persons Mental Health Service psychiatrist until the end of the following week, which is the next available diary opening which allows a large block of time to travel to Mr B in Casterton. Mr B cannot see his GP because the visiting GP is not attending in the next two weeks. Mr B's mood continues to deteriorate, necessitating an admission to the Mental Health Acute Inpatient Unit (**MHAIU**) 165km away in Warrnambool. This distance makes it more difficult for Mr B's family to visit him, prolonging his recovery and discharge planning.*

2 Availability of CAMHS beds locally

Rurality results in fragmentation of mental health services, particularly for vulnerable groups, such as children. For example, there are no adolescent beds accessible in the SWH MHS and Barwon SW

catchment.

The 2019 Victorian Auditor-General's report into Child and Youth Mental Health (**CYMHS Report**) identifies SWH MHS as the lowest funded AMHS in the state for child and youth mental health services. Page 8 of the CYMHS Report outlines the significant lack of system design and access in the CAMHS/CYMHS space. These design and access issues are particularly profound for SWH MHS, given it is the furthest regional/rural AMHS from CAMHS beds. The closest adolescent beds to the SWH MHS catchment are located at the Royal Children's Hospital in Melbourne, which can be up to 500 kilometres away from where consumers live (requiring up to four ambulance transfers/handovers). Multiple ambulance transfers can be due to ambulance catchment boundaries, and low numbers of ambulances available or capability of particular hospitals; or a combination of both. For example, a person living near the South Australian border in a mental health acute crisis may be transported to a small rural hospital via ambulance. Upon arrival at the small rural hospital, if the hospital is unable to treat the consumer, the consumer may be transferred to Portland District Health UCC or Hamilton ED. If the person requires care at a designated mental health service, a further transfer may occur to Warrnambool Base Hospital. If a Melbourne bed-based service is required (CAMHS or out of area), a transfer to Melbourne will usually involve an ambulance transfer at Colac, in Geelong and then on to Melbourne.

Accordingly, regarding children, families are forced to wait for bed availability and then travel to Melbourne to receive intensive bed-based treatment and assistance. This means families require time off from employment and have to pay expensive accommodation costs to support their child during a very stressful period, or families may be separated. Some families will choose not to pursue services, and will attempt to cope with the young person at home, rather than endure the stress of traveling to Melbourne for treatment. This does not support best outcomes, and can result in rapid onset of other maladaptive issues associated with the consumer's condition (for example, if school attendance declines).

It is especially important for Aboriginal youth to be able to receive mental health care "on-country" and be with family and closely connected to their community, SWH MHS has no capacity to provide for this when inpatient services are required.

Recommendation: SWH MHS have suggested improvements to DHHS regarding access to CAMHS beds, and have recommended that CAMHS beds be available closer to Warrnambool (for example, CAMHS beds available in Geelong). This approach would mean CAMHS/CYMHS trained clinicians

could provide care closer to a consumer's home, and the burden of travel for family and friends is reduced. Making beds available in Geelong would be preferable to making beds available in Ballarat (or the existing beds in Melbourne), because family and friends would have the option of using public transport to Geelong (for example, travelling by train from Warrnambool or travelling by bus from other major towns in the catchment).

Additionally, services without beds within their own catchment, such as SWH MHS, ought to receive a higher proportion of funding to supportive intensive home-based care so that consumers and families can be supported in the least restrictive environment in their own community. This would also enable such consumers to be supported early, when signs of emerging or relapse into mental ill-health are identified. SWH was identified in the 2019 Victorian Auditor-General's report into Access to Mental Health Services in Victoria (**VAGO report**) as the lowest funded CAMHS in Victoria. This limits SWH's ability to provide other intensive interventions which would otherwise offset some of the impact of having no easily accessible local child and adolescent beds.

Ballarat MHS has, since 2009,[14] received funding for two CAMHS beds.[15] In the past, SWH MHS has not been able to access these beds, as they are not open.

3 Recruitment

Attraction and retention of allied health and medical mental health professionals has proved more difficult in rural locations, despite placement programs and incentives. The concentration of tertiary health courses in metropolitan settings exacerbates this. Difficulty attracting staff to rural locations also means that replacing staff often lags after resignation, and staff may be replaced with a less experienced clinician, in order to fill the role. Furthermore, the period of orientation and mental health competency training for staff without clinical mental health experience can be up to two years. This means that caseloads need to be reallocated to the remaining staff members for the duration of the recruitment and the training period (new mental health clinicians carry lower caseloads and are usually allocated less complex cases whilst they master the skills necessary to provide comprehensive, recovery oriented case management and therapy).

The above issues mean that SWH MHS teams are often understaffed and at risk of burnout which

[14] https://www.bhs.org.au/sites/default/files/finder/pdf/reports/annual%20reports/BHS_AnnualReport_201109.pdf, p 46.

[15] CYMHS report.

impacts on the team's ability to provide comprehensive, holistic and proactive treatment and support. Under these circumstances, crisis situations take precedence over consumers who are not at that time experiencing a crisis (yet may be at risk of experiencing one). This also means that individual therapeutic interventions or group programs delivered by SWH MHS are limited by the need to prioritise high acuity and crisis situations.

Additionally, many staff are new graduates who are very early in their career. These clinicians are expected to provide highly specialist services that would exist as stand-alone teams in metropolitan areas (for example, services for eating disorders or infant mental health). It takes considerable time for clinicians to learn, and be proficient in these specialties and involves significant effort on the part of the senior clinical staff to mentor and supervise graduates and less experienced clinicians.

Further, since 1993 when the Nursing syllabus was changed,[16] there has been a lack of undergraduate mental health specific training in either the enrolled or registered nursing pathway. Nurses are expected to study the general 'comprehensive' Nursing degree, with a specialist mental health nursing post-graduate Master's degree being available. This diminishes the pool of nurses who may choose a career in mental health, and it also means general nurses in acute hospitals are not comprehensively trained in, nor have specific competence and confidence to identify and respond to the mental health needs of patients admitted for other medical reasons.

Unfortunately this issue is not unique to the nursing workforce. Psychology graduates often enter the workforce with very limited exposure to moderate to severe mental health presentations. Limited options for public psychology placements results in a larger portion of placements occurring in community and private practice settings, and therefore higher rates of psychology graduates entering private practice, rather than public mental health services. Public mental health services also has limited ability to provide specialist supervision to graduates seeking endorsements in areas such as 'clinical psychology' due to the senior staff resources required to provide this supervision. SWH MHS may have limited psychologists with supervision credentials for clinical endorsement pathways restriction options to offer those pathways, such as clinical psychology. SWH MHS' only option would be to engage and pay a private practitioner to provide clinical supervision which is very expensive. Rural AMHS are limited in their ability to offer adequate positions across all psychology gradings due to budget constraints. When psychologists reach level 2, there are limited

[16] Happell, B., 2009. Appreciating history: The Australian experience of direct-entry mental health nursing education in universities. *International Journal of Mental Health Nursing*, *18*(1), pp.35-41.

pathways to progress their careers and this impacts on attraction and retention of psychologists with experience to a smaller AMHS such as SWH MHS.

The Regional workforce is also impacted by professional isolation and limited access to quality professional development opportunities. The added costs of transport and travel, and the lesser availability of discretionary funds at the agency level, result in a greater risk that staff are not able to access professional networks and therefore it is extremely difficult to retain them in rural mental health services. The experience of such professional isolation may impact morale and negative community perceptions.

4 Block funding for bed-based services

The current model of funding clinical bed based services (i.e. acute inpatient services) in a block is inadequate. This is particularly so for small units in the rural setting, due to their inability to leverage economies of scale. For example, current funding for clinical bed based services covers only around 70% of the actual costs expended by SWH MHS to provide the services. Care, treatment and support cannot be compromised when consumers are experiencing an acute mental health crisis. It is therefore necessary for SWH MHS to divert funding provided for other programs (for example, community-based services) to clinical bed based services in order to make up the funding shortfall, which in turn leaves the community-based services depleted. This results in a reduction of community-based staff and services, making early intervention more challenging, and resulting in a crisis-driven practice across a large geographic rural catchment. For many years, SWH has been aware of bed based funding disparity between AMHS in Victoria.

This diversion of funding from one service to fund another is referenced in the VAGO report. The VAGO report found that funding models that support the delivery of quality and evidence-based care will be important for the future sustainability of services. SWH MHS participated in the VAGO Audit, and was the only rural AMHS to do so.

Recommendation: A funding model which reflects the impact and additional expense in delivering services rurally and regionally and allocates a proportionally higher amount, would support the intensive early intervention and suicide prevention community-based approach that is needed. Following a community-based approach means mental health services and their partners must not only provide relevant and individualised services in the community where the recipient of the care lives.

5 Population-based funding model

Due to the large geography covered by rural services, together with small population numbers and lower bed numbers, rural services struggle to leverage economies of scale when it comes to making the most efficient use of funding. Accordingly, population-based funding places limitations on the ability of rural AMHS to provide services equitably to all locations within the catchment area.

The current population-based funding models by which SWH MHS receives funding from DHHS, do not support equitable access to services for people in regional and rural areas. Population-based funding is inadequate to support rural communities because it:

- does not consider the vast geography of the catchment areas;
- does not account for the additional costs associated with transport to visit consumers in remote locations;
- does not account for the impact on clinician time (and therefore staffing levels and cost) of delivering services to consumers in rural communities; and
- does not account for the additional costs to regional AMHS of wellbeing interventions to support staff in dealing with the unique stressors associated with working in rural settings (such as increased travel).

SWH MHS often receives limited EFT (Effective Full-time Equivalent human resource) based funding for small programs, which DHHS intends for SWH MHS to deliver across the large geographical catchment. SWH MHS are unable to do this equitably. For instance:

- SWH has been provided with funding for 1 FTE Nurse Consultation and Liaison, which is expected to service the entire region, seven days per week. The funding does not factor in the need for a senior registrar and consultant to be allocated to the Consultation and Liaison (**CL**) service. Consequently, this service is operating in a limited capacity in Warrnambool only;
- Similarly, the Mental Health and Police Response Initiative is currently only operating in Warrnambool, but there is a great need for this service in the surrounding local government areas and townships; and
- The NDIS interface role (0.6 FTE) and Family Violence Advisor role (0.5 FTE) are expected to build

workforce capacity and develop a consistent approach to their area of focus, where the workforce is spread over a vast geography and in multiple teams and at multiple levels of authority, as well as represent SWH at meetings and forums, usually in Melbourne. These project or capacity building roles usually draw our more experienced senior clinicians away from direct care work, placing further pressure on the workforce to meet demand for the service.

- Intensive child support services (0.5 FTE) and Autism Spectrum Disorder Assessment Coordination (0.5 FTE) are also examples of limited resourcing.

Recommendation: Going forward, funding flexibility will be required to help address some of the challenges of rurality, including the location of service delivery. These should include:

- Changes to the funding of Psychogeriatric Nursing home beds. Currently, the funded Psychogeriatric Nursing home beds are located in two specific locations in the SW catchment not at SWH (10 in Warrnambool and 4 in Hamilton). The majority of residents occupying these beds are not consumers of SWH MHS, which means that SWH MHS consumers can only access beds if they become vacant (SWH MHS is generally unable to obtain access to the psychogeriatric beds in the two funded residential aged care facilities, with only 1 to 2 admissions annually as a result of the APMHS referral). The location of the funded psychogeriatric beds, if accessible, means consumers often have to be relocated and dislocated from their extended families, further isolating them. If funding were to be held by the AMHS, it could be provided to, for example, Residential Aged Care Facility (**RACF**) where the consumer usually resides and utilised for additional supports and capacity building of the staff of the RACF in the community the consumer is part of. This would lead to better outcomes for consumers, families and the RACFs.

- To reduce transfers for less complex cases, funding could seek to build workforce capability within smaller hospitals so that some level of mental health care can be provided within the hospital, rather than forcing consumers to go to an AMHS. For example, a program similar to the former Mental Health Nurse Initiative Program (**MHNIP**) within public hospitals as well as primary care settings may be effective.

6 Information sharing

Although there are clear provisions for the sharing of mental health information under the *Mental Health Act* for consumers who are admitted compulsorily, information sharing pathways require

express consumer consent when the consumer is accessing treatment on a voluntary basis. There are few established memorandums of understanding with private treatment providers, and those which exist are established on an ad hoc basis.

Recommendation: A consistent approach to information sharing should be adopted, in order to improve communication between services. Clear guidelines regarding consumer consent and when duty of care and duty to warn must take precedence should be developed.

7 Waiting lists for Autism assessment services

Autism assessment services are overstretched, with a waiting list of over twelve months for both public and private assessments. This means many families are struggling to manage children with special needs. With the delay in assessments there is a consequence of an impact on the opportunity for access to early intervention services. In the SWH MHS catchment, funding is only sufficient enough to cover about 0.5 FTE staff. Furthermore, in a rural area, recruiting suitably trained clinicians to undertake the assessments and coordinate input from specialist services including paediatricians and speech pathologists is a major challenge. Non-mental health clinical services report being pressed to meet the demands of their own practices and may not be in a position to collaborate, especially if not funded. Comprehensive Autism Assessment and treatment resources are not available in the South West of Victoria. SWH CAMHS does not have access to paediatric speech pathologists, has limited access to paediatricians with expertise in autism and is not sufficiently funded to purchase specialist paediatric services. SWH CAMHS has limited ability to provide cognitive assessments for children younger than 6 years of age, as this is a highly specialised field. There is high community and primary care sector expectation on the AMHS to provide autism assessment and currently SWH MHS is not able to meet needs or expectations of the community and our stakeholders despite our efforts to work innovatively with the resources available.

8 Aging population

The population in the SWH MHS catchment is aging, as is a significant proportion of the SWH the workforce. This brings challenges in accessing scarce residential aged care services, and can lead to social isolation. The aging workforce creates the risk that over one third of SWH MHS' workforce will retire within 3 years of each other. The retirements, particularly with inpatient nursing staff commenced at the end of 2018 and has and will steadily continue in to the next 2 – 5 years. As experienced staff begin to retire, SWH MHS find it challenging to fill the vacancies because of the

challenges of finding and attracting qualified staff to rural/regional areas. As previously discussed, often vacancies will be filled with less experienced clinicians or nurses without undergraduate mental health qualifications since the undergraduate mental health nursing degree was replaced by a generalist nursing degree with the option of post-graduate mental health qualifications. Allied Health undergraduate degrees are also generalist in nature and do not adequately equip new clinicians to work in clinical mental health specialist services.

The aging workforce also means that SWH MHS has a uniquely high proportion of the workforce with several decades of service. These staff are paid salaries at the highest rate on the pay scale, which impacts on SWH MHS' staffing budget.

9 Complying with regulatory requirements

AMHSs, particularly small rural services, have the same regulatory requirements placed upon them as large metropolitan based services, but the work must be completed by a small number of staff. SWH does not have funding to support project officers or administrative staff to meet the high level of regulatory, human resources and medical administration work undertaken on a daily basis, for example:

- Data must be entered twice, as the Statewide database (CMI/ODS) does not support integration with SWH MHS electronic health record;
- Obligations to provide documentation to the Office of the Chief Psychiatrist and the Mental Health Tribunal are necessarily onerous and therefore take up a lot of clinician and administration time;
- The Mental Health Complaints Commission (**MHCC**), although well supported and promoted at SWH, now deals with complaints in real time, when as a service SWH MHS are actually dealing with the clinical and non-clinical situation. The MHCC often requires a phone call back or a written response on the same day about a complaint whilst the matter is still unfolding, or requires large amounts of clinical records to be provided;
- Following critical or serious incidents, SWH MHS has a number of additional compliance, reporting and quality activities it must undertake. Due to the small size of SWH MHS and the demand on the frontline clinical leaders, the bulk of the work is undertaken by the same two to three senior staff, diverting them from their core roles and responsibilities.

- Although respected and highly promoted throughout SWH MHS, Community Visitors and Independent Mental Health Advocates demand the attention of managers, senior staff operating inpatient shifts and clinicians in the most part without notice.

10 Inadequate funding for collaborative projects

Although AMHS are not intended to be 'everything to everyone', community expectations in rural and regional areas are at odds with this view. It is therefore seen as the AMHS' role to take a coordinated approach with local services such as GPs, and non-governmental organisations (such as local mental health community support services (**MHCSS**) to deliver services. Additionally, there is an expectation by DHHS that AMHS collaborate with Primary Health Networks (**PHNs**) in relation to mental health, suicide prevention, catchment planning, and dual diagnosis care. Such collaborative projects are a significant impost on AMHS resources, in circumstances where no funding is provided to the AMHS for project management roles, or roles required to execute the project. Staffing at AMHS is already stretched, and AMHS do not have additional financial or human resources available to allocate to such collaborative projects.

Particular vulnerable groups (in a rural context)

In addition to challenges resulting from rurality, there are particular barriers and challenges which exist in accessing and delivering mental health services for vulnerable groups in the community; specifically, LGBTIQ+ persons, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander communities.

A person's experience of mental health related problems is impacted by their socio-economic status, sex, gender identity, LGBTIQ+ status and Indigenous status. Many people with mental illness experience discrimination and stigma. Combined with other forms of discrimination and stigma, including racism, ableism, gender stereotypes, poverty and low socio-economic status, many people deal with two or more types of discrimination and stigma. This in turn affects their mental wellbeing and psychological distress and can make accessing services more difficult. Access to the right support, at the right time, and in the right area is frequently harder to find for people with diverse backgrounds in regional and rural areas. Couple this with increased visibility in a rural or regional community, especially where traditionally conservative cultures prevail, the result can be poor access at the early stages and later crisis-driven, engagement with mental health services.

1 LGBTIQ+ community

SWH MHS is not funded to provide (and accordingly cannot provide) early intervention and positive mental health programs for the LGBTIQ+ community, who are very vulnerable in terms of mental health. Accordingly, such support in the SWH catchment is provided by non-governmental organisations, such as Brophy Family and Youth Services (**Brophy**). Brophy provide services such as face to face support groups and education programs for LGBTIQ+ youth in Warrnambool. However, the same level of support and services is not provided further afield from Warrnambool or in a systematic way for adults. Although Brophy run education programs in some schools in Portland, the services do not have a consistent reach across the catchment, because the services are concentrated where the critical mass is (in Warrnambool). With increasing remoteness comes diminishing access to services, meaning the only support available for the LGBTIQ+ community in more rural areas is online, or over the phone.

If LGBTIQ+ identification is coupled with Aboriginality, refugee and migrant status or English as a second language, access to the treatment and care the consumer requires is further diminished, leading to poorer health outcomes.

2 Culturally and linguistically diverse communities

Over the past few years, the cultural demographic in Warrnambool has been shifting. Warrnambool and other areas within the SWH MHS catchment have a lack of multi-lingual staff, and translated resources to assist in explaining mental health disorders and treatment options to culturally and linguistically diverse consumers and their families. The telephone-based translation service which is commonly used allows for the translation of only limited information, and is no comparison for the full engagement that is evident with a face-to-face interpreter. Accordingly, staff still feel tempted to use family members for translation purposes, which is not best-practice and is high risk in circumstances of family violence.

There are also barriers to access for services for people from refugee backgrounds, including stigma and the taboo of mental-ill health.

3 Indigenous communities

The SWH MHS catchment includes a population of Aboriginal and Torres Strait Islander people which is three times higher than the Victorian average. Nationally, there are higher rates of psychological

distress and suicide among the Aboriginal and Torres Strait Islander population. Indigenous communities are engaging further in service partnership and co-design, including acting in an advisory capacity with Mental Health Services and SWH more broadly. However, accessing locally relevant cultural competence training for staff has not been possible due to a number of reasons, including:

- Turnover of leadership staff in three local Aboriginal controlled health organisations;
- Disagreement between the different aboriginal communities as to what the local context is and should represent.

In circumstances where accessing locally relevant cultural competence training is not feasible, AMHS may utilise generic cultural safety training resources. However, accessing generic cultural safety training resources usually comes at great cost if sources are face to face. Although there are many online resources, they do not allow for partnership development and engagement or co-design with local Aboriginal organisations. SWH is developing a Reconciliation Action Plan in 2019, which may further support this work.

Furthermore, SWH MHS is not funded for Aboriginal and Torres Strait Islander clinicians or consultants, however SWH MHS have sought this funding in the next funding package.

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

Current status

Despite the prevalence of mental illness (with some studies indicating one in two people will suffer a mental illness at some point in their lifetime), overall community understanding of mental illness is poor. Community understanding is often informed by inadequate reporting in the media, that perpetuating outdated thinking about mental illness (for example, a belief that schizophrenia is a 'split personality' or that those with serious mental illness are a danger to others and/or should be institutionalised long term). This means that people often do not identify mental health issues or

mental illness in themselves or others and seek treatment or support early. Safe and informed reporting on mental illness and suicide is essential.

The majority of politicians at local, state and federal levels also display a lack of understanding of modern mental health practice, which impacts public policy development in terms of under-resourcing, results in inaccurate communication to the public and creates unrealistic public expectations as to what should and can be realistically delivered. Until all community members are exposed to a different view, those with mental health concerns will continue to be discriminated against in areas outside of direct health care, including health, employment, housing, and education.

Public figures (often sporting 'heroes') who openly identify with high prevalence disorders to raise awareness and reduce stigma is positive, although most public figures have the means to access private mental health care, and usually a support network around them.

SWH MHS are not resourced financially to provide mental health promotion and awareness to the extent that is required to change community perceptions. Considering the prevalence of mental ill-health for persons at some stage in their lifespan, mental health prevention is largely underfunded, with very limited resources being allocated to address the impact of mental health and wellbeing on chronic disease outcomes. Another division of SWH, the Primary and Community Services Division, receive some funding for mental health promotion work. However, that division generally focus efforts on preventative interventions for targeted identifiable vulnerable populations, such as specific schools in the region, with an emphasis on social inclusiveness. These activities are often delivered by Health Promotion Clinicians who, although being specifically skilled in health promotion, do not have an in-depth understanding of the prevention of suicide and mental illness. Furthermore, there is currently no coordinated approach to community education in relation to moderate to serious mental illness (which are often low prevalence disorders such as schizophrenia, bipolar disorder, and borderline personality disorder). Rather, there is a strong focus on high prevalence disorders (such as depression and anxiety).

Stigma in rural communities

SWH MHS undertook to survey a cohort of the farmer population at the Annual "Sheepvention" field days held in Hamilton. Sheepvention, the biggest farming event in Victoria, brings together farmers and farming-related industries (food, fashion, and machinery) for a two day event. Sheepvention attracts more than 25,000 visitors each year. Of the Farmer population surveyed (72

people):

- all had limited understanding about mental health presentations;
- few knew where and how to access services;
- many cited high risk behaviours as their current coping strategy (e.g. binge drinking);
- all cited barriers to accessing services, such as feeling ashamed, weak, embarrassed, and not being able to access services at the farm gate (i.e. they would need to leave the property for long periods of time for appointments, and they felt time pressure);
- some indicated they feared for their livelihoods if mental illness was disclosed, because tools of their trade such as guns or their driver's licence may be confiscated.

The mental health clinician manning the information stand at Sheepvention recounted that the male farmers would look around and behind them, before approaching the stand. Some farmers reported that they needed information, but did not want to be seen by their peers taking brochures or leaflets.

What might help

1 A comprehensive community education program, starting in schools, which teaches the stress vulnerability model of mental illness. The model, also known as the diathesis-stress model, highlights that three critical factors are responsible for the development of mental illness and its course over time[17]:

(a) biological vulnerability (such as a genetic factors, physical illness, or the impact of substance use);

(b) stress (such as life events, poor relationships or lack of meaningful activity); and

(c) protective factors (such as stable housing, supportive relationships or good problem solving skills).

[17] Monroe S. M.; Simons A. D. (1991). "Diathesis-stress theories in the context of life stress research: Implications for depressive disorders". Psychological Bulletin. 110 (3): 406–425.

In helping young people build their resilience to stress (i.e. enhancing protective factors), the impact of any biological predisposition they may have to developing a mental illness can be mitigated. This can also help reduce the impact and intensity of the illness, if they do develop a disorder. Ensuring people know where to seek help early is also important in minimising the impact of mental illnesses over time. Schools are institutions with mandated attendance and are therefore well placed to teach children resilience building (protective) skills, to monitor for signs that children may not be coping well with stress, and to link to services early to engage additional support if required.

2 Media campaigns, coordinated by a body specialising in mental health promotion, that reinforce the message of positive mental health and building resilience, and inform the audience about the early signs of mental health problems and the first steps to getting help, so that help seeking can occur much earlier. The communications should be broad reaching (such as TV and radio campaigns, social media) so as to reach particular vulnerable communities (such as farmers/isolated rural communities).

3 Development of an established standard operating procedure or guidelines for frontline staff within government agencies (such as Centrelink, employment agencies, and hospitals) regarding how to respond when someone is vulnerable to the development of mental illness or is showing signs of mental illness. The guidelines should aim to preserve the person's dignity and privacy and to proactively link people with services and support.

4 Engaging 'Lived Experience' presenters (people who have recovered from mental health concerns and are living meaningful and contributing lives) to deliver the above community education programs, will enhance their effectiveness. Education provided by those with lived experience (also known as peer workers) is both powerful and effective, and serves to demonstrate that recovery is achievable and possible, lives and relationships can be restored and people can take control of their decisions.

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

What is working well

There is now knowledge in the community generally about how to identify and respond when

friends and family are 'struggling' and may be at risk of harm or death as a result of planning or attempting suicide. Locally, this awareness raising has been in response to a number of suicides of young men across the catchment between 2016 and 2018.

Many communities, sporting clubs and large employers are accessing services such as privately provided mental health first aid training, or employee assistance programs (provided by both SWH and private providers). These services promote mental health literacy, mental health responsiveness and open discussion about what to do if a person has suicidal ideation or is displaying behaviours which may indicate risk factors for deliberate self-harm. Some sporting clubs and agencies also offer Suicide Prevention training, such as Lifeline's Applied Suicide Intervention Skills Training (**ASIST**) to arm themselves with knowledge about how to prevent suicide.

Limitations of what is working well

In 2018, Primary Health Network Data indicates that Western Victoria had a higher rate of death from suicide and self-inflicted injuries compared to the Victorian average (being 12.5 deaths per 100,000 people, compared to 11.7). Unfortunately, many communities are prompted to participate in awareness campaigns and training only after tragic events, such as losing friends and loved ones to suicide.

A number of specific suicide prevention and post-vention programs (support provided to families and communities following a death by means of suicide) exist, including access for young people to Headspace Youth Mental Health Services. These are largely funded by the Commonwealth Department of Health and are commissioned by Primary Health Networks (**PHNs**). According to the Department of Health's website:[18]

> *"PHNs were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time. PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients."*

[18] Australian Government Department of Health, *PHN Background* (19 July 2018) <https://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background>.

However, access to the programs is not equally available to all citizens of Victoria (and indeed Australia). This is despite the programs being rolled out via the PHN which the Federal Government thought would result in funds being used for bespoke programs within the communities of each PHN catchment, after extensive planning and consultation activities (or even co-design exercises). The funds are limited within regional settings, and accordingly, once a program is commissioned, the program struggles to expand beyond larger regional city areas to rural and remote areas, where perhaps the greatest need lies. Funding for programs also appears to be significantly delayed in the roll out across catchments due to the processes undertaken by the PHNs in planning, consultation, procuring and commissioning. For example, in the South West, PHN Western Victoria announced via a media release in March 2018 'Suicide prevention trial underway in the Great South Coast area'.[19] The 'State Government Place Based Suicide Prevention Trial' is jointly funded by DHHS and the Australian Government under the Western Victoria PHN program. As at late June 2019, the placed-based trials are only in the planning phase. Once a plan is developed over the coming months, a procurement process will follow, and commissioning will occur, which will leave approximately 6 to 7 months for services to actually run the suicide prevention trial because it is only funded until 30 June 2020.

Funding limitations, a focus on the larger towns, difficulties developing suitable programs to scale up, and recruiting suitably qualified clinicians or peer support staff remain challenges, and often barriers in rural areas.

What can be done better to prevent suicide?

1 AMHS require specific funding to enable them to actively participate, support and co-facilitate early intervention and suicide prevention programs. Funding should be adequate enough to allow for a clinical and peer workforce with appropriate skills and training to deliver the programs effectively across an entire regional and rural catchment.

Such programs may be designed to partner with Mental Health Community Support Services (MHCSS) and other non-mental health community groups, including sporting clubs. MHCSS are distinct from clinical mental health services such as SWH MHS. The role of MHCSS is to support people with psychosocial disability associated with mental illness, especially with self-

[19] <https://westvicphn.com.au/about-us/latest-news/media-centre/32354-suicide-prevention-trial-underway-in-the-great-south-coast-area>.

care, social functioning, relationships and quality of life aspects of care, in a similar manner to Prevention and Recovery Centres (**PARCs**) and the Early Intervention Psychosocial Response Service (**EIPRS**). However, the programs should be co-commissioned by DHHS, rather than expecting small health services such as SWH to procure, commission and provide governance over the programs.

2 A framework built upon the LifeSpan™ model developed by The Black Dog Institute could be implemented, to address the reality that locally, the majority of suicides that occur are persons who do not currently or have never had contact and treatment by the AMHS. The Black Dog Institute's website[20] explains LifeSpan as follows:

> *"LifeSpan is a new, evidence-based approach to integrated suicide prevention. It combines nine strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community. Based on scientific modelling, LifeSpan is predicted to prevent 21% of suicide deaths, and 30% of suicide attempts. LifeSpan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis."*

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

The needs of family members and carers

According to Tandem, Victoria's peak body for supporting carers of people with mental illness, research and lived experience attests to the fact that caring for someone with mental health issues often has a profound impact on the health and wellbeing of the carer. The *Victorian Chief Psychiatrist's Guideline: Working together with families and carers* (**the Guideline**) recognises the vital support that carers provide, and assists services to better respond to families and carers in the

[20] Black Dog Institute, *Lifespan* (2018) <https://www.blackdoginstitute.org.au/research/lifespan>.

delivery of mental health services. The Guideline sets out the following key messages:[21]

- Families and carers should be recognised, respected and supported as partners in providing support and care to consumers.
- Families and carers should be identified and engaged as soon as possible in assessment, treatment, care and recovery.
- Services must have clear processes and practices that support open communication with consumers, families and carers regarding information sharing, privacy and confidentiality.
- Services are required to have regard for the impact of mental illness on family members and to assist families and carers to identify their needs, including in relation to the caring role.
- Families and carers should be engaged in organisational practice and governance."

Recommendations

In considering the Guideline, SWH MHS makes the following recommendations in relation to what can be done to better support family members and carers.

1 Family members should be included in all aspects of consumer care

Firstly, families often report being given little or no notice that their loved one is to be imminently discharged from an inpatient unit. Without such involvement, carers are unable to ensure that the transition to home is safe and the consumer is supported. This can have an enormous emotional and financial impact on carers, not to mention the practical impact of acquiring transportation at short notice.

Secondly, when active follow up of a consumer finishes, without advising the carer (as carers report frequently occurs), the consumer may be left unsupported and without active monitoring for signs of relapse (a role played by carers when services cease). Once a consumer begins showing signs of relapse, they may not recognise it themselves and if there is no carer or family member well informed enough to recognise the signs, treatment may become delayed and the opportunity to

[21] Victorian Government Department of Health and Human Services, *Victorian Chief Psychiatrist's Guideline: Working together with families and carers* (August 2018) 5.

avoid a complete relapse may be missed.

Thirdly, in practical terms, carers may be responsible for supporting or providing aspects of treatment such as supervising medications or other interventions. Without the information provided to perform such tasks, carers may become vulnerable in terms of the impact on their own health and wellbeing, may be financially disadvantaged or have access to their own support services diminished.

It takes additional clinical time and clinical expertise to work directly with family members, however SWH MHS recognise it is fundamentally important to ensure family members receive adequate education and support for their important roles.

Recommendation: Mental health services must be sufficiently resourced to:

- develop expertise and provide family focussed interventions consistently with all families; and
- allow clinicians enough time to work with families and other stakeholders, including Independent Mental Health Advocates (**IMHA**).

DHHS and statutory bodies (such as the Office of the Chief Psychiatrist, The Mental Health Tribunal and The Mental Health Complaints Commission) put out guidelines and practice directions in relation to the involvement of carers and families for AMHS to follow, however sufficient resourcing should be provided in order to enable these guidelines to be implemented.

2 Language used in materials for carers should be easy to understand

In addition to medical sources, information that carers receive is often derived from the internet or from other carers. Any materials shared by AMHS (such as through in-person education, leaflets, pamphlets, etc.) need to be pitched at a level that is easy to understand and not inclusive of clinical terminology. If carers are unclear about what is expected of them, this can impact on the quality of care they provide to the consumer.

3 As far as possible, information should be provided to carers, to support them in their caring roles

Carers report providing support and care to consumers through all aspects of their treatment, and that expectations are not always clear. To the extent that they are able to (with the consent of the consumer or through provisions in the *Mental Health Act*), clinicians should share information specific to the ***consumer*** with the carer, regarding:

- the consumer's specific mental health illness, current treatment plans, any medications, and early warning signs that might indicate the consumer is becoming unwell, so support can be obtained early;

- regional age appropriate carer support services (including after-hours services) and clear referral pathways to access such services. This can be difficult in the South West region the further someone lives outside the major towns.

- suicide, including who to contact in crisis, strategies to help the consumer and support services for carers (including after-hours services).

4 Provide sufficient and appropriate housing

The government must ensure that there is enough appropriate housing for consumers in regional areas, so the default position for consumers is not living at home with their carer or family; especially in circumstances where independent living is a possibility. Anecdotally, there is currently a long waiting list for housing in South West Victoria depending on the type of property required. Consumers with mental illnesses may experience discrimination or be challenged in navigating the system, therefore being further disadvantaged when applying for public housing.

5 Redevelop the Centrelink application form for a carer's allowance

The current application form to apply for a carer's allowance is focused on disability rather than psychosocial challenges associated with mental ill-health. Carers and families would like to see another form developed specifically for carers who care for consumers who experience mental health symptoms, to recognise the unique challenges and circumstances experienced when looking after someone with a mental health illness.

6 Clinician training should include training in relation to Family Inclusive Practice

Firstly, clinicians' core competency training must include how to provide a Family Inclusive Practice intervention to ensure consumer care and treatment is discussed and actioned with family and carer involvement. There is evidence to suggest that Family-based interventions are as effective as medication interventions, particularly with schizophrenia.[22]

Secondly, the Family Inclusive Practice training should be inclusive of open dialogue principles. The 'open dialogue' approach to mental health crisis intervention and ongoing care for people experiencing a crisis originated in Finland. With a focus on people, open dialogue involves a consumer's family, friends and broader social network in a series of meetings. Open dialogue is founded on seven main principles of treatment: immediate help, a social network perspective, flexibility and mobility, responsibility, psychological continuity, tolerance of uncertainty, and dialogism. Engaging in discussions about the consumer's needs and difficulties aims to increase the capacity of the consumer and their family and friends to take action in their own lives.[23]

Thirdly, education in the role of carers in the treatment of a person with mental health concerns should also be incorporated early in tertiary studies so as to become the expectation in workplaces.

7 Funding for bed based services should be increased

As discussed in more detail above, funding should be increased to provide better access to acute inpatient beds, specialised services, and child and adolescent beds in regional areas. This would ensure the need to travel is kept to a minimum, and would enable families and carers to stay with consumers locally, where there is additional family and carer support.

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[22] J Leff et al, 'A controlled trial of social intervention in the families of schizophrenic patients' (1982) 141 *British Journal of Psychiatry* 121-134; J Leff et al, 'A controlled trial of social intervention in the families of schizophrenic patients: two-year follow-up' (1985) 146 *British Journal of Psychiatry* 594-600; L Kuipers et al, 'Psychosocial family intervention in schizophrenia: a review of empirical studies' (1992) 160 British Journal of Psychiatry 272-275; L Kuipers et al, 'Family intervention in psychosis: who needs it?' (1999) 8(3) *Epidemiologia e Psiciatria Sociale (editorial)* 169-173; S Pilling et al, 'Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy' (2002) 32(5) *Psychological Medicine* 763-782; G Szmukler et al, 'An exploratory randomised controlled trial of a support programme for carers of patients with psychosis' (2003) 38 *Social Psychiatry and Psychiatric Epidemiology* 411-418; E Kuipers et al, 'An RCT of early intervention in psychosis: Croydon Outreach and Assertive Support Team (COAST)' (2004) 39(5) *Social Psychiatry and Psychiatric Epidemiology* 358-363; PA Garety et al, 'Cognitive behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial' (2008) 192 *British Journal of Psychiatry* 412-423.

[23] N Buus, J E Kragh, A B Bojesen, A Bikic, K Müller-Nielsen, J Aagaard & A Erlangsen, 'The association between Open Dialogue to young Danes in acute psychiatric crisis and their use of health care and social services: A retrospective register-based cohort study' (2019) 91 *International Journal of Nursing Studies* 119-127.

8 *Funding for carer support services should be increased*

Funding for carer support services should be increased, to enable the following recommendations to be implemented.

Firstly, carer support services should employ more people with lived experience (peer workers). Most peer support workers working at SWH are consumer peer workers. Carer peer workers can:

- work with, and support families and carers in all age appropriate areas; and
- assist services to understand the perspectives of families.

Secondly, consideration needs to be given for after-hours family and carer support including access to support workers in outer areas of the catchment. Providing 24/7 online and telephone support may also assist carers to meet their own support needs at a time that suits them.

Thirdly, the current cap of $1,000 per annum on the Carer Support Fund is too low. The Carer Support Fund is discretionary funding that is administered by Tandem[24] and funded by DHHS, which AMHS can access to assist people in their support role, to promote and sustain the caring relationship, and improve the wellbeing of families and members of the community performing this role. The fund recognises that caring can come at a great financial cost to carers of people with mental illness. For example, supporting a child whilst they are an inpatient in Melbourne often exceeds the $1,000 annual funding available. In practical terms, this may mean some families pay the additional costs associated with travelling to and staying in Melbourne for the duration of the admission. Carer Support Funding gaps can be a barrier resulting in some children being admitted to hospital in Melbourne without the support of their family close by, or the family making attempts to keep the child at home and not accessing the appropriate services due to the associated costs. An average stay in a child and adolescent bed of between 6 and 8 days, accommodation costs can be up to $1760, a round trip in fuel could cost $200 or more, and there are additional costs of food, parking or public transport.

These costs may not be payable for metropolitan children who have family living close by or accessible to public transport. The Carer Support Fund cap should be increased, or alternatively, funding could be provided to health services in Carer Support funding or held centrally with an easy

[24] < https://www.tandemcarers.org.au/carer-support-fund.php>.

to access claim process to reduce administrative burden on AMHS. This would mean family and carers have adequate financial support if they are required to stay out of the region in order to assist the consumer in accessing treatment.

Fourthly, increased funding should be provided to support carers through respite services. Currently, only limited funding and services are available. Commonwealth funded respite services have not been available in the South West region since services were ceased in 2015. Carers report they are unable to have a break from their caring role due to the financial impact. For a recent carer group trip away, carers were required to fundraise and contribute themselves for the cost of a 2 night get away to Mt Gambier in addition to the cost of the services to care for their loved one during their absence.

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

Victoria's 10-Year Mental Health Plan, Mental Health Workforce Strategy appears to not have been fully implemented and AMHS have not been engaged by DHHS directly in the implementation. Whilst well intentioned, there has been no systematic approach to reviewing and researching the progress and outcomes of the recommended actions across Victoria's Mental Health system.

In order to attract, retain and better support the mental health workforce in rural communities, SWH MHS offers the following suggestions.

Remuneration and benefits

1 Paying a 'rural' loading on remuneration as an incentive for mental health clinicians to work in rural and remote areas of Victoria. This would require the AMHS in these areas to be funded at a higher rate than their Metropolitan counterparts. This increased funding could also assist in supporting the practitioners in their ongoing professional development, thereby promoting a skilled and confident mental health workforce.

2 Promoting and organisations being able to have family flexible work hours is essential in ensuring the retention of skilled mental health practitioners.

3 Improving working conditions, especially decreasing workloads. Adequate staffing significantly reduces the potential for increased workloads, and staff dissatisfaction.

4 Considering state-wide family friendly policies and practical support for staff of mental health and alcohol and other drug (**AOD**) services beyond what is provided for in the relevant Enterprise Agreements.

Education and Training

1 Promoting a positive image for mental health nursing and promoting mental health nursing as a desirable career (for example, by advertising on social media and delivering presentations at secondary school level).

2 Introducing mental health nursing training into Enrolled Nurse TAFE courses. In the current Enrolled Nurse TAFE courses, there is no specific mental health pathway and only limited content that covers or prepares an Enrolled Nurse to become a Psychiatric Enrolled Nurse (**PEN**). PENs are unable to nurse in an inpatient setting for high dependency or intensive care units until they have a minimum of 6 months experience, which is a challenge for smaller services who have to navigate modified rostering during the 6 months that does not involve a rotation to the high dependency unit (**HDU**). To support PENs in a mental health setting, each AMHS requires a specific mental health transition program to ensure increased confidence and competency in this area. AMHS require support in developing and implementing these programs. The ongoing increase of PEN salaries is an impost on AMHS, given the scope of practice is limited and PENs require an RN to supervise them.

3 Re-introducing mental health nursing training into undergraduate nursing degrees. As noted above, in 1993, the Nursing syllabus was changed[25] and there was no longer a mental health nursing undergraduate degree available to students.

4 Collaborating with universities to:

(a) ensure the delivery of a more comprehensive mental health and AOD curriculum in both nursing and allied health. Such a curriculum could include training as to the assessment of this client group, and address evidence based interventions that assist in the provision of treatment for this client group who often present with additional complexities.

[25] B Happell, 'Appreciating history: The Australian experience of direct-entry mental health nursing education in universities' 18(1) *International Journal of Mental Health Nursing* 35-41.

(b) promote an understanding of mental health presentations to a range of other practice areas, to ensure consumers with mental health concerns have appropriate screening identified early intervention support. This would lead to a broader understanding of mental health presentations, a recognition of the universality of mental health conditions and the breaking down of arbitrary practice silos.

(c) promote mental health placements occurring in a variety of mental health settings (including acute inpatient, community - adult and aged person, AOD, and extended care). Mental health placements traditionally occurred in a psychogeriatric setting. Unfortunately, this does not promote an understanding of the broader nature of mental health, nor does it provide a lifespan coverage and understanding of mental health presentations.

Ongoing professional development

1 Extending mental health continued education opportunities for professional development, so it is facilitated locally in regional areas. Often professional development opportunities occur in Metropolitan locations. Whilst ongoing professional development is essential for all mental health practitioners, the ability to access training can be impacted by the distance and additional costs borne by the health service in filling roles and paying expenses, and by the individual, such as accommodation.

2 Ensuring professional development can be accessed in a flexible manner, including by:

(a) using quality technology platforms for regional sites to link in with each other and with Melbourne, thereby reducing the burden of having to drive 4 hours each way to attend training in Melbourne;

(b) conducting briefer sessions on a regular basis, to ensure reduced staffing levels do not prevent staff from attending training sessions. For example, small inpatient units often struggle to release staff for training and clinical supervision.

3 Developing improved career pathways, structures and opportunities within the rural mental health setting, to support development for mental health practitioners in a range of specialty areas. Often within rural communities, there can be limited opportunities for career development. This is generally caused by the services being smaller, with a more flattened

hierarchy. Career development can be further supported and enhanced by increasing access to professional development opportunities in locations nearer to the rural AMHS.

4 Introducing programs (such as mentoring programs) to reinvigorate job satisfaction and to bolster morale for nurses and mental health clinicians. Such programs assist in promoting confidence and skills, and support staff to reach their professional goals.

5 Reintroducing funded mental health nurse refresher and return to nursing programs, which were previously available in the early 2000s in Victoria; and Enrolled Nurse medication endorsement training accessibility.

6 Developing and implementing career pathways and programs to support the peer workforce (lived experience workers), including in the transition to tertiary qualifications, should they choose this pathway. The peer workforce is an emerging and highly valued component of the mental health service system, and there is much work to be undertaken around how peer workers are integrated, inducted, trained and supported within the sector.

7 Promoting the ability for nurses to work across a range of health areas, including mental health, acute, Intensive Care Unit (**ICU**), and accident and emergency (**A&E**), to promote the development of a range of skills. In order for this to be successful, there would need to be clear and supported transitional programs. Such a process could occur at every level (i.e. graduate nurse, post graduate nurse, experienced nurse, enrolled nurse), if the service has the capacity to promote the transition across these areas. In addition, promotion of the ability to work in a range of areas may assist with retention of staff as it ensures development of skills in a range of areas.

Funding for staff

1 Funding specific grants for Mental Health/Alcohol and Other Drug Nurse Practitioners for rural AMHS at regular intervals (such as annually for 3 years, then every 3 years to support rural AMHS' increase their scope of practice and offerings).

Other

1 Advancing effective nursing, allied health and medical leadership and management, including ensuring greater multi-disciplinary involvement in decision making - both about their professional work and broader health policy. Engaging clinical staff in change management and developing skills in change management provides a broader view which can inform decision making.

2 Implementing clear policies and processes regarding occupational violence and aggression (**OVA**) with all staff being aware and supported in adhering to these processes including implementing programs to assist in de-escalation and management of aggression. This would improve safety and be a positive move towards MH staff having less fear, and risk of intimidation and violence.

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?

1 Evidence based supported employment

Evidence based supported employment is focused on setting competitive employment as the goal, helping people find work quickly, working in an integrated way with the person's mental health treatment and support teams, and providing high levels of support for workers and employers once a job is secured. Unemployment for people with mental-health disorders is very high, with rates of up to 95% for those with severe mental illness.[26]. The so-called "place and train model" of supported competitive employment has proven efficacious in the United States and Europe at addressing this issue,[27] but is largely untested in the Australian context. Having meaning and purpose in life roles supports a person's recovery from serious mental illness. Economic participation and contribution can contribute to a person's development of a sense of meaning and

[26] G Bond, R Drake & D Becker, 'An Update on Randomized Controlled Trials of Evidence-Based Supported Employment' (2008) 31(4) *Psychiatric Rehabilitation Journal* 280-290.

[27] R Drake, G McHugo, D Becker, W Anthony & R Clark 'The New Hampshire study of supported employment for people with severe mental illness' (1996) 64(2) *Journal of Consulting and Clinical Psychology* 391–399; R Drake & G Bond, 'IPS Supported Employment: A 20-Year Update' (2011) 14(3) *American Journal of Psychiatric Rehabilitation* 155–164; K Kin Wong, R Chiu, B Tang, D Mak, J Lui & S N Chiu, 'A Randomized Controlled Trial of a Supported Employment Program for Persons with Long-Term Mental Illness in Hong Kong' (2008) 59(1) *Psychiatric Services* 84–90.

purpose, and assists the person in establishing a personal identity.

2 Evidence-based access to education pathways (e.g. Recovery Colleges)

For mental health services to assist people in their journey of recovery, a major change in culture and practice is required to redefine the purpose of services; from reducing symptoms to rebuilding lives.[28] Recovery Colleges embody this transformation and can be central to driving broader organisational change. In practical terms, a Recovery College offers educational courses about mental health and recovery which are designed to increase students' knowledge and skills and to help them feel more confident in self-management of their own mental health and well-being. This may help consumers to move on with their life despite their mental health challenges. Consumers could use the college as an alternative to mental health services alongside support offered from MHCSS or to help them move out of mainstream mental health services. The model has been in operation in the United Kingdom since the early 2000s.

Recovery Colleges support the development of more recovery-focused mental health services, enabling people to grow beyond what has happened to them; discover a new sense of self, meaning and purpose in life; explore their possibilities and rebuild a satisfying and contributing life. Courses are developed in partnership with, and delivered by people with lived experience. Peer trainers are encouraged to use their own experiences to support and inspire students in their recovery journey. Recovery Colleges operate on educational or college principles including a process of registration, development of a preferred learning plan, attending seminars and workshops, choices of subjects, access to tutors, shared learning with fellow students and graduation with a recognised qualification. Recovery Colleges provide a physical base for participants but are not intended to be a substitute for specialist assessment, treatment or therapy offered by clinical teams. They also do not replace mainstream tertiary institutions such as University or TAFE, and may even provide a pathway into mainstream education.

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

[28] J Mcgregor, J Repper & H Brown , 'The college is so different from anything I have done: A study of the characteristics of Nottingham Recovery College' (2014) *The Journal of Mental Health Training* 9; A Perkins, J Henry Ridler, L Hammond, S Davies, & Corinna Hackmann, 'Impacts of attending recovery colleges on NHS staff' (2017) 21 *Mental Health and Social Inclusion* 1-7; A Crowther, A Taylor, R Toney, S Meddings, T Whale, H Jennings, K Pollock, P Bates, C Henderson, J Waring & M Slade, 'The impact of Recovery Colleges on mental health staff, services and society' (2018) *Epidemiology and Psychiatric Sciences* 1-8.

change?

1 Intersectionality and Services Connectedness

As we understand it, any funding for mental health treatment contributed by the Commonwealth to the state of Victoria occurs via Commonwealth-State funding agreements, often arising from broader heads of agreement in relation to areas such as hospital funding. Within the mental health sector there is prevailing confusion amongst consumers and service providers about the role and interface between State funded clinical health services and federally funded mental health packages. It is not always clear who services are targeted to, which leads to difficulty in navigating the mental health stepped care model.

Accordingly, a radical change needs to occur as a whole of government (State and Federal) approach. To effectively tackle prevention of mental illness and early intervention, a lifespan approach should be adopted, whereby social services (including housing and disability services), health services (including maternal and child health), education, and emergency services all coordinate and work together to prevent mental illness across a person's lifespan. Connecting services through this lens of intersectionality would lead to greater agility in meeting all the bio-psychosocial needs of those with serious mental illness making a significant positive impact on the trajectory of a major mental illness.

There should be one body responsible at a State level for coordinating these services (including commissioning Commonwealth funding), to ensure the right prevention and early intervention activities and care is provided to the right people, at the right time, no matter what their address is.

Furthermore, an enhanced connection between non-government support agencies and the clinical health sector, as well as enhanced access and availability of essential and fundamental resources would mean a shorter duration of distress and the use of fewer maladaptive coping strategies such as self-harm, and alcohol and other drug use.

For example, under a former Victorian Dual Diagnosis initiative (**VDDI**), the phrase "no wrong door" was coined and used extensively across Alcohol and Other Drug (**AOD**) and Mental Health services, with a number of great outcomes for both workforce development and consumer centred provision of services. "No wrong door" refers to a strategy whereby services are so interconnected that no person in need of either mental health or drug and alcohol services is turned away from treatment,

no matter which service they initially seek care from. Rather, it is quickly established where the person will receive the most appropriate care. When a person presents at a facility that is not equipped to provide a particular type of service, the person is guided to appropriate facilities, with follow-up by staff to ensure they receive appropriate care. Both mental health and drug and alcohol services were sufficiently competent to meet the initial assessment and referral needs for both mental health and drug and alcohol related needs under VDDI.

The Office of the Chief Psychiatrist could play a leadership role across the sector in supporting intersectionality and services connectedness including consideration of an operational component to the office to navigate or coordinate access to 'state-wide' beds and partner services, such as with the disability sector. The 'no wrong door' principle ought to apply to 'dual diagnosis' services for persons with mental health and intellectual disability.

2 Post-vention

Post-vention should be a priority for mental health reform. Persons who have significantly self-harmed or attempted suicide and present to the ED, GP or who have come to the attention of the AMHS via police or other emergency services should be followed up and actively supported for at least 30 to 90 days, to reduce the risk that the person will go onto complete a suicide or die by misadventure. However, AMHS are not currently funded to undertake this work and are often not aware of the people who fit into this category. Research shows that intensive support post suicide attempt assists people during a period of crisis and shame, to reconnect with supports and meaningful life activities.[29]

The Way Back Support Service (**WBSS**) is a suicide prevention service developed by Beyond Blue, developed to support people for the three months after they have attempted suicide (which is when they are most at risk of dying by suicide). The WBSS adopts a collaborative model which incorporates clinical input and intensive follow up by community based mental health workers (including lived experience and peer support workers). The WBSS is scheduled for implementation in SWH by October 2019.

[29] P Reynolds & P Eaton, 'Multiple attempters of suicide presenting at an emergency department' (1986) 31 *Canadian Journal of Psychiatry* 328-330; EK Moscicki, 'Identification of suicide risk factors using epidemiologic studies' (1997) 20(3) *Psychiatric Clinics of North America* 499-517.

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

1 Address the social determinants of mental health

Adequate and agile funding is required to address social issues such as housing, drug and alcohol addiction, and interaction with the criminal justice system. The impact of family violence, transgenerational trauma and childhood sexual assault is directly linked to poor social and emotional outcomes in communities. Such issues can lead to lowered resilience and distress tolerance and to high rates of suicide and alcohol and other prescription and non-prescription drug use. Coping strategies learned in childhood can become maladaptive in adulthood and can lead to a range of issues such as interaction with the criminal justice system, perpetuated cycles of family violence, mental illness and self-harm. Universal providers such as education systems and primary health providers have a huge role to play in early identification and intervention, however the current alcohol and drug sector and social support services are not adequate enough to meet demand.

Furthermore, Federally funded services such as Centrelink, National Disability Insurance Agency (**NDIA)**, the Department of Veterans' Affairs, Medicare, Refugee and Migrant Services, Microfinance and so forth (which are funded by the Federal Government in full or in partnership with the Victorian Government) need to be equally accessible to those who need services in rural and regional areas.

Rural AMHS do not currently have the ability to offer active case management for consumers that includes links to psychosocial supports. In the current landscape, rural AMHS for the most part, really can only offer crisis based services with the limited resources we have. SWH MHS has to be innovative in partnering with other non-public agencies to support consumers. This is often relationship based.

2 Critically Evaluate the medical model

Ongoing evaluation and review of medical models of practice are necessary to ensure:

- strengths-based workforce development;
- true consumer-lead recovery focussed treatment and care;

- alignment of shared treatment goals across systems and treatment destinations.

Clinical interventions should fit with contemporary, state-wide, evidence-based practice to both empower clinicians providing care as well ensure consumers receive high quality treatment/support.

Frequently employed models with a strong biological treatment focus lack strength in addressing additional determinants of health in the psychosocial sphere.

Medications and biological interventions are important to recovery but may be 'prescribed' in isolation from other strategies that could improve psychological and social functioning and well-being.

3 Consider the workforce when implementing other changes

In order to be sustained, any changes or improvements must include elements of workforce development such as ensuring:

- clear communication of direction;
- the knowledge exists in the workforce to support the improvements being made;
- professional development resources and tools of the trade are available;
- support (such as family, continuous improvement and feedback) is provided to staff to make the necessary changes.

There needs to be a recognition that a stable, engaged and informed workforce will be the drivers of future reform.

4 Redesign the systems used for collecting and accessing data

The antiquated nature of the statewide mental health database Client Management Interface (**CMI**) and data collection systems has been well documented. For example, the VAGO report (p 46-47) discusses the onerous data entry being undertaken by AMHS and gaps in data being collected. The limitations of these statewide systems restrict the efficacy with which mental health services can accurately determine service demand and service outcomes, and the agility with which data informed proactive planning can occur. The KPIs of mental health services require a robust review

with contemporary measures of quality implemented that include a mix of quantitative and qualitative measures of consumer and carer experience and outcomes. With recovery-orientated practice now strongly embedded in state and federal mental health frameworks and policies, outcome measures that are person-centered and fit for purpose need to be implemented.

5 Ensure the outcomes of any changes implemented post-Royal Commission are meaningfully assessed

Post Royal Commission reform, it is important that the outcomes of changes made are meaningfully assessed, strategies evaluated and altered accordingly.

A research body with government authority to oversee, monitor and regularly review the implementation of recommendations from the Royal Commission should be commissioned. This body could oversee the recommendations of the Royal Commission to Victoria's Mental Health system, and recommendations made by other bodies, such as in the VAGO report.

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