Submission to the Royal Commission into Victoria's Mental Health System

Victorian Mental Health Social Workers (VMHSW)

A Practice Group of the AASW

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VMHSW
Victorian Mental Health Social Work
Working Towards Recovery & Good Mental Health

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Section 1. Introduction

The Victorian Mental Health Social Work (VMHSW) is a Practice Group of the Australian Association of Social Workers (AASW). The VMHSW has over 140 members across Victoria who are employed in both clinical and community mental health services as well as in private practice. Most social workers working in an Area Mental Health Service (AMHS) do so within a multi-disciplinary team where they bring distinctive social work knowledge, skills and values.

The purpose of this submission, which has been developed by ten Senior Social Workers, is to identify some key areas which impact on the services provided to consumers. The submission does not cover all areas of concern, but rather specific areas of interest or expertise of the contributing authors. It provides an overview of systemic issues and individual work through a social work lens.

There is a recognition that Victoria spends less per capita on Mental Health care than any other state in Australia (having previously spent the most per capita). This Royal Commission is an opportunity to set the structure for a great mental health system from one which is seriously stretched. There is recognition that mental health impacts on all aspects of a person's life. There is evidence of the social determinants of health being strong predictors of an increased likelihood of compromised mental health, which must be taken into account when planning and developing services.

"The social work profession is committed to maximising the wellbeing of individuals and society. Social Workers consider that individual and societal wellbeing are underpinned by socially inclusive communities that emphasise principles of social justice and respect for human dignity and human rights, including the right to freedom from intimidation and exclusion. Drawing on theories of social work, social sciences, psychology, humanities and indigenous knowledge, social workers focus on the interface between the individual and the environment and recognise the impact of social, economic and cultural factors on individual wellbeing. Accordingly, social workers maintain a dual focus in both assisting with and improving human wellbeing and identifying and addressing any external issues (known as systemic or structural issues) that may impact on wellbeing, such as inequality, injustice and discrimination". (AASW Scope of Social Work Practice: Mental Health 2015).

"The domain of social work in mental health is that of the person with a mental illness or disorder and their significant others. This includes their social context and the bio-psychosocial consequences of mental illness. The purpose of practice is to promote recovery, support individual and family wellbeing, to enhance the development of each person's self-determination and to advance principles of social justice. Social work practice occurs at the

interface between the individual and the environment: activity begins with the individual, and extends to the contexts of family, social networks, community, and the broader society". (AASW, Practice Standards for Mental Health Social Workers 2014, p 7)

Recovery in mental health

Recovery refers to a unique personal experience, process or journey that is defined and led by each person with a mental illness.

It is owned by, and unique to, the person. The role of mental health services is to create an environment that supports and does not impede people's recovery efforts. (DHHS – Framework for Recovery Oriented Practice 2011.)

This submission focuses on the following areas identified as being of priority because of their impact on and interface with mental illness:

- Trauma, childhood abuse, sexual assault;
- Homelessness;
- Dual diagnosis;
- Culturally Responsive Practice;
- Aged mental health;
- Service collaboration.

Section 2. Trauma, childhood abuse & sexual assault

Whilst there is a stated underpinning of The Recovery Framework, current clinical mental health services are structured to primarily provide services under the medical model with a biological understanding of mental illness. Consumers need a trauma informed bio-psychosocial spiritual model of care.

It is well documented that Adverse Childhood Experiences (ACEs) are traumatic events that can have negative and long-lasting effects on an individuals' health, wellbeing and life outcomes.

ACEs include issues such as substance abuse, parental separation/divorce, familial mental illness, family violence, incarceration, childhood neglect, physical, sexual and emotional abuse.

Within services there is awareness but minimal training about the importance of linking early trauma to mental illness. Research indicates that people with the diagnosis of Borderline Personality Disorder have often come from markedly traumatic backgrounds, (Kezelman C and Stavropoulos P, 2012). Childhood sexual abuse is reported as being strongly related to psychotic disorders and also a frequent causal link to depression, (Read, J et al, 2004).

The same authors reported that childhood sexual abuse was a bigger predictor of suicidality than depression.

The Royal Commission into Institutional Responses to Childhood Sexual Abuse exposed the high rate of sexual abuse towards children in institutional care. Numerous studies demonstrate that around two thirds of both inpatients and outpatients in the mental health system have a history of childhood sexual and/or physical abuse, (Kezelman C and Stavropoulos P. 2012).

Recommendations

1. Employ specialized childhood trauma informed clinicians to work directly with consumers across all mental health teams.

2. Training to ensure mental health clinicians are able to demonstrate knowledge of trauma (Practice Guidelines for The Treatment of Complex Trauma and Trauma Informed Care and Service Delivery, ASCA Adults Surviving Child Abuse. P.17).

This submission recognizes the value of a Trauma Informed Care system based on the principles of:

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

(Fallout Roger D and Harris Maxine, 2009)

2.1 Safety: In bed-based services

The complexity and acuity of patients on In-Patient Units (IPU's) often combined with outdated infrastructure and low staff to patient ratios does not provide a safe environment for patients. There are difficulties providing safe areas for women patients. Frequently there are insufficient beds in a women's only corridor or male clients can access these areas. Even with women's only corridors communal areas (kitchens/laundries) are often shared. Issues around the need for women only spaces have been well documented in the Mental Health Complaints Commission "Right to be Safe" report 2018.

Security guards are regularly used in inpatient units to try and provide a sense of safety however this can change the therapeutic environment to one of surveillance and control. It is difficult for hospital admissions to be about a vulnerable person who is in the first stages of their recovery journey. The demand for beds (statewide) results in short lengths of stay where people are not given the opportunity to achieve stability before they are discharged. There is a huge need for increased beds at a local level statewide. This will reduce the pressure on early discharge to allow a person to recover with a gradual re-integration into community settings.

It is recognized there has been great value with programs such as 'Safe Wards', the introduction of Peer Support Workers, Independent Mental Health Advocates (Imha) and an increase of groups run by Occupational Therapists & Social Workers. In some IPU's Social Workers facilitate family meetings, which can be an essential dimension to a person's re-integration back to the community. However the primary focus of the social work role on IPUs is often finding accommodation to facilitate discharge (see Homelessness section).

Prevention & Recovery Centres (PARCs) were established as Partnerships between Clinical & Community Mental Health Services. Originally set up as facilities for a 'step-up' (prevention) and 'step down' transition back to community. Increasingly they appear to be catering for primarily a stepdown from IPU's with a significantly higher acuity with the residents.

CCU's provide a mid-term residential support program, but many have outdated facilities and few are wheelchair accessible. The lack of suitable residential rehabilitation accommodation

combined with bed pressure on IPU's can result in a resident group which is complex, challenging and with higher needs than CCU's are resourced for.

Therapeutic housing models that were once a part of larger psychiatric institutions need to be revisited as a way of providing secure safe accommodation while also providing living skills to increase chance of successful reintegration into mainstream housing.

Recommendations

3. Increased bed based services across the spectrum, from IPUs to PARCs and CCUs.
4. Increased women only bed based services.
5. In reach services such as CASA or employment of specialized sexual assault clinicians.
6. Development of therapeutic communities with the length of stay aligned to the persons identified recovery pathway.

2.2 Trustworthiness

In 2007 Mental Health Services were planning mandatory training for all staff on responding to disclosures of sexual assault. Policies and procedures for responding to past disclosures of sexual abuse were developed. Recommendations were made regarding the employment of specialized workers in all clinical services. Unfortunately, these were not implemented.

Central to the disability movement has been equal partnership in decisions about healthcare. St. Lukes in Bendigo had a process where all case notes were written as a letter to the consumer, which proved to be a useful therapeutic tool aligned to narrative therapy.

Recommendations

7. Adopting a Trauma Informed model will work from a basis of accepting the person's beliefs about past events including assaults and abuse.
8. "Nothing about me, without me" principle: Develop process for documents and clinical notes to be "co-authored" by consumers and their treating teams.

2.3 Choice:

There needs to be greater recognition of services that consumers say ***they*** find useful. Co-designed and Co-Produced services with significant input at all stages of planning and development are essential if the Mental Health System is to improve and develop.

Day programs run by Community Mental Health services (such as MIND & NEAMI) previously provided an important dimension to the person in community. With the shift of funding from these organisations to the NDIS many consumers report a loss of connection with 'their community.' The NDIS provides people with an individual package of care, for many this works extremely well. However it is based in a disability/ skill deficit model, not a Recovery focused model and does not recognise the often episodic nature of mental illness. Many support workers under NDIS have great skills working with people with a disability but have little understanding or training as to the needs of a person with a mental illness. The NDIS has also impacted on the accessibility to Supported Independent Living Programs (where consumers must now have an NDIS package).

Men's Sheds, Libraries and Community Centres/ Neighbourhood Houses provide an important dimension to the social wellbeing of many service users.

Recommendations

9. Increase funding for programs such as consumer hearing voices group (Prahran Mission, Vic Voices).
10. Embedding small multi-disciplinary mental health teams in local GP surgeries as part of the integration of mental health with general health.
11. Increase funding of local community centres to support the development of communities and provide a social hub in outer suburbs and regional towns to reduce the transport burden on patients.
12. Develop a greater flexibility of non-catchment-based services allowing consumers greater say from whom they receive care.

2.4 Collaboration: Healing happens in relationships and partnerships.

The current public mental health model is structured around the training of psychiatrists rather than the continuity of care. Registrars are expected to rotate every six months which severely impacts on the ability to develop a therapeutic relationship. Consumers regularly complain about this as they develop relationships with the people providing the care not the 'service'.

This is further impacted by staff turnover because the system is so stretched or work conditions are unsatisfactory. Combined with an ageing workforce, recruitment and retention of quality staff is a high priority. Terms and conditions of clinical staff have not kept pace with other states. There has been positive developments with the growth of the Lived Experience workforce who engage with consumers at a different level to clinicians and are more readily accepted.

Recommendations

13. Reduce the number of rotations of medical staff.

14. Increase in consumer and carer peer workers in clinical mental health services.

2.5 Empowerment- Legal & Human Rights

The principles of the 2014 MHA enshrines some key points from the U.N. Convention on the Rights of Persons with Disabilities (CRPD).

(s11) states: persons should receive assessment & treatment in the least restrictive way possible; with the best therapeutic outcomes; promoting recovery and full participation in community life; involved & supported in all decisions even if these involve a degree of risk.

There has been limited take up of Advance Statements and patients regularly report that on admission these are not adhered to. There are also reports of IPU's not being aware of Advance Statements on admission (which appears to part of a systemic problem).

Many long-time users of services are still adapting to a Recovery Model with an increased emphasis on their rights. Equally, services are still struggling to adapt. The medical model stresses symptom relief and also has to assess the level of risk to the person and the community. This can be an uncomfortable fit with some of the provisions of s11. The human rights and the personal recovery goals of the patient can be at odds with both the MHA 2104 and the clinical assessment that the person requires symptom relief. There is additional fear that if harm occurs, clinical services are held to account. Family & media can be critical where a patients "views and preferences respected….and making decisions …that have involved a degree of risk" (s11 MH Act 2014).

Recommendations

15. Supporting consumers to make Advanced Statements should be a priority for all services.

16. When treating teams need to override the provisions of an Advance Statement this should clinically noted by the Consultant and clearly explained to the patient and their family.

17. Further training is required in Supported Decision Making for all clinical staff.

18. Greater emphasis on biopsychosocial-spiritual models of care which respect the complexity and diversity of a person's lived experience.

19. Service models must recognize the importance of personal recovery and the dignity of risk.

Section 3. Homelessness and mental health

Many individuals accessing public mental health services have multiple and complex needs. These include poverty, forensic risk factors, drug and alcohol use, family violence and trauma as a result of adverse events experienced in their lives. Sometimes a combination of these factors has led to homelessness. Mental illness is also a common pathway into homelessness particularly for those with both a psychotic illness and severe substance use.

People with a mental illness are over represented in the homeless population. Complex needs, poverty and the lack of suitable housing options exacerbate this. Specialist Homelessness Services (SHS) in Victoria (eg. Vincent Care) provided a service to 29,467 people in Victoria with a mental health issue in 2016-17. This was an increase of 98% since 2011-12. (Australian Institute of Health and Welfare, (AIHW), SHS data 2016–17).

The homelessness crisis in Victoria is having a huge impact on the mental health service system. Housing in Victoria is among the least affordable in the world with skyrocketing rental costs. This is compounded by income support payments not keeping up with the increase in the cost of housing. Data for Victoria shows that 99 people are turned away from specialist homelessness services in Victoria every day, (AIHW). There are also 82,000 people on public housing waiting lists.

SHS report there are bottlenecks in crisis accommodation and transitional housing. The rate of service and repeat service use has increased and those with a mental illness diagnosis appear to need more support and return more often.

Due to bed pressure, social workers on inpatient units spend considerable time trying to find housing to facilitate discharge. Mental health social workers are not specialist housing workers and struggle to find suitable accommodation for people.

Consumers are frequently discharged to cheap motels or unsafe rooming houses that are not considered safe for staff to visit due to violence, high incidences of criminal activity, and trafficking/use of illicit substances.

These environments are not conducive to stable mental health. Those residing in these rooming houses have no say over who else lives there and people will sometimes move several times to try and find the least unsafe accommodation. Some consumers choose to sleep rough rather than risk being assaulted in a substandard, unsafe rooming house. If the accommodation is in a different clinical catchment area then providing consistent clinical treatment, follow-up and care is difficult.

This can contribute to a revolving door of homeless consumers returning to the inpatient unit when their accommodation breaks down or their mental health deteriorates due to inconsistent treatment, with the stress from the unsafe accommodation impacting on mental health recovery.

Being caught in a cycle of instability and moving between inpatient stays and accommodation that is highly unsuitable exacerbates people's mental state, jeopardizing the opportunity for consistent treatment, care and support.

Social work staff in three metropolitan acute mental health inpatient units recorded the number of homeless consumers admitted to the inpatient unit between 1/01/19 and 30/04/19 and a summary is displayed below. Consumers were identified by social workers on the inpatient unit as being homeless on admission using the Australian Bureau of Statistics – A statistical definition of homelessness, 2012:

- Primary homelessness: living on the streets
- Secondary homelessness: moving between various forms of temporary shelter and crisis accommodation
- Tertiary Homelessness: living in crowded rooming houses without their own bathroom, kitchen or security of tenure.

In addition, consumers were identified as at risk of homelessness due to issues such as family burn out, family violence preventing return to the family home, potential eviction due to unpaid rent etc.

	Consumers homeless on admission	Additional consumers at risk of homelessness on admission	Consumers discharged to homelessness
Inpatient Unit 1	29 (12.24%)	11 (4.64%)	30 (12.71%)
Inpatient Unit 2	33 (11.11%)	28 (9.43%)	40 (13.47%)
Inpatient Unit 3	42 (14.29%)	11 (3.74%)	37 (12.42%)
All Inpatient Units	104 (12.56%)	50 (6.04%)	107 (12.88%)

This data shows that at least 12.5% of people admitted to these acute units were homeless with a further 6% at risk of homelessness. The discharge rate to homelessness is higher than on admission as a result of complex issues preventing return to their previous accommodation.

These consumers present with complex issues resulting in homelessness such as:

- Family breakdown
- Intervention orders preventing return to the family home
- Breaching IVO's
- Eviction due to hoarding, squalor, assault, rental arrears, property damage or challenging behaviors
- Blacklisted from rooming houses or crisis accommodation
- Alcohol or drug issues
- Gambling addiction
- Intellectual disability

- No income and difficulty accessing Centrelink
- No identity documents
- Asylum seeker status
- Recent release from prison
- Socially isolation
- Itinerant lifestyle (often arriving from interstate)

Consumers usually present with many of these issues simultaneously. It is time consuming for social work staff to unravel these issues and identify the necessary actions and supports taking them away from doing more therapeutic work, such as conducting family meetings or trauma focused therapy. This can result in reduced quality of service for other consumers on the ward.

The work of homelessness services intersects with a range of other sectors. Homelessness reflects the failure of the service system to provide all necessary supports. Supported, tolerant housing options are required. There are a number of different housing models and service delivery models associated with housing that could be replicated/ implemented.

a) Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life. To develop this model there needs to be:
    - A supply of social housing to meet demand
    - Resourcing services to provide the support people need to establish and maintain tenancies
    - Different approaches for different people, including rough sleepers, people leaving prison, people with complex needs, families and young people, those with mental illness.

b) Peer recovery housing models were previously available through Mind, eg. Peer Recovery Centres at Brunswick, West Brunswick, Williamstown and Albert Park. Clinicians could refer interested consumers to these programs. Living in a supportive place for 12 – 18 months often enabled those with a mental illness to gain stability in their life, develop skills and prevented the drift into homelessness. Staff assisted them to find suitable ongoing accommodation once their time was up at the peer recovery centre. Consumers must now have a NDIS package with Supported Independent Living funded in their package to be eligible for these services. This has reduced many people's access to these valuable housing models.

c) Sacred Heart Mission's Journey to Social Inclusion program (J2SI) has been found to be successful with complex consumers facing multiple challenges. J2SI takes a relationship-based approach, provides long-term support, and works from the premise that if people can sustain their housing, this provides a solid foundation to improving other areas in people's lives. This includes improving mental health and wellbeing, resolving drug and alcohol issues, building skills and increasing connection with community. This program has been evaluated and found to be successful in assisting people with a mental illness to secure and sustain long term housing.

d) VincentCare's new Ozanam House in North Melbourne is a world-class, modern and safe location where people experiencing homelessness are given every opportunity to access housing, health and social support services relevant to their individual needs. The facility includes a Homelessness Resource Centre to meet the immediate physical and psychological needs of men and women experiencing homelessness, including:

- A homeless drop-in program
- Health services
- Case management and counselling
- Client participation programs

Flexible accommodation options provide different floor plans suitable for short, medium and long-term placements. Including separate bathroom facilities and storage facilities, with some having separate kitchenettes allowing for privacy and self- sufficiency.

Governments must provide support to other sectors which have a vital role in homelessness intervention. It cannot be left to the mental health service system to solve the problem of homelessness for those with a mental illness. The current housing crisis is negating the efforts of mental health services to provided treatment and support to these vulnerable Victorians.

Recommendations

20. Significantly increase Government investment in social housing. Without this mental health services will continue to struggle to house vulnerable Victorians with a mental illness who are homeless or at risk of homelessness. This investment would reduce the readmission rate for the growing number of homeless consumers. Once housed safely mental health issues can be addressed because it is not possible to do this whilst people are living in insecure or unsafe housing.

21. Introduce specialist housing workers into mental health acute inpatient units to assist consumers to obtain appropriate housing.

22. Implement new/replicate successful housing and service delivery models such as Housing First or Ozanam House models.

23. Expand the Journey to Social Inclusion program (J2SI) run by Sacred Heart Mission.

Section 4. Dual Diagnosis

People with a mental illness as well as drug and alcohol issues (dual diagnosis) have differing needs and challenges. Some may experience depression or anxiety when using alcohol, others might find that their cannabis use exacerbates their psychotic symptoms. Each person's presentation depends on the type of mental health symptoms and the substance/s used.

The service systems set up to deal with those with a mental illness have different structures and legal parameters from those that treat and support people with an alcohol and/or drug issue. The Mental Health Act (2014) provides for services to treat people as compulsory patients if they have a mental illness and meet stated criteria, but the same legislative treatments are not available to those with a drug or alcohol issue.

Many of the interventions currently offered in either mental health or drug and alcohol services, or even combined services, are not tailored to individual needs and frequently have long waiting lists. Wait lists for withdrawal and rehabilitation services in regional areas are particularly concerning. There are no publicly funded long stay therapeutic facilities where people can have significant periods of time post withdrawal to recover from their mental illness, rebuild their lives and consolidate functional independent living skills.

People with a dual diagnosis experience higher rates of mortality, homelessness, physical health problems, suicidal behaviour, violence and incarceration.

Many hospital staff are not adequately trained to deal with the complexities of dual diagnosis, with mental health staff not given training around withdrawal from substances, use of Naloxone, or other similar medications, nor harm reduction strategies re Hep C. Stigma and discrimination are much higher for consumers with a dual diagnosis which can significantly impact on a person's ability or capacity to deal effectively with their condition.

The current pathway of care for people with a dual diagnosis is difficult to navigate and largely relies on two independent service systems providing separate interventions. Integrated treatment is considered the gold standard but mental health services and alcohol and other drug services rarely communicate, coordinate or collaborate in the management and treatment of shared consumers. This response often leaves people with a dual diagnosis, their families/carers and friends, feeling frustrated, unmotivated and/or defeated.

There are few housing models to support people with complex needs resulting from their dual diagnosis, particularly for people who are continuing to use substances. Harm reduction principles are important to ensure people who continue to use substances are able to do so in safe, secure environments that are conducive to therapeutic treatment.

Given the lack of housing options for those with a dual diagnosis, many people end up living in unsuitable housing or moving back in with family/friends which can often lead to strained relationships due to the level of care needed. There are very few options for home based outreach services that could be able to provide treatment for people and support for the family and friends.

Social work adopts a human rights-based approach to health. All individuals have the right to the highest attainable standard of physical and mental health. People with a dual diagnosis are entitled to receive quality integrated treatment adapted to their individual needs. The provision of this treatment should be non-judgemental, stigma sensitive, and convey optimism and belief in the possibility of recovery.

Social workers endeavour to increase the capacity and accountability of people, and the organisations that they work for, to take responsibility for respecting, protecting and fulfilling these rights.

People with a dual diagnosis have a specific experience of services and therefore have a valuable perspective to provide services around how to best deliver services to those with a dual diagnosis. Developing a dual diagnosis Lived Experience workforce will help services ensure equality and participation in decision-making.

Recommendations

24. Harm reduction to be at the forefront of all treatment and staff training.

25. The provision of dual diagnosis services that cover the lifespan (including those aged over 65years) and provide prevention, early intervention and a range of treatment options.

26. Increased consumer and carer lived experienced workforce in dual diagnosis services.

27. Specific Aboriginal and Torres Strait Island dual diagnosis clinicians and lived experienced peers.

28. The establishment of multiple state-wide dual diagnosis withdrawal services. Preferably integrated into, existing psychiatric inpatient services.

29. The development of a mental health gazetted modified residential therapeutic community for people with more complex and severe or treatment-resistant dual diagnosis presentations

30. The establishment of intensive dual diagnosis outreach teams. This model is essential due to the longitudinal approach and complexities associated with engaging and working collaboratively with dual diagnosis consumers and their families/carers.

31. Appropriate and safe accommodation for people with a dual diagnosis regardless of whether they choose to continue using or not. This is particularly important for people who are being discharged from inpatient units.

Section 5. Culturally Responsive Services

Cultural safety is about providing quality service that fits within the cultural values and norms of the person accessing the service that may differ from your own and/or the dominant culture. (Vaccho)
In New Zealand, cultural safety is the effective (nursing) practice of a person or family from another culture that is determined by that person or family. Symbols of Cultural Safety are very valuable and recognize the history and importance of the First Nations people.

Mental Health Services have little to no access to Aboriginal Liaison Officers or Aboriginal Mental Health staff. This reduces the numbers of Aboriginal and Torres Strait Islander people accessing mental health services and reduces capacity for cultural responsiveness. In programs where Aboriginal workers are employed in specific roles they act as a 'cultural interpreter' for staff as well as an important point of contact for consumers. Word of mouth ensures the community access these services in greater numbers. Where there are such workers, it is essential they are well supported and recognized for their unique skill set. Sole positions are isolating and not tenable long-term.

The framework of 'Social and Emotional Wellbeing' which is utilized in Aboriginal and Torres Strait Islander communities is recognized as a valuable holistic and trauma informed way of working. 'Yarning Circles' are a traditional practice for support and connection. Both these paradigms can be adapted to work with consumers from any background. They are also increasingly used in community programs as a staff support / reflective practice.

In the late 1990's bilingual case managers were employed across Mental Health Services to work with and engage people from key emerging as well as recently arrived communities. Services have moved on to train staff to have a culturally responsive approach to their work, with effective statewide training provided by Victorian Transcultural Mental Health (VTMH.) However this training is not seen as core training and relies on services or staff within them prioritising this as an area of professional development.

One function of bi-lingual workers was to engage with communities, provide education and assist in reducing stigma of engaging with services. This is a function which has been lost. Most services are set up with access to interpreters and have literature and posters as symbols of Cultural Safety welcoming people from CALD backgrounds. However not having specifically trained Mental Health Interpreters is a loss. Additionally phone interpreters are often not in a conducive environment for confidential conversations.

For recently arrived migrants or those seeking asylum there is a well-documented fear that treatment for mental illness will negatively impact their immigration application. There can be abuse by migration agents in prolonging the process, financial abuse and not providing sufficient information about their legal status. Since the Red Cross lost funding to support

refugees with payment for prescriptions, ongoing adherence with medication is often more difficult. Lack of knowledge of how to navigate the Australian welfare/financial/ support/ education/health systems whilst navigating the systems could itself trigger ongoing trauma.

The development of the Lived Experience workforce who engage with consumers has earlier been described as a positive development. This workforce can be a valuable contribution to the suite of services provided to consumers with a mental illness but also for those who have additional cultural complexities as outlined above or for those who are LGBTI.

The problems all these groups face are very similar. They include:

- Extensive history of trauma resulting in PTSD
- Stigma of mental illness
- Language barriers
- Difficulty in trusting people and system
- Social isolation
- Limited access to psychological treatment (or that which is delivered in a culturally appropriate way)

Recommendations

32. Adoption of the Social and Emotional Wellbeing framework.

33. Employment of First Nations staff as 'cultural interpreters' and in a health liaison role with a clear career development plan.

34. Increased employment of Lived Experience workers to cover a range of experiences.

35. A culturally and linguistically diverse workforce trained in gender sensitive practice.

36. Co-location of mental health clinicians in refugee centres.

37. Offer long term slow engagement with psychological support through agencies like Migrant Resource Centre or AMES.

38. Provide one stop shop model- like ASRC, VAHS – with access to GP, mental health clinicians, legal support, private psychiatrist, Centrelink etc.

39. Publicly funded mental health services to include community development staff to focus on migrant groups and offer focused support individually or in groups.

40. Intensive focus in upskilling and integrating migrants and refugees into the main stream community.

Section 6. Aged mental health

Public aged mental health services provide acute, community and residential mental health services to people aged 65 years and over. These services address the needs of older people experiencing all types of mental health issues, including both functional mental health disorders (eg. depression, anxiety, suicidal ideation, psychosis, schizophrenia, bipolar disorder, personality disorders, etc) as well as mental health issues stemming from organic/neurodegenerative conditions (eg. Behavioural and Psychological Symptoms of Dementia; Huntington's disease, etc).

Client Population

The client population is characterised by the following:

- An increasing ageing population;
- Ranging from younger older person, who may be both physically and cognitively robust, but presents with serious mental health distress older, to the frail people with multiple co-morbidities (physical and mental);
- Rate of completed suicide markedly increases over the age of 65 years;
    - Males over 85 have the highest suicide rate in Australia (National Ageing Research Institute, 2010);
    - Older men are 3 to 4 times more likely to commit suicide than older women (ABS, 2011)
- Older people entering residential aged care being at particular risk of anxiety, depression, and loneliness;
- Older Care Leavers (eg. Forgotten Australians, Stolen Generation) with either long-term or later onset mental health issues due to life-long trauma histories;
- Older CALD patients with either long-term or later onset mental health issues due to migration/refugee experiences, language barriers, and social isolation.
- A correlation between the severity of physical illness(es) and mental illness, meaning those individuals are presenting with both significant physical/ and mental health co-morbidities.

Changing patient cohort:

There is a gradual change in the patient cohort, as we move from the Traditionalist Generation into the first of the Baby Boomer generation. The Baby Boomer cohort are demanding a more holistic and consumer-directed approach to their mental health, and are expected to demand better quality and more accountable services into the future. This requires a culture change within the Aged Mental Health sector and staff that are well-versed and skilled in the Recovery Model and its psycho-social knowledge base and skills. The newer

patient cohort are presenting with more complex psychosocial care needs, due to more complex family structures (Australian Institute of Family Studies (AIFS), 2019), complex financial situations (AIFS, 2019), migration/refugee histories, substance use and addiction issues, trauma experienced throughout the lifespan (including family violence, child abuse, sexual assault, institutional abuse (eg. Forgotten Australians), elder abuse, and grief/loss and bereavement issues). [AIFS, 2019]

KEY ISSUES

Underfunding

Aged public mental health has been consistently underfunded for many years. It is often over-looked in 'growth funding', and funding it does receive is disproportionate to the funding allocated to adult and youth mental health services. This is partly due to ageist attitudes, and due to the fact that aged mental health sits between both the aged care sectors and the mental health sector- and subsequently, tends to fall between the two.

Service/Staffing gaps

Underfunding within public aged mental health has continued service or staffing gaps in many areas:

No gradation or 'continuum of care' service delivery:

- No crisis service for older people (eg. CAT team)
- No 'step up-step down' facilities (eg. PARCs)

Limited specialist services:

- No Dual Diagnosis specialists
- No Forensic specialists

Limited Lived Experience Workforce:

- Limited or no Consumer/Carer Consultant or Peer Support Worker positions

No Community Psychosocial Support services:

There are no community psychosocial support services for older people, with an inaccurate assumption that the aged care system can meet this need. Clinical mental health services currently don't have the resources to provide this support. Older people need service providers with psychosocial focus and mental health skills to address their often-complex

psychosocial needs in the community – this is more complex than the support provided by domestic or personal aged care services.

Limited allied health in all streams (acute, community, residential)

Old, unsuitable infrastructure:

Many aged mental health facilities were built many years ago and are not fit for purpose. There is an increasing acuity of consumers admitted to aged mental health facilities and the current designs of facilities does not lend itself to managing behavioural disturbance. Many facilities provide no areas for quietness and reflection, no spaces for consumer and care connection, no interview room for privacy and confidentiality, and no intensive care areas (and staffing models) to separate, contain the risk and manage the extremely highly aroused and/or aggressive consumers).

As with adult mental health services, the gender mix within acute facilities continues to present sexual safety issues for older women and dementia patients. Whilst a gender mix may be considered a positive environment for day activities and to facilitate social Recovery, it is considered an unsafe mix within the bedroom/bathroom areas of facilities. The current facility structure is not designed to ensure safety within bedroom/bathroom areas.

Medical Model vs. Recovery Model

Despite a mandate to deliver mental health services from a Recovery model, mental health services continue to operate predominantly from a medical model. This is even more so the case within aged mental health services, due to the significance of physical health issues within older consumers. The continued dominance of the medical model has meant:

- Clients are not receiving a holistic, person-centred and integrated approach to mental health care;
- The focus of care is still largely based on diagnosis and symptoms, rather than on a consumer's past and present situation and experiences (including trauma experiences) and the impact of these on their current functioning and quality of life;
- An unhealthy dependence and focus on pharmacological interventions, rather than utilising a broad range of psychosocial interventions;
- A limited trauma-informed care approach;
- Poor recognition and response by clinicians of significant social issues impacting on consumers, such as past abuse/trauma, elder abuse, substance use and addictions, grief/loss/bereavement, financial stress, family conflict, discrimination/exploitation, sexual assault, risk to children, forensic issues, intergenerational conflict, and issues relating to cultural diversity and the migration/refugee/asylum experience.

- Consumers becoming bored and agitated in acute settings due to a lack of availability of therapeutic counselling or group programs.

The Medical Model and Social Work

Acute setting:

The limited funding of social work services in the acute setting has continued to restrict the social work role to that of a traditional caseworker, whose primary focus is to lead discharge planning and to promote bed flow and patient throughput. While many social workers engage in excellent casework and advocacy for consumers, and some acute settings do provide some time for family liaison work (such as convening of family meetings), social workers generally have no time to utilise their therapeutic skills to provide individual counselling to consumers or to run therapeutic group programs. This means that the full range of skills of a mental health social worker are not utilised, and consumers miss out many non-pharmacological interventions and therapies. This is particularly unfortunate in the aged mental health setting where the length of stay provides an optimum time to deliver psychosocial therapies. *[It would be worth looking at overseas models, eg. Singapore, where acute aged mental health units are staffed with a combination of general social workers and therapeutic social workers]*

Also, of note, is the increased demand on social work services as a result of greater awareness and recognition of social safety issues. The outcomes of the Royal Commissions into Family Violence and Institutional Abuse, has meant that there is now greater recognition of abuse/trauma issues (eg. elder abuse, intimate partner violence, childhood sexual abuse, etc.) and a greater demand placed on social workers to assess and respond to these issues in aged mental health. Whilst the demand is steadily increasing, and the complexity of client situations is increasing, the resourcing of social work services remains at the same level. This pressure on social work services cannot be sustained.

Another particular concern of social workers in the acute setting is the mix of organic and functional mental health issues. Aged acute inpatient units have a mix of consumers with dementia and behavioural disturbance and functional mental health illnesses such as depression, anxiety, bipolar disorder and schizophrenic illnesses. The mix of very frail older patients with dementia and older people who are physically robust and cognitively intact is becoming more difficult to balance- it tends to create greater depression, anxiety, trauma and a loss of hope in consumers entering the acute units who are cognitively intact. This mixing of cohorts does not create a therapeutic and healing environment, and results in

patient emotional harm (Usher, 2016). Hence, acute aged mental health units require more specific units for consumers with dementia or cognitive decline.

Aged community mental health teams:

Unlike many adult community teams, aged mental health community teams continue to have limited allied health staffing. These teams clearly need to be more multi-disciplinary to increase the knowledge base and treatment options for the vast array of mental health and psychosocial issues that are presented. In some aged community teams, there are unwritten rules about limiting social work and occupational therapy EFT to ensure the majority of positions remain with nursing. This has also led to the majority of community teams being managed by nursing staff, despite allied health clinicians being equally capable of leading and managing community aged mental health teams. Equal ratios of all disciplines would lead to a greater likelihood of the provision of more holistic, recovery-oriented care and a fairer opportunity for all disciplines to move into management positions.

A further long-standing issue is the generic nature of aged community mental health teams. As all positions tend to be generic case manager (or 'key clinician') positions, the specialist nature of discipline positions has been lost, and tends to de-skill clinicians in their discipline-specific knowledge and expertise. This is particularly problematic for newer clinicians who have not had many years to develop their professional identity or expertise. Hence, the non-existence of discipline-specific roles in community teams is problematic in terms of providing specialist interventions, and also poses problems in terms of allied health job satisfaction and allied health recruitment and retention (Hayes, Bull, Hargreaves & Shakespeare, 2008).

Residential Mental Health Aged Care Facilities (formerly Psychogeriatric facilities)

In recent years there has been some reduction (closures) of specialist residential mental health aged care facilities. Whilst some of these facilities were clearly old and unsuitable for mental health aged care, this means that many mainstream Residential Aged Care Facilities (RACFs) have been forced to take the bulk of the load of residential mental health care. Unfortunately, mainstream RACFs are not well equipped to care for residents with mental health issues, because:

- Residents do not have regular access to, and ongoing care from, psychiatrists or mental health social workers/clinicians.
- the current Aged Care Funding Instrument (ACFI) does not adequately support funding for behavioural symptoms/ perceptual disturbances associated with mental illness or behavioural and psychological symptoms arising from dementia

- Many RACF staff are not only poorly trained in Aged Care (eg. 10-week Aged Care courses), they have almost no skills or training in dealing with mental health issues or complex behaviors.
- Whilst specialist visiting support services (eg. DBMAS, BASICS, etc.) are beneficial resources, they are temporary and time-limited.

This also means that residents with mental health issues are at more risk of institutional elder abuse, restraint and restrictive practices, over-medication, under stimulation, and neglect. Families often choose mainstream RACFs over public mental health RACFs because mainstream facilities are newer and purpose built for aged care, even though they do not necessarily meet the mental health care needs of the resident.

RECOMMENDATIONS

41. Increased funding for the aged mental health sector to ensure a recovery-oriented and holistic model of mental health care.
42. Introduce specific *therapeutic* social work roles in both acute and community teams to ensure a more comprehensive and effective mental health service for consumers.
43. Provision of dual diagnosis and forensic specialists to aged mental health services
44. Introduction of a specific aged mental health residential social work position to provide a range of services to residential mental health aged care facility residents, including counseling (focused psychological therapies), casework (including assessing and addressing suspicions of elder abuse/sexual assault), residential transition work (in and out of facilities), family work (including family-facility mediation or conflict resolution), residential rights and advocacy work, staff education and training, and community liaison and development work to address social isolation and loneliness of residents.
45. Establishment of a new service delivery model that provides separate, recovery or person-centred treatment and care for consumers with dementia and consumers without.
46. Re-design acute facilities to ensure gender mix occurs only in supervised day activity areas, with no gender mix occurring in bedroom/bathroom/toilet areas or other areas where patients may be particularly vulnerable.
47. A review of the model of care for aged mental Health that includes consumer lived experience workforce and involvement in all aspects of the services.
48. Upgrading and expanding public aged mental health facilities (both acute and residential) to meet basic community expectations, such as private rooms or single bathrooms/toilets, availability of family rooms or private consultation rooms.
49. Review of ACFI to better support funding for mental health conditions.

Section 7. Service collaboration

The NDIS, while benefitting many disabled people, is not a comfortable fit with Mental Health. Working within a Recovery paradigm recognising that mental health conditions can be episodic does not match the NDIS criteria. The loss of funding of many programs run by recognised agencies (eg MIND, NEAMI) has left a significant gap in the services available and valued by consumers. Many NDIS service providers do not have experience of mental health.

Building connections between agencies and staff on behalf of consumers is an underrated skill. Social workers are good at creating opportunities for social connection for their clients. Smoothing the way for clients to be successfully included in community groups and generic services does not happen without behind the scenes systemic work. Research demonstrates that action taken to improve social wellbeing and a person's social capital directly promotes good mental health. Social work has expertise in this often overlooked and undervalued area.

Clinicians are time poor as a result of high caseloads and burdensome administration & reporting requirements. Since the introduction of the NDIS and the loss of the MHCSS services there has been less opportunity to develop these important networks which allow people with a serious and enduring mental illness to successfully engage with local community facilities.

The NDIS does not fund services to engage in this back of house relationship and partnership development. Nor are services funded by the NDIS to attend case conferences and coordinate care with clinical mental health services.

Social work recognises the importance of the community context to mental illness and the importance of building community resilience to support mental wellbeing. Mental health services need to work in partnership with local communities and support communities to develop their ability to promote good mental health and include consumers in their programs. Advocacy work needs to be undertaken with a range of social and human services to ensure that stigma is reduced and the needs of people with a mental illness are understood and accommodated by these services.

Recommendations:

50. Increased funding for Area Mental Health Services to enable lower caseloads and the opportunity for important linkage work to be done with consumers.
51. Specific community development/social work positions within each Area Mental Health Service to enhance the development and maintenance of partnerships with key agencies (housing, income security, community services, carer supports, NDIS providers, migrant services etc). Policy and protocols could then be developed for

service delivery in areas of interface between mental health and other social and human services.

52. For the NDIS to better understand the needs of people with a psychosocial disability and fund services to undertake the necessary coordination and collaboration with clinical services.

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