BANYULE
Community Health

SUBMISSION TO THE VICTORIAN ROYAL COMMISSION INTO MENTAL HEALTH, 2019

Executive summary

When Banyule Community Health consulted with our community, what we heard overwhelmingly was that people want access to help when they need it, in places where they feel safe and where care is provided by people who welcome and accept them, no matter what their range of issues may be.

Banyule Community Health (BCH) is optimistic that this is entirely possible. However a vastly improved experience for all Victorians seeking support for their mental health will not be possible unless the things that impact most significantly on people's health, the Social Determinants of Health, are concurrently addressed. BCH holds that this Royal Commission into the Mental Health of Victorians must support a **whole-of-government** approach, social and economic, in realising a new and better way forward.

BCH has the following vision for the mental health of Victorians;

- *All Victorians at every age and stage are supported to thrive*
- *People feel a part of a community and have places to meet and connect in a variety of ways*
- *Environments are welcoming places where people feel valued, respected, included and safe to have conversations about all aspects of their health and wellbeing*
- *People with lived experience of mental health issues are central to designing, delivering and evaluating services targeted to them*
- *No person is ever turned away from a service when they are concerned about their mental health*
- *Workplaces, schools, clubs, groups and places of worship drive improvements that promote the mental health of all Victorians.*

Assumption

In using the term "mental health" BCH sees comorbid addiction of any kind as entirely interrelated, requiring an integrated response.

Summary of Recommendations

Through this Royal Commission, BCH hopes that;

- A long term vision for a mentally healthy Victoria is designed, implemented and maintained
- People with lived experience of mental illness are central in the reforms
- Changes are made taking a considered and measured approach
- The Social Determinants of Health are recognized and form part of this reform agenda
- That mental illness becomes more widely understood through open conversations
- There is significant investment in early intervention, prevention and integrated community based support.

Acknowledgement of Lived Experience

BCH foremostly acknowledges the contributions of people with lived experience of mental health distress, their carers and loved ones. These contributors include people who have shared their experiences for the first time and many more people who have shared their stories again. BCH acknowledges the courage of these contributors and their persistence in the re-telling of difficult and distressing events, histories and current realities. Accepting that what has occurred in the past cannot be changed or undone, people have shared not only in the hope that their quality of life may be improved in their own lifetime, but that their experiences inform new benchmarks for what is and isn't acceptable in health care.

Contributors to this Submission

BCH community members, many of whom have experienced poor mental health, who want a better mental health system for themselves, their families and their community.

BCH staff who support members of our community who are marginalised, vulnerable and often without a voice, themselves as workers and their families and communities.

BCH friends and partners who work together collaboratively towards system improvements, big and small.

Banyule Community Health

BCH is a stand-alone, not for profit organisation, governed by a volunteer Board of Directors to deliver on its purpose 'to improve the health and wellbeing of our community'. BCH works across many sites and delivers multiple modalities of care and support in the primary health and welfare sector. Building on its strong values base and reputation of being truly responsive to its community, BCH strives to continually provide high quality services, develop partnerships which benefit its community and innovates to create better health outcomes and health equity.

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SUBMISSION TO THE ROYAL COMMISSION INTO MENTAL HEALTH

Community Health - Multidisciplinary Service Hubs Focusing on Whole of Person Care

BCH estimates that 80% of people accessing the range of community health services offered at BCH are experiencing symptoms of mental health distress. In very rare cases, these may be discreet episodes in an otherwise reasonably well person; but overwhelmingly our clients are experiencing poor mental health along with chronic physical health issues and significant other stressors in their lives. The prevalence of mental illness for patients attending the BCH Medical Practice is 29.5%, well above the Victorian and National average which are both 17.5%. BCH rates of comorbid substance use problems are also higher at 5% compared to the state average of 1%. Half of all external enquires to access services at BCH relate to mental health concerns.

BCH utilises state and federal (short term) funding to deliver AoD services to its community and has secured a further short term federally funded grant to deliver mental health stepped care services. These services make some headway in addressing the mental health needs of the community but demand always outstrips capacity. BCH receives no funding from the state of Victoria to deliver mental health services.

Welcoming Community Spaces

BCH delivers a wide range of services from many sites but sees improved client outcomes where numerous supports can be accessed from one location. Wherever possible, BCH locates staff in integrated health and wellbeing centres (Community Health Centres) where care for mental and physical health can be delivered alongside other commonly interrelated needs such as housing support, help with financial and legal concerns and family violence advice.

Operating out of two main sites and 16 colocations, BCH operates a purpose built facility in the heart of West Heidelberg. Offering over 34 services from this location and including community spaces, computer and WIFI access, informal indoor and outdoor areas and a café means that many local people feel they have a safe, inclusive and welcoming place to be, both when they are feeling well, and not well.

Connected People, Connected Care

Whether service users or service providers, one thing is clear, people need to be able to connect with others in relationships where there is safety, trust and respect. Working with vulnerable population groups, where client needs are expected to be complex, BCH staff report that their ability to provide holistic, flexible, timely and tailored care is made possible by easy access to a multidisciplinary team. BCH employs counsellors, psychologists, social workers, peer workers, nurses and care coordinators within its mental health and addiction program and in other areas of the service. Specialists such a as psychiatrists and addiction medicine experts are co-located. The benefits of a multi-skilled workforce include increased safety and quality of care for workers and clients.

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"It became clear that peer workers, psychologists and nurses spoke about clients differently. Over time the peer workers have positively influenced the language of other team members".

-BCH Care Coordinator

Providing a broad range of support for mental and physical health and other concerns under the one roof leads to care that is coordinated, simplified, integrated and works with pressing needs as determined by the client. Further, warm referrals are made possible where one staff member can personally introduce another and make linking to other supports easier for our clients.

"Many of the group members come and say how it was a struggle to get out of bed and come, but that they made themselves do it. We have a cuppa and a laugh and we draw and paint...and talk about all sorts of things. And we know we are not alone in our troubles and we are safe together. If anyone needs any extra help we can do that because it's all here" ***-BCH Volunteer Artist***

Service Gaps

BCH is committed to addressing the Social Determinants of Health through integrated services that create easy to navigate pathways of service delivery for our most vulnerable clients. Like others, BCH is concerned about the growing number of people who require longer term or more intensive support than the primary care system is resourced to provide. Many of these clients do not meet the threshold of acuity to be eligible for state funded mental health care either. This gap in service delivery between what the state and federal mental health systems provide is known as the "missing middle", where people who are experiencing high levels of mental health distress have only help-lines or emergency departments to call on for help.

In recent times, capacity to meet client needs has been adversely affected by the number of chronically unwell clients either unable to obtain NDIS funding or needing significant assistance due to the protracted & complicated NDIA application process. Often when clients are successful in obtaining NDIS funding, services are not available to meet the support needs. As a result BCH is unable to service many clients who would otherwise be able to access our supports and they often become more unwell as a result of the added stressors and uncertainty. There is a clear need for appropriate programs that support people throughout their mental health journey, rather than interactions that are small, meaningless and transactional in nature.

".. I have used many hours dealing with NDIS.. one client who first applied for NDIS .. was rejected sixteen months later.. we have supplied additional documentation ..and today we still have no idea where his application is at. I call NDIS every few weeks and I am told they cannot give me any information ... In the meantime the client goes without the support he should have. I have another client in a similar situation and I was told recently .. "do a whole new application" ..however that means my client would have to get new documentation which doctors are not keen to continue to do. At the end of the day it is always the clients who suffer".

-BCH MH Stepped Care Coordinator

Recommendation: Taking a whole of system and whole of government approach, dedicate the time needed to co-design a new system with all stakeholders and implement changes carefully over time, maintaining engagement and supporting significant cultural change where needed. The Social Determinants of Health are key drivers of poor mental health and **must** be addressed as part of this reform.

Recommendation: Work with consumers to develop definitions of terms such as "integrated", "client centred" and "flexible" care so that there is a shared understanding in Victoria of what is required, expected and acceptable in healthcare and provides the means for measurement against these terms.

Recommendation: Scale up community based, multidisciplinary mental health and addiction services to provide out-of-hours and home-based support to the "missing middle". This can be done in the short term while longer term plans are developed.

Recommendation: Invest in community based hubs that are designed in close collaboration with their local communities, are welcoming and inclusive and which cater to a broad range of community need in close proximity to other community based services such as schools and recreational facilities. Strong links should exists between the hubs and tertiary care for acute physical and mental health concerns equally.

Recommendation: Prevent avoidable deaths where high risk can be foreseen by prioritising the development of strategies to drive improved safety and more culturally appropriate care in known cohorts showing high levels of mental health distress.

Access & Outcomes - Building on Existing and Emerging Evidence

There are many current examples of care that demonstrate excellent client outcomes. Typically these services are designed based on long-term observations and consultation regarding consumer need, are resourced and supported in a manner that is likely to promote successful service delivery and use client input and feedback to continually monitor performance and design improvements in a continuous cycle. At BCH, our most successful mental health and addiction programs expect complexity, reduce barriers to access, include access to peer workers and work as a team to provide the most flexible and tailored care possible within the resources available.

> *"It's the only thing I've come across that has made me feel there's other people out there like me".*
>
> ***-BCH Peer Support Recipient***

Recommendation: Invest in community based mental health care which has a strong interface with tertiary care, facilitating seamless transitions as needed. Eligibility for mental health care should be open to any person concerned about their mental health state whether mild, moderate or severe and mental health services should be able to attend to other co-occurring issues. Drug use, homelessness, catchment boundaries and acuity of illness are some of the most frequently reported barriers to support.

Recommendation: Prevent avoidable deaths by scaling-up service provision and resource the mental health system adequately in the long term so that people get the care they need, for the duration and intensity they require.

Recommendation: As part of the co-design process, invite presentations and interview service deliverers and their clients where existing examples of safe, client centred, integrated and flexible care models can be demonstrated. This may inform opportunities for scaling up in the short term or inspire a longer term hope and vision for what a better mental health system could look like.

Efficient, Accurate and Meaningful Data Capture

While BCH staff and consumers can provide a narrative demonstrating successful outcomes, data capture rarely provides an accurate representative of this. The BCH program area that works with mental health and addiction alone use 7 mutually exclusive, incompatible data bases and data sets. Most staff report into at least two databases per funded stream requiring training, monitoring, error reporting and data cleansing, consequently posing a barrier for staff with transferable knowledge and skills to work across teams or co-manage client work. BCH service delivery across all programs is reported into 12 databases, with multiple requirements for double and sometimes triple entry.

> *"Working to support clients who have significant mental health and substance use issues I enter notes into the hospital database and then into the AoD database and then I record a third set of data separately to ensure that my team are clear on plans for discharge and referral, so they can assist the client to get to the next step in treatment".*
>
> ***-Dual Diagnosis Care Coordinator***

Recommendation: Develop a shared state-wide outcome measurement tool to ensure all funded programs are monitored and evaluated against measures that demonstrate performance against desired outcomes, as informed by this inquiry.

Recommendation: Eradicate inefficient data capture and move towards simple electronic means of collecting, storing and transferring data that better supports the management of transition and continuity in care.

Recommendation: In consultation with consumers, consider the implications of the separation between the storage of physical health information and mental health information including its role in perpetuating stigma, the structural barrier it poses in providing holistic, joined-up health care and implications for accuracy in recording mental health prevalence as a principal diagnosis within this system.

> *"Trying to monitor and evaluate our work in the ED was made more difficult by data recording. If someone sustains an injury in the context of major mental health distress, they may be categorised as a person with a broken bone"*
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> ***-AoD Care Coordinator, ED***

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It's time to consider opportunities

Victoria and Australia are not alone in the struggle to determine the best ways of seeding intergenerational mental wellbeing for its people into the future. Although it is unarguable that more investment is needed, this inquiry presents a unique opportunity to consider models of care that build on strengths and emerging evidence.

The recent state investment to address the alarming and growing rates of homelessness in Melbourne is encouraging. Insecure housing was a commonly cited barrier to effective mental health care during this consultation. Models of supported social housing that are trauma informed and attend to the range of intersecting issues are in gross undersupply.

Locally and internationally there are good examples of successful and cost effective models of mental healthcare that may have good local application or ability to be scaled up.

Ember Korowai Takitini, Integrated Mental health and Addiction Service, New Zealand
Building on rich sector knowledge and experience, this collaboration integrates AoD and MH services with other wrap-around support and uses innovative means to consider how it may best serve its communities now and into the future. One of its programs makes mobile peer support an option for people concerned about their mental health and in need of connecting with others who understand that experience. https://ember.org.nz/

Recovery starts with hope…even the slightest glimmer! Recovery in Peer Support comes through seeing ourselves as people, rather than as 'mental health patients'. It's about building relationships where new information and knowledge can emerge and where each person can start moving towards the life they choose.

Reach Out Program, Ember Korowai Takitini

Community Mental Service, Trieste, Italy
Since 1980 the city of Trieste has closed psychiatric hospitals and set up a network of 24-hour community mental health centres capable of dealing with the most severe conditions and of supporting clients in their daily life, with a vision towards recovery and social inclusion.
http://www.triestesalutementale.it/english/mhd_department.htm

> *"As a result of the community mental health centres, deep changes have also occurred in the attitude of communities towards mental health issues."*
> —Roberto Mezzina, Director, MH Dept / WHOCC, Trieste

The Friendship Bench, Zimbabwe

The Friendship Bench is a model for connecting people with conversations about wellness. With just 11 psychiatrists and 20 clinical psychologists for 13 million people, Zimbabwe had to radically rethink how it would attend to the growing mental health crisis in its population. Friendship benches were introduced locally and are now being scaled up internationally as an evidence based model of intervention that enhances metal wellbeing and quality of life. https://www.friendshipbenchzimbabwe.org/#!

> *"We are not conventional, our therapy rooms are outdoors under trees and our therapists are elderly Zimbabwean women. These women are city lay health workers who have become known as "community grandmothers".*
>
> - Friendship Bench Project, Zimbabwe

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Recovery and Support Program (RaSP), Banyule Community Health

Supporting each other to be the people we want to be, working out how to get "un-stuck" from negative thought patterns and learning how to sit with very uncomfortable emotions has ultimately been helpful for participants wanting to move beyond their mental health and substance use issues. Listen to one participant share her journey in this 3 minute clip: https://youtu.be/Oo_UMd0JdAU

Recommendation: Take the time to review existing and inspiring research findings and consider the local replicability of evidence based models of mental health care, which demonstrate the outcomes called for by Victorians.

Recommendation: Consider the development of Apps that can better connect people to the care they need in a mental health crisis. Recently developed Apps such as GoodSAM demonstrate that it is possible to mobilise local people with suitable skills to respond in times of crisis. Bear in mind that the use of social media applications are unlikely to reach some parts of the community and should not replace on the ground services.

Towards a Thriving and Empowered Workforce

High workloads are symptomatic of chronic under-resourcing, continued sector re-shuffling and burdensome data entry in the face of clear and increasing client need. Workload pressure frequently leads to exhaustion and burnout in this sector. In order to consistently deliver care that is safe, empathic and hopeful the workforce needs appropriate levels of staffing at a minimum. The workforce feel particularly undervalued when they struggle to take breaks, work longer hours attending to crises or cumbersome data entry and worry, when they do take breaks, about returning to their high caseloads.

A recent survey of BCH staff showed that the ability to work in teams was particularly valued by the workforce. A high staff engagement rate was reported when better and more coordinated client outcomes were seen and when teams worked collectively towards improving the health and wellbeing of the communities they work with. Despite high staff engagement and positive client

outcomes there is no long term funding commitment for many of these programs, leading to instability in continuity of employment, for which clients ultimately suffer.

> *"I had a dual support worker who did outreach and adjusted things to suit the way I did things, he would come check in with me at my house or we would go for a drive and talk. I was making a lot of progress but then the program was defunded and there was no handover or referral for any other service. The lack of quality assessment of how I was really going and lack of follow up after discharge has happened to me again and again in the mental health system."*
>
> **-BCH client**

In order to deliver high quality and safe care, those working in the mental health system need regular access to a variety of professional development opportunities including reflective practice that is tailored both to peer and non-peer workers.

> *"With the* [peer work] *supervisors with lived experience, they just look at you differently. You can talk about stuff that will bother you as a peer, and they'll understand what you're talking about".*
>
> **-BCH Peer worker**

There are also promising indications where Communities of Practice can be locally supported and include people from a range of disciplines or are multi-agency in structure. These forums support better client outcomes by linking and strengthening the relationships between the people in the service system and form rich learning platforms for workforces.

> "These meetings provide the ability to network, collaborate and learn from other staff that I wouldn't normally engage with; we combine ideas and approaches resulting in holistic outcomes for our clients"
>
> **-BCH Drug and Alcohol Care Coordinator**

Recommendation: Adequately resource the sector with the appropriate workforce mix that meets the needs of the community, offers stability of employment (and therefore service delivery) and within considered models of care that promote the mental health and wellbeing of all parties.

Recommendation: Further develop a peer workforce utilising the recently launched Victorian Lived Experience Workforce Strategy, and support a thriving peer workforce into the future.

Recommendation: Ensure safety and quality in care by providing access to appropriate reflective practice supervision within a clinical governance framework.

Recommendation: Establish or build on existing localised workforce development strategies that brings mental health and addiction providers together regularly for shared planning and collaborative opportunities. Ensure that local strategies maximise opportunity for mental health issues to be better understood within the broader health system, including allied health.

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Longsighted Shared Stewardship

It is widely agreed that the current Victorian mental health system is under resourced and operating in crisis mode. Although it will and should take time, there is no doubt that increasing resources to the "missing middle" will lead to a more cost effective health system and broader social and economic benefit in turn. As mentioned, significant added pressure to the system has been widely observed in the rollout of the NDIS and was one of the challenges most commonly cited by BCH clients and staff.

The recent cycles of funding and commissioning in this sector and the implementation of recommendations in other Royal Commission processes should have a place in informing the best ways to deliver on this inquiry. The Victorian and Australian mental health systems hold a legacy of "band aid fixes" that are inherently flawed, rapidly implemented and ultimately deliver poor outcomes in the absence of a shared long term vision and commitment.

Recommendation: Ensure that the planning and designing of a new system is fully integrated with a clear and shared vision towards long term measureable outcomes and holds people with lived experience central throughout.

Recommendation: Work towards the pooling of all Victorian funding for mental health and addiction together with Commonwealth funding/investment and commit this in the long term. This will provide stability in the workforce, provision for multi-skilled and integrated teams across the spectrum of need and the ability to continuously monitor and improve models of care over time.

Recommendation: Limit rapid commissioning of service delivery to emergency or extraordinary circumstances.

Recommendation: Recognising that *pilots* and other short-term initiatives serve only as a purposeful mechanism for legitimate trialling of new innovations or improvements and are integrated with funded services thus serving as meaningful opportunities to make improvements to services over time.

Recommendation: Thoroughly review the actual implications of requirements for annual acquittal of funds across the funding continuum and whether funds could be managed more effectively to deliver better value for investment against agreed long term strategies in longer term cycles.

Recommendation: Consider the disruption caused by competitive tendering. While competitive tendering may be appropriate for vastly new or innovative programs that cannot be catered to within the existing resource, it serves mostly as a significant disruption to the governance, day to day operation and client experience of the existing service system. This time would be better invested working collaboratively with consumers and in regional planning, monitoring, evaluating and improvement cycles.

Recommendation: Given the implications to state funded mental health care, advocate for a critical review of the NDIS; its ability to deliver timely and appropriate care for people with severe and enduring mental health issues, the critical role of coordinating supports in the longer term, NDIS planning review mechanisms and the pricing schedule.

Early Intervention and Prevention

From a Community Health perspective a key component to early intervention and prevention of mental illness is connection; the ability to have people linked with a person, service and place where they feel known, welcome and safe. Local community based organisations are well-placed to embed mental wellness within communities and provide connection across the lifespan together with holistic integrated responses as needs change.

BCH works actively in the early intervention and prevention space through many programs and groups based on community interest and need. Informal, social and peer connection groups such as exercise groups, supported playgroups, discussion forums and wellbeing groups for vulnerable community members foster new connections within the community and also with staff. Community social capital is built when environments and conditions are conducive to building and maintaining social connections.

Screening for mental health issues across all health services and referral when appropriate is an important element for early intervention at BCH. Priority appointments are made available across the health service where there are severe mental health concerns. Despite this, the system continues to fail people when opportunities to prevent deterioration cannot be serviced.

> *" As a peer worker one of the things I do is to draw on my lived experience to support clients in making Wellness Action Plans so that if they start to become unwell they have a framework to help them recognise their symptoms and seek appropriate help before becoming seriously unwell. I had a client who had the presence of mind to act on his Wellness Plan and seek help in the hospital system after speaking to one of the 24hr phone supports. He sat in ED for several hours, becoming very distressed, before being told that because he had the insight to seek help, he couldn't be as unwell as he thought. He was sent home without being seen by a specialist mental health practitioner and was understandably extremely frustrated and angry that having followed his plan he couldn't get the support he needed as he "wasn't sick enough".*
>
> ***-BCH Peer Worker***

BCH delivers services to families with young children, working with the whole family to promote health and wellbeing earlier in life. Programs at BCH such as the *Early Years Health and Literacy program* and supported playgroups take a trauma informed approach to breaking the intergenerational cycle of complex trauma, disadvantage and poor mental health. The early years (0-5) are a critical time for intervention to prevent poor mental health. These programs foster social connection for caregivers and promote positive attachment and early communication between parent and child through songs, rhymes, stories and more. These positive interactions help lay the foundation for children's social and emotional wellbeing and mental health.

The Youth Foundation West Heidelberg is a youth led community strengthening program that focuses on promoting holistic wellbeing by promoting positive places, people and experiences. The program engages young people to lead projects to address issues that concern them and make a real difference in their community. For example, Parkville Flexible Learning College hosted a charity art

exhibition, showcasing students' work from across the campuses to raise funds for Headspace and The Smith Family.

> *"We had a place to show our art and share our voice, where we felt safe, loved and supported. We have also given back to the community – mental ill health affects most of us here."*
>
> ***-Youth Foundation Participant***

A significant proportion of young people in their middle years (particularly those with a disability, young carers, materially disadvantaged, CALD, indigenous and in out of home care) have poorer health and wellbeing, and are missing out on opportunities at this crucial time. BCH is considering combined efforts with local schools, parents and children that take into consideration the changes and transitions experienced in the middle years. Youth Foundations are developing project ideas to support the engagement, wellbeing and development of young people aged 10 – 14 years, as they transition from primary school to high school. The use of electronic devices by young people is a significant concern for the workforce and caregivers in terms of the impact on relationships, behaviours and overall wellbeing.

Recommendation: Knowing that most mental health concerns start before 24 years of age, schools should be used as a key platform to promote strategies and behaviours that promote good mental health and wellbeing. Schools could be resourced and supported to focus on promoting resilience, building coping skills, dealing with uncomfortable emotions, learning to identify early warning signs and providing avenues for early intervention support that are simple and timely to access.

Recommendation: Increase the availability of clinical services for young people with no waiting times or session limits, within appropriate and safe models of care that are family inclusive.

Recommendation: Urgently enquire into the effects of electronic devices on the mental health of young people, with a particular focus on links to addictive behaviours as gaming and gambling. In an environment of rapid advances to technology and clear early warning signs in children and young people, this is an example of an opportunity to intervene up-stream.

Recommendation: Work with key stakeholders such as local government to promote community connection by providing positive places, people and experiences for vulnerable communities and young people.

Recommendation: Roll-out freely accessible state-wide mental health first aid training in schools, communities, clubs and workplaces.

Recommendation: Support and resource the public and private sectors to promote better mental health and wellbeing in all workplaces.

Recommendation: Develop and maintain a strong mental health communication strategy with clear and regular messaging as the service system is redesigned and rebuilt so that *knowing where to go for help* is easy to navigate.

Recommendation: Via public awareness campaigns, make mental health "everyone's business". These should focus on reducing stigma, promoting good mental health and support timely help-seeking behaviour. In order to deconstruct the notion that mental illness cannot be talked about, campaigns should move beyond broad awareness and messaging and encourage conversations at an individual person-to-person level, particularly given the high prevalence of these experiences.

Recommendation: Invest in universal access to mental health care to prevent any further deterioration in mental health. Consider flexibility in service delivery and workforce mix where services may be able to provide a range of interventions from prevention, early intervention, on-going service delivery and crisis support within the one service.

Recommendation: Given the episodic nature of mental illness ensure aftercare and follow up is built into the system so that recovery can be supported over time and people can link back into support if they need. The ability to access and utilise relapse prevention or wellness plans, advanced care plans and flexible support options for follow-up are much more likely to lead to better recovery experiences and outcomes.

Recommendation: People with mental health issues should be screened for common physical health conditions. There is a significant disparity in health outcomes for people with comorbid mental health and substance use often because of diagnostic overshadowing.

Recommendation: Conduct a literature review of local and international evidence of the causes and contributors to poor mental health and develop an informed research agenda.

Addiction and Mental Health

A recent survey conducted by the Victorian Alcohol and Drugs Association (VAADA) found that the greatest concern for the Victorian AoD workforce is that their clients will not get appropriate mental health care, if and when they need it.

The capacity of the AoD sector has been strengthened by recognising the links between drug use and poor mental health, commonly known as dual diagnosis. BCH estimates at more than 70% of people accessing the service for mental health support have issues with other substances including prescription and over the counter medications.

The availability of a range of support in one location builds confidence in clients and enables them to work on issues based on what they are ready to address. The central location also makes attendance at appointments less complicated and more likely. Staff are also well placed to coordinate complex needs within a team care approach. This sense of team care can enhance clients' appreciation of the service and their own personal feelings of self-worth. Recognising the prevalence of intergenerational trauma along with traumatic experiences of the healthcare system is critical in establishing safe and effective therapeutic relationships and models of integrated care.

Increased access to peer support workers and peer led groups in AoD and mental health have increased client engagement and trust often creating health pathways into services through informal, non-clinical relationships and settings. Catering to the wide variety of client needs and preferences BCH deliver a non-residential dual diagnosis rehabilitation service, AoD and MH counselling, care coordination, GP liaison, onsite AoD support within the local Emergency Department, onsite drug withdrawal nursing care and peer support provided by both paid workers and volunteers within the community health environment.

> *"I started going to the BCH drug and alcohol peer support group to connect with the West Heidelberg neighbourhood into which I had recently moved. A voracious drug abuser most of my life, my appetites had left me close to death on occasion and ultimately saw me serve five years in prison. The*

group has helped me laugh off the gloom and see that for all our different paths to sobriety, there is a common, unifying task for us all. That task is to help navigate away from the anxiety, depression and self-loathing. And that nurturing a mentally healthy outlook is essential personal housekeeping".

-Volunteer AoD Peer Group Leader

Clients experiencing harmful gambling report high rates of mental health distress and are at higher risk of suicidal thoughts and behaviours. Of the participants in the BCH telephone based peer support service *Peer Connection,* 53% said they had had thoughts of suicide either recently or in the past, while 75% reported issues with anxiety and depression. Research by the Victorian Responsible Gambling Foundation shows that 2.79% of the population are moderate risk gamblers and 20% of those have problems with depression compared to 7% in non-gambling people on average. A suite of services to address gambling harms works in many ways in parallel with the drug and alcohol model of care where there are choices for types of care. Recently BCH has trialled a peer led group with very promising results.

"Gambling [made] me progressively more isolated, and less and less healthy. Just committing to come here for 2 hours, I'm out of my house; I can say 'yeah you're doing something positive to aid your recovery'."

-Gamblers Help Peer Group participant

Overall people with comorbid addictive behaviours are likely to have their needs overlooked or dismissed as character flaws, particularly in times of crisis. There is significant stigma and shame associated with drug use and gambling at harmful levels. Largely not screened for and invisible, people with harmful gambling behaviour struggle to find services responsive to their cries for help or who recognise the serious implications to mental health.

"I was 18 when I first gambled on poker machines and I was 35 before I talked about it with a general counsellor. I was told I needed to find a specialist counsellor. I talked about it in a meeting in a psychiatric hospital when I was 37, and nobody talked about it again. I mentioned it to my family GP who said, "I didn't know about THAT", as if it was something different, or more, than a mental illness."

-Gamblers Help Client

Recommendation: Prevent suicide by recognising that gambling is a serious threat to mental health and wellbeing, work collectively to reduce shame and stigma and introduce broad screening that may lead to people accessing help sooner.

Recommendation: Mental health problems along with addiction of any kind needs to be seen as one and the same thing, with concurrent treatment provided, either by an adequately skilled worker or by teams, depending on the severity of symptoms and client choice.

Recommendation: Rehabilitate, don't incarcerate. Adopt a flexible, person centred model with intensive support. The state-funded AoD system is at crisis point and in absolute gridlock processing forensic referrals to the detriment of others wanting to access assistance to support change. The

current proposed investment in more prison beds commits funds to the absolute wrong end of the system.

Recommendation: Provide additional residential and non-residential drug withdrawal and rehabilitation services (at least comparative to other states) that respond to mental health issues concurrently. In Victoria these are permanently at capacity and waiting lists mean clients can wait months and are at high risk of relapse.

Recommendation: Build the AoD service capacity to appropriately respond to clients aged over-55 who are a growing cohort and who have had much more diverse drug experiences than previous generations.

Recommendation: Consult with Victorian Emergency Departments and their frequent users for AoD concerns and other relevant stakeholders to better understand the needs of people with drug use issues attending those locations. Use learnings to co-design models of care that could be more efficient and effective in the context of 24 hour mental health care. Co-locating community based drug and alcohol and mental health workers in these settings can be helpful in linking clients to community based supports.

Legal and Justice System

The legal and justice system is often encountered by those suffering from mental illness; a misunderstanding of mental illness within the community and an inappropriate response in crisis can result in criminalisation and interaction with the justice system that may exacerbate poor mental health.

> *"A client reports feeling suicidal and leaves their appointment. Police are called to check on the client and finds them in possession of an illegal substance and arrests them"*
>
> **-West Heidelberg Legal Service Solicitor**

The judicial process, officers, lawyers and the court environment can impede the mental wellbeing of those who participate. The inaccessibility of legal representation, unless there is a real risk of imprisonment, means that many people with mental illness are left to navigate a complex justice system on their own. For many community members self-representation in a system that has very specific criteria and rules, that may not be well understood leads to conflict, anger, feeling unheard and poor legal consequences. These consequences, such as a criminal record, heavy fines, restriction of movement or prison sentence can be detrimental to mental wellbeing.

BANYULE Community Health

At BCH a health justice partnership with West Heidelberg Community Legal Service is a collaboration across the centre to promote total wellbeing. Health justice partnerships support populations that are particularly at risk of poor mental health and unmet legal need, like people experiencing family violence, people at risk of elder abuse, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and people experiencing poverty. Access to legal services within a community health setting has improved rates of access for vulnerable clients, such as those with mental illness, and contributed to better outcomes for clients which are less detrimental to mental health. However, there are still limitations and areas for improvement which form the basis of our recommendations for establishing and improved response for those at risk of poor mental health and those experiencing mental illness.

Case Study – West Heidelberg Legal Service - [redacted]

[redacted] is a public housing tenant who was referred into to the legal service by the BCH medical clinic after he received a Notice of Hearing. [redacted]'s landlord was applying for possession of his rented premises because he had accrued substantial rental arrears over a significant period.

He had also missed multiple VCAT hearings regarding his rental arrears and had broken a number of 'payment plans' to repay the money owed. [redacted] had been a long-term client of BCH. He had been diagnosed with multiple mental health problems and identified as a current ice user (dual diagnosis).

[redacted] initially engaged with the lawyer and social worker about his tenancy problems. Immediately prior to his VCAT hearing, however, he ceased responding to calls and did not attend his hearing. His landlord obtained a possession order but the legal service was unable to contact [redacted] after his hearing.

Subsequently, [redacted] re-presented to the health service and approached the social worker in the foyer asking for help to avoid eviction.

By this stage [redacted]'s landlord had purchased a warrant of possession and had set a date to change the locks at his house. The lawyer, social worker, general practitioner and mental health nurse helped [redacted] apply to VCAT for a review and rehearing of the possession order. They also helped [redacted] re-engage with his AOD counsellor.

[redacted] continued to be difficult to contact and frequently missed appointments arranged with the legal service. However, he attended his review hearing and entered into another 'payment plan' to repay the outstanding arrears.

Through a flexible and coordinated approach [redacted] was provided with help to maintain his tenancy, seek treatment and address other issues affecting his life.

BANYULE Community Health

Case Study – West Heidelberg Legal Service - [redacted]

[redacted] lives alone, is reliant on the Disability Support Pension and has been diagnosed with Depression and Anxiety. [redacted] receives support from her mental health outreach worker through an NDIS plan for her psychosocial disability. [redacted] was particularly close with her grandmother who had recently passed away, this traumatic event had exacerbated her symptoms. [redacted] had never broken the law or incurred fines before.

As [redacted] symptoms worsened she began incurring a number of traffic infringements and most significantly an excessive speeding charge (for exceeding the speed limit by more than 25km/h). Victoria Police attended [redacted] home and informed her that she had been charged with a traffic offence and that her car was to be impounded.

Soon after, [redacted] driver's license was suspended due to exceeding her demerit point limit. Notice was sent in the post to [redacted] that her license was suspended.

[redacted] is socially isolated and withdrawn and did not tell anyone about these charges or her license suspension. [redacted] failed to take her car in for impoundment and missed her court hearings. As [redacted] had missed her court date Victoria Police executed a warrant to arrest her and released [redacted] on bail, a new court date was set.

[redacted] had still not told anyone about her charges or sought support from anyone about her driving suspension. [redacted] was then pulled over while driving without a license and charged with another traffic offence (driving while license suspended), Victoria Police again arrested [redacted] and she had another court hearing to attend. [redacted] was pulled over a further two times for driving while her license was suspended and on each occasion she was arrested and interviewed by Police.

Still, [redacted] had not sought any legal help or told anyone about her charges. [redacted] NDIS outreach worker noticed some mail from Police at her house and asked about it, [redacted] outreach worker then contacted the West Heidelberg Community Legal Service to book in an appointment.

[redacted] attended the appointment with her outreach worker where she was advised that she could be facing a prison sentence and lengthy driving suspension for her multiple traffic offence charges.

[redacted] was not eligible for a grant of legal aid assistance as the Victoria Legal Aid guidelines for assistance didn't apply to traffic offences in the Magistrates' Court. The community legal service lawyer helped [redacted] join her four separate court hearings into one joint hearing and encouraged [redacted] to meet with a psychologist as she had not done so for many years.

The community legal service attended court with [redacted] and assisted her in negotiating the withdrawal of some charges and pleading guilty to others, [redacted] failure to initially attend court was explained and instead of a prison sentence [redacted] received a "good behaviour bond" and has been engaged with a new psychologist.

The community legal service also identified many of [redacted] fines were unpaid or were being deducted from her pension on a payment plan. The community lawyer helped [redacted] submit a review of fines to Fines Victoria under the *Fines Reform Act 2014*.

Recommendation: An improved response for those with mental illness that does not involve criminalisation and interaction with the justice system for minor offences such as summary criminal offences, non-violent offences or drug possession.

Recommendation: Improved access to legal help for those with mental health issues and ability to provide earlier intervention in legal matters to promote better outcomes. This would include

investment in health justice partnerships to be able to increase awareness and availability of services to more clients.

Recommendation: Removing barriers to accessing legal help or court models that promote wellbeing outcomes for those with mental health issues such as strict eligibility criteria for legal aid, catchment areas, complicated referral pathways and restrictive funding models. Funding models need to allow for intensive work at times that is outcome focused and widen access to innovative models of justice that promote better outcomes for participants suffering from mental illness.

Recommendation: Further expansion of innovative justice models such as Koori Court and Neighbourhood Justice Centre that are person-centred and focus on collaboration for total wellbeing outcomes in legal matters.

Aboriginal and Torres Strait Islander Mental Health

The Aboriginal and Torres Strait Islander (ATSI) community is one where statistics show an urgent need for better targeted mental health care. Studies have shown that a lack of culturally relevant mental health support services contributes to higher rates of depression, anxiety and suicide. Suicide is twice as common within the indigenous community as the non-indigenous.

Suicide is a significant issue for ATSI young people, with young men aged between 25 and 29 dying by suicide at four times the rate of non-indigenous males and women aged between 20-24 dying by suicide at five times the non-Indigenous female rate.

The Aboriginal Health Team (AHT) at BCH create a safe and welcoming entryway to a wide range of services. Local Aboriginal community members can be resistant to engaging with and seeking help from mainstream services due to underlying fears, experiences of racism and the experience of intergenerational trauma. Community members are sometimes reluctant to ask for help and speak about concerns related to family problems because of the possible consequences, facing judgment, and the involvement of child protection.

The team work to foster different and more culturally appropriate service delivery styles, such as outreach visits or “yarning” while going for a walk or a drive. Indigenous community members respond well to the BCH AHT counsellors because:

> “It’s not in our ways to speak to white people about culture or dreamtime.”
>
> **-BCH Aboriginal Community Development Worker**

AHT workers make a culturally relevant link to build trusting relationships with community members so they may benefit from health services and achieve better wellbeing outcomes. Team members work holistically in linking the community into mainstream services because they understand that issues often intersect and cannot be dealt with in isolation.

Recommendation: Initiatives to increase the number of male ATSI and CALD workers to establish more comfortable connections for discussing mental health with boys and young men.

Recommendation: Provide better training pathways for ATSI youth to gain qualifications and be successful in these roles. Initiatives to increase Aboriginal staff and liaison services within mainstream services and promote connection across these services to work in a more integrated way.

Recommendation: Place greater emphasis on ongoing cultural sensitivity training so that health responses are culturally relevant and safe and can be built on over time.

Recommendation: Support ATSI community members in returning to country and cultural healing days. Making the connection with country and knowing where your mother and father were born is healing and fosters mental wellbeing. Return to country enables a sharing of history and culture which fosters mental wellbeing.

Recommendation: Offer flexibility in access to care across catchment boundaries, which are irrelevant to many members of the indigenous community.

Supporting the Somali community

When civil war broke out in Somalia in 1991 a significant portion of the population was forced to seek refuge in other countries. Several thousand sought new homes in Australia. The largest community of formerly displaced Somalis has grown up in the Banyule area, with more than 3,000 Somali people living mostly around West Heidelberg and Bellfield.

For the Somali community as with all displaced peoples the trauma of violence and loss has created intersectional issues including PTSD, depression, grief, and demoralization. Culturally, Somali people are reluctant to seek help for their mental health because they consider this to be showing a lack of gratitude for all the good things in their lives.

> *"They lost fathers and mothers, brothers and sisters. They came here but most had never been out of Somalia. It was a different language, a different culture. They became lonely and isolated. Some developed mental health problems but they don't want to tell anyone. Everybody is trying to hide and it's not helping. A lot have mental health problems but they don't want to tell a doctor."*
>
> ***- Local Somali Community Leader***

For many the violence they were witness to during the civil war is compounded by their experiences in refugee camps where they endured constant threats and aggression. The most debilitating factor for the Somali community in mental health terms is reported to be the stigma around looking for help. Needing help for anxiety and depression can be interpreted as a sign that one does not practice their religion properly, creating a barrier to support.

Community leaders say that high unemployment creates a pool of frustrated and unoccupied young people. Community members are concerned that drugs and alcohol are fuelling a serious breakdown in social values and further isolating young people. Anti-Muslim sentiments and racism undermine young Somalis' sense of identity and belonging. Women as caregivers experience the burden of their own struggles as well as the compounding effect of trying to assist their children and young people to thrive.

Recommendation: That localised responses to the mental health and wellbeing needs of communities are inclusive and represent the emerging diversity of need, with local opportunities for community based early intervention and prevention supported.

Recommendation: That community leaders be better supported to start conversations with their communities about the common causes of poor mental health, and provide avenues for informing

more culturally appropriate and community embedded strategies to support their mental health and wellbeing.

Supporting Family and Carers

Family and carers are integral to the support of those with mental health issues. The needs of carers and impacts of the mental health system on this group are often overlooked. The Carer Recognition Act 2010(Cth) and 2012(Vic) and the Mental Health Act 2014(Cth) have been beneficial in recognising the role and impact of carers in the service system but this framework needs to be expanded to include more practical support.

Carers are facing ongoing stress and anxiety while attempting to navigate a complex and unknown mental health system to find help for their loved ones; often having to tell and re-tell their story when told that they have called the wrong place or service. Family and carers feel that they are often shut out of discussions due to privacy. Family and carers are an at-risk population for mental health issues; often pre-occupied with advocating for and tending to the needs of someone else can lead to situations of isolation, financial stress and lower levels of wellbeing.

At BCH the Carer Support Program provides a support worker who forms a relationship with family and carers. The support worker assists in a variety of flexible ways to fit their needs and help them set and achieve goals in relation to their caring role. Through establishment of a care plan the support worker assists with a variety of needs to address total wellbeing ranging from system navigation and access for both themselves and the person they are caring for, advocacy and emotional support. The flexibility of the carer support role to do home visits and provide support during their episode of care, with the option of re-entering for further support are some of the benefits to clients. Further to this, a service for carers provides someone who knows their story and can follow up and ensure they are heard and receive an action and response. At BCH carers can be connected in with a variety of services in one place to help manage care for their loved one and themselves.

Recommendation: An increase in availability and centralisation of information regarding mental illness for families or carers would be helpful for reducing stigma, improving understanding of mental illness and providing practical help in service options and navigation. The ability to have an understanding of the mental illness being experienced and the path towards wellbeing or recovery is crucial to fostering a sense of control, empathy, ongoing connection and support for carers.

Recommendation: Reduce isolation and increase opportunities for social and economic participation for family and carers. Greater recognition is needed of the diversity of mental health carers, the service they provide and the barriers they face in participating in society as they would like.

Recommendation: Continued funding and more widespread community promotion of carer service organisations who provide valuable information and services and support to carers.

Recommendation: A family inclusive approach to remain a priority in clinical mental health services, both at the intake/triage, assessment point, right through to treatment, follow up and ongoing care. Carer Peer Workers would be a valuable community resource for carers and family members, particularly early in their caring role.

Recommendation: Family therapists more widely available in the workforce mix to work with or alongside other team members and strengthen the capacity of families to manage difficulties earlier.

Recommendation: In the short term and with a view to preventing further deterioration where we can foresee it, increase carer support capacity who provide a relationships, continuity, connection with appropriate support and services, follow up and check in on the wellbeing of the carer. As the system is redesigned to be more accessible and functional, the burden on carers caused by the dysfunction and under resourcing should be significantly reduced.

Recommendation: Resource and implement the Victorian Carer Strategy 2018-2022 which was developed in consultation with carers. Develop an implementation plan and measurable outcomes against the strategies. Ensure that people caring for others who have mental illness have more flexible and practical supports according to what carers say about what they need, rather than trying to fit them into the models of care available. Current pensions, respite options, alternative care and employment options for carers do not specifically recognise the complex, unpredictable and episodic nature of caring for someone with mental health issues.

Recommendation: Consider models of localised, community based responses in times of crisis by a team of people who are trained and understand mental health issues. The most readily available options puts an unnecessary burden on police/ambulance/emergency departments and frequently contribute to further distress, trauma and increased stigma for both clients and their families/carers.

Voices of lived experience and client submissions

This section of our submission consists of the stories, experiences and comments shared with us by our clients and community members who wanted to "have their say" into the Royal Commission. Responses were received via interviews, e-mail, community consultation days and local suggestion boxes.

"Joining the peer support group made me realise how wrong I was, that quitting drugs was only the start to getting better. I wanted to quit because addiction was depressing me. Being drug-free did restore some sense of the joy of living. But I was still severely depressed. It was also like breaking up with a lover. Old drug-related friendships become untenable. Friends of longstanding tell me to stay away because they have children. As if I would contaminate them. Former colleagues just cease to know you. Gradually, grudgingly you realise isolation and loneliness are your reliable companions. It's easy to believe you are alone and the damned quicksand has you powerless. And despair feels like an iron weight across your shoulders. Exhausted, you think death may be a mercy.

Anonymous (mental health, alcohol and drugs)

"And you see people arrive new to the group looking like a haunted house. Those who return over time can be transformed into pictures of health, clarity and determination to resume their places in society. One young chap in the group at the moment has gone from being a hollow-eyed shut-in to applying for the Defence Force and the SES. It's a privilege and a joy to see such transformations."

Anonymous (mental health, alcohol and drugs)

"When I was admitted to hospital for mental health issues, they always asked about alcohol and drugs but no one ever asked me about my gambling. Drinking and gambling really come close

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together. It was never about money, it was always about an escape basically. That numbness when I drink and gamble I would get that feeling of being a winner. When you're on that rollercoaster the highs and lows get higher and lower; Mental illness then started to play a factor and basically at the end of the day, it's so intertwined the gambling, the alcohol and drugs combined with high levels of personal and financial stress. Something had to give.

I wasn't aware of many services that were available to me. I never had any long term supports for any of my issues, I fell through the cracks in the system after some periods of relative stability. This resulted in frequent relapse and placed a great strain on myself and my family. Stigma and shame attached to poor mental health and gambling contributed to me not seeking help until I was really desperate."

[redacted](mental health, gambling, alcohol and drugs)

"It would have been nice if there was more help available when I was living in refuge. I was really struggling with what was happening and felt isolated and like I had no control. A mental health counsellor to come and check in on us and provide some support would have been really helpful. As an asylum seeker, I can't access services in the way other people do, I wish that organisation were more upfront with information around what services I can access, it's not always easy to ask. Also, as a single mother I need services that are child-friendly or at least understanding of me bringing my child"

Anonymous (mental health, family violence, asylum seeker)

"At times I needed someone to reach out to me, I couldn't get out of bed to make my appointments and it was just assumed that I didn't care about my health. I had a dual support worker who did outreach and adjusted things to suit the way I did things, he would come check in with me at my house or we would go for a drive and talk. I was making a lot of progress but then the program was defunded and there was no handover or referral for any other service. The lack of quality assessment of how I was really going and lack follow up after discharge has happened to me again and again in the mental health system. There needs to be more flexibility for treatment around where you are at; sometimes I need weekly face-to-face sessions and sometimes a phone call once a month is fine. But it is important that I have someone who knows me and can tell when I'm overwhelmed, overmedicated or showing signs of becoming unwell. Constantly having new workers or psychiatrists every six months is frustrating. At a time when I was in a good place with my mental health, my dual support worker helped me to put together a document that identifies my stages of becoming unwell. This type of client led planning helped me to self-recognise and question what I say but also help others recognise when I am becoming unwell.

When I decided to stop alcohol and drugs I was really lucky that I had a dual care coordinator who came to check in on me and work with the doctors there regarding my mental health as I stopped using drugs. It was my experience that if you had a mental breakdown in rehab they would kick you out because they couldn't deal with it. If you are coming off drugs and alcohol, you should expect mental health issues.

That feeling that no one cares when you ask for help- it's enough to push you over the edge."

[redacted] (Mental health and AOD)

"As a user of mental health services for many years, one of the biggest issues is lack of continuity in programs and workers. I have gone through that many workers in the last five years as staff turnover is high or programs are discontinued. I like talking to someone that I know and it's really upsetting when I'm told someone won't be continuing with me and I am shuffled around constantly between mental health nurses, counsellors, mental health workers, rotating psychologists and psychiatrists. Having to constantly retell my story is exhausting.

I live alone and find with my chronic health issues, isolation and anxiety that I need to speak to someone every week to help me cope with all of the other issues going on in my life. The lack of practical help such as cleaning, shopping, etc. also adds to my daily stress and anxiety. I have applied to NDIS twice and been rejected. I have been told to apply a third time but I don't want to go through it again. It's exhausting both mentally and physically and I can't deal with that alongside all of the other issues in my life right now.

I also have concerns about the use medication for mental health. I have had psychiatrist who sit down with me for five minutes and prescribe me very strong medications and send me on my way. When my prescriptions were changed I had to advocate for myself to have a voluntary admission because I was afraid of how the medications might affect me. I was prescribed a very addictive anti-anxiety medication that I was later told that I needed to go to detox to come off of because they could no longer prescribe it. Having to be sent to detox because of a medication I was prescribed by doctors was embarrassing.

I also have a son who is in prison and I worry about his mental health. It has been very difficult to get him an assessment in prison. I worry about where he will go and how he will get help when he is released.

All of the uncertainty and not knowing what is even out there that can help is very frustrating.

In my experience, a service that I found worked well for me was when I had an outreach worker through NEAMI who would come to my house. Being able to access health services in one place that is local to me at the community health centre is helpful, but even here I have been shuffled through different programs and workers. Access to my social connection group through the community health centre has been extremely helpful in getting me out of my house and less isolated which has been very beneficial for my mental health."

[redacted] (mental health, anxiety)

"My gambling harm was predominantly due to online sport and racing gambling. I became a gambling addict, who could think of very little other than to recover the money I had lost. Throughout this extremely difficult time in my life, I developed the following mental health problems

directly as a cause of gambling: depression, anxiety, stress, addictive behaviour, social isolation and extreme anger.

As far as I know, I did not have a mental health problem before I suffered gambling harm. Moreover, through the appropriate support, particularly peer support, my recovery process has resulted in a significant reduction in the mental health problems that dogged me during my gambling addiction.

My experience showed me that there is a direct causation between gambling harm and mental health problems. I am a qualified statistician and whilst I am only a sample of one, I firmly hold the view that this causation is true and should not be ignored."

Anonymous (mental health and gambling)

"There needs to be access for kids to information in settings that are away from their parents particularly in situations of abuse. I felt like I had no one to turn to and nowhere to go for help. I was constantly afraid of my parents and becoming like my parents, I had no idea that there were things that could help me cope and be different but no I'm facing a lifelong problem."

Anonymous (mental health and AOD)

"GP's are a key entry point for getting help and there needs to be more availability. More advertising of programs that are available to help people might have triggered me to reach out and seek help earlier and find a service that I could relate to. There needs to be service availability that is more inclusive, the timing of one support group is during school pick up so the parents aren't able to attend. BCH is really helpful because the staff talk to each other about a case before you see them."

[redacted](PTSD, depression, insomnia and AOD)

"There are not enough services provided for adolescent mental health. This group is dismissed as being young, attention seeking and it's said that they will move on or get over it. My sister committed suicide at 15, our young people are facing such a loss of hope. We need to focus on suicide prevention and mental wellness in aboriginal communities. Also, there needs to be more support for families after experiencing a suicide.

[redacted](ATSI)

"It is really difficult when the psychiatrists switch over every six months; I'm always having to repeat my story, it's a waste of time and really upsetting. It feels like you are never going to get better when you have to constantly repeat what has happened to you. People with mental health issues are often misunderstood and assumptions are made, I've been assaulted and pinned down for rubbing my handbag; it's terrifying. Police make assumptions too, they verbally abuse you when they think you are wasting their time. I've had half a dozen mental health workers in the last year because the service I had was being defunded. The new service doesn't offer as much support as they used to."

[redacted](mental health and domestic violence)

"You don't know what you don't know until you stumble across it. It's taken many years to find different sorts of assistance that are out there. You rely on coordinators to suggest things and there is not always good, experienced workers out there because of constant turnover and burnout. There is no collective summary of what is available and who it's for. A website listing all the primary sources of help and links to indirect assistance would be helpful. The NDIS approach for mental health services is appalling; a lack of simple processes and flows."

Anonymous (mental health carer for 15years)

"People are being over-medicated by very strong drugs. We need to make psychiatrists and psychologists more accessible, you are always out of pocket. It's really hard for older people to find transport, I can maybe only attend appointments once per week when I have someone to take me."

Anonymous (Bipolar)

"I find the exercise classes here really helpful for my mental health."

(BCH Client)

"Public housing environments can be really traumatic. We need more support. My neighbour is screaming and psychotic, the police come and take him away and then a couple hours later he is back with no support. In the meantime I'm traumatised from all of his screaming.

Over-medication is a big problem. Trying different drugs all the time is torture, I'd rather talk to someone who is going to be nice to me and not judge me. You can't just give someone a pill and tell them to go away.

Being in the public system, it is dictated to me what services I can have and who I can talk to; I don't get any choice. I had a counsellor who I was really achieving with but they left, now I see someone else and it's ok but it's not helping me. I have no other options.

There seem to be advertisements and professional athletes all telling you to seek help but it's not real, there is only help and support if you have money.

I feel like an outcast for my struggles with mental health, even my family don't want to have a 'crazy' daughter."

Anonymous (depression, anxiety, PTSD and chronic pain)

I will never be certain what came first out of gambling and mental health issues but I am certain they are close cousins. Different kinds of grief compounded my gambling– when my sister in law began struggling with mental illness, when clients I cared for passed away, when my intimate relationships

were lacking authentic connection, when I felt other things I could not talk about or face, I was vulnerable to the pokies. In different periods in my life when I was struggling emotionally, I have found it more difficult to set limits, disengage from gaming and to connect with nurturing past times. Periodically and with some success, I would commit to strategies that assisted in my wellbeing such as better budgeting, planning for and seeking social connections and accessing support.

Gambling does not contribute to wellness. If everyone could gamble responsibly, then we would not need that health warning. We are vulnerable to mental illness because of gambling, and we are vulnerable to gambling if we experience mental illness.

I gambled when I was a student, had a low income, had a higher income, when I was pregnant, when I was a Mum. I smoked more when I gambled, I drank more coffee, I sometimes ate less and sometimes ate too much. I experienced anxiety, depression, grief, insomnia, hyperactivity and exhaustion.

I was 18 when I first gambled on poker machines and I was 35 before I talked about it with a general counsellor. I was told I needed to find a specialist counsellor. I talked about it in a meeting in a psychiatric hospital when I was 37, and nobody talked about it again. I mentioned it to my family GP who said, "I didn't know about THAT", as if it was something different, or more, than a mental illness. I was engaging with Gamblers Help counselling via phone before I fell into a quick descent into Post Natal Depression. I commenced with face to face gambling over the last five and a half years.

My mental health has benefited from this and other interventions. I worked. I faced legal appearances. I socialised. I sought support from my family. I focussed on strategies for single parenting. I continued counselling and sought courses in mindfulness. I helped others in difficult situations and supported family members with cancer and reached out to other people with stories of mental illness. I braved intimate relationships but kept parts of me hidden – especially the gambling experiences. I built up my resilience at work and sought challenges and then, suddenly, learnt that my work area was closing-down.

On the outside I remained stoic and positive and open minded. It took very little time for me to re-introduce gambling into my life and it suddenly engulfed the strategies I had known worked in keeping it out of my life. I started to have nightmares and shame and guilt. I wanted to sleep more than I needed and I withdrew from my friends and family. I felt mentally depleted and unwell. There are related recovery and relapse stories in mental illness and gambling harm.

The things that damage us are the hardest things to talk about, but I was lucky enough to find the only existing Victorian support group for people with lived experience of gambling harm via Banyule Community Health. With my heart beating in my throat, I told my GP about it. We need more of these created, trained, funded and promoted as soon as possible.

- ***Reflecting on mental health services, what do you think works well?***

We are truly blessed to be able to access counselling services at very little cost. There is a strong research and education community that seeks to promote mental health initiatives and to educate the public on mental wellbeing. We have some areas of community health that seem well educated on issues of mental wellbeing, such as MHCN

- ***Reflecting on mental health services, what do you think did not work well?***

Given relapse is a known experience for many people who have experienced mental illness, I do not believe enough education about relapse is targeted at people who have experienced mental illness or who are at risk of mental illness. There are often services or supports around but their existence might be buried on a one service provider's website or agencies who could offer referrals are not aware of them, or there are not enough community members aware who might be more trusted by some people than websites or leaflets.

I also think discharge planning can become rushed and that it is common to focus on one area of concern (for example, PND) and not probe enough about other areas of concern (for example, Family Violence, Gambling, Alcohol, Mental Health of supports)

- ***What needs to change to improve Victoria's mental health service?***

Speaking specifically of those impacted by mental harm associated with gambling or gambling harm as a result of mental illness, and the known comorbidity, there should be specialist training and education readily available to mental health service workers and peers on the best ways to introduce the topics of gambling experience, gambling prevention and gambling strategies and services available. For this to work, there needs to be a readily available safety net of services and information accessible.

It is my wish that the mental health services would advocate strongly for policy and legislation that acknowledges the vulnerability of all consumers of gambling products.

Anonymous (mental health and gambling)

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Suggestion Box Responses

Have your say!

The mental health system needs to provide secure facilities for those offenders who are ageing in the secure mental health facilities and also those who are 'too old' to receive treatment from Community services. It is imperative that these older people receive the treatment they need, not only mental health care but also physical care that the secure facilities cannot provide to them.

Have your say!

Maybe have a peer group of people who are on the better side of Mental illness - Please Please More Free Angery Management group for all - women - men teenagers

Thank you.

Have your say!

More funding is Need and cancelling services

Have your say!

NEED MORE PLACES FOR THEM TO LIVE AS THEY GET CAUGHT UP IN JAIL SYSTEM OR LIVE ON THE STREETS NOT RIGHT. GOVERMENT LOOK AFTER OUR PEOPLE

[redacted]

BANYULE
Community Health

Have your say!

The security officers need to back off in the hospitals. They are causing distress to people.

[redacted] 26/6/19

Have your say!

How about Truth in every respect, field

It is much needed to right wrongs; heal hurts

I am positive

Have your say!

I've been rejected from NDIS twice now. They won't recognize my condition. I'm now in limbo and have gone downhill very fast with no supports in place. Please provide some support that has been taken away.

[redacted] 25/06 3.35 PM

Have your say!

I used to have a mental health nurse who I lost when NDIS came in. I have been knocked back by NDIS 3 times. I am very lucky I found one psychiatrist who bulkbills or I would have nothing.

Treating mental health issues needs to be integrated into drug & alcohol treatment.

[redacted]

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Community Health

Have your say!

THE CAT TEAM NEED TO NOT BE SO BRUTAL I CAME TO THE CAT TEAM AS A VOLUNTARY CLIENT AND ON THE PHONE THEY SAID " I NEED TO SEE THEM" ' WELL NO I DONT HAVE TO SEE THEM

BECAUSE I AM VOLUNTARY SO I PICKED UP ON IT AND THEY SAID YOU ARE RIGHT " YOU DONT NEED TO SEE US YOU ARE VOLENTARY SO THE CAT TEAM NEED TO WATCH TO WHAT THEY SAY TO PEOPLE

Have your say!

- Closer Supervision when having a "Meds" change
-

BANYULE
Community Health

Have your say!

Expectations and long hours at work are overwhelming for people. Its harder + harder for people to cope.

[redacted]

Have your say!

The doctors at the [redacted] Hospital told me if I walked there from [redacted] im ok and dont need to see a CAT team member like I dont know my own body? Listing to the person not assuming there ok when there not.

Thanks Hoping People open there ears not eyes and Presume it Drugs And it's not

Dont Presume Somthing talk to the Person first

BANYULE
Community Health

Have your say!

Very Helpful
Service and Lovely
people. thank you
for all of your help.
peace + Love

Have your say!

Just off the top of my head.
MORE HELP FOR PEOPLE
(children in families of:-)
THE 'MIDDLE - UPPER CLASS'

ALSO CHANGE THE NAME
OF "KIDS LINE"... I KNOW OF
MANY WHO ARE 7-18 YEARS
OLD WHO DESPERATELY NEEDED
THEIR HELP (HOWEVER A 10YR
OLD DOES NOT CONSIDER
THEMSELVES AS KIDS).
Thank You!

[redacted]

Have your say!

Empower people
financially to
seek the treatment
that works best
for them
- psychotherapy
- psychology
- counselling
Educate Dr's to
prescribe medication
there are ~~no~~
talking therapies
that can help.

Thank
You.

BANYULE
Community Health

Have your say!

Mental Health Facilities in this state are disgraceful they need to be able to visit out patients to give them their meds. as they are not all capable of getting apps. themselves. They can be very uncaring some of the staff are so jaded they should quit if they no longer enjoy their job most patients end up homeless they need to make sure this

Have your say!

They need to have better follow up for their patients they need to have home visits ongoing as long as need be to give them their medication if its an injection if tablets it needs to be sorted somehow cos a lot of patients don't stay on their meds. They also need to have better follow up and make sure that they don't become homeless. Make sure that carers are coping my daughter took her own life due to the hospitals incompetence.

Have your say!

There is a need for inpatient facilities. People aren't given time to stabilize mentally + with medications before they are sent home.

[redacted]

[redacted]

Have your say!

Very good Service Most of the time but find it hard to get into See my elecated Docter [redacted] but can Never get appointment with him

. Dental is great

Timing with some docs are sometimes up to 45 MINS LATE

BANYULE
Community Health

Have your say!

Care plans leaving Psych facilities for Adults with Mental Health issues in Victoria is not enough. No ongoing support or evidence based rehabilitation for 2019 is not ok.

Have your say!

IM HAPPY HERE TODAY

HOORAY!

Have your say!

More GROUP ABOUT MENTAL HEALTH

Have your say!

BETTER RESEARCH INTO THE BRAIN, BETTER DRUGS, MORE EDUCATION AND UNDERSTANDING OF WHAT MENTAL ILLNESS LOOKS LIKE

[redacted]

BANYULE
Community Health

Have your say!

No More
SMOKING

Have your say!

I have had mental health - B.P.D for 14 years. please please put More funding for pyshcyitrist and more speacialised Worker for individuals Case's - Many people need - multidisciplinary teams

Thank you.

Have your say!

Give children a voice.

Have your say!

Let's and Let's

But I stand out - I was Recently discharged and the social work team gave me a coles voucher The phyciatrist [redacted] said to me too swap it for Money to get to [redacted] so they could use the bed for people that were sicker than me.

True story.
Also the kitchen staff were more involved than should. But thats my opinion