

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

July 2019



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Executive summary

Mental Health Victoria is the peak body for organisations that work within or intersect with the mental health sector in Victoria and is an advocate for reforming the mental health system to ensure that people living with mental health issues can access the care they need, when they need it.

Reflecting the composition of the mental health system itself, our members come from a mix of clinical and non-clinical, acute setting and community-based, and public and private services. All are critical to the system reform needed to ensure Victorians receive the mental health care they need.

Our collective vision is a mental health system where Victorians can access effective and appropriate treatment and community support to enable them to participate fully in society. Our purpose is to drive system reform to ensure people receive the mental health care they need, when they need it.

To that end, we welcome this opportunity to make a submission to the Royal Commission into Victoria's Mental Health System, which represents an historic opportunity to provide the long-term investment required to build and sustain a world class mental health system that ensures better outcomes for people experiencing mental illness.

As this submission documents, Victorians living with mental illness do not get that now, despite some significant budget commitments in recent years which we have welcomed.

Victoria has historically underinvested in mental health, slipping well behind other Australian jurisdictions over recent decades. Once a leader in mental health service design, delivery, quality, research and education, Victoria now lags behind other states and territories, with under-resourcing across all parts of the system resulting in the rationing of services, ageing infrastructure, and failure to meet growing demand.

Although funding is critical, it is not the only issue. Our system is also plagued by ineffective system governance, no 'whole of system' monitoring or planning, a lack of alignment between service regions and other service silos, and an insufficient focus on prevention, early intervention and recovery in the community and on the critical social determinants of health like housing and employment.

On top of that we know that many people with mental illness do not seek support due to a range of factors including stigma and poor prior experience of the mental health system and can experience harm through inappropriate medication, treatment and other interactions.

Yet while our mental health system faces a complex range of challenges, there are also many solutions and examples of how things can be done better.

The Royal Commission is bringing together people and organisations from a broad range of sectors and presents an unprecedented opportunity to construct a system that can not only meet the needs of Victorians, but also set an example for best practice across the country.

In preparing this submission, we have made a number of assumptions, including that Victoria has a strong foundation from which to work, that some areas requiring reform are more urgent than others, and that part of the solution lie in closer collaboration between the Victorian and Commonwealth parts of the system. We hope and expect that collaboration will be fostered by the concurrent Productivity Commission inquiry into mental health.

This submission outlines issues and priorities across key areas and issues of service delivery and policy making, including:

- workforce
- integrated mental health and addiction services
- mental health care in the community
- mental health care in hospitals
- suicide prevention
- physical health care
- early life care
- employment
- families and carers
- mental health governance
- prevention.

In broad terms we seek a renewed focus on large scale investment at both ends of the mental health system – community-based and hospital-based care, a shift towards prevention and primary care, a greater focus on early intervention particularly for young people, equity of access in growth corridors and rural and regional areas and to all community groups, consistent and integrated whole of life services that provide care across the health and social systems, and overarching governance reform.

To achieve that, we make 37 detailed recommendations for reform. They include to:

- follow the recent lead of New Zealand to urgently establish a Mental Health and Wellbeing Commission
- develop and implement a properly scoped and fully funded Mental Health Service and Infrastructure Plan
- establish a fully-funded Centre for Mental Health Research and Innovation
- develop and implement a new Community Mental Health Care Model, and
- redevelop the Victorian Mental Health Workforce Strategy and conduct a peer workforce trial.

We thank the Royal Commission for its work and attention.

Summary of recommendations

System reform:

1. Commit to ensuring Victoria is recognised once more as a leader in person-centred mental health service design, delivery, quality, research and education.
2. Develop a fully costed Mental Health Services & Infrastructure Plan which includes specific targets, milestones, performance and outcome measures.
3. Ensure all reforms promote integrated approaches across systems.
4. Ensure all reforms promote equitable outcomes.

Workforce:

5. Redevelop Victoria's mental health workforce, integrated with services and infrastructure planning, and supported by an implementation and monitoring framework.
6. Implement and evaluate a paid peer workforce trial.

Mental health and addiction services:

7. Develop and implement an adequately resourced transition plan for the integration of mental health and addiction service systems at every level.
8. Consider integrating all mental and behavioural health programs and services, from prevention to treatment and recovery, under one structure.

Mental health care in the community:

9. Develop a new Community Mental Health Care Model as the basis for the delivery of integrated services across Victoria.
10. Incorporate adult community mental health centres into the new Community Mental Health Care Model and roll these centres out across the state in partnership with the Commonwealth and, where applicable, existing community health services.
11. Develop and implement a state-wide model for Child Mental Health Services (0-11 years) and Youth Mental Health Services (12-25 years), underpinned by a clear and consistent framework, governance and service specifications.
12. Rapidly scale-up of existing psychosocial support programs for people not eligible for the NDIS while broader mental health system design and planning work is undertaken.
13. Develop an integrated housing strategy through a consultative process, including specific consideration given to people with experiences of mental illness.
14. Improve access to adequate, stable and affordable housing for people living with mental illness.
15. Expand programs that integrate housing and mental health support.
16. Develop a state-wide discharge policy.
17. Develop and implement housing models for key cohorts.

Mental health care in hospitals:

18. Raise access to clinical mental health care from 1.1% of the Victorian population to at least 3.1% as an interim measure, and 5.0% over the longer-term.
19. Expand the mental health bed base to meet an interim target of at least 36 mental health beds per 100,000 Victorians (matching NSW) and a longer term target of at least 50 mental health beds per 100,000 Victorians (matching OECD).
20. Reduce Emergency Department (ED) presentations, a interim target of zero net growth, and a longer term target of year-on-year reductions, in mental health related ED presentations per 10,000 population.

Suicide prevention:

21. Employ a whole-of-government suicide prevention outlook.
22. Better facilitate co-design for service improvement.
23. Reinforce support for regional networks for suicide prevention.
24. Improve suicide crisis response and aftercare.
25. Improve suicide data collection and use.

Physical health care:

26. Embed preventative physical health interventions across the health sector.
27. Research and expand evidence-based physical health interventions for people with mental illness.

Early life care:

28. Expand early life care services.

Employment:

29. Expand individualised placement supports to help people with mental illness gain and retain employment.

Carers and families:

30. Guarantee funding for carer supports.
31. Mandate carer-inclusive practice in all commissioned mental health services.
32. Work with the Commonwealth to ensure carer-inclusive practices in the National Disability Insurance Scheme.

Mental health system governance:

33. Establish an independent Mental Health and Wellbeing Commission to provide system leadership for mental health and addiction, implementation support for system transformation, and independent monitoring and oversight.
34. Align Commonwealth, state and local catchment areas.
35. Work with the Commonwealth to consolidate multiple state and Commonwealth 'central intakes'.
36. Establish a centre for mental health research and innovation, a research and innovation fund and embed research functions across the entire mental health system.

Prevention:

37. Provide a Mental Health & Wellbeing Commission with a clear responsibility to develop and monitor strategies for the promotion of mental wellbeing and prevention of mental illness.

Mental health in Victoria

Mental health prevalence

In 2014/15 approximately 17.5% (or 1,012,000) of Victorians had a long-term mental health or behavioural problem.¹

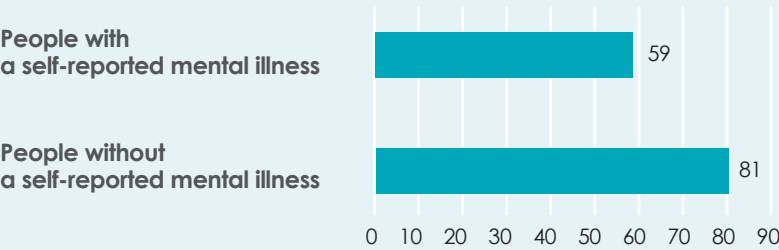
Population ²	5,926,624
Median Age ³	37
Growth rate ⁴	2.20%
Aboriginal population ⁵	47,781 (0.18%)
Median Age Aboriginal population ⁶	23

Planning for the future

Victoria's population is projected to reach between 7.5 million and 7.9 million people by 2027, the largest and fastest increase in population of all the States and Territories.⁷

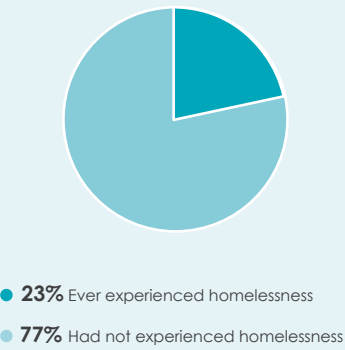
Employment

Victorians (16-64) who were employed (2011-12)



Homelessness

People with a mental condition and experiences of homelessness.⁸

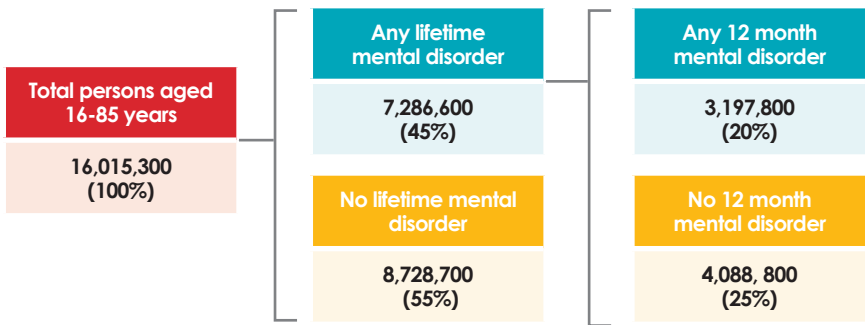


Suicide

Number of suicide deaths in Victoria (place of usual residence)⁹

2008	545
2009	576
2010	558
2011	526
2012	514
2013	533
2014	658
2015	668
2016	624
2017	621

Mental health in Australia



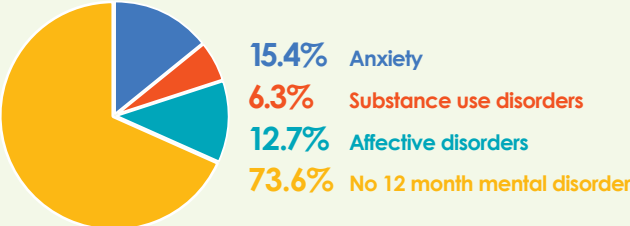
Australian population



- Over 75 per cent of mental health problems occur before the age of 25.
- LGBTIQ+ people are twice as likely to be diagnosed and treated for a mental health disorder.
- 30% of Aboriginal people are suffering from some form of psychological distress, compared with 20% of Australians overall.¹⁰

Mental health prevalence

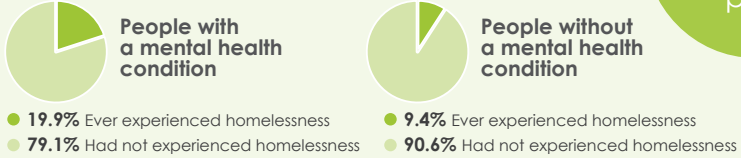
12-month mental disorders¹¹



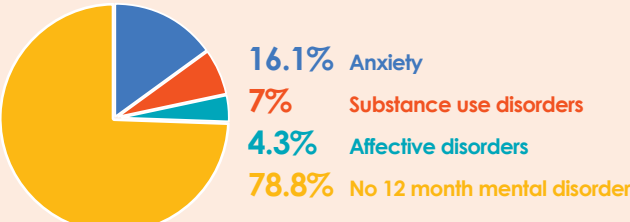
15-24
YEAR OLDS

Suicide rate¹³
49.3 people
per 100,000

Homelessness¹²



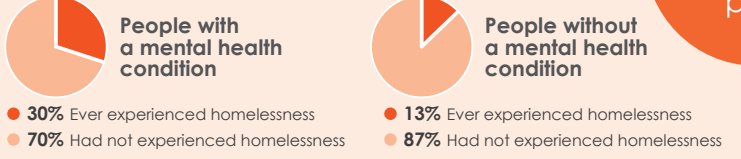
12-month mental disorders¹⁴



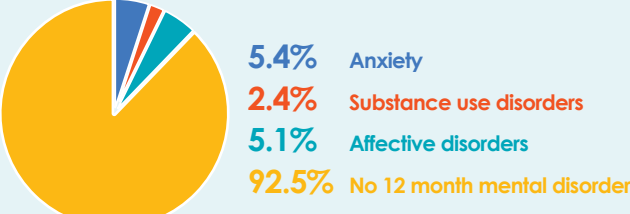
25-64
YEAR OLDS

Suicide rate¹⁶
275.6 people
per 100,000

Homelessness¹⁵



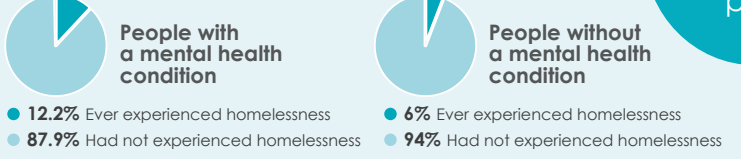
12-month mental disorders¹⁷



65+
YEAR OLDS

Suicide rate¹⁹
135.2 people
per 100,000

Homelessness¹⁸



1. ABS 2015, National Health Survey: Final Results, 2014-15, available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012014-15?OpenDocument>.
2. ABS 2016, Census of Population and Housing: Nature and Content, Australia, available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2008.0Main+Features922016?OpenDocument>.
3. ibid.
4. ibid.
5. ABS 2016, 2016 Census: Aboriginal and/or Torres Strait Islander Peoples QuickStats, available at: https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/IQS2.
6. ibid.
7. ABS 2017, Population Projections, Australia 2017 (base) – 2066, available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3222.0>.
8. ABS 2014, Mental Health and Experiences of Homelessness, Australia, 2014, available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4329.0.00.0052014?OpenDocument>.
9. ABS 2017, Causes of Death, Australia, available at: <https://www.abs.gov.au/austats/abs@.nsf/Lookup/by%20Subject/3303.0-2017-Main+Features-Intentional%20self-harm,%20key%20characteristics-3>.
10. The Wire 2016, Mental Health Week: Taking indigenous mental health seriously, available at: <http://thewire.org.au/story/76778/>.
11. ABS 2007, National Survey of Mental Health and Wellbeing: Summary of Results, 2007, available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4326.02007?OpenDocument>.
12. ABS 2014, Mental Health and Experiences of Homelessness, Australia, 2014, available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4329.0.00.0052014?OpenDocument>.
13. Commonwealth of Australia 2013, National Mental Health Report: Tracking progress of mental health reform in Australia 1993-2011, Commonwealth of Australia, available at: <https://www.health.gov.au/internet/main/publishing.nsf/content/8090F03865A7FAB9CA257C1B0079E198/%24File/rep13.pdf>.
14. ABS 2007, op cit.
15. ABS 2014, op cit.
16. Commonwealth of Victoria 2013, op cit.
17. ABS 2007, op cit.
18. ABS 2014, op cit.
19. Commonwealth of Australia 2013, op cit.

1. Introduction

The Royal Commission into Victoria's Mental Health System presents us with an unprecedented opportunity to improve health, social and economic outcomes for hundreds of thousands of Victorians living with mental illness.

Mental illness is the single largest contributor to years lived in ill-health and is the third largest contributor (after cancer and cardiovascular conditions) to a reduction in the total years of healthy life for Australians.¹

Despite this, it is widely known that our mental health system cannot meet the current and future needs of Victorians. This is due to many interconnected and reinforcing factors, including:

- ineffective system governance – compounded by Commonwealth and State service silos, a multitude of commissioning bodies, ineffective planning, lack of real targets and outcome measures, and with no single body being responsible for monitoring 'whole of system' performance
- a history of under-resourcing across all parts of the system, resulting in the rationing of services, ageing infrastructure, and failure to meet growing demand
- insufficient focus on prevention, early intervention and recovery in the community
- a lack of action to address well documented problems with system design including the lack of alignment between service regions.

These systemic failures result in gaps in service delivery and a lack of continuity in care which mean that many Victorians are not getting the support they need to maintain good mental health or recover from episodes of illness. Further compromising the system's capacity to meet demand is the fact that many people with experience of mental illness do not seek support due to a range of factors including stigma and poor prior experience of the mental health system.

Mental health issues are shaped to a great extent by the social, economic and physical environments in which people live.

The risk factors for many common mental health issues are strongly related to social inequalities, reinforcing the need for integrated and flexible support and treatment services that recognise the diversity of people, their cultures, individual circumstances and location.² Substantial evidence demonstrates that a lack of integrated prevention and management strategies within healthcare provision contributes to greater burdens of chronic illness and disability, greater health care costs, and a range of other avoidable social and economic costs. The social exclusion that often results from mental illness has a significant impact on the wider community.

Yet while our mental health system faces a complex range of challenges, there are also many solutions and examples of how things can be done better. The Royal Commission is bringing together people and organisations from a broad range of sectors, presenting an unprecedented opportunity to construct a system that can not only meet the current and future needs of Victorians, but can also set an example for best practice across the country.

1.1 Key assumptions

In preparing recommendations for the Commissioners, we have made a number of assumptions. They are:

- We have a strong foundation from which to work – many of the solutions will be based on scaling up existing services and supporting our outstanding workforce.
- There are some obvious pressure points that need to be addressed without delay while longer term fixes are put in place.
- Part of the solution lies in closer collaboration between the Victorian and Commonwealth parts of the system – the Royal Commission and the concurrent Productivity Commission Inquiry provide an opportunity for finding better ways of working together.
- Addressing social determinants must be part of the solution – housing, employment, social inclusion and justice are fundamentally important and need to be considered as part of the solution.

1.2 Acknowledgments

This submission has been prepared in consultation with the Victorian Mental Health Policy Network (VMHPN).

Members include:

- Australian Medical Association Victoria
- Australasian College for Emergency Medicine
- Australian College of Mental Health Nurses
- Australian Psychological Society
- Australians for Mental Health
- Carers Victoria
- CHIA Vic
- Council to Homeless Persons
- Ethnic Communities Council of Victoria
- Mental Health Foundation Australia
- Mental Health Legal Centre inc.
- Orygen
- The Police Association Victoria
- Royal Australian and New Zealand College of Psychiatrists, Victorian Branch
- Victorian Alcohol and Drug Association
- Victorian Council of Social Service
- Victorian Healthcare Association
- Women's Mental Health Network Victoria.

Many VMHPN members will be providing individual submissions and Mental Health Victoria encourages the Commission to consult these for more detailed recommendations in each organisation's areas of expertise.

1. Australian Institute of Health and Welfare 2016, Impact and causes of illness and death in Australia 2011, Australian Burden of Disease Study series no. 3, Canberra.

2. World Health Organization and Calouste Gulbenkian Foundation 2014, Social determinants of mental health, World Health Organization, Geneva.

1.3 Our vision

Figure 1: Our vision for the Victorian mental health system.³

From where we are...

A mental health system that lags other jurisdictions
Victorians with lived experience, families and support people often have a poor experience of care • Multiple sources of information and advice • Distressed people having to provide the same information to multiple organisations • Vulnerable people left to navigate a complex and fragmented service system • Families and support people excluded from consultations and planning • Limited choice
A mental health system that doesn't prioritise people's needs • Program focus on generating activity not necessarily on making anyone better • High level of unmet need, with many people not seeking or finding necessary support • Lack of attention to the social inclusion needs of people with mental illness
A system that is poorly resourced • A workforce overwhelmed with demand for services • Failure to at least keep up with comparator states – NSW and Queensland – in terms of mental health beds, community treatment and support • Research carried out in isolation of mental health strategic objectives, with a haphazard approach to the translation of evidence into practice
A mental health system that is fragmented • A myriad of providers, many with limited capacity and poor economies of scale • A myriad of commissioning bodies and siloed funding streams • Variable access to quality services largely depending on where people live or their income • Poor planning, coordination and operation between the Commonwealth and the Victorian Government, resulting in duplication, overlap and gaps in services
A mental health system that does not see the whole person • People discharged from hospital and treatment services into homelessness, or without adequate planning • High rates of 16–25 year olds with a mental health condition who are 'Not in Education, Employment, or Training' (NEET) • Poor physical health among those with severe and persistent mental health problems • High rates of unemployment among adults with a mental illness and their support people

Recommendation 1

Commit to ensuring Victoria is recognised once more as a leader in person-centred mental health service design, delivery, quality, research and education.

... to where we need to be

Recognised once more as a leader in person-centred mental health service design, delivery, quality, research and education
Victorians with lived experience, families and support people encounter a system that involves them in decisions, is easily navigable and provides continuity of care • Individuals, families and communities know where to go to get practical information and advice • Clear pathways available with care coordination and case management for those who need it • Families recognised and included as vital members of the care team • Enhanced choice of providers
An outcomes-focused mental health system • Focus in funding and activity on outcomes, to achieve value for money and for individuals and society • More people getting the services they need, when and where they need them • Enhanced access and participation in services focused on prevention and recovery
A well-resourced system capable of meeting current and future needs • A well supported workforce • Leading the nation in access to services and outcomes • Research that is priority driven in accordance with targets and objectives, with clear pathways for translation into practice
A mental health system that wraps around the person • Integration of services around the needs of individuals, covering the continuum of needs of the person, including primary and community based care, housing, employment, and acute care • A team based approach where the person, their family and support people are working together to provide support and services, with an enhanced role for peer workers • Greater consistency in access to services which meet safety and quality standards • Clarification of roles and responsibilities between Victoria and the Commonwealth with shared policy development, system design, implementation, monitoring and reporting
A mental health system that responds to whole-of-life needs • No one discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services without an appropriate discharge plan which provides for necessary supports and includes regular follow-up • Increased productivity, participation and economic impact: continuous improvement measured by reductions in the NEET rate • Reductions in risk factors resulting in high morbidity and premature mortality of people with a mental illness

3. Based on the National Mental Health Commission's 2014 report, Contributing Lives, Thriving Communities, available here <https://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx>.

2. Key reform and investment areas

In broad terms, we recommend a renewed focus on the following:

1. Concurrent large scale investment in both community-based and hospital-based care.
2. A shift in focus towards prevention and earlier interventions in community and primary care settings where possible.
3. Consistent and integrated whole of life services that minimise disruptive and painful service transitions for individuals, their families and carers, and ensure coordinated and continuous care provision across the broader health and social systems in which they engage.
4. Reconfiguration of service regions to promote sensible access to a comprehensive range of mental health services, and ensure that growth corridors receive adequate investment to service both unmet demand and future growth in demand.
5. Governance reform through a new leadership body and blueprint for change that includes (as highlighted by the Victorian Auditor-General):
 - clear targets and measures to monitor progress in improving access
 - forward plans for capital infrastructure
 - specific targets in the current workforce strategy, including to address particular issues in regional and rural areas.⁴

Improved mental health care within the criminal justice system is a key gap which requires attention. Mental Health Victoria will be providing a separate submission with recommendations on the system reform required to address mental health service delivery in the criminal justice system.

Recommendation 2

Develop a fully costed Mental Health Services & Infrastructure Plan which includes specific interim and long-term targets, milestones, performance and outcome measures.

2.1 System integration

The integration of mental health related services is imperative to achieve better overall outcomes for service users. The mental health system is comprised of a broad range of services covering the entire spectrum of care from preventative programs to recovery services, encompassing community and clinical settings and services. A stepped care model is needed to ensure continuity of care across all care settings, including those provided within the public and private sectors, and by local, state and Commonwealth bodies.

Further complicating matters is the nexus between the mental health system and related systems including the broader health system, housing, social services and criminal justice. Homelessness, drug and alcohol, and mental health services share many of the same clients and need to address similar problems for clients. Despite some promising initiatives it is difficult to find truly integrated care models that consider the whole person and their full range of needs. Further work is needed to develop and implement flexible models to suit a range of needs.

Care should be taken to ensure that all of the Royal Commission's final recommendations will work to facilitate improvements in integration across and between all relevant systems including:

- within the health sector, across:
 - community, primary and acute/tertiary mental health systems
 - public and private sectors
 - mental health and physical health systems
- between all aspects of the health system noted above and other relevant systems, including but not limited to:
 - disability
 - housing
 - education
 - aged care
 - immigration and migration support services
 - criminal justice
 - family violence
 - maternity and parenting services
 - out-of-home care.
- across local, state and Commonwealth systems.

Recommendation 3

Ensure all reforms promote integrated approaches across systems.

4. Victorian Auditor-General's Office (VAGO) Report 2019, Access to Mental Health Services, Melbourne, March 2019.

2.2 Equitable outcomes

While this submission makes note of key population groups at specific junctures, all recommendations and targets should be implemented with specific consideration given to the specific needs of all key population groups to ensure equity across all demographics including age, gender, location, race/ethnicity, sexuality, gender identity, health status and life experiences.

Mental health responses must be individualised to people's needs and there is no one-size-fits-all approach. Otherwise, there is a risk that broad system reform will further entrench the invisibility of population groups whose individualised needs differ to the needs of the 'mainstream' population.

Key population groups include but are not limited to:

- children and adolescents
- youth
- older people
- women
- infants
- people in rural and regional areas, including those living outside regional centres
- Aboriginal and Torres Strait Islander peoples
- culturally and linguistically diverse (CALD) communities, including refugees and asylum seekers
- people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ+)
- people with co-occurring health conditions, including neurodevelopment and physical disabilities
- people experiencing family violence
- people experiencing homelessness
- survivors of abuse and trauma
- people with experiences in the criminal justice system
- people with intersectional experiences.

Recommendation 4

Ensure all reforms promote equitable outcomes.

3. Workforce

While Victoria's mental health system requires extensive reform and a quantum scaling up in investment, success cannot be achieved without an expanded and well-supported workforce. Currently, there are numerous challenges facing Victoria's mental health workforce, including workforce shortages, maldistribution, skillset deficiencies and recruitment and retention difficulties. Due to both the multidisciplinary nature of mental health service provision and the interaction between mental health and related needs, ensuring that Victoria's future mental health system is supported by an adequate workforce requires a strategic approach. The current workforce strategy is not sufficient.

3.1 Workforce strategy

The existing Victorian Mental Health Workforce Strategy, published in 2016, should be redeveloped with an implementation and monitoring framework to ensure it is put into action. It should be integrated with service and infrastructure planning, and should include targets to attract and retain workers in each segment of the workforce including community mental health, psychiatry, psychology, mental health nursing, general practice and other relevant health areas.

It should aim to ensure that each workforce is of a sufficient size, appropriately distributed across the state, with particular attention paid to regional and rural areas, as well as across the private and public sectors.

The strategy should address the mandatory skillsets for each profession and include a workforce capability and competency plan. Particular attention should be paid to expert areas such as perinatal, child and adolescent, trauma, family violence, addiction and forensic mental health, as well as approaches to care including person-centred, recovery-oriented, culturally responsive and trauma-informed care.

Strategies regarding the core competencies of related workforces, such as educational professionals, disability service providers, first responders and corrections officers, should also be considered.

Strategies to support the health and wellbeing of mental health workers should also be included, with particular attention paid to supporting workers with lived experience, or those from key population groups, such as Aboriginal and Torres Strait Islander, and CALD communities, who would benefit from a supported workforce with community roots.

Recommendation 5

Redevelop Victoria's mental health workforce, integrated with services and infrastructure planning, and supported by an implementation and monitoring framework.

3.2 Peer workforce

Peer workers are people with lived experience of mental illness who provide additional supports to people currently receiving care from mental health professionals.

There is emerging evidence of the benefits of a peer workforce. Development of a peer workforce not only presents further employment opportunities for people with mental illness, it can also improve treatment and recovery for those who are supported by peer workers.

A peer workforce can also help to grow the mental health workforce – although training and supervision from qualified mental health professionals will be required, and it should not be used to fill the gaps in the existing workforce.

Development of a peer workforce not only presents further employment opportunities for people with mental illness, it can also improve treatment and recovery for those who are supported by peer workers.

Victoria should implement a peer workforce trial with built-in evaluations for both mental health outcomes and economic returns to ensure that peer workers are supported and empowered with clearly delineated roles designed to provide effective and cost-efficient supports to people experiencing mental illness.

Such a trial is likely to be relatively inexpensive and could be modelled on similar trials in nearby jurisdictions, like the NSW Peer Workforce Initiative.

Recommendation 6

Implement and evaluate a paid peer workforce trial.

4. Integration of mental health & addiction services

The integration of mental health and addiction services on every level is a particularly high priority centred on population needs. It is well-known that there is very close relationship between mental health and alcohol and other drugs (AOD), and that many people accessing mental health services have substance misuse disorders and vice versa. Victoria needs a considered, well-planned and resourced integration of mental health and AOD services with the needs of people at the centre of the care provided.

Recent census and other data demonstrate the strong relationship between mental health and AOD:

- Levels of psychological distress are higher among people who drink more than four standard drinks a day (16.1%) than those who don't (9.3%).⁵
- Between 2013 and 2016, self-reported mental health conditions and levels of psychological distress were significantly increased among recent users of cannabis, ecstasy, meth/amphetamines and cocaine.⁵
- Self-reported mental health conditions and levels of psychological distress are increasing among users of tobacco and illicit drugs.⁵
- Up to 71% of people accessing mental health services experienced a substance use issue, and 90% of people in substance use treatment settings also experienced mental health uses.⁶
- 12% of patients (n= 46,515) attending General Practice (for any reason) had a mental health condition and substance misuse.⁷

People living with these co-occurring conditions experience worse outcomes than those with only one condition and far worse outcomes than the general population. People with both mental health and substance use conditions have a reduced life expectancy of up to 30 years and are more likely to experience suicidal thoughts.⁸ There is also evidence⁹ that people with co-occurring disorders are at a substantially greater risk of experiencing:

- stigma
- blood-borne infections
- compounding trauma
- forensic involvement
- more frequent relapse
- more frequent hospitalisation
- physical disorders
- poverty
- unemployment and work instability
- violence and exploitation.

5. Australian Institute of Health and Welfare (AIHW) 2018, Alcohol, tobacco & other drugs in Australia, available at <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions>.

6. Deady M, Teeson P, Mills K, Kay-Lambkin F, Baker A, Baile A, Shand F, Manns L, Christensen H & Haber P 2013, One person, diverse needs: living with mental health and alcohol and drug difficulties, NHMRC Centre for Research Excellence in Mental Health and Substance Use, UNSW, Sydney, available at <https://www.mentalhealthcommission.gov.au/media/100021/One%20person,%20diverse%20needs%20Living%20with%20a%20mental%20illness%20as%20well%20as%20the%20challenges%20from%20difficulties%20with%20alcohol%20and%20drugs%20Use.pdf>

7. Hickie I et al. in Croton G 2011, Potential: Australia's evolving responses to co-occurring mental health and substance use disorders, Submission to the Senate Community Affairs Committee: Commonwealth Funding and Administration of Mental Health Services Inquiry, Eastern Hume Dual Diagnosis Service, August 2011.

8. Deady M et al. 2013, op cit.

9. Croton G in Croton G 2011, op cit.

The inability of the current mental health system to intervene early and to adequately respond to multiple support needs is contributing to people being pushed to the acute end of the service spectrum. In 2016/17 Emergency Department data showed that the most frequently recorded mental health-related presentations were mental/behavioural disorders due to psychoactive substance use (such as alcohol dependency).¹⁰

Many of these people end up being repeat visitors to hospitals. This group of people are also twice as likely to be homeless than those who have only one of these problems, and twice as likely to have been in prison or a correctional facility.¹¹

If we fail to adequately support people with co-occurring mental health and substance abuse disorders we will continue to see increases in:

- people being turned away or giving up trying to find the right service
- other health services impacted by the chronic physical health consequences
- emergency departments overwhelmed by repeat presentations
- longer stays in hospital due to difficulties with diagnosis.

Although co-occurring conditions are common, there is considerable variation in the severity and impact of the vast range of combinations of conditions experienced by service users. Generally though, once both mental and substance use problems are established, each condition can maintain and/or exacerbate the other.

Treatment that only focuses on one of the disorders is less likely to be successful than treatment that identifies and responds to all those that a person presents with.¹² Developing a service system that has the capacity to recognise and respond effectively to co-occurring disorders will improve treatment outcomes for the 'target' disorder of any single intervention and ultimately the person participating in that treatment.

There is a need to develop a broad evidence base and build a service system that is "complex capable" and responsive to the full spectrum of circumstances.

4.1 Policy support

The integration of mental health and AOD has been on the reform agenda in Australia for some time. In 2006 a Senate inquiry into mental health found that the difficulties of providing services for people who have both mental health problems and substance misuse disorders were consistently raised as one of the greatest service limitations.

The separation of mental health and substance abuse administrations was found to make operational coordination of services difficult.¹³ The inquiry also found there was a strong body of evidence to show that a more integrated approach to service provision for people with dual diagnosis "will not only improve outcomes for those affected but will be more efficient and cost effective".¹⁴

Dual diagnosis specialists agree that systematically addressing co-occurring disorders at all levels "is the most efficient, cost-effective means of initiating the web of strategies necessary for sustained change".¹⁵

The integration of mental health and AOD services is necessary and possible, however it requires careful and sustained planning and effective governance to ensure service users' experience and outcomes match the collaboratively developed vision. A suitable change management strategy with a sustainable transition schedule would be advised as the process is likely to be lengthy.

Past attempts to better integrate mental health and drug and alcohol services in Victoria have been both commended and criticised. The 2002 Victorian Dual Diagnosis Initiative has won praise for its work developing local networks, training, and consultation and for modelling good practice through direct clinical interventions and shared care. The initiative has also been criticised for creating a 'third tier' or 'niche' of specialised service provision which only exacerbates the likelihood of people falling through gaps.¹⁶ Ultimately, the scale and scope of the integration effort must be commensurate with population needs in order to provide better experiences and outcomes.

More recent attention has focused on broader sectoral integration. As recently as June 2019, at a government-led roundtable meeting reviewing progress in mental health and suicide prevention, integration of mental health and AOD service was highlighted as an area of priority for service reform.¹⁷

It is also important that reforms focus on a scaling up of funds across all systems, not scaling across. The complexity of the system is such that failures in any segment will have flow-on effects for the entire system.

Funds should not be diverted from any one segment for another: each have an integral role to play in ensuring Victorians have access to the right care at the right time.

To consistently improve outcomes, integration needs to occur at all the following levels:

- **Person-centred care:** The person receiving the service feels the care and support they receive is seamlessly meeting their needs and they are an active partner in the process.
- **Service delivery:** Service provision is multidisciplinary and effectively coordinated (via, for example, case management and co-location). The workforce is appropriately trained and information sharing, referrals and professional relationships reflect knowledge of both mental health and AOD.
- **Organisational:** New inter-agency relationships are established with particular attention to developing mutual trust. New networks, brokering arrangements or mergers build on the strengths and capacities of the existing organisational mix, specialisations and workforces.
- **Functional:** Administrative functions of both sectors are integrated, in particular information technology, communication and data systems.
- **Governance:** A central governing agency carefully plans and sustainably manages the integration of the service systems. Transition planning is inclusive of all stakeholders, including service users, and has measureable goals and time-scales and is regularly evaluated. A collaboratively developed vision, based on shared values and priorities permeates the policies, contracts or rules governing action.

Recommendation 7

Develop and implement an adequately resourced transition plan for the integration of mental health and addiction service systems at every level.

10. AIHW 2018, op cit.

11. Deady M et al. 2013, op cit.

12. Croton G 2011, op cit.

13. Senate Select Committee on Mental Health 2006, A national approach to mental health – from crisis to community: First Report, available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/index.

14. Ibid.

15. Croton G 2011, op cit.

16. Senate Select Committee on Mental Health 2006, op cit.

17. National Mental Health Commission 2019, Government-led roundtable meeting to review investment to date in mental health and suicide prevention, 5 June 2019, available at <https://www.mentalhealthcommission.gov.au/media-centre/news/government-led-roundtable-meeting-to-review-investment-to-date-in-mental-health-and-suicide-prevention.aspx>

4.2 Prevention, treatment and recovery

The Royal Commission should consider fully integrating other relevant contributions to mental wellness, such as gambling help and assistance to address behaviours, habits, and other external forces that impact mental health, or at the very least consider linking related sectors (especially, housing/homelessness – see more in the chapters to follow) on some of the above levels.

It would also be useful to integrate mental health and AOD interventions at the prevention and early intervention end of the spectrum (as opposed to treatment of acute illness and recovery).

For example, mental health and substance use problems both typically have their onset in late adolescence and early adulthood.¹⁸ Promoting healthy behaviours or intervening early where there are symptoms of both or either problem would clearly be more effective if integrated. Brief interventions delivered to those with co-existing conditions in primary care settings also show promise. There is an imperative to move away from a focus on individual disorders towards multifaceted health behaviour change right across the spectrum of interventions.

Mental health and substance use problems both typically have their onset in late adolescence and early adulthood. Promoting healthy behaviours or intervening early where there are symptoms of both or either problem would clearly be more effective if integrated.

Recommendation 8

Consider integrating all mental and behavioural health programs and services, from prevention to treatment and recovery, under one structure.

18. Deady M et al. 2013, op cit.

5. Mental health care in the community

General Practitioners (GPs) are often the primary contact for many people in the community with mental health issues. GPs generally have limited referral options for people with complex mental health issues except Emergency Departments (EDs) and hospitals. As a result, EDs are inundated with people in distress who could have been supported earlier through effective early intervention services in the community.

There is a widespread understanding that ongoing mental health support provided in the community before a person reaches crisis can significantly reduce distress and harm for those experiencing mental illness as well as costly hospital presentations.

Across Victoria, people with mental illness and their carers are crying out for alternatives to EDs that do not require having to navigate a multitude of fragmented service streams and 'wrong doors'. They often have a poor experience of care, due to:

- inadequate access and rationing of services
- high level of unmet need, with many people not seeking or finding necessary support
- multiple sources of information and advice
- limited choice
- a workforce that is overwhelmed with demand for services
- a myriad of commissioning bodies and siloed funding streams
- variable access to quality services largely depending on where people live or their income
- poor planning, coordination and operation between the Commonwealth and the Victorian Government, resulting in duplication, overlap and gaps in services
- people being discharged from hospital and treatment services into homelessness, or without adequate planning.

5.1 Community Mental Health Care Model

A Community Mental Health Care Model should be developed, based on the following principles:

- Victorians with lived experience, families and support people encounter a system that involves them in decisions, is easily navigable and provides continuity of care.
- Wrap-around team-based approaches are employed where the person, their family and support people are at the centre of the team, and the various members work together in providing support and services, with an enhanced role for peer workers.
- Interdisciplinary supports are universally available and accessible with integrated services wrapped around the needs of individuals, covering the continuum of needs associated with truly person-centred and recovery-oriented care with a focus on early intervention.
- Mental and behavioural health services are based on population needs and integrated with the wider health, welfare and justice systems.
- People can access services that address whole-of-life needs at all life stages. Arbitrary restrictions on eligibility based on age should be eliminated except where necessary for the provision of developmentally appropriate care.
- Services deliver treatments commensurate with need across the care continuum.
- Prevention and early life care are core pillars of service provision.
- People can access safe and effective care with no disadvantage in access, service delivery, input or any other aspect of the mental health system due to age, gender, location, race/ethnicity, sexuality, gender identity, health status and/or life experiences including family violence and contact with the criminal justice system.
- All workers are qualified to provide high-quality treatment that is strengths-based, culturally appropriate and trauma competent.
- Human rights are embedded into all aspects of the system with accountability ensured through the enforcement of agreed standards and targets.
- Services provide evidence-based treatments which are outcomes-focused to achieve value for money and for individuals and society.
- Access to care is facilitated through multiple access points or front-doors – e.g. drop-ins, GP referral, hospital referral, family, schools.
- Consistent approaches to data collection and analysis facilitate the effective undertaking of monitoring, review, quality improvement, evaluation and research.

5.2 Adult Mental Health Centres

In the 2019-20 Federal Budget, the Commonwealth allocated \$114.5 million to fund a national trial of adult community mental health centres. Mental Health Victoria urges the Victorian Government to incorporate the broader Community Mental Health Care Model into these centres and work with the Commonwealth to design, develop and roll them out across the state, with particular attention to ensure equity of access in regional areas.

The centres would provide additional intervention, treatment and support options for people with mental health issues through a range of tightly coordinated services delivered at community mental health centres, and through outreach to homes and other places in the community.

The model could be used for both scaling up services that are currently in short supply and ensuring that people get the integrated care that they need.

Figure 1: Overview of Adult Mental Health Centres



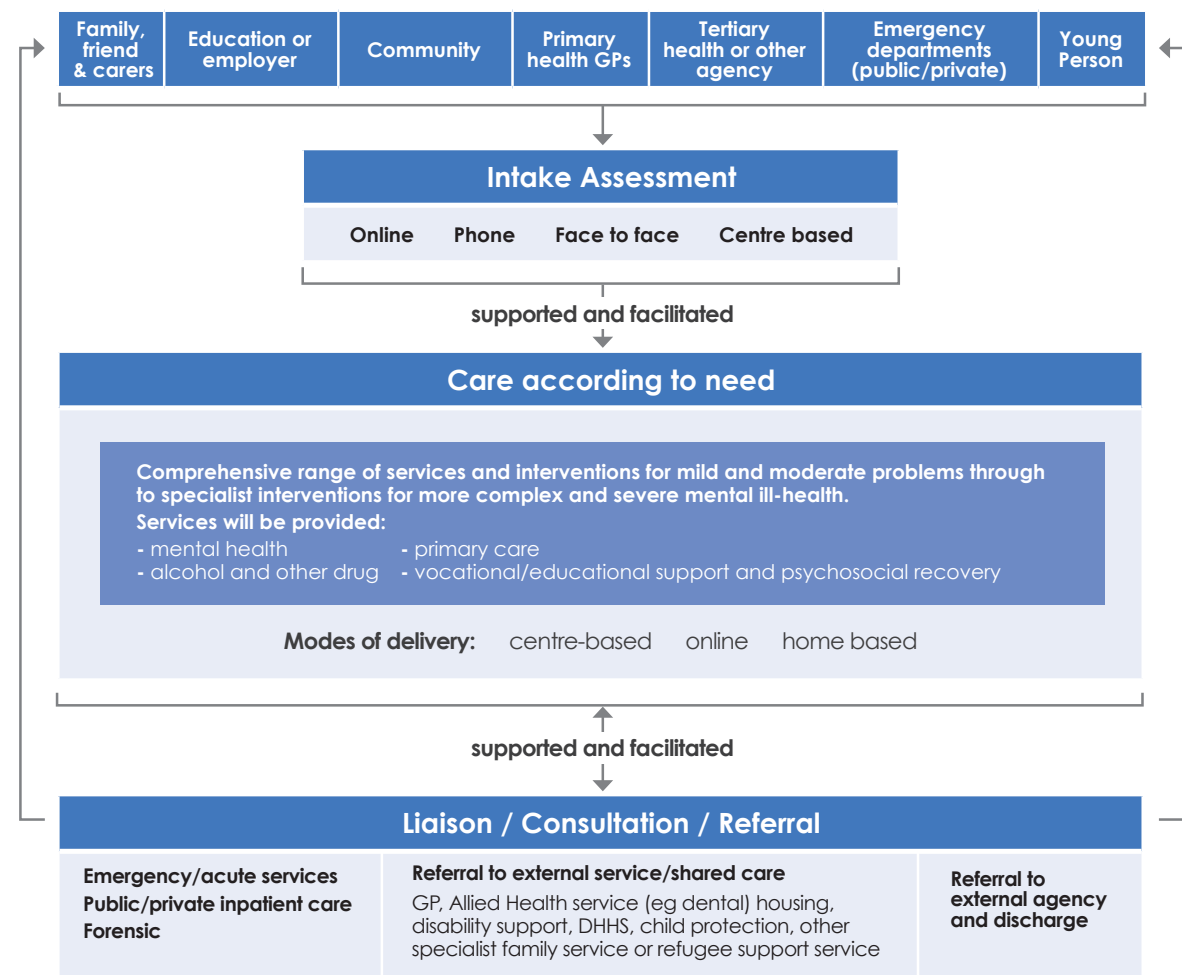
Recommendation 9

Develop a new Community Mental Health Care Model as the basis for the delivery of integrated services across Victoria.

Recommendation 10

Incorporate adult community mental health centres into the new Community Mental Health Care Model and roll these centres out across the state in partnership with the Commonwealth and, where applicable, with existing community health services.

Figure 2: Components of Adult Mental Health Centres



New adult mental health centres need to adhere to the principles of the Community Mental Health Model discussed above and:

- be highly visible and branded like Headspace to encourage people to access community mental health services as an alternative to the ED – and further normalise early help-seeking
- seamlessly combine a range of services, including (but not limited to):
 - case management
 - peer support
 - mental health treatment and support
 - psychosocial disability support
 - allied health
 - addiction services
 - primary care
 - family and parenting support
 - education, employment and housing
 - community legal services
 - family violence services
 - trauma and abuse services
 - outreach and home visitor services
- after-hours support
- carer support services.
- engage clinical and community partners in the commissioning process, who will be selected on the basis of their commitment to service redesign and system reform
- act as a platform upon which collaboration with consumers and families can be built, which will extend into and include a peer workforce and peer leadership
- have a clear requirement to step-down patients from local EDs (through collaboration and shared care processes) and step-up patients from local GPs and PHN-commissioned stepped care mental health services
- have a clear requirement to develop intake processes that are integrated with local tertiary and PHN-commissioned mental health intake services.

5.3 Youth mental health system

The recent report into Child and Youth Mental Health Services by the Victorian Auditor General’s Office (VAGO) identified successive failures of Victorian governments to articulate a framework for child and youth mental health services. While a reform policy was articulated in 2009 which included elevating the transition age to adult services to 25 years, this was never fully resourced or realised.

As a result young people in Victoria still must access the mental health system through a number of service models demarcated by various age limits including those that work with children and adolescents aged 0-18 years (CAMHS), those that work with children and young people aged 0-25 years (CYMHS) and adult mental health services (AMHS) that work with young people aged 16 years and over. There is also a specific youth model in the North West of Melbourne (Orygen Youth Health) for young people aged 15-24 years.

Not only has this under-resourcing and inconsistency in age eligibility brackets created significant service confusion and inequity across the state in provision of and access to evidence-based and appropriate youth mental health care, the system has resulted in significant gaps in care and a dangerous discontinuity of service provision for young people aged 12-25 years as they move between services and catchments. In particular, CAMHS services withdraw when clients are aged 18 years – a point of significant transitional vulnerability for young people . Even within Orygen Youth Health, under-resourcing has restricted the tenure of care for patients to a maximum of two years or up to 18 years.

In addition, there are a growing number of young Victorians falling into the ‘missing middle’ – too unwell to be provided effective services through the primary mental health system but not acutely unwell enough to access state-funded services. The level of crisis that needs to be reached to access this level of care in Victoria has increased in recent years due to under-resourcing. Some services report that their commencing CYMHS clients are experiencing much greater severity of symptoms than national averages.

Victoria needs a youth mental health system which:

- prioritises funding toward community-based youth specialist services with governance of these services situated within community-based organisations
- removes service eligibility based on catchment areas for young people seeking to access specialist youth community-based care (and aligns to the approach of Headspace in primary youth mental health care)
- moves away from block-based funding models in favour of activity-based funding and ‘packages of care’ that are designed to:
 - provide evidence-based treatment, of the required dose and duration dependent on condition, severity and complexity, with links to acute services as required (see section 7.2)
 - provide wrap around services and supports tailored to the needs of that individual, including family-inclusive practices, group programs, vocational supports and peer workers
 - involve co-investment with the Commonwealth Government into community-based platforms of care that can address the ‘missing middle’.

Recommendation 11
Develop and implement a state-wide model for Child Mental Health Services (0-11 years) and Youth Mental Health Services (12-25 years), underpinned by a clear and consistent framework, governance and service specifications.

5.4 Addressing NDIS gaps

We know that out of the 184,000 Victorians with severe mental illness, only around 15,000 or 8 per cent will be eligible for the National Disability Insurance Scheme (NDIS) when it is fully rolled out.¹⁹ This leaves many tens of thousands of Victorians without access to the care they need.

The Victorian Government has stepped in and provided short-term, limited funding over two years through the Early Intervention Psychosocial Support Response (EIPSR). The EIPSR is a psychosocial support model targeted to adult clients of the clinical mental health service system living with a severe mental illness and associated psychiatric disability who are either:

- not eligible for the NDIS because they do not have significant, permanent functional impairment/s associated with their mental health condition, or
- eligible for the NDIS and waiting for an access decision and the commencement of their NDIS plan.

THE EIPSR is readily scalable, and could be rapidly expanded in the short-term while broader system design and enhancement work is undertaken. Additional care should be taken to ensure equity of access for children, and people in regional areas.

Additional investment should be targeted towards key population groups in Victoria, including Aboriginal and Torres Strait Islander peoples, people from CALD communities, including refugees and people seeking asylum, and people who identify as LGBTIQ+.

Recommendation 12

Rapidly scale-up existing psychosocial support programs for people not eligible for the NDIS while broader mental health system design and planning work is undertaken.

19. Victorian Government 2018, Early Intervention Psychosocial Support Response – Overview: A clinical and community partnership model for psychosocial support services, November 2018.

5.5 Safe, secure and affordable housing

Victorians with mental illness commonly experience insecure accommodation, frequent moves, unsuitable housing and homelessness. Both private and public rental accommodation are incredibly difficult for people with mental illness to access because of cost, availability, discrimination and stigma.

The closure of stand-alone mental and psychiatric institutions was based on the assumption that those living with psychiatric disability would have access to heavily subsidised social housing underpinning the provision of community based care. Unfortunately since that time, governments have reduced the provision of social housing.

Permanent and affordable housing options are desperately needed. 'Housing First' models, which prescribe safe and permanent housing as the first priority for people experiencing homelessness to be followed by multidisciplinary support to address other complex needs such as mental illness or drug and alcohol issues, show impressive outcomes for tenants (particularly those with long histories of housing insecurity) and cost-savings for governments.

However, not all housing options are suitable for all people. Increased investment and effort are required to supply a range of housing options and to support people with mental illness to access those options and keep their homes.

To achieve this, governance bodies will need to lead the integration of the housing and mental health sectors and work together to develop and implement a housing strategy which makes particular reference to people with mental illness. The strategy should also address the disparity of access to housing options for people living in rural or regional areas.

Lack of safe, secure and affordable housing has significant impacts:

- The rate of mental illness among people experiencing housing crisis is significantly higher than that of the general population. In 2017-18, 31 per cent or 81,000 people presenting to Specialist Homelessness Services (SHS) had a current mental health issue. Almost 2 in 3 (64 per cent) were returning clients.²⁰
- Homelessness for people with mental illness comes at a very high cost both for the impact on a person's mental health and cost to the economy in terms of their service usage. One Australian study reported an average annual inpatient expenditure of \$47,425 per person.²¹ This does not account for the use of other non-mental health related government services.
- The personal and financial burden extends beyond the 'homeless' or 'roofless'.²² Many others live in accommodation that is poor quality, unstable, overcrowded, unaffordable and not of their choosing.
- Housing difficulties can impact the families and carers of people experiencing mental illness who may take on housing responsibilities in the absence of suitable alternatives.

Recommendation 13

Develop an integrated housing strategy through a consultative process, including specific consideration given to people with experiences of mental illness.

20. AIHW 2018, Couch surfers: a profile of Specialist Homelessness Services clients, Cat. no. HOU 298, Canberra.

21. Bruce J, McDermott S, Ramia I, Bullen J, and Fisher KR 2012, Evaluation of the Housing and Accommodation Support Initiative: Final Report for NSW Health and Housing, Sydney.

22. Fels A 2019, Productivity Commission Inquiry into Mental Health Submission, available at https://www.pc.gov.au/_data/assets/pdf_file/0005/240845/sub303-mental-health.pdf.

Table 2 (below) outlines the risks and gaps across a range of housing models in Victoria.

Accommodation Type	Issues and solutions
Permanent Housing: Public and social housing	In Victoria, there were 59,556 applicants for public housing as at March 2018.²³ In 2016, the Community Housing Federation of Victoria estimated that an additional 30,000 new social housing properties would be needed in the state over the next decade to meet demand.²⁴ Of the accommodation services needed by clients with a current mental health issue, 41 per cent were looking for medium-term accommodation but only 26 per cent could be provided with assistance. More than 50 per cent needed long-term accommodation but only 5 per cent were provided with it.²⁵ The homelessness and rough sleeping action plan in the Victorian 2018-19 Budget contains funding of \$23.9 million over 4 years or around \$6 million per year. A range of activities have been announced since the beginning of 2017, including \$9.8 million for Towards Home, an investment to house vulnerable people in Melbourne, and \$19 million for assertive outreach teams in suburban, regional and rural areas. These are welcome investments, however further effort and investment is required.
Private rental	Private rental housing is the most common form of accommodation among people with a lived experience of mental illness.²⁶ However it often lacks reliable length of tenure and is increasingly costly and difficult to access and maintain. People living with mental illness report discrimination in the private rental market and high rental costs as major barriers.²⁷ Those who do find private rental are vulnerable to losing their home when they are not adequately supported and/or crises occur.
Other private accommodation: Rooming houses & Supported Residential Services (SRS)	People with mental illness and psychosocial disability are a prominent population within rooming houses.²⁸ Rooming houses are "often expensive, unsafe and run by unaccountable private operators".²⁹ Rooming house residents across Australia overwhelmingly advise that they live in conditions that are dangerous, violent, dirty, and/or harmful to their mental health. Despite the high level of need there are very few health and social services provided to rooming houses. SRS are private businesses that provide accommodation and some personal support services for people who need assistance with daily living, including people with mental illnesses. SRS vary in staffing skills and levels. In many cases people with severe mental illness will need well-coordinated and integrated care provided by external services to ensure they maintain their health and housing. The State Government's recent work developing guidelines for collaborative care to residents with mental illness is noteworthy.

Accommodation Type	Issues and solutions
Specialist supported accommodation	Only a very small proportion of community housing is specialist supported housing for people living with severe and enduring mental illness or psychosocial disabilities. These services are not consistently available across regions, rely on adapted inappropriate infrastructure and are generally filled to the brim. It is difficult for people to know where the vacancies are and how to access them.
Housing at points of transition, including step-down transitional housing	Housing is critically needed for those people with mental illness vulnerable to entering a cycle of homelessness, including young people exiting out-of-home care, and people leaving institutional care (treatment and correctional facilities). Some of these people will require step-down supported transitional housing; for others 'Housing First', private options and social housing models might be preferable. It is worth noting that transitional options can become 'clogged' unless adequate, affordable, long term options are also available. Children and young people who have been placed in out-of-home care experience high rates of developmental and mental health issues and are hugely overrepresented among young people who are homeless.³⁰ One study found they made up nearly two-thirds (63 per cent) of a group of homeless youth surveyed.³¹ The move from out-of-home care towards independent living requires stable independent housing with adequate wrap-around support. In 2016-17, more than 500 people were discharged in Victoria from acute mental health care into precarious housing or homelessness, an increase of 45 per cent over the previous three years.³² A lack of suitable housing options is obviously problematic but there is also evidence of inadequate discharge planning, time pressured discharge assessments and a lack of coordination across sectors, as well as a lack of available beds which puts additional pressure on discharges, creating a distressing cycle.³³ Failed discharges increase the likelihood that people will end up back in hospital or other treatment settings. The same devastating and costly cycle exists between our prisons and communities. Those experiencing homelessness and mental ill-health are 40 times more likely to be arrested and 20 times more likely to be imprisoned than those in stable accommodation.³⁴

Recommendation 14

Improve access to adequate, stable and affordable housing for people living with mental illness.

23. Brackertz N, Wilkinson A, Davison J 2018, Housing, homelessness and mental health: towards systems change, AHURI.

24. Community Housing Federation of Victoria 2016, Quantifying the shortfall of social and affordable housing, available at <https://chiaviv.com.au/wp-content/uploads/2017/09/Housing-Shortfall.pdf>.

25. AIHW 2018, op cit.

26. Brackertz et al. 2018, op cit.

27. SANE Research 2008, Housing and mental illness, Research Bulletin 7, available here https://www.sane.org/images/PDFs/0807_info_rb7_housing.pdf.

28. Goodman R, Nelson A, Dalton T, Cigdem M, Gabriel M and Jacobs K 2013, The experience of marginal rental housing in Australia, AHURI Final Report No.210, Melbourne.

29. Mental Health Legal Centre Inc. 2019, Submission to the Productivity Commission inquiry, available at https://www.pc.gov.au/_data/assets/pdf_file/0006/240864/sub315-mental-health.pdf.

30. Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2015, The mental health care needs of children in out-of-home care, available at <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/the-mental-health-care-needs-of-children-in-out-of-home-care>.

31. Flatau P, Thielking M, MacKenzie D and Steen A 2015, The cost of youth homelessness In Australia study: The Australian Youth Homelessness Experience, Snapshot Report 1, Salvation Army, available at <http://www.salvationarmy.org.au/en/Who-We-Are/Publications-reports-submissions/Reports-Submissions/Latest-Reports/The-Cost-of-Youth-Homelessness-in-Australia---Research-Briefing/>

32. AIHW 2019, Specialist homelessness services annual report 2017-18, available at <https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2017-18/contents/client-groups-of-interest/clients-with-a-current-mental-health-issue>.

33. Brackertz et al. 2018, op cit.

34. Victorian Government 2018, Family Violence Blitz Package evaluation - executive summary, available at <https://www.vic.gov.au/family-violence-housing-assistance-implementation-taskforce>.

5.6 Integrated housing support

Better and more integrated mental health/housing support is required for people with mental illness. This is important both for people who have stable accommodation, as well as those in more precarious situations.

- For some people experiences of mental illness and its associated crises are episodic. There is a need to expand programs that offer intermittent, time limited support and brokerage to support them to sustain their private rental accommodation, such as the Victorian Government's Private Rental Access and Tenancy Plus programs.
- Support needs also to be more systematic than just supporting individual tenants. It is cost effective to better resource and educate housing providers to identify the early warning signs of mental health issues and intervene before housing is at risk. The Doorway program, an innovative partnership between the Victorian Government, a community mental health provider and the peak body for real estate professionals, has shown promise.

- Programs coordinating mental healthcare and access to housing have been shown to be effective across both private and social housing tenure.³⁵ However, housing subsidies must recognise the nature of the difficulties participants face. Time limited private rental subsidies can be effective for those who have experienced time-limited crisis.³⁶ But those who are likely to experience recurring or ongoing difficulty affording or sustaining a rental may require ongoing subsidies, such as those provided by social housing.

Group based rooming house outreach programs have been shown to achieve dramatic improvements in residents' wellbeing.³⁷ However, these pilot programs lack funding and have been short-lived, with low-quality evaluations.³⁸

Recommendation 15

Expand programs that integrate housing and mental health support.

35. Brackertz et al. 2018, op cit.

36. Victorian Government 2018, Family Violence Blitz Package evaluation - executive summary, available at <https://www.vic.gov.au/family-violence-housing-assistance-implementation-taskforce>.

37. Goodman et al. 2013, op cit.

38. Council to Homeless Persons' 2019, Submission to Productivity Commission inquiry, available at https://www.google.com/url?sa=rctj&q=&esc=s&source=web&cd=2&ved=2ahUKewirgseE2IHjAhUCVH0KHcfGDvcQFjABegQlABAC&url=https%3A%2F%2Fwww.pc.gov.au%2F_data%2Fassets%2Fword_doc%2F0007%2F240298%2Fsub145-mental-health.docx&usg=AOvVaw37KhvqheWYYbM2mXlV8mql.

5.7 State-wide discharge policy

Complementary to adequate, stable and affordable housing for people with mental illness would be a state-wide discharge policy for people exiting institutional care (including mental health and AOD treatment facilities, prisons and juvenile detention) that would connect people with suitable housing options and the support to keep their home.

Consistency is required, particularly in relation to a definition of 'no exit to homelessness'. At present, this can often translate to mass referrals to housing support services and little more.

Discharge planning needs to be adequately resourced to allow discharge planners sufficient time to build connections between the person leaving institutional care, appropriate housing options, and support services. The workforce needs to be adequately skilled to assess risk factors and to ensure the delivery of services that are well-planned and integrated.

Recommendation 16

Develop a state-wide discharge policy.

5.8 Tailored housing models for priority populations

No one model or approach is suitable for every circumstance or person but there are guiding principles known to facilitate good housing outcomes for people with mental illness, including the most vulnerable.³⁹

They include:

- timely access to appropriate, affordable and stable housing
- policy and stakeholder coordination between housing and mental health, including formal agreements, MOUs, collaboration and local coordination
- integrated, person-centred support, wrap-around services as needed.

Priority should be given to those at particularly increased risk of repeat homelessness, including people with mental illness who are also:

- leaving out-of-home care or exiting other institutional care, including mental health and AOD treatment facilities and prisons
- living with family members in unsustainable situations because of lack of more appropriate alternatives
- single mothers and women experiencing family violence.

Any new housing should also be developed with particular reference to the needs of, and in consultation with, diverse communities including Aboriginal and Torres Strait Islander communities and LGTBQ+ people. Similarly, age appropriate options should be considered.

39. Brackertz et al. 2018, op cit.

Possible models of housing to scale up further include The Haven and Rooming House Plus:

Housing Model	Description
The Haven: A model of long-term housing for people with mental illness	One model particularly well suited to those eligible for funded supports (such as the NDIS) would be a supported housing cluster model, such as those developed by the Haven Foundation (now overseen by Mind). This model houses and supports anywhere between 10-30 residents in self-contained apartments on one property. Residents are responsible for their own activities of daily living, with support being provided (via the NDIS) where required and a staff member on site at all times to address unforeseen support needs. The funding model would be mixed, with non-government organisations purchasing land, state government funding the buildings, and a proportion of the residents' Disability Support Pension allocated to cover maintenance and upkeep as well as residents own living costs. An agreed funding model and collaborative planning process would see timely and successful action on such projects.
Rooming House Plus: A model of housing for people caught in the cycle	This is a model that has enabled people with histories of chronic homelessness, including people with mental illness, to break the cycle of disadvantage through the provision of long-term accommodation and support needed to maintain housing. Melbourne-based examples of this model include the Rooming House Plus Program (RHPP) and Elizabeth Street Common Ground. Both properties provide self-contained accommodation for about 65 single adults over 18 years of age who have experienced chronic homelessness. Common Ground also provides an additional 66 apartments for low income workers and students. Both services are collaborative initiatives between non-government organisations (providing for example 24/7 support, tenancy management), state government and, in the case of Common Ground, a trust fund and a developer.

Recommendation 17

Develop and implement housing models for key cohorts.

6. Mental health care in hospitals

Victorian hospitals are under-resourced and cannot cope with demand for mental health services. Consequently, access is limited and services are rationed, creating a vicious cycle where not enough people with severe mental illness get access to care, and those that do don't get the care and support they need for long enough. Access to care is particularly limited in rural and regional areas and so all system reforms should be conducted with particular attention paid to ensuring equity of access in rural and regional areas.

6.1 Access to clinical mental health care

3.1 per cent of Victorians experience severe mental illness, however only 1.1 per cent of the population received access to clinical care in 2017-18. This is well below access in comparable states – e.g. both the national and NSW rate was 1.8 per cent in 2017-18.

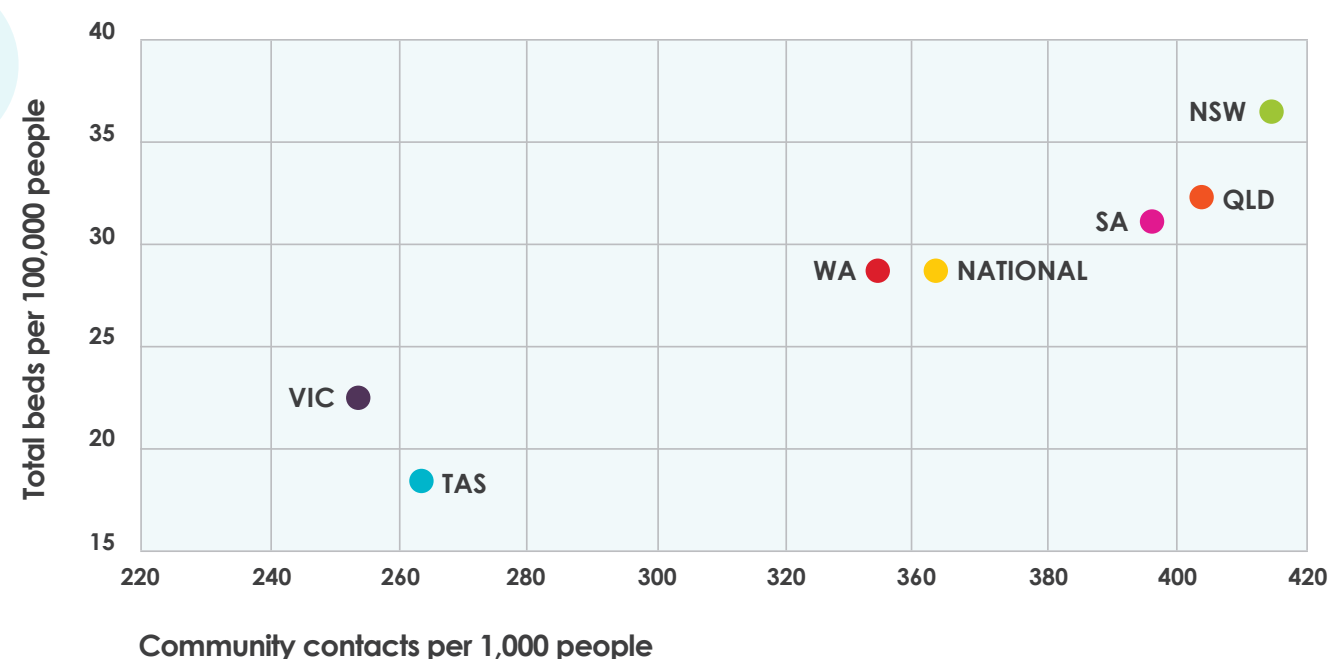
Improvements to access to clinical mental health care are urgently needed, with particular attention paid to ensure equity of access in rural and regional areas, including after-hours care. Planning to achieve sufficient improvements must take numerical and geographical trends in birth rates into account.

Table 1: Estimated number of Victorians with a mental illness.⁴⁰

Severity of illness	Victorians with a mental illness (%)	Number (thousands)	Victorians requiring treatment (%)	Number needing treatment (thousands)	Primary government responsibility
Mild	9.0	537	50	268.5	Commonwealth
Moderate	4.6	272	80	217.6	State/Commonwealth
Severe	3.1	184	100	184	State
Total with mental illness	16.7	993		670.1	

40. ibid.

Figure 2: Victorian mental health beds and community contacts, 2016-17.⁴¹



Victoria has slipped from the highest funder per capita for mental health in Australia to the lowest. Compared to the national average, Victoria covers half as many people, a mere 1 per cent of the Victorian population, for their mental illness needs, with greatly reduced community mental health care and fewer beds. The target should be 3 per cent, reflecting the proportion of the population who experience serious mental illness every year and who should expect access. Victoria's mental health system is turning away around two-thirds of those who need expert care.

Professor Patrick McGorry AO, 2017



Recommendation 18

Raise access to clinical mental health care from 1.1% of the Victorian population to at least 3.1% as an interim measure, and 5.0% over the longer-term.

6.2 Mental health beds

Following the deinstitutionalisation of the public mental health system from the 1950s, the number of psychiatric beds available for the care of people with mental illness has fallen dramatically.

Much of this decrease is welcome with increasing provision of community-based care. However, there remains a need for acute and longer-term beds for the care of people with serious mental illness whose needs cannot be met in the community. This is particularly so for certain population groups including children and adolescents, via CAMHS, and people within the criminal justice system.

Victoria has just 22 mental health beds per 100,000 people – by comparison, New South Wales has 36 per 100,000 and the OECD average is 50 beds per 100,000.^{42,43} Consequently, beds are under great pressure with occupancy rates of 94 per cent statewide, forcing longer wait times in Emergency Departments (EDs) with just 53 per cent of people transferring from EDs to a bed within 8 hours.⁴⁴

Insufficient beds has also meant that the average length of stay has declined between 2010-11 and 2016-17 from 16.1 acute inpatient stay days to 13.6 days, a reduction of 16 per cent overall, while the child and adolescent length of stay has declined by 25 per cent.⁴⁵ The result is that inpatients are not spending long enough to gain the full benefits of care and are at risk of cycling back through the system.

Other negative outcomes associated with insufficient bed numbers include premature discharge practices, high rates of readmission, homelessness, suicide and incarceration, increased risks for workforce safety and wellbeing, increased burden on carers, and increasing inequality of access as private sector growth outstrips public sector growth.⁴⁶

While an increase in mental health beds is urgently needed, this should and need not presage a return to pre-deinstitutionalisation models of care. Mental health service provision has come far since the 1950s with broad recognition and increasing provision of person-centred, recovery-oriented care.

Rather than the asylums of the past, such care should be provided in specialised built-for-purpose care and rehabilitation centres including already-existing Prevention and Recovery Care centres. These could be attached or closely linked to hospitals and community mental health hubs, or built as stand-alone facilities, depending on the specific purpose of each facility.

Victoria has just 22 mental health beds per 100,000 people – by comparison, New South Wales has 36 per 100,000 and the OECD average is 50.

41. AIHW, Specialised mental health care facilities tables 2016-17, Table FAC.13 and AIHW Community mental health care tables 2016-17, Table CMHC.5.

42. AIHW, Specialised mental health care facilities tables 2016-17, Table FAC.13.

43. OECD, Hospital beds, available at https://www.oecd-ilibrary.org/social-issues-migration-health/hospital-beds/indicator/english_0191328e-en

44. Victorian State Government, Adult Mental Health Performance Indicator Report 2018-19 – Quarter 1, available at <https://www2.health.vic.gov.au/about/publications/researchandreports/adult-mhpi-report-2018-19-qtr-1>

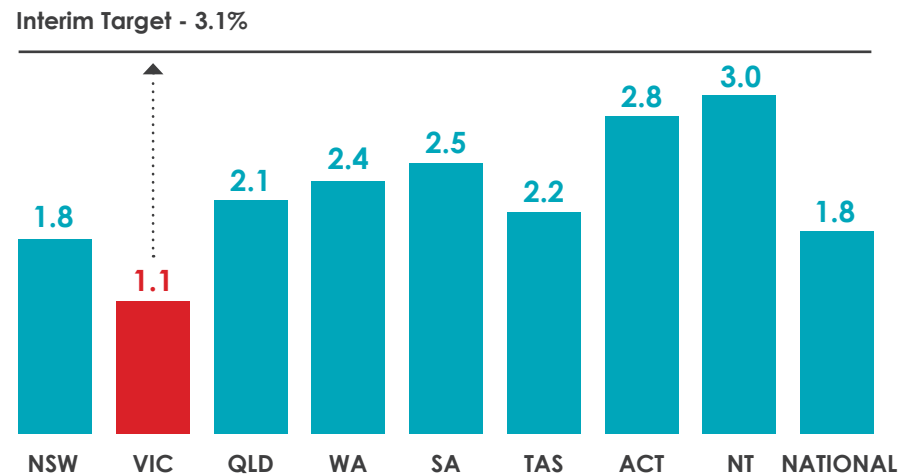
45. AIHW, Key performance indicators for Australian Public Health services 2019, Table KPI4.

46. Allison S, Bastiampillai T, Licinio J, Fuller DA, Bidargaddi N, Sharfstein S 2018, 'When should governments increase the supply of psychiatric beds?', *Mol Psychiatry* 23(4):796-800; Allison S, Bastiampillai T and Castle D 2017, 'Victoria's low availability of public psychiatric beds and the impact on patients, carers and staff', *Australian & New Zealand Journal of Psychiatry* 52(1).

Some facilities for acute care and rehabilitation should remain embedded within hospitals to reduce stigma, support health literacy and insight, and improve access to medical and surgical support for people with complex health needs. Wherever the location, the design and operations of these facilities should be informed by the following principles:

- **Integration of care, education and research** to support the provision of high-quality, evidence-based care both within and across centres and to train the mental health workforce of the future.
- **Gender and cultural safety** to ensure women, Aboriginal and Torres Strait Islander peoples, and people from CALD and LGBTIQ+ communities are not put at risk by entering care facilities.
- **Recovery-oriented practice** to ensure patients are treated with the aim of supporting their re-entry into the community, and discharged when they are well enough to re-enter the community.
- **Discharge and transitional supports** to ensure continuity of care including outpatient services and links to support services as required (including housing, legal, employment etc.).
- **Robust and independent governance** encompassing government and public oversight, external auditing and close links to complaints, regulatory, advocacy and support bodies to ensure human rights, best practice guidelines on restraint and seclusion, and legal and community standards are met.
- **Purpose-built designs** including bright, recuperative spaces and minimisation of suicide risks.
- **Case management** to ensure the provision of multidisciplinary, patient-centred clinical care provided in tandem with peer and community care supports.

Figure 3: National % of population receiving clinical mental health care, 2017-18.⁴⁷



Recommendation 19

Expand the mental health bed base to meet an interim target of at least 36 mental health beds per 100,000 Victorians (matching NSW) and a longer term target of at least 50 mental health beds per 100,000 Victorians (matching OECD).

6.3 Emergency Departments

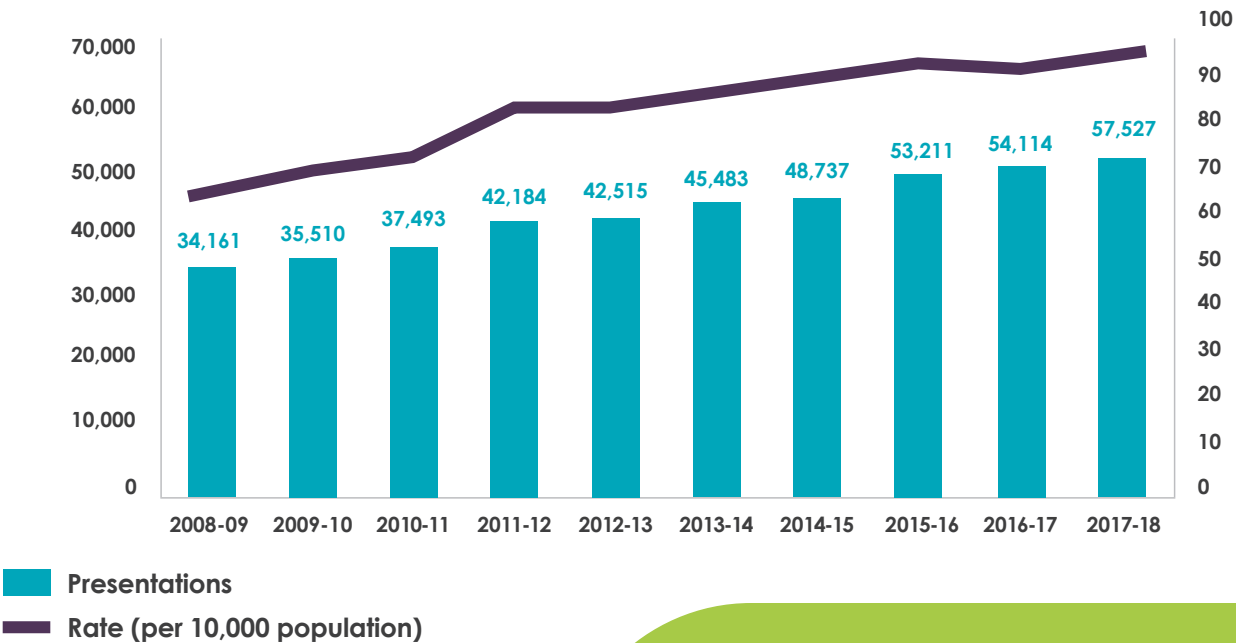
EDs are a key point of contact with the health system for people with mental health problems who require urgent medical care, including psychiatric care. These units are located within acute general hospitals. Admission to a more suitable environment may be required to provide short-term inpatient management and treatment during an acute phase of mental illness, until the person has recovered enough to be treated effectively and safely in the community.

Mental health related presentations to EDs have increased to unsustainably high levels – a 68 per cent increase over the 10 years from 2008-09 to 2017-18 to 57,527 each year or 1 presentation every 9 minutes. In population terms, mental health presentations have increased from 64.3 per 10,000 people in 2008-09 to 90.1 in 2017-18 – an increase of 40 per cent.⁴⁸

As a result, people seeking help from EDs for mental health problems are waiting increasingly long times for assessment and treatment, and are increasingly likely to leave before their treatment concludes.⁴⁹

This requires reform outside EDs, to ensure access to clinical and community services is sufficient to reduce demand on ED services, and within EDs, to ensure that people with mental illness presenting to EDs are catered for in suitable spaces, and within the timeframes set by the National Emergency Assessment Target. The Australasian College for Emergency Medicine has developed the Mental Health in the Emergency Department Consensus Statement in consultation with key stakeholders. The consensus statement sets out the policy priorities for mental health in the ED, and includes members of the Victorian Mental Health Policy Network as signatories.

Figure 4: Victorian Mental Health Presentations to Emergency Departments, 2008-09 to 2017-18.⁵⁰



48. AIHW, Mental health services provided in emergency departments 2017-18 Table ED.1, available at <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services>

49. Australasian College for Emergency Medicine, The Long Wait: An analysis of mental health presentations to Australian Emergency Departments, available at https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018.

50. AIHW, Mental health services provided in emergency departments 2017-18 Table ED.1 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services>.

Recommendation 20

Reduce Emergency Department (ED) presentations, with a interim target of zero net growth, and a longer term target of year-on-year reductions, in mental health related ED presentations per 10,000 population.

7. Suicide prevention

In 2017, the most recent year on which Australian Bureau of Statistics (ABS) reports are available, 621 people in Victoria ended their lives by suicide: 434 deaths were recorded in greater Melbourne and 184 in regional Victoria.

Victoria has consistently had a suicide rate lower than the national rate, and for two of the 10 years reported had the lowest suicide rate in Australia – including in the last reporting year 2017. The fluctuations in suicide rates in Victoria are also less pronounced than some other jurisdictions. Similarly, Victoria has consistently had the lowest suicide rate among young people, in ages between 5-17 years, across all jurisdictions and nationally, for the period from 2013 to 2017.

These comparative rates are welcome and suggest some effective efforts in Victoria compared to other jurisdictions but overall the suicide rate remains intransigent. Shifts in approach, resource levels and effort across all sectors in Victoria will be required to achieve a meaningful reduction in suicides.

Overall, the World Health Organization (WHO) estimates for every death by suicide there are 20 people who will attempt or re-attempt suicide.

Many people who survive a suicidal crisis and/or suicide attempt do not interact with the hospital and health system and remain somewhat under-recognised for service planning and responses. A recent report prepared for Beyond Blue⁵¹ used ambulance data on presentations/call outs for suicidal behaviour involving men and found three times the number of ambulance attendances between July 2014 and June 2016 compared to hospital presentations.

Overall, the World Health Organization (WHO) estimates for every death by suicide there are 20 people who will attempt or re-attempt suicide. On an annual basis in Victoria this will translate to 12,420 people who require immediate responses and continuing follow up and care to address their suicidality and prevent further harm or death, regardless of whether or not they have had contact with hospitals and health services. The service system needs to be prepared for this across community and health domains.

Suicide deaths impact on many others associated with the person, including family members, partners/spouses, work colleagues, friends, sporting and social contacts. It is estimated that 135 persons are impacted by suicide, which translates each year in Victoria to 83,835 people.

This suggests that in Victoria 83,835 persons per annum are associated with a person who died by suicide. These people are vulnerable to negative impacts including the stimulation of their own suicidality as a result of this association.

These should take into account:

1. Hospital and community mental health service responses to suicidal persons need to foster recovery and reduce repeat suicidal crises. Deficiencies in the operation of the mental health system through hospitals, clinicians, primary health, community mental health services and non-clinical support services directly affect how a suicidal person may receive help and influence future contacts seeking help.
2. Population level shifts in mental health and wellbeing will contribute to reduced suicidality and focus more attention on early interventions and de-escalation of suicidal persons – saving lives and improving lives. Many suicidal people have contact with primary health professionals (GPs) in the 12-month period prior to a suicide attempt. GPs should be trained to recognise and manage mental ill health such as anxiety and depression and substance abuse disorders. Moreover, broad efforts on population wide mental health promotion will encourage people to seek help and build greater resilience that will aid suicide prevention.

51. Turning Point 2019, Beyond the Emergency: A national study of ambulance responses to men's mental health. Richmond, Victoria, available at <https://www.beyondblue.org.au/docs/default-source/default-document-library/beyond-the-emergency-report.pdf>.

7.1 Victoria's Suicide Prevention framework

The Victorian Suicide Prevention Framework offers the basis for which programs and services are funded and deployed. It has set a target of a 50 per cent reduction in suicide in Victoria by 2025.

While the principles and strategies contained in this Framework are sound, and broadly aligned to the Fifth National Mental Health and Suicide Prevention Plan and the Living Is For Everyone (LIFE) national policy guide, there are various issues surrounding the implementation and adoption of the Victorian Framework, which could be more detailed and strategic in its orientation.

Reform in suicide prevention in Victoria should relate to a mix of specialist strategies and services that are intended to engage with suicidal persons and enable effective responses while also addressing longer term prevention to occur at a population level.

The case for a public health approach to suicide prevention, as advocated by experts such as Silverman and Felner, and reinforced by the World Health Organization should relate to reforms in the Victorian mental health system, embracing services across the full range of promotion, prevention, intervention and recovery elements. The Integrated Motivational Volitional Theory on Suicide⁵² is a sound base from which to view this multi-factorial characteristic of suicide. Suicide prevention needs to be approached from a perspective of the evidence and theory on suicidal behaviour.

Specific issues associated with the Victorian Suicide Prevention Framework are:

Absence of a plan of action

It is difficult to understand what the 50% reduction target is based on, and which mix of services and level of funding is required to achieve this – there does not appear to be an operational plan to apply the strategies in the Framework.

Business as usual/Investment hard to determine

The emphasis in funding commitments is on trials and development, with little detail on which programs are being funded on a continuing basis. For instance, what education or awareness programs on resilience building are being adopted and for whom and to what extent? What training for health professionals in basic suicide response skills is underway and what is the target? What suicide prevention programs are being provided – or developed – for schools in Victoria?

Coordination across tiers of government

Linkages to existing services and national services are not made clear. For instance, Victorian trials of the Hospital Outreach Post-suicidal Engagement (HOPE) model of outreach to persons following a suicide attempt makes no reference to the Beyondblue The Way Back Service which will be implemented nationally. Supports for people impacted by suicide are mentioned, but there is no plan for use of the national StandBy Response Service in Victoria. Construction industry workforce is mentioned for priority suicide prevention but there is no Victorian presence of Mates In Construction. There are no linkages formed on the role and contribution of national helplines such as Lifeline or the Suicide Call Back Service. The irony is that many of these national services are developed in Victoria by organisations such as Beyondblue and On The Line.

The Place Based and Assertive Outreach (HOPE) trials have funding of \$27 million over four years and will undoubtedly create better understandings and models of service improvements in how a local and regional response to suicidal persons and the promotion of suicide prevention can occur. However, there are no indications at this stage how the knowledge from these trials will be applied to the reform of the overall system.

The HOPE model of service is unclear in how it would involve clinical community mental health services, yet this would seem to be a point of coordination that hospitals and health services are particularly well placed to facilitate.

Investments in mental health require suicide prevention specific components

The Help Equal Youth (HEY) project which has seen \$6 million allocated to more than 17 projects over four years is aligned to suicide prevention, but it is not clear how the suicide prevention component of these projects is being addressed or evaluated. Moreover, it is not clear how this aligns to the national LGBTIQ Suicide Prevention Strategy, developed by the LGBTI Health Alliance.

Funding of \$11.7 million for Aboriginal led demonstration sites and the \$8.4 million to develop an Aboriginal Mental Health Workforce is welcomed and will help formulate improved service models and capacity on Indigenous mental health but it is not clear if these projects will be responsive to and contribute to the best practice evidence as generated through the national Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

National and whole of government efforts required

The Victorian Government should align its outlooks on suicide prevention with those held nationally by Suicide Prevention Australia and reflected in the national policy directions including the recent commitment by the Australian Government to enhance whole of government responsibilities for suicide prevention by appointing a Coordinator role within the Department of Prime Minister and Cabinet.

Suicide prevention needs to be viewed as a responsibility beyond the health portfolio; a whole of government outlook should be established and responsibilities allocated for other portfolios such as family and community services, justice, education, for instance.

Recommendation 21

Employ a whole-of-government suicide prevention outlook.

52. O'Connor RC and Kirtley OJ 2018, 'The integrated motivational-volitional model of suicidal behaviour', Philosophical transactions of the Royal Society of London. Series B, Biological sciences, 373(1754), 20170268. doi:10.1098/rstb.2017.0268.

7.2 Key population groups

Greater involvement and co-design of services with people with lived experience of suicide and their carers will result in improved services and greater utilisation of those services. This should account for the particular experiences of key population groups including young people, older people, women, Aboriginal peoples and LGBTIQ+ people.

This could be achieved through the establishment of a high-level central government advisory body (like that established in South Australia), that includes persons with lived experience perspectives.

Victoria could also require that regional and local suicide prevention services involve consumers and carers in the continual improvement of services and the provision of feedback on performance.

Recommendation 22

Better facilitate co-design for service improvement.

7.3 Rural and regional areas

Regional approaches to suicide prevention are sound as they enable local coordination of services and a responsiveness to local issues and population variances.

Victoria is well placed to reinforce a regional approach to suicide prevention through ongoing funding and policy commitments to regional networks for suicide prevention, involving regional health services and local government, intersecting with existing local community networks, services and resources. These networks should be supported with the national and state areas of technical and specialist expertise.

The findings from the place base trials in Victoria should inform the ongoing establishment of regional networks and approaches to suicide prevention, along with findings as they emerge from other regional suicide prevention trials throughout Australia.

Recommendation 23

Reinforce support for regional networks for suicide prevention.

7.4 Providing aftercare

The HOPE trials are important initiatives in Victoria and consistent with policy reforms nationally for more attention to aftercare and follow-up support of suicidal persons who contact the hospital and health systems.

The findings from the HOPE trials should be translated into practice, program and resource commitments on an ongoing basis in every region of Victoria. There should be a standard established for the crisis response and aftercare services – regardless of where a person lives.

Recommendation 24

Improve suicide crisis response and aftercare.

7.5 Suicide data

Victoria is fortunate to have the Victorian Suicide Register in place as a source of highly valuable data to inform suicide prevention planning at a regional and state-wide level. Its funding and continued maintenance should be a priority for the Victorian Government.

Suicide related data should not be restricted to deaths. Data on suicidal behaviour particularly suicide attempts helps measure the prevalence of suicidality across the population and is vital for suicide prevention policy and service planning purposes. The period of highest risk that a person will attempt again to end their life is immediately and shortly after an attempt and subsequent hospitalisation, i.e. in the first week, the first month and up to three months.

To be in line with national directions for improved suicide data coordination, Victoria could ensure hospital and health system recording of presentations associated with suicidal behaviour. This data could be reported as a measure of system responsiveness and effectiveness, especially with regard to re-occurrences of suicidal behaviour by persons who have had contact with the hospital and health system.

Recommendation 25

Improve suicide data collection and use.

8. Physical health care

People living with mental illness experience significantly poorer physical health, including higher rates of chronic health conditions, than the general public. According to international evidence, people with mental illness experience a life expectancy gap of up to 15 years, while being:

- more likely to be diagnosed with a respiratory disease
- more likely to have a stroke at a younger age (under 55)
- 2–3 times more likely to have diabetes
- 6 times more likely to die from cardiovascular disease.⁵³

Much of this is due to the higher prevalence of risk factors such as tobacco consumption, harmful alcohol consumption, poor nutrition, physical inactivity and risky behaviours among people with mental illness. Further compounding these risks are the impact of medications and treatments on physical health and the role of stigma, discrimination and other factors in lower rates of help-seeking among people living with mental illness. Other factors include greater difficulties with treatment adherence as well as communication and cognition issues which may impact comprehension of health advice or recognition of physical needs.

With almost 40 per cent of potentially preventable hospitalisations by people with mental health issues due to chronic conditions,⁵⁴ preventative interventions are needed to improve physical health. These are also likely to have flow-on benefits for the mental health⁵⁵ and financial wellbeing⁵⁶ of people living with mental illness, and to reduce unnecessary pressures on our hospital system.

8.1 Chronic disease risks

Screening for chronic disease risk factors must be embedded into all mental health services with clear referral pathways to relevant services including for smoking cessation, weight management, exercise and behaviour change. To mitigate the risk of external services being unavailable or incapable of catering to demand, all multidisciplinary teams in both community and hospital settings should be funded to include appropriate allied health professionals such as dietitians, diabetes educators, exercise/fitness experts and smoking cessation nurses.

Chronic disease prevention activities should also be embedded into non-mental health services as this will likely improve mental health outcomes across the population. For example, reductions in tobacco consumption and improvement in nutrition have both been shown to have benefits for mental health. Population-based chronic disease prevention is therefore consonant with a preventative approach to mental health.⁵⁷

A systems-based approach is important to ensure that the holistic assessment and care of people with mental illness is embedded into organisational policies and procedures, rather than relying on the conscientiousness of individual clinicians. Such an approach should include the provision of training and education resources and the development of evidence-based policies and procedures. For example, Quit has been working with mental health services in Victoria to implement a systems-based framework to ensure that consumers accessing these services receive best practice smoking cessation support.

All policies should account for the experiences of women and other key population groups, including Aboriginal and Torres Strait Islander peoples, to ensure that messaging and service delivery do not reinforce stereotypes which may themselves be detrimental to mental health. Targeted services may also be beneficial for key population groups with differentiated needs and experiences including young people, older people, Aboriginal and Torres Strait Islander peoples, people from CALD communities, people who identify as LGBTIQ+, men who have sex with men, and people in the perinatal period.

Recommendation 26

Embed preventative physical health interventions across the health sector.

8.2 Physical health interventions

People living with mental illness must have access to evidence-based physical health interventions that are tailored to their needs, including services for the management of chronic conditions, such as diabetes and chronic pain, and risk factors associated with metabolic health and the consumption of tobacco, alcohol and other drugs.

This should include tailoring to key population groups including Aboriginal and Torres Strait Islander peoples, CALD communities and people who identify as LGBTIQ+, who may require culturally appropriate interventions.

There are numerous examples to draw upon, as documented in the Australian Health Policy Collaboration's report *Beyond the fragments: Preventing the costs and consequences of physical and mental diseases*.

Recommendation 27

Research and expand upon evidence-based physical health interventions for people with mental illness.

53. RANZCP 2015. Keeping Body and Mind Together: Improving the physical health and life expectancy of people with serious mental illness, Melbourne. The Royal Australian and New Zealand College of Psychiatrists.

54. AIHW Chronic disease overview. Available from: <https://www.aihw.gov.au/reports-data/health-conditions-disabilitydeaths/chronic-disease/overview>.

55. See for example, Taylor G, McNeill A, Girling A, Farly A, Lindson-Hawley N, Aveyard P 2014, 'Change in mental health after smoking cessation: systematic review and meta-analysis', *BMJ* 2014;348:g1151.

56. Australian Chronic Disease Prevention Alliance and Quit Victoria 2019, Joint submission to the Productivity Commission inquiry into mental health, available at https://www.pc.gov.au/_data/assets/pdf_file/0017/240290/sub140-mental-health.pdf.

57. Taylor G et al. 2014, 'Change in mental health after smoking cessation: systematic review and meta-analysis', *BMJ*; Jacka FN2017, 'Nutritional Psychiatry: Where to next?', *EBioMedicine*, 2017 Mar; 17: 24–29.

9. Early life care

Early life services are crucial to ensuring that future generations of Victorians have the foundations they need for good mental health. The foundations of good mental health are established in the brain's rapid development in the first 1000 days of life.

By supporting families to build strong and secure relationships in these early years, we can improve the feelings of safety and confidence that our children will carry into adulthood. By providing this crucial support to our youngest citizens, we can begin to stem the tide of unmet need that is flooding our mental health system. While better early life care is not a panacea and will never address or prevent all mental illness, it is a necessary pillar of a whole-of-government system that can facilitate good mental health.

Recommendation 28

Expand early life care services.

As the wellbeing of children depends on the healthy functioning of their caregivers, expanding evidence-based early life supports including perinatal health, early parenting and disability assessment services are critical to giving our children a running start to life. These services should occur across the care continuum, in different settings and geographical areas. Equity of access is important for key population groups, though care should be taken not to stigmatise particular groups like Aboriginal and Torres Strait Islander or LGBTIQ+ families.

10. Employment

The social determinants of mental health describe the ways in which a person's mental health is shaped over time amid the broader context of their social lives, while also offering a framework for how to prevent mental illness and intervene early.

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Some of the most powerful root causes of inequalities in mental health are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life. People living with mental illness are also more likely to experience a range of adverse social, economic and health outcomes, including experiencing homelessness, being unemployed, being incarcerated and dying prematurely. This reciprocal relationship between mental illness and other social, economic and health factors means that many investments and policy reforms that have the potential to improve the mental health of Australians may come from outside the health sector and vice versa.

(National Mental Health Commission 2019)

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Although people with serious mental illness consistently rank employment as one of their highest goals, only one in five are employed on a full- or part-time basis.⁵⁸ This may be due to a range of reasons including stigma and discrimination, school non-completion, cognitive deficits, or difficulties retaining employment in areas of qualification. Addressing the issue therefore requires highly individualised supports targeted at an individual's specific needs and circumstances, as well as systemic changes.

Employment can be a critical step in a person's recovery as it can provide daily structure, a sense of purpose and opportunities for social interaction as well as independence and income.

Conversely, unemployment increases the risk of a range of negative outcomes including relapse, harmful substance use, crime and suicide.

Supporting people experiencing mental illness to gain and retain employment also presents significant economic benefits. Unlike most other illnesses, mental illness disproportionately affects people of schooling and working age, with the average onset of serious mental illness (18-25 years) often occurring just when people are trying to find their place in the workforce.

58. Ramsay C et al. 2011, 'Life and treatment goals for individuals hospitalised for first-episode nonaffective psychosis', *Psychiatry research* 189: 344–8.

Investing in mental health within the workforce will also improve participation and reduce absenteeism.

Mild depression can lead to 50 hours in absenteeism per person every year, rising to up to 138 hours for moderate to severe depression.⁵⁹ With the productivity costs of mental illness 12 times the associated healthcare costs,⁶⁰ supporting Victorians with mental illness to gain and retain employment would result in considerable savings.

Individual Placement Support (IPS) programs help people with mental illness to gain and retain employment. Evidence shows that participation in IPS programs can triple workforce participation rates of people with serious mental illness, from 20 per cent to 60 per cent,⁶¹ and that programs quickly reap short-term economic gains which build over the long-term.⁶²

Supports are based on eight core principles but are highly individualised to ensure that people are placed in the right jobs, and that employers are supported to keep people in their jobs, securing the longevity of program gains. To date, IPS programs have been generally targeted at young people⁶³ but have also proven effective among adult populations.⁶⁴

There is a strong evidence base for expanding the IPS model, both in terms of its effectiveness and positive impact on the economy. To meet the different employment needs of people with mental illness, expansion should occur both within community mental health and jobseeker services. Consideration should also be given to linking IPS programs with educational services, such as free TAFE.

Recommendation 29

Expand individualised placement supports to help people with mental illness gain and retain employment.

59. McTernan WP, Dollard MF, LaMontagne AD 2013, 'Depression in the workplace: An economic cost analysis of depression-related productivity loss attributable to job strain and bullying', *Work and Stress* 27(4): 3221–338.

60. Lee YC et al. 2017, 'Cost of high prevalence mental disorders: Findings from the 2007 Australian National Survey of Mental Health and Wellbeing', *Australian and New Zealand Journal of Psychiatry* 51(2): 1198–2011.

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11. Families and carers

Families and carers are a fundamental but often underappreciated pillar of the mental health system. Nationally, informal mental health carers provide over 100 million hours of care every year, with an estimated replacement value of over \$14.3 billion per annum.⁶⁵ More than a third of informal mental health carers provide over 40 hours of care every week. The majority of Victorian carers providing unpaid care (71%) are women.⁶⁶

11.1 Carer support services

Providing long-term unpaid mental health care can have a significant impact on a carer's own health and wellbeing as well as their financial, vocational and educational security.

While broad reform of the mental health system is likely to relieve some of the pressures which carers and families currently face in filling in the plethora of service gaps, carers and families are likely to remain at heightened risk of developing their own mental health conditions due to the inevitable pressures of informal caring.

As such, they will continue to require a broad range of supports related to their caring including respite, peer support, counselling, education, and financial supports. Unfortunately, services and supports for carers are often inadequate, inaccessible, underfunded or simply unavailable, particularly in regional areas, while the full impact of the transition to the NDIS and the roll out of the Integrated Carer Support Service (ICSS) model on the availability and accessibility of carer supports is difficult to ascertain.

Continuing deficits in supports available to carers is a serious risk for the mental health system. Carers with unmet needs may develop their own mental health issues, and when carers are no longer able to provide care, the person receiving care may be at greater risk of relapse, hospitalisation, suicide and other negative outcomes. These sequelae of unmet need only exacerbate the pressures on health, justice, housing and other government support systems.

Carers and families have a range of support needs, including carer-specific and general mental health services, but these are difficult to access for the majority of Victorian carers, particularly in regional areas. Continued and expanded funding for carer supports should be guaranteed, along with improved communication channels to ensure carers and families are aware of the local supports that are available to them. Particular attention to be paid to ensuring equity of access to supports in regional and rural areas, including accommodation services for carers and families visiting their loved ones.

Attention should be paid to the needs of particular groups of carers with differentiated needs such as women, older people, people caring for women in the perinatal period, and young carers. Ensuring Victoria's young carers are adequately supported to complete their education and obtain ongoing employment is important. Doing so would likely provide long-term benefits to the economy by ensuring they can become the productive members of society without impacting their mental health and wellbeing or that of their care recipients.

Recommendation 30

Guarantee funding for carer supports.

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11.2 Carer-inclusive practices

The Practical Guide for working with carers of people with a mental illness produced by Mental Health Australia in 2016 contains six partnership standards regarding carer-inclusive practices in the provision of mental health services.

Australian services using this guide have strongly improved their engagement with carers, but this improvement has been limited by the voluntary nature of the standards. The six partnership standards should be mandated for all specialist mental health services in Victoria, both clinical and the community sectors.

Recommendation 31

Mandate carer-inclusive practice in all commissioned mental health services.

11.3 Under the NDIS

Currently, NDIS procedures and policies do not adequately take the perspectives and needs of carers into account.

This is important not only to ensure the carer has access to their own supports, which will in turn help to ensure their care recipient is able to utilise their funding packages as planned, but also to ensure the carer's perspectives can be considered in the preparation of the funding package.

It is important that planning processes allow carer input as they are likely to have useful insight into the needs of their care recipient. The NDIS Psychosocial Pathway provides an ideal avenue for ensuring carer's views are taken into account in the planning process.

Recommendation 32

Work with the Commonwealth to ensure carer-inclusive practices in the National Disability Insurance Scheme.

12. Mental health system governance

12.1 A comprehensive state-wide governance framework

Transforming the mental health system will take years. The changes required will depend on careful management, new ways of working, cultural change, and sustained system improvement and learning. Victorians need confidence that decision-makers will hold the vision and deliver the strategy, and that the directions will stay broadly consistent, despite political change.

Transformation requires strong leadership and accountability. Leadership of the mental health and addiction sector is necessarily dispersed across a complex system. The sector has many parts and many different people and organisations with leadership roles including Primary Health Networks (PHNs), non-government organisations, and professional and representative groups. Several 'watchdog' organisations are responsible for advocacy and rights protection (such as the Mental Health Complaints Commissioner) and quality improvement.

It is critical that reforms implemented through the Royal Commission process are enduring and that Victoria resumes its place as a leader in service design and delivery, quality, research and innovation. Without changes to our governance structures, there is high risk that this hard work will be undone.

We need to ensure that there is a robust and effective state-wide governance framework that oversees mental health initiatives for the whole Victorian population. This framework must encompass the broad range of services and initiatives across the spectrum: from health promotion and preventative programs to treatment and recovery services, encompassing community and clinical settings and services.

12.2 Mental Health and Wellbeing Commission

In New Zealand, a Mental Health and Wellbeing Commission is being established to strengthen leadership and oversight of mental health and addiction treatment in response to He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. A similar body should be established in Victoria, independent from the State Government and staffed by people with experience and knowledge of the health sector.

We consider that the fundamental purpose of the independent Mental Health and Wellbeing Commission should be to:

- Act as a system leader of mental health and wellbeing, with a strong oversight and monitoring role.
- Act as an important institutional mechanism to help Victorians hold decision-makers and successive governments to account, including by monitoring how well strategies relevant to mental health and wellbeing are being implemented by responsible agencies and by publicly reporting on progress.
- Report regularly and publicly on the implementation of recommendations from the Royal Commission, with the first report to be released one year after the Victorian Government's official response.
- Provide independent expert advice to the Government, on its own initiative or as requested, on any matters relevant to mental health and wellbeing.
- Advocate for the collective interests of people with mental health and addiction challenges and their families.
- Drive change while bringing others along on the need for innovation and best practice and to promote better collaboration, communication and understanding about mental health and wellbeing.

Specific responsibilities of the Mental Health and Wellbeing Commission should relate to:

- leading sector integration across mental health, justice, housing and other relevant sectors
- promoting co-design approach to research and service delivery and evaluation
- monitoring the capacity of Victorians to navigate the mental health system
- ensuring suitable data collection and monitoring processes are undertaken at all levels, with data disaggregated according to key demographics
- ensuring all processes associated with co-design, target setting, policy planning, service delivery and evaluation, data collection, health promotion and primary prevention are appropriately tailored for key population groups with differentiated needs
- encouraging a universal wellbeing approach with a focus on protective factors identified in resilience literature, such as social connection, belonging, value and meaning in life.

Recommendation 33

Establish an independent Mental Health and Wellbeing Commission to provide system leadership for mental health and addiction, implementation support for system transformation, and independent monitoring and oversight.

12.3 Alignment of geographic catchments

State-wide planning and governance oversight is considerably hampered by what is known as 'catchment misalignment', whereby:

- Clinical mental health service catchment areas are not aligned with other Victorian health and human service areas, local government area boundaries, or PHNs, which makes service coordination difficult for consumers and carers, many of whom need support from multiple services.
- There is misalignment between service levels and types within a catchment and population growth and demographic changes in that area.
- There is a lack of coordination between catchment areas when patients need to access services across catchment borders.

- Geographic catchments and age-based service groupings are not aligned.

Recommendation 34

Align Commonwealth, state and local catchment areas.

Recommendation 35

Work with the Commonwealth to consolidate multiple state and Commonwealth 'central intakes'.

12.4 Research and evaluation

Establishing a well-funded Centre for Mental Health Research and Innovation to ensure that the collection and use of data across the entire system is strategic and well-coordinated. Research functions should be embedded across the entire system's architecture to enable:

- service improvements: improving accountability, effectiveness and efficiency
- better outcomes for service users, families and carers
- development and innovation: feeding back practice knowledge/evidence for growth, improvement and change.

There is a need for the systematic incorporation of learning into everyday practice. The strategic placement of research and evaluation functions throughout the service system, overseen by a central body, will enable the development of an evidence base that is adequately shared and fed back into service delivery and system design. To allow this, ample consideration must be given to:

- establishing an independent governance structure – such as a Centre for Mental Health Research and Innovation
- ongoing development of research capabilities across the system
- adequate resourcing for the Centre and for external research initiatives within a strategy overseen by the Centre
- incorporating co-design of research objectives and practices with people with a lived experience, including key population groups and their peak bodies, as a guiding principle.

Recommendation 36

Establish a centre for mental health research and innovation, a research and innovation fund and embed research functions across the entire mental health system.

13. Prevention

Preventative approaches that take a coordinated and strategic approach to address mental illness and the social determinants of health are more cost-effective than treatment approaches.

This is because:

- They are crucial to reducing the growing burden of mental ill-health and rates of suicide, which, despite increasing investment, continue to worsen.
- Investing in the promotion of mental health and wellbeing, and the prevention of mental ill-health, not only leads to a more efficient use of resources, particularly Emergency Departments, but has flow-on effects for a range of services including general health care, drug and alcohol services, education, child and family services and the justice system.⁶⁸

There are a range of preventative interventions and work promoting mental health in Victoria, but they are sporadic and there is a lack of priority, oversight and investment in this area.

The Department of Health and Human Services currently provides and supports an impressive but somewhat ad hoc range of programs and oversees key strategies, such as Victoria's 10 year mental health plan, the Victorian suicide prevention framework 2016-2025, mental health workforce strategy, and local suicide prevention trials.

From a broader health and wellbeing perspective, the Victorian Health Promotion Foundation (VicHealth) undertakes work in the following areas: arts and social connection, preventing violence against women, and reducing race-based discrimination. VicHealth also places significant effort into addressing the health and wellbeing of young people.

Finally, the Victorian Government's Public Health and Wellbeing Plan sets the State's priorities in relation to population health, with a focus on: healthier eating and active living, tobacco-free living, harmful alcohol and drug use, mental health, violence and injury and sexual and reproductive health.

However, despite some quality programs, the prevention of mental illness and the promotion of health at the state and Commonwealth level is piecemeal. The lack of priority and investment is evident and the current approach lacks both a unifying strategy and clear oversight.

Some of the barriers to effective prevention and promotion activities include:

- difficulty attracting political and media attention away from crisis responses to prevention efforts which are harder to see.
- a false assumption that we can only afford direct services and support to those with ill health, rather than funding both treatment and prevention.⁶⁹
- lack of governance and the multitude of different organisations involved.

Despite these challenges, research shows a small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains if it is well governed and funded.⁷⁰

The World Health Organisation also is clear on the principles and actions to effectively address the social determinants of mental health:⁷¹

- **Proportionate universalism** – universal services, especially health and education, provide a critical foundation for wellbeing throughout life. Interventions should be universal, yet calibrated proportionately to the level of disadvantage. "Solely focusing on the most vulnerable and disadvantaged people will fail to achieve the required reduction in health inequalities necessary to reduce the steepness of the social gradient in mental health".⁷²
- **Act across multiple sectors** – action is required across a range of sectors, such as health, education, welfare, transport, housing etc. Effective leadership is crucial to drive collaborations, negotiations and focus. Other crucial elements are: information sharing, joint planning, strategic design and support and ensuring good delivery.
- **Adopt a life course approach** – preventative strategies must be targeted to life stage. While the early years are critical, there are opportunities for prevention and resilience-building activity throughout life.
- **Intervene early** – it is particularly important that every child gets the best possible start in life. Early intervention strategies are also helpful to disrupt the intergenerational transmission of inequity.
- **Physical health and mental health are inextricable** – reducing inequalities in mental health cannot be achieved without reducing inequalities in physical health. All actions to tackle health inequalities should consider both mental health and physical health.
- **Mental health in all policies** – reducing inequalities in mental health must be taken on by the whole of government and across all sectors. All policies across all sectors must ensure that their programs and strategies 'do no harm', and aim to reduce mental health inequities. Policies from non-health portfolios should explicitly state their likely contribution to mental health.⁷³

Particular attention should be paid to the needs of key population groups such as young people, people in regional areas, Aboriginal and Torres Strait Islander peoples, and people from CALD and LGBTIQ+ communities.

Mental Health Victoria supports the recommendations put forward by Prevention United in their submission to this Royal Commission. We particularly agree that there is a need for greater centralised leadership to provide oversight to mental health promotion and prevention activity.

Recommendation 37

Provide a Mental Health & Wellbeing Commission with a clear responsibility to develop and monitor strategies for the promotion of mental wellbeing and prevention of mental illness.

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