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4 July 2019

Royal Commission into Victoria's Mental Health System
PO Box 12079
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Dear Commissioners

Uniting Vic.Tas welcomes the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System. We commend the Victorian Government for instigating this historic undertaking and committing to implement all recommendations.

Uniting in Victoria and Tasmania is the community services organisation of the Uniting Church in Victoria and Tasmania. We were created in 2017 from the merger of 24 entities: 21 UnitingCare agencies, Wesley Mission Victoria and two divisions of the Synod of the Uniting Church in Victoria and Tasmania. Together we are more than 7000 people delivering over 770 program and services to people experiencing disadvantage including children at risk, aged and carer services, disability and mental health, employment services, alcohol and drug dependence services, housing, family violence and early learning.

The attached submission reflects our expertise and experience in the causes and consequences of mental health issues; comments on the effectiveness of current programs and supports; and proposes an integrated reform approach that positions the mental health system as extending beyond the traditional realm of health services and programs. In line with Uniting's commitment to support consumers to play an active role in their own health and wellbeing and in the development of services to support them, this submission has been informed by consumers and includes case studies to voice their lived experience.

As part of the Commission's deliberations, we would welcome an opportunity to host you at any of our mental health programs. In particular we believe we have two programs that would be of particular interest. The 101 Engagement Hub in St Kilda provides social connections and pathways into secondary health services for people with mental health conditions that would otherwise face isolation. Voices Vic is an award-winning peer-led service model that improves quality of life for people who hear voices.

We look forward to ongoing opportunities to contribute to the Royal Commission's work and would be happy to provide further input if requested.

Yours sincerely,

Paul Linossier
Chief Executive Officer

Bronwyn Pike
Board Chair

Submission by Uniting Vic.Tas

to the Royal Commission into Victoria's Mental Health System

4 July 2019

Contents

Based on feedback from Uniting's staff and consumers, we urge the Commission to prioritise the following actions for reform:

- Increase **strategic investment** focused on both **early intervention and prevention, as well as consumer-informed collaborative program design** to improve the appropriateness and sustainability of interventions;
- Improve the **integration and coordination of services offered by clinical and community mental health services,** include the development of consistent referral pathways;
- Expand and **scale-up the delivery of existing psychosocial support programs** while broader mental health system design and planning work is undertaken in the context of NDIS transition;
- Review current mental health services funding arrangements to prioritise sustained investment and facilitate measurable social return on investment;
- Develop a broader definition of the mental health system and fund initiatives that **coordinate linkages** between the various policy areas and supports necessary to promote, prevent and manage mental illness. These include alcohol and other drugs (AOD), housing, financial assistance, financial counselling, stable employment and psychosocial support;
- Invest in a **paid peer workforce program** and promote opportunities for people with lived experience to share their stories to drive the wider societal attitude change needed to **tackle stigma and discrimination**, and shape more responsive and higher quality services;
- Mandate **carer-inclusive practice** in all commissioned mental health services; and
- Ensure the sustainability of reforms by establishing new governance structures and an independent body responsible for providing system leadership, implementation support for system change, and monitoring and oversight to hold decision-makers and successive governments to account.

Stigma and Discrimination

It is widely acknowledged that being ignored, talked down to, or treated differently is a reality for many people living with mental ill health. Almost three-quarters of respondents to a SANE Australia survey reported experiencing stigma and discrimination due to their mental ill health that:

- reduced their feelings of self-worth;
- made it harder to manage their mental health issues; and
- reduced their ability to return to work or study and engage in social activities.[1]

Negative stigma about mental health is recognised as the primary reason why more than half of Australians experiencing a mental health problem will not seek help.[2] Uniting's consumers are sometimes rejected by family members and the broader community due to fear that their illness is contagious and/or that they are dangerous. This social isolation further discourages people from sharing their stories, which in turn reduces the opportunity to raise community awareness and social acceptance of mental illness.[3] Addressing the stigma associated with mental illness is therefore critical to normalising and welcoming conversations about mental health. As best said by one of our consumers, "mental health should be as easy to talk about as having a cold".

In our experience we have noticed reduced stigma around depression and anxiety, with positive increased community awareness and conversation mental health. However there is still a significant amount of stigma and misunderstanding, particularly diagnoses such as schizophrenia, borderline personality disorder and bipolar disorder. Consumers have reported instances of this stigma impacting the level of care and treatment they have received, including inconsistent treatment for incidents of self-harm, being left waiting long periods of time in emergency departments before they are seen by medical staff, denied medical attention as they are judged as "attention-seekers" and being treated with less respect and dignity compared to people diagnosed with a physical illness or who are injured in other ways. This leads to feelings of rejection, exacerbating their negative self-view of 'being different' and/or not feeling validated, and ultimately reducing the potential for recovery.

As a voice hearer, **Andy*** found it difficult to engage with others. He would spend a lot of time isolated and at home, in a rooming house.

While Andy has a quiet and calm disposition, he had found it difficult to make new and long-lasting friendships, except for the friendship with his brother, who he sees every now and then. Andy decided to participate in the Hearing Voices Network with the Voices Vic team at Uniting, where he was able to connect with other voice hearers as well as professionals and carers.

No one at the group judged Andy for his voice hearing experiences, and he was accepted and welcomed into the group's discussions and reflections.

The opportunity to engage with others in this way was life changing for Andy, and he no longer wanted to spend his days at home and by himself. Andy wanted to give back to the community, so he started volunteering with Uniting's Hartley's Café and neighbouring Opportunity Shop. He has been a familiar and welcomed face at these services and the Hearing Voices Group now for many years, where he feels welcomed, supported and appreciated.

[1] SANE Australia 2007. Research Bulletin 4: Stigma and mental illness. SANE Australia
[2] Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra: ABS; 2008
[3] Reavley NJ, Jorm AF. Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma. Australian and New Zealand Journal of Psychiatry. 2011;45 (12): 1086-93

As outlined in the Fifth National Mental Health and Suicide Prevention Plan, there is no single solution to reducing stigma and discrimination.[4] There is inconsistent evidence of success across previous large public education approaches so Uniting supports the implementation of a multi-faceted approach encompassing both whole-of-population and targeted education and training initiatives.[5] As experiences of stigma and discrimination are not consistent across all people with a mental illness, we believe that targeted programs should be prioritised for people who frequently come into contact with those experiencing mental health difficulties, including medical and mental health professionals, police and the justice system, and students and young people. These groups comprise a significant proportion of society so shifting prejudices and upskilling these groups is likely to have a flow-on effect to improving broader societal responses to mental illness.[6]

An example of a program that would be appropriate for roll-out across Victoria is Mental Health First Aid (MHFA) training. This is upheld as global best-practice and has consistently demonstrated effectiveness in reducing stigma and increasing mental health literacy. MHFA offers great potential to educate people about how to provide initial support to people who are developing a mental illness or experiencing a mental health crisis.[7] It is also appropriate for equipping families and carers with the knowledge and skills to better understand mental illness and respond appropriately. Other beneficial programs include:

- Live4Life operates in rural areas to train local community members to become Accredited Youth and Teen MHFA instructors and deliver age-appropriate courses to year 8 and year 11 students [8]; and
- headspace schools face-to-face training and education sessions have helped boost mental health literacy across school students, staff, parents and carers.[9]

In addition to implementing training and education strategies to combat stigma and discrimination, it is essential that the Commission consider the role of the media as part of the recommendations. The media is a primary source of information and attitudes about mental illness for the majority of Australians, so it is essential that media outlets communicate and portray mental illness in a safe and responsible way.[10] As evidenced by recent tragic murders in Victoria, inaccurate or sensationalised reporting can reinforce stigma and bias. A number of our consumers who are diagnosed with schizophrenia have voiced their concern that media coverage of these events has heightened public fear and increased negative biases about all schizophrenics being "criminals and mass-murderers".

Uniting encourages the Commission to develop stronger mechanisms to monitor media reporting, such as through State Government endorsement of the SANE Australia's StigmaWatch initiative,[11] and requirement for all media outlets to comply with the Mindframe media reporting guidelines,[12] with penalties for non-compliance. The Commission should also implement strategies to incentivise and promote media stories that feature positive and accurate portrayals of mental illness. This will help reduce stigma and discrimination by improving community understanding of how widespread mental illness is, that it can affect anyone, and that many people successfully manage their symptoms and lead fulfilling lives.

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[4] Department of Health. The Fifth National Mental Health and Suicide Prevention Plan. 2017. Canberra: Australian Government.
[5] National Mental Health Commission. A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention. 2013. Sydney: NMHC.
[6] National Mental Health Commission. A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention. 2013. Sydney: NMHC.
[7] Kitchener BA, Jorm AF. Mental Health First Aid: An international programme for early intervention. Early Intervention in Psychiatry. 2008; 2(1): 55-61.
[8] http://www.live4life.org.au/about-us/
[9] https://headspace.org.au/schools/headspace-in-schools/
[10] SANE Australia. StigmaWatch: Tackling stigma against mental illness and suicide in the Australia media: A SANE Report. 2013. Available from: https://www.sane.org/images/PDFs/stigmawatch2013.pdf
[11] https://mindframe.org.au/sane-stigma-watch
[12] https://mindframe.org.au/mental-health/communicating-about-mental-ill-health/mindframe-guidelines

Promotion, Prevention and Early Intervention

Early Intervention

Mental health promotion, prevention and early intervention are critical in preventing the onset of mental illness and reducing the burden on individuals and the wider community. In regards to defining primary and secondary prevention activities, these can be delivered early in life, early in illness and early in episode.[13] With one in seven children experiencing a mental illness and mid-late adolescence a common age for the onset of psychotic disorders, Uniting believes these activities are particularly important for improving outcomes in children and young people.[14] Organisations such as headspace have demonstrated the benefit of activities focused on boosting feelings of self-worth and teaching resilience and coping strategies. However, many schools and early childhood services are still ill-equipped to identify problems and intervene early so we urge the Commission to develop recommendations for improved resourcing and supports.

Prompt diagnosis and early intervention upon first signs of a mental illness are crucial for not only reducing the progress of symptoms at that point in time but also determining a person's future mental and physical health, community participation and socioeconomic outcomes. Untreated mental illness contributes to a significant and tragic burden of suicide so early intervention services are critical to suicide prevention activities.[15] Delivering training specifically focused on suicide prevention, such as SafeTalk[16] and Wesley LifeForce[17], should also be factored in as part of any suicide prevention strategy.

Early intervention should be available for all people regardless of the severity of symptoms.[18] However, this is unfortunately not the case as mainstream health services often promote the view that consumers must prove their mental illness is 'serious enough' to qualify for help and support. Our consumers revealed that many of them had not been listened to and/or were not taken seriously by family, friends and health professionals when they first displayed symptoms of mental illness. Even if people did attempt to access services early however, many experienced a long delay between the start of symptoms presenting and when they received help.

Uniting's mental health staff have voiced concern that there are minimal programs appropriately funded and resourced to deliver early intervention mental health services. This is particularly the case in regional and rural areas where access to early treatment and support is largely due to the commitment and capacity of individual services so is inconsistently delivered. We therefore urge the Commission to develop recommendations that acknowledge the critical role of the community mental health sector to provide preventive and early intervention programs that help stop mental health issues from spiralling into crisis and requiring acute services. These recommendations should address the specific challenges faced in regional and rural areas and by people in lower socio-economic communities.

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[13] Department of Health. Fourth National Mental Health Plan— An agenda for collaborative government action in mental health 2009–2014. 2009. Canberra: Australian Government

[14] Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR. The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. 2015. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-child2

[15] Anderson J, Mitchell PB, Brodaty H. Suicidality: prevention, detection and intervention. Australian Prescriber. 2017; 40(5): 162-166.

[16] http://www.livingworks.com.au/programs/safetalk/

[17] https://www.wesleymission.org.au/find-a-service/mental-health-and-hospitals/suicide-prevention/wesley-lifeforce/

[18] Department of Health. The Fifth National Mental Health and Suicide Prevention Plan. 2017. Canberra: Australian Government.

Primary and Secondary Prevention

Primary and secondary prevention activities must extend beyond the health sector as a wide range of social, psychological and biological factors can determine an individual's state of mental health. As a significant provider of services and programs for people experiencing disadvantage, Uniting is strongly aware of the impact of life experiences or circumstances that increase vulnerability to mental health issues, including

- unemployment;
- lack of housing;
- lack of social support;
- trauma;
- grief and bereavement;
- domestic violence; and
- cultural and language barriers[19]

The following statistics are offered to the Commission to provide insight into areas where prevention and early intervention should be prioritised based on high-risk groups and vulnerable circumstances:

- People with a mental health condition experience higher rates of unemployment than people not affected by a mental health condition;[20]
- More than 27% of people accessing specialist homelessness services in 2016-17 had a current mental health issue;[21]
- Aboriginal and Torres Strait islander peoples have significantly higher rates of mental illness and suicide, and are twice as likely to experience psychological distress compared to the rest of the population;[22]
- Australians who identify as lesbian, gay, bisexual, transgender, intersex, queer or asexual (LGBTIQA+) have the highest rate of suicide and are four to six times more likely to experience major depressive episodes than any other group in the Australian population;[23]
- Rates of mental illness are significantly higher for people with a disability, particularly people with an intellectual disability who are two to three times more likely to have a mental illness than the general population;[24]
- incidence of suicide is almost 1.5 times higher in regional and remote Australia and 2 times higher in remote areas, compared to major cities. The burden of mental illness is also felt more greatly in these areas due to the lack of adequately trained mental health professionals and appropriate services;[25]

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[19] World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014.
[20] Department of Health and Ageing. National Mental Health Report 2013. Canberra: Australian Government, 2013. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-report13
[21] Australian Institute of Health and Welfare (AIHW). Specialist homelessness services annual report 2017–18. Cat. no: HOU 299. Canberra: AIHW, 2019. Available from: https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2017-18/contents/contents
[22] Australian Bureau of Statistics (ABS). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2012. Cat. no. 4704.0. Canberra: ABS, 2016.
[23] Rosenstreich G. LGBTI people mental health and suicide. Revised 2nd Edition. Sydney: National LGBTI Health Alliance, 2013. Available from: https://lgbtihealth.org.au/resources/lgbti-people-mental-health-suicide/
[24] Department of Developmental Disability Neuropsychiatry. Accessible mental health services for people with an intellectual disability: a guide for providers. Sydney: University of New South Wales, 2014. Available from: https://3dn.unsw.edu.au/the-guide
[25] Australian Institute of Health and Welfare (AIHW). Healthy communities: hospitalisations for mental health conditions and self-harm in 2013–14. Canberra: AIHW, 2016. Available from: https://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/september-2016/report/intentional-self-harm

- As highlighted by the Royal Commission into Institutional Responses to Child Sexual Abuse, experiencing childhood trauma, especially childhood sexual abuse, has a lasting impact on mental health and greatly increases the risk of mental illness;[26]
- The age at which an individual experiences mental health issues can make a difference. One in seven children experience a mental illness and mid-late adolescence is a common age for the onset of psychotic disorders.;[27] and
- There is a large overlap of people experiencing substance misuse problems in addition to mental illness. This makes diagnosis and early intervention difficult, with the success of interventions depending on concurrent responses to both disorders.[28]

In Uniting's experience, we have witnessed the positive impact of addressing the drivers of poor mental health outcomes through our 101 Engagement Hub located in St Kilda that currently meets the needs of 450 vulnerable people and sees around 90 people per day. This service provides valuable psychosocial supports and is commonly cited by these consumers as drastically reducing feelings of social isolation and loneliness. This service was not developed as a mental health service. However without its operation these people would not have a space to engage in meaningful social interaction and feel a part of the local community. Many of our clients would likely be on the street with nowhere to go, increasing their susceptibility to developing a mental illness and engaging in socially challenging behaviours that would have negative flow-on impacts on local residents, businesses and other service systems (police, emergency departments etc).

Bradley* had been experiencing debilitating bouts of diagnosed depression and anxiety as well as obsessive compulsive behaviours for many years and has been unable to hold down work as a result. His doctor recommended he attend the St Kilda 101 Engagement Hub. Without knowing what to expect, Bradley made his way to the Engagement Hub during their Christmas Drop-In celebrations back in 2010.

He met others who could relate to his experiences with mental health concerns, and it reminded him that he was not alone. While there, he also found out more about the different classes and workshops the Engagement Hub offered, and decided he wanted to see what they were like.

From that day, Bradley has been able to enjoy the friendships he's built over the years, as well as the delicious food, and all the programs on offer. He enjoys yoga classes, and has also tried his hand at singing, drama and writing classes.

"For some of us experiencing mental health concerns, our goal is just to stabilise. Just keep our heads above water," says Bradley. "Being here every week, we're treated with real respect. We're reminded that we are capable of doing things, we have the chance to learn and engage. I think, if we couldn't come here, a lot of us would deteriorate…When we come here and connect with one another, we are reminded how important community is. And it's because of the support of this team and their programs that we can manage better in our everyday life."

*Name changed

Our programs with young people identifying as LGBTIQA+ have also demonstrated the importance of targeted support services for groups known to experience higher levels of isolation and likely to disengage from services or organisations which do not promote and affirm the community that they identify with. Feeling connected to peers and supportive networks increases feelings of positivity and in turn builds their confidence to seek further support from outside services. Groups where young people can step into a safe space and explore their feelings around gender and/or sexual identity by listening to and learning from other peers can help to decrease any stigma and shame they feel internally. This can help them to increase their self-esteem and self-worth, known

[26] Royal Commission into Institutional Responses to Child Sexual Abuse. Final report. Canberra: Australian Government, 2017. Available from: https://www.childabuseroyalcommission.gov.au/final-report
[27] Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR. The mental health of children and adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health, Canberra, 2015. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-child2
[28] Department of Health. The Fifth National Mental Health and Suicide Prevention Plan. Canberra: Australian Government, 2017. Available from: http://www.coaghealthcouncil.gov.au/Publications/Reports

protective factors for mental health.[29] Youth-led and youth-facilitated groups with the support of adult peers assist in ensuring capacity and skills are developed and help to shine a positive example on the journey and outcomes for people identifying as LGBTIQA+.

As a provider of out-of-home-care (OOHC) services, Uniting has also witnessed the impact on children and young people of experiencing violence, neglect or abuse in their family environment. These early-life experiences place these children and youth at greater risk of experiencing a range of mental health issues, including post-traumatic stress disorder, depression and anxiety. Targeted prevention and early intervention activities should be prioritised for this group.[30] Uniting supported the Home Stretch Campaign calling on governments to extend support for young people in Out-of-Home-Care (OOHC) until the age of 21. We have seen the need for this change for some time so are pleased that Victoria has committed to providing this support. This improved access to care and early intervention will make a big difference to the lives of these young people, reducing their vulnerability to homelessness, mental health issues, unemployment, early parenthood and interaction with the justice system.[31]

Another program that was not specifically designed to prevent mental illness but has shown great potential to reduce vulnerability to mental illness is Uniting's CareRing program.[32] We support Victorian individuals and families experiencing financial issues who are customers of major banks and utility providers. Mental health issues are consistently named as one of the top five vulnerabilities faced by these clients. Through this service we have witnessed the huge impact alleviating financial difficulties can have on a person's mental health. Similar flow-on effects for preventing mental health are also evident in our range of programs that provide emergency relief and help people move out of homelessness and crisis accommodation into secure, stable housing. These social policy issues unfortunately operate in public sector silos so coordinating prevention and early intervention initiatives across sectors continues to be a challenge.

In Uniting's view, a critical area for prevention and early intervention is in addressing the link between housing and homelessness and mental health. This link is well documented internationally and the connection between deinstitutionalisation and the increase in homelessness (particularly among people with mental health issues) cannot be overlooked.[33] On a daily basis our homelessness services are having to manage and respond to people being exited from mental health facilities into homelessness as well as people experiencing homelessness as a result of their mental health. These clients are often on Newstart and barely able to survive financially, further reinforcing their mental distress. We are often required to assist homeless clients who are finding it very difficult to access mental health services as they either do not meet the criteria or are unwilling/unable to participate in the assessment process. Inadequate referral pathways, the lack of appropriate training for housing services staff and a general lack of integration between these support sectors fuels the harmful cycle of mental health crisis, inpatient treatment, and discharge.[34]

We strongly encourage the Commission to focus on the integration of housing, homelessness and mental health support services as part of preventive and early intervention initiatives. An example of an effective program is the Supported Housing At Discharge Eastern Service (SHADES) that

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[29] Meyer IH. Prejudice, social stress and mental health in lesbian health in lesbian, gay and bisexual populations: conceptual issues and research evidence. Psychology Bulletin. 2003: 129(5): 674-697.
[30] Australian Institute of Family Studies. (2014). Effects of child abuse and neglect for children and adolescents. Available from: https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents.
[31] Deloitte Access Economics. Raising our children: Guiding young Victorians in care into Adulthood. Socioeconomic Cost Benefit Analysis. 2016. Available from: https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-guiding-young-victorians-in-care-into-adulthood-anglicare-220816.pdf
[32] https://www.unitingkildonan.org.au/programs-and-services/financial-support/carering/
[33] D. Green. The End of Institutions, Housing and Homelessness. In: Parity. 2003. Melbourne: Council to Homeless Persons.
[34] Brackertz N, Wilkinson A, Davison J. Housing, homelessness and mental health: towards systems change. Australian Housing and Urban Research Institute Limited. 2018. Melbourne: AHURI

operates from Maroondah Hospital to prevent homelessness among patients discharged from the mental health wards.[35] This program provides short-term support to prevent relapse and re-admission, and longer-term support with help with finding stable housing appropriate to the individual's situation. Uniting also supports the key preventive and early intervention recommendations for action outlined in a recent report from the Australian Housing and Urban Research Institute (AHURI) about the systemic issues and policy issues that affect the intersection between these disparate policy systems.

We particularly agree there is a need to:

- reshape government policies to address housing insecurity for people with lived experience of mental illness;
- scale up successful models of consumer and recovery-oriented housing, such as the supportive residential service developed by the Haven Foundation; and
- make greater use of tenancy sustainment services and capacity building in the housing sector to recognise and appropriately respond to the early warning signs of a mental health crisis.[36]

Tamara* was working as an enrolled nurse in Victoria when her mother passed away interstate. During the process of grieving and organising her mother's funeral, Tamara stopped taking her mediation for schizophrenia, a disorder that affects a person's ability to think, feel and behave clearly. This led to Tamara experiencing financial hardship and she was forced to sleep in her car for a prolonged period of time.

Tamara presented to a Uniting housing entry point and was referred to a rooming house, for more secure accommodation. Tamara stayed at the rooming house whilst she stabilised her mental health after she was linked in to local mental health services by the team at Uniting. The Housing Ready team was then able to support Tamara with interview preparation, and she found employment as a casual kitchen hand.

The team then worked with Tamara around budgeting and living skills. Together they found appropriate properties to apply for, discussed how to speak to agents over the phone, how to make a good impression at housing inspections, and how to complete paperwork to apply for rentals. Tamara was then approved for a rental in a shared house and now secured permanent part time employment. Tamara has stabilised her financial and housing situation thanks to the support of Uniting, which in turn has enabled her to stabilise her mental health.

*Name changed

Service Access, Availability and Experience

Australia's mental health system is made up of a patchwork of services including primary care, community-based services, alcohol and other drug treatment, specialist and clinical services, and now, the National Disability Insurance Scheme (NDIS). Within this complex and piecemeal system, the respective roles of the Commonwealth, Victorian Government, private organisations and the community sector are not always clear. People struggle to navigate the fragmented system and therefore miss out on services they need.[37]

[35] http://www.each.com.au/service/support-and-discharge-eastern-service-shades/

[36] Flanagan K, Martin C, Jacobs K. and Lawson JA. Conceptual analysis of social housing as infrastructure, AHURI Final Report
No. 309, Australian Housing and Urban Research Institute Limited. 2019. Melbourne: AHURI

[37] Medibank Private and Nous Group. The case for mental health reform in Australia: a review of expenditure and system design. 2013. Available from:
https://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

Both our staff and consumers have voiced frustration at the lack of integration in the system, particularly for people with complex needs and dual-diagnoses that do not neatly fit into eligibility criteria for community mental health services or the tertiary system. There are significant gaps in sub-acute services and without clear referral pathways, people are passed between services risking worse symptoms and the development of severe mental health conditions. Ensuring all people have timely access to appropriate services will dramatically reduce the need for people to access acute services and enter the tertiary system.

Joint case-planning models present valuable opportunities to improve integration and continuity of services across community and clinical services by improving communication between providers and clients. These models should also be expanded to facilitate more coordinated work between mental health and AOD services in cases where there is disagreement about what the primary need is and who should be providing support. Uniting's AOD services are recognised as having good capacity to screen, assess and provide interventions for those experiencing AOD and high prevalence mental health conditions (such as depression and anxiety). However our staff have communicated concern that they have limited capacity to respond to severe mental illness conditions (such as schizophrenia) unless the condition has been diagnosed and stabilised by specialist mental health services. Collaborative program delivery by specialist staff skilled in both mental health and AOD issues is therefore needed to ensure the availability of appropriate services that address all issues and maximise service outcomes.

Despite strong evidence that investment in mental health has wide-reaching positive impacts across the community, mental health services face chronic under-funding and unsustainable funding arrangements.[38] This is particularly the case in rural and remote communities where community organisations are funded to provide services across regions often hundreds of kilometres wide with no extra funding to cover the additional expense of delivery in these locations. Funding provided under current agreements is often short-term, episodic and focused on outputs. This neglects the need for longer term treatment for many mental health conditions and impairs the ability of services to deliver evidence-based best practice, perpetuating the harm experienced by vulnerable and at-risk clients.

Despite the majority of our consumers experiencing higher rates and substantial burden from mental illness than the general population, their social disadvantage leads to them accessing treatment and supports at a lower rate.[39] We believe that targeted strategies are needed to address the following barriers that facilitate this inequitable access and availability of supports:

- the lack of appropriate services (or awareness of available services);
- administrative barriers (such as not having a permanent address, Medicare or healthcare card);
- mistrust of institutions;
- past experiences of discrimination when accessing services;
- language/cultural barriers;
- geographic location.

As highlighted in the above discussion of prevention, daily survival needs are taking precedence over the person's health needs.[40]

Despite barriers to access and availability being particularly pronounced in regional and rural areas, previous government inquiries into mental health have predominantly focused on urban or metropolitan contexts. This has led to past recommendations and service models ignoring the significant differences and barriers faced by these communities and implementation failing due to

[38] Mental Health Victoria. Saving lives. Saving money. The case for better investment in Victorian mental health. Melbourne: Mental Health Victoria, 2018. Available from: https://www.mhvic.org.au/policy-publications/mhv-publications

[39] Australian Bureau of Statistics. Australian social trends: health and socioeconomic disadvantage. 2010. Cat. No 4102.0. Canberra: ABS.

[40] Strassmayr, C. Mental Health care for socially marginalised people in Europe: Results from the European Commission funded PROMO study. Medicine & Health. 2012.

the lack of transferability. Furthermore, the isolation and hardships of rural life can contribute significantly to declining mental health as people struggle with drought, frosts and hail ruining crops, poor harvest, very limited mental health supports and services, loneliness and lack of public transport for those who don't have their own means of transport. Not being able to access mental health services in their local area causes further stress and can impact negatively on mental health. We encourage the Commission to continue to engage directly with these communities and develop recommendations that acknowledge the distinct specific needs of people in regional and rural Victoria.

While we acknowledge that much of the responsibility for the NDIS falls with the Commonwealth Government, the Commission does need to recognise the significant impact of the NDIS on mental health service access, availability and experience in Victoria. The NDIS was never intended to replace the mental health system. However funding previously allocated for Mental Health Community Support Services (MHCSS) has been transferred into the scheme, leading to enormous pressure on the community mental health sector, with services closing their doors, and a rapid loss of occupational expertise in the mental health workforce.[41] We welcome the transitional support provided by the Victorian Government however this will only provide short-term relief and we are concerned about how we can continue to support our consumers who were previously eligible for the Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR), and Support for Day to Day Living in the Community (D2DL) programs. Uniting's mental health workforce are greatly concerned about consumers who do not qualify for NDIS support or those who do qualify but insufficient support has been provided. In Uniting's experience, only 20% of people using our existing psychosocial service (aimed at disadvantaged individuals) are eligible for an NDIS package, while others with severe but episodic illness, dual diagnosis, complex needs or over the age of 65 are left without services. With limited access to and availability of community mental health services, the burden will increasingly fall to acute and clinical services, the police and the justice system. Uniting urges the Commission to recommend the development of alternate supports for people ineligible for the NDIS to ensure these people do not fall between the gaps.

Furthermore, NDIS reforms have significantly changed the philosophy underpinning mental health services and reduced access to mental health rehabilitation, an essential and mental health response to those with severe mental illness which has demonstrated results. Rather than providing a holistic approach to overall wellbeing and focusing on recovery as a priority for action, clients must now describe how they are on their very worst day and must argue that they are not going to 'get better'. This contradicts the recovery-oriented practice underpinning Victoria's Mental Health Act 2014. It is also counter to the core principles of the NDIS that claim to promote consumer choice and control. We are concerned that this model perpetuates maintenance and dependence. We urge the Commission to recommend the development of alternate service models that promote recovery and independence. Lived experience must be at the core of all services to ensure approaches are flexible to an individual's needs, and that access and availability are not determined by how well people can "fit into boxes" to prove their eligibility.

Family Members and Carers

Reduced access and availability of appropriate services means that an additional burden is falling on the 240,000 unpaid carers that support people with mental illness. According to a report commissioned by Mind Australia,[42] these people provide an estimated 208 million hours of informal care per year to people with mental illness (the equivalent of 173,000 full time employees). Replacing carers with formal support workers would cost $13.2 billion annually. Unfortunately

[41] Psychiatric Disability Services of Victoria (VICSERV). Submission on Market Readiness to the Joint Standing Committee on the NDIS. Melbourne: VICSERVC, 2018. Available from https://www.mhvic.org.au/policy-publications/policy-submissions

[42] Diminic S, Hielscher E, Lee Y, Harris M, Schess J, Kealton J, Whiteford, H. The economic value of informal mental health caring in Australia. Brisbane: Mind Australia & University of Queensland. 2018. Available from: http://www.caringfairly.org.au/sites/default/files/pdf/The_economic_value_of_informal_care_full_report.pdf

many programs and supports for family members and others caring for people with mental illness are being dismantled to fund the NDIS. Carers are increasingly losing the services and supports that helped them provide the best possible care for their loved one while maintaining their own mental health and wellbeing. This is particularly concerning given the overwhelming evidence that carers experience poor mental health outcomes themselves. We urge the Commission to develop recommendations for the Victorian Government to provide adequate and appropriate training and information to carers, to support them financially and ensure they deliver care in a safe environment.

As many people have preconceived ideas about mental illness and are influenced by stigma and bias, it is very important that family members and carers have better access to education and support services to equip them to support their loved ones and develop effective strategies to maintain their own mental health and wellbeing. This will assist families and potentially reduce conflict and family breakdown, as is often the case in situations where carers and family members feel ill-equipped and uninformed about how to cope with the challenges presented by a mental health condition.[43] Furthermore, there is strong evidence to suggest there are benefits by involving carers and family members in treatment and discharge planning, including reduced frequency of inpatient admissions, significant improvements in the affected individual's symptoms and quality of life and reductions in relapse for severe mental disorders.[44] Implementation of family and carer involvement is still lacking in community and clinical practice so we encourage the Commission to consider the benefits to be gained from this model.

Mental Health Workforce

It has been the experience of Uniting's mental health workforce that they are often expected to have qualifications in social work, occupational therapy, psychology or counselling. Award wages are comparatively lower in mental health support professions than other sectors and due to short-term funding cycles a large majority of the workforce is employed on short term contracts, leading to high staff turnover. Difficulty attracting and retaining qualified and experienced mental health workers is particularly pronounced in regional areas, leading to these communities having insufficient access to mental health services and experiencing a higher burden from mental illness.[45] Providing longer-term funding for programs would greatly improve job security and enhance the attraction and retention of staff.

NDIS funding arrangements have also impaired the ability of services to pay for qualified mental health workers. Therefore, many organisations that were previously providing mental health support under block funding i.e. MHCSS programs, have closed as they are unable to maintain qualified staff under the NDIS price guide.[46] Furthermore, no funding is provided to deliver essential specialised mental health training to the NDIS workforce so there are an increasing number of inexperienced staff delivering services to highly vulnerable clients. It is therefore critical that supports for the Victorian mental health workforce are reviewed to prioritise investment in upskilling staff to better address mental health issues.

Reflecting our vision for a future integrated mental health system extending beyond the health sector, mental health capabilities are also needed to upskill workforces who intersect with the mental health system, including:

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[43] Avison W. The impact of mental illness of the family. In: Aneshensel CS, Phelan JC (eds) Handbook of the Sociology of Mental Health. 1999. Boston: Springer.
[44] Giacco D, Dirik A, Kaselionyte, Prieve S. How to make carer involvement in mental health inpatient units happen: a focus group with patients, carers and clinicians. BMC Psychiatry. 2017. 17: 101.
[45] Australian Institute of Health and Welfare. National Health Workforce Planning and Research Collaboration 2011: Mental Health Non-Government Organisation Workforce Project Final Report. Adelaide: Health Workforce Australia, 2016.
[46] Psychiatric Disability Services of Victoria (VICSERV). Submission on Market Readiness to the Joint Standing Committee on the NDIS. Melbourne: VICSERVC, 2018. Available from https://www.mhvic.org.au/policy-publications/policy-submissions

- Emergency service personnel
- Education staff
- Child protection and OOHC workers
- Aged care staff
- Domestic and family violence workers

The potential valuable impact of integrating the lived experience of consumers must also be recognised a part of workforce strategies. Many people with lived experience are keen to share their perspectives and peer worker/peer support programs are emerging as highly appropriate workforce models that can facilitate a renewed focus on recovery-oriented supports. Importantly, peer-led workforce models can help support improved consumer outcomes by the directly address the detrimental power imbalance that may exist between consumers and mental health service provides. There is currently an emerging body of research demonstrating that mental health services controlled and delivered by people with lived experience are effective in supporting recovery.[47]

Priority Areas for Reform

Based on feedback from Uniting's staff and consumers, we urge the Commission to prioritise the following actions for reform:

- Increase strategic investment focused on both early intervention and prevention, as well as consumer-informed collaborative program design to improve the appropriateness and sustainability of interventions;
- Improve the integration and coordination of services offered by clinical and community mental health services, include the development of consistent referral pathways;
- Expand and scale-up the delivery of existing psychosocial support programs while broader mental health system design and planning work is undertaken in the context of NDIS transition;
- Review current mental health services funding arrangements to prioritise sustained investment and facilitate measurable social return on investment;
- Develop a broader definition of the mental health system and fund initiatives that coordinate linkages between the various policy areas and supports necessary to promote, prevent and manage mental illness. These include alcohol and other drugs (AOD), housing, financial assistance, financial counselling, stable employment and psychosocial support;
- Invest in a paid peer workforce program and promote opportunities for people with lived experience to share their stories to drive the wider societal attitude change needed to tackle stigma and discrimination, and shape more responsive and higher quality services;
- Mandate carer-inclusive practice in all commissioned mental health services; and
- Ensure the sustainability of reforms by establishing new governance structures and an independent body responsible for providing system leadership, implementation support for system change, and monitoring and oversight to hold decision-makers and successive governments to account.

[47] Greg, F, O'Hagan M. 2015. The effectiveness of services led or run by consumers in mental health: rapid review of evidence for recovery-oriented outcomes: an evidence check rapid review brokered by the Sax Institute for the Mental Health Commission of New South Wales. Sydney: Sav Institute.