16 June 2019

Royal Commission into Victoria's Mental Health System
PO Box 12079
A'Beckett Street
VIC 8006

Dear Commissioners,

Thank you for the opportunity to provide a submission to this Royal Commission. As a mental health consumer and carer, I value this chance to contribute to this once-in-a-generation process.

I am a 29 year old woman with a lived experience of mental illness, of caring for others with a mental health condition/dual diagnosis of alcohol and other drug use, and of working in the mental health sector. Since first experiencing depression and anxiety as a pre-teen in the UK, I have received numerous diagnoses, including depression, anxiety, bipolar disorder II and binge eating disorder. I am currently well enough to maintain function in everyday life, but my mental health conditions are ever-present. I have lived in Victoria for the past eight years and have a wealth of direct and indirect knowledge about the mental health system here.

A particular challenge in addressing the Commission's Terms of Reference is the jurisdictional scope of the inquiry. Many of the mental health services accessed by people with mental health conditions are outside the scope of this Commission, including Medicare-rebated services (e.g. GPs and psychologists), PHN-funded services and NDIS funding. Many of the significant challenges faced by people in their daily lives relate to these services – and their intersections with state-funded services.

As far as possible, I have limited the scope of my submission to that of the Victorian mental health system. However, I think there is a fundamental role for the Victorian Government as an advocate for people in Victoria with a mental illness in dealings with the Federal Government and through COAG processes.

In responding to the Commission's questions, I have grouped my submission into several key themes. These are based, primarily, on my own experiences as a consumer and carer,

but also drawing upon my professional knowledge as a mental health policymaker and evaluator.

My submission is far from comprehensive, but I hope gives some insight into the changes I think would support our mental health system to improve my life and those of the people in my communities.

Yours sincerely

Joanna Farmer

Contents

Service system design 4

Complex mental health needs 8

Universal suicide prevention 14

Stigma and discrimination 16

Measurement 20

Summary of recommendations 22

References 25

Service system design

> "I'm sorry, but you don't fit our service eligibility requirements."
>
> "I'm sorry, but I am not taking new patients right now."
>
> "My next available appointment is in three months."
>
> *Comments I have heard while calling to access a psychiatrist, following a referral from a GP during a suicidal crisis.*

System complexity

Like many components of our health system, responsibility for mental health is spread across jurisdictions, with further complexity added with the inclusion of the private system. This has a daily impact on the lives of people with mental health conditions.

The Victorian mental health system is predominantly structured around supporting people with acute mental health needs, either through short-term support in hospital beds or longer-term community support through Area Mental Health Services.

While services are funded based on neat diagnostic categories and states of functioning, mental health consumers are usually more complex.

GPs are inadequate system gatekeepers

The interface between services is not clear for consumers. People navigating the system on their own (rather than under compulsory treatment orders) are usually advised to seek help via their GP.

GPs are the functional gatekeepers, but there are few structural or financial incentives for them to remain engaged in the complexity of the system. As a result, the usual process is for a GP to develop a Mental Health Plan and refer their patient to a psychologist for access to Medicare-rebated sessions. This creates three potential challenges:

- The consumer is required to follow-up on that appointment themselves, often a challenge given motivation and cognitive impairments associated with mental ill-health.
- A psychologist may be the appropriate treatment option, but the Better Access scheme entitles participants to a limited number of rebatable sessions. (This challenge is outside the scope of this Commission.)

- Referral to a psychologist may not be the most appropriate treatment option for that consumer.

Some may require a lower intensity treatment option. These are expected to be provided by federally-funded Primary Health Networks (PHNs). However, since the National Mental Health Commission's *Contributing* Lives report in 2014, there remains a lack of clarity among PHNs and mental health professionals around what a low intensity system looks like in practice.[i]

For some, a more intense treatment option is required. Community mental health services have been established to support people with complex mental health needs to remain in the community. However, the majority of people attending community mental health services are referred at discharge from an acute stay in hospital. This suggests that community mental health services are predominantly being treated as a 'step-down' service, rather than as an early intervention and support service. At a community level, 'gatekeeper' professionals, such as GPs and psychologists, are not adequately connected to the services that could most benefit their clients.

> *Recommendation 1: The Victorian Government should work closely with Primary Health Networks to encourage the uptake of low intensity mental health services and act as a knowledge broker across the state.*
>
> *Recommendation 2: The Victorian Government should fund Area Mental Health Services to undertake outreach with GPs, psychologists and other system gatekeepers to encourage earlier referrals to community mental health services.*

Service access and demand

Services are overstretched, and are ill-equipped to cope with ever-growing demand.[ii] As a result, services are only able to see the most unwell. The system has almost no capacity for prevention and early intervention services currently.

When treatment is required, in many areas there is a lack of services and those that do exist can be challenging to access. Some specific challenges include:

- **Child and youth mental health services (CYMHS)** – three quarters of mental health conditions will manifest before the age of 24. The Victorian Auditor General's Office recently found that "The Department of Health and Human Services (DHHS) has not provided the strategic leadership necessary to effectively plan, fund and manage CYMHS. Consequently, the system consists of a collection of fragmented and overstretched health services. DHHS has created a system that cannot

effectively work together even when client need requires it."[iii] DHHS has accepted all recommendations from the review.

- **Public psychiatry** – the median wait time in Victoria for a public psychiatrist in the first quarter of 2019 was around 100 days.[iv] Low capacity within the public system means that many people experience an exacerbation of their condition while awaiting treatment.
- **Services for specific mental health conditions** – increasingly, we are coming to understand how specific individualised and group therapy approaches can help people with a variety of specific diagnoses. However, in Victoria, access to such approaches is predominantly only available through costly private clinics.

Recommendation 3: The Victorian Government should undertake a comprehensive mapping exercise of available public mental health services (including waiting times) and fund increased capacity and improved treatment pathways.

Service variation

Mental health services are subject to significant geographic variation. The lack of services in rural and regional areas is well-documented.[v]

This has a real impact on the quality of care and recovery that people in rural areas can access. It makes it harder to access adequate treatment at a lower level of intensity, risking the escalation of health conditions.

Undertaking consultation in rural Victoria, I heard of people in acute distress who were required to be sedated for long periods to be safely taken to an appropriate hospital hundreds of kilometres away. Sometimes, by the time they arrive at the emergency department, sedation has taken effect and the consumer no longer presents as requiring hospitalisation and is returned to their home. For those that do require treatment away from home, this is problematic in and of itself as community and social connection are vital for recovery.

However, rurality is not the only dimension impacting service accessibility. The Area Mental Health Service model, while designed to support the development of regionally-tailored services effectively creates a postcode lottery on access to care. VAGO has found, in relation to Child and Youth Mental Health Services that DHHS has created a fragmented system with limited oversight, accountability and knowledge-sharing.[vi]

For example, Orygen Youth Health operates world-leading early intervention and treatment services for young people, especially those with severe mood disorders and early psychosis.

The services are strengthened by their connection to Orygen, the National Centre for Excellence in Youth Mental Health who undertake innovative research and intervention trials. However, the services are only available to those who live in the north and west of Melbourne.

Recommendation 4: The Department of Health and Human Services should implement VAGO's recommendation to reassess Area Mental Health Service catchment boundaries and service distribution.

System navigation

Online information on how to access specialist services is hard to navigate, links are often broken or outdated. While the DHHS website includes information on services as generally available, it is challenging to find information on specific services available in your area and service eligibility requirements. This is of particular concern given that mental health is associated with decreased cognitive functioning. If the onus is on the consumer to navigate to a service and the system makes it too hard, consumers will simply not access the service.

Recommendation 5 The Department of Health and Human Services should develop a consumer-facing online system navigation tool.

Recommendation 6: The Department of Health and Human Services should invest in a peer support workforce to support consumers and carers on their mental health journey.

Complex mental health needs

> "Your binge eating disorder cannot be treated under their current eating disorder trial as we are only accepting clients with a diagnosis of bulimia. So I guess that means you have to options: try being sick after binging. Or we wait until you develop diabetes and then you can get help."
>
> *My GP was only half-joking.*
>
> I drank to oblivion until I was too drunk to want to die any more.
>
> *The night before I tried to become sober.*

The complexity of our mental health system most disadvantages those who are already the most disadvantaged.

The social determinants of mental health are well known.[vii] People with mental health conditions are significantly more likely to experience or have experienced:

- homelessness, or living in unstable housing[viii]
- interactions with the justice system[ix]
- poverty[x]
- unemployment[xi]

Many of these social determinants are 'chicken and egg' with continued exposure likely to lead to a worsening of mental ill-health that in turn contributes to increasing socio-economic disadvantage, and so on.

However, we have created a service system that treats people based on symptom, rather than a holistic approach that understands and addresses cause.

Multidisciplinary care

One approach to resolving the siloed nature of mental health care is to embed multidisciplinary care into mental health practice. This is the approach utilised in community mental health services in Victoria.

In practice, there are several challenges to multidisciplinary care. In consultation with mental health nurses, I have heard that multidisciplinary care is stymied by ongoing siloes in work responsibilities and scopes of practice. Those within a team still consider treatment from within their disciplinary silo, rather than putting the client at the centre of the process.

A case management approach is meant to prevent this through ensuring a dedicated case manager understands and advocates for a client's holistic needs. However, services are so frequently overstretched that it is very challenging for case managers to undertake all the work it would require to do this to a high standard for their full caseload.

Additionally, many services rely on sessional and part-time staff. This presents a logistical challenge when organising case conferences as it is often simply too hard to get all the right voices in the room at the same time.

> *Recommendation 7: The Department of Health and Human Services should adequately resource a multidisciplinary approach, including dedicated case management funding.*

Trauma-informed care

The mental health sector is ill-equipped to deal with the substantial impact of trauma, including:

- Single-event trauma, such as sexual assault or a natural disaster
- Prolonged traumatic events, such as family violence or bullying
- Vicarious trauma, often experienced by those in caring professions
- Intergenerational trauma, such as that experienced in Aboriginal communities

Trauma has a huge impact on Victorian public services, including child protection, the justice system and the long-term physical and mental health effects of trauma. The Blue Knot Foundation has found that the impact of unresolved childhood trauma in Australian adults is $9.1 billion annually.[xii] This was based on suicide and suicide attempts, the cost of alcohol abuse, the cost of depression/anxiety, and the cost of obesity. Therefore, it is likely this figure underestimates the economic impact.

The impact of trauma on the mental health system is broader than just diagnoses of Post Traumatic Stress Disorder. Trauma in childhood has been shown to be the most significant predictor that someone will have contact with the mental health system.[xiii]

Trauma Informed Practice is a strengths-based framework which is founded on five core principles:

- safety
- trust
- choice
- collaboration
- empowerment.[xiv]

Recommendation 8: The Department of Health and Human Services should embed a trauma-informed practice framework into all public health services.

Aboriginal and Torres Strait Islander social and emotional wellbeing

Aboriginal and Torres Strait Islander people experience significantly worse mental health outcomes as a result of the ongoing impacts of colonialisation.

Aboriginal social and emotional wellbeing cannot be achieved without Aboriginal communities' self-determination.

Recommendation 9: The Victorian Government should continue its progress towards treaty with Victoria's first peoples.

Aboriginal communities are best-placed to provide culturally safe care that is appropriate and trusted by communities. Despite this, Aboriginal community-controlled health organisations are historically under-funded and subject to short term, ad hoc funding arrangements.

In mainstream health settings, Aboriginal people are subject to stigma and discrimination, by health staff and other clients. In addition to identified Aboriginal positions, such as Aboriginal Health Workers, it is important that DHHS makes employment in all health roles safe for Aboriginal people.

Recommendation 10: Increase recurrent funding for Aboriginal community-controlled health organisations.

Recommendation 11: The Department of Health and Human Services must adequately resource the Aboriginal health and human services workforce strategic action plan 2018-2019*, and commit to future years of Aboriginal workforce planning*

Alcohol and other drugs

About 50% of people with severe and complex mental health conditions experience problematic alcohol and other drug (AOD) use.[xv]

Despite this, the system views AOD misuse as to be treated by the AOD system and mental health conditions to be treated by the mental health system. For all the talk of 'dual diagnosis', the system is not set up to provide treatment this way. It is even less well-equipped to provide trauma-informed dual diagnosis care.

Separating AOD and mental health services simply creates additional barriers to access for people in need, and prevents useful information sharing between practitioners.

While the public AOD system in Victoria is home to some excellent facilities, the system is severely under capacity for the level of need in the community. As a result, those who can often turn to private rehabilitation providers. These services are under-regulated. Vulnerable clients, and often their families, are exploited at a time of need, and not provided with the integrated care they require.

> *Recommendation 12: The Department of Health and Human Services should support the co-location and integration of mental health and AOD services.*

> *Recommendation 13: The Department of Health and Human Services should develop and implement a dual diagnosis strategy, including commitment to increased AOD system capacity and interdisciplinary training for staff.*

> *Recommendation 14: The Department of Health and Human Services should regulate private AOD rehabilitation providers.*

Justice mental health

People with mental health conditions are significantly over-represented in the adult and juvenile justice systems. Currently, the justice system is used as the de facto treatment pathway for people experiencing complex mental health needs.

For many, prison is the first time they have access to regular, quality mental health services: 39% of prison discharges reported their mental health improved while in prison (compared to 10% who reported it declined).[xvi] Women are significantly more likely to receive mental health medication in custody than men.[xvii]

The justice system should not be the place where so many in our communities experience mental health treatment. With adequate prevention activities, health and community support it is likely that a custodial sentence could be avoided. Justice reinvestment projects, including that in Bourke NSW, demonstrate the benefits that such an approach can bring to both the health of individuals, their communities and the economy.[xviii]

> *Recommendation 15: The Victorian Government should adopt a justice reinvestment approach which prioritises place-based mental health interventions for at risk communities.*

Physical health needs

People with mental health conditions live shorter lives than their mentally well peers.[xix]

Physical and mental health needs are predominantly treated separately by the health system. A clear example of where this results in nonsensical treatment is in relation to eating disorders.

Approximately one in eight people in Australia has experienced an eating disorder.[xx] While the public perception of eating disorders is typically associated with anorexia and bulimia, binge eating disorders (BED) and other specified feeding or eating disorders (OFSED) are actually the most common eating disorders in Australia.

There is a substantial lack of understanding among the general public about these disorders. More concerning is the lack of awareness and understanding among mental health professionals and GPs.

Access to mental health support is primarily given on the basis of most immediate risk and need. In the case of eating disorders, this means that eating disorders such as BED and OFSED are deprioritised in practice, as the physical impacts of such conditions are less immediately risky. That said, long-term, people with BED are at significant risk of chronic obesity-related conditions.

There are few affordable, holistic treatment options available in the community to people experiencing eating disorders. The Federal Government's recent announcement of the expansion of the Medicare rebate for up to 40 annual psychology and 20 annual dietician sessions is a significant step towards closing this gap. However, support of this kind continues to dichotomise physical and mental health conditions. Evidence suggests a multidisciplinary treatment approach is most effective for eating disorders.

> *Recommendation 16: The Department of Health and Human Services should support access to affordable holistic physical and mental health treatment programs.*

Mental health in all policies

Mental health has many complex and interdependent contributing factors. Preventing mental health requires the creation of mentally healthy environments throughout society, with the support of the whole of government. Mental health is not simply the province of the Department of Health and Human Services.

Victoria has an opportunity to embed mental health in all policies. In order for this to occur, mental health must be embedded into the processes of government, including accountabilities and funding systems.

New Zealand's recent 'Wellbeing Budget' provides Victoria with a blueprint for how such an approach could look, by encouraging interdepartmental collaboration and assessing budget proposals not simply as 'expenditures' but as investments against wellbeing indicators.

Recommendation 17: Embed preventative mental health approaches across government through:

- *the development of a whole-of-government mental wellbeing framework assigning responsibilities and accountabilities across departments*
- *monitoring and annual reporting of whole of government mental health indicators*
- *the development of a social and mental wellbeing assessment framework by the Department of Treasury and Finance in the assessment of budget bids.*

Universal suicide prevention

> I am only alive today because I have capacity and trust in others, even in my hardest moments, to reach out to others to provide that safe haven.

In 2017, 621 Victorians took their own life.[xxi]

This is simply the tip of the iceberg, as for every death by suicide, there are many more attempts and even more people whose lives are affected by suicidal ideation.

Under the *Victorian suicide prevention framework 2016-2025*, the Victorian Government has committed to three place-based suicide prevention trials. This is a good start, as the trials emphasise contextual solutions using the lived experience of people in the community. However, these are limited in scope. It is vital that the Government continues to support these initiatives and provides opportunities for the learnings to be shared to other Victorian communities. Too often, a 'trial' approach leads to short-term funding and pockets of progress that cannot be sustained beyond the life of the trial. Without long-term commitment, there is no way that the Victorian Government can meet its current commitment to half the suicide rate in Victoria by 2025.

Victoria requires a universal suicide prevention approach that systematically approaches the impact of suicide on our communities, rather than a piecemeal funding approach. A universal suicide prevention approach recognises a continuum of suicidal thoughts and behaviours:

1. pre-suicidal distress
2. support for people experiencing suicidal ideation
3. post-vention support for people who have attempted suicide.[xxii]

Other submissions will write compellingly about the first and third components of such a system. In my submission, I focus on the second component: supporting those experiencing suicidal ideation.

Support for people experiencing suicidal ideation and crisis

Currently, when experiencing suicidal thoughts, people have few intervention options available to them, usually contacting a helpline or accessing crisis support.

Emergency departments are not welcoming places for people in suicidal crisis. Physicians report nearly one-third of patients with an acute mental illness wait more than eight hours in emergency departments.[xxiii]

Recent research into men's experiences of suicidal crisis, undertaken by Turning Point and Monash University on behalf of Beyond Blue, found that men who accessed ambulance services for mental health issues felt they required more from paramedics than simply being transported to hospital.[xxiv] This is not surprising given that an accompanying survey of paramedics found paramedics felt they did not have adequate education, skills and training in mental health issues, although they have frequent contact with people experiencing these issues. Less than 14% of paramedics felt they had comprehensive coverage of different mental health issues.[xxv]

Often what is most-required is a safe space for the most acute suicidal thoughts to pass. But many Victorians do not have such an option available. What is needed is a safe haven or intervention approach that de-escalates a person's distress, rather than triggering an acute hospital response.

Several initiatives have been, or are currently being trialled, to demonstrate the value of a de-escalation approach, including:

- the Safe Haven Café trial at St Vincent's Hospital in Melbourne, modelled on a successful initiative in the UK
- Distress Brief Intervention, a Scottish intervention designed to provide time-limited support to someone who presents at an emergency department
- Police Ambulance Crisis Emergency Response (PACER), whereby police and mental health clinicians could jointly attend a first-responder call out to a person in crisis.

Recommendation 18: The Department of Health and Human Services should incorporate de-escalation models into their plan to achieve a 2025 suicide reduction target.

Stigma and discrimination

In my time living with mental illness:

- a rival job candidate has used my disclosure of depression to attempt to knock me out of competition for a role
- a GP has dismissed my repeated requests for help to treat hypomania by asserting I did not understand what that symptom meant (despite holding a Bipolar II diagnoses)
- a psychiatrist suggested I could treat my eating disorder by “making different food choices”
- I have had to choose between lying on travel insurance disclosure forms or risk being inadequately covered
- I have received online abuse for discussing my mental illness.

For many like me, the impacts of stigma and discrimination are tangible. Symptoms escalate through distress, self-stigma and low self-esteem, and an unwillingness to seek help for fear of mistreatment.[xxvi]

While much has been done to reduce stigma and discrimination in recent years, challenges remain. The Fifth National Mental Health Plan identifies the core areas for improvement:

- stigma against people with severe and complex mental health conditions
- stigma by mental health professionals
- stigma faced by people with multiple ‘stigmatised’ attributes, which I’ve called here ‘compounded stigma’.

Stigma against people with severe and complex mental illness

Over time, stigma against people with high prevalence disorders (such as depression and anxiety) has decreased considerably in Australia.[xxvii] However, this is not the case with severe and complex mental health conditions, including psychotic illnesses, personality disorders and suicidality.

Language is critical to how those with mental illness are discussed. We have only developed a language for mental health and mental illness in recent decades, with terms often contested and emerging. It is in this environment that stigma and discrimination find a foothold.

Recommendation 19: The Victorian Government should model stigma reduction through the rollout of a workplace health and wellbeing strategy across the Victorian Public Service.

Stigma by mental health professionals

You might expect that those working in the mental health sector are less likely to discriminate against those with mental illness. Unfortunately, that is not the case. A 2011 survey by Mental Health Australia of consumers and carers found:[xxviii]

- 29% had been shunned or avoided by the professional treating their mental illness
- 34% had been told to lower their expectations for accomplishments in their life
- 61% reported a lack of understanding about the lived experience of mental illness from their service providers
- 45% indicated that their service provider had changed their behavior towards them once finding out about their mental illness.

A majority of consumers worried about health professionals having a negative perception of them. Regardless, of the reality of this treatment, self-stigma is a significant barrier to people disclosing their mental health condition and seeking treatment.[xxix]

The effect is even more pronounced for certain conditions. It is common knowledge among those in the mental health sector that borderline personality disorder (BPD) is ‘the worst’ diagnosis, with health professionals more likely to experience negative beliefs about their client.[xxx] This results in under-diagnosis and a failure to provide effective treatment.

The current complaints process is complicated. Those making complaints about treatment within publicly funded mental health community support services can complain to the Victorian Mental Health Complaints Commissioner (MHCC). The MHCC provides some guidance on how to make a complaint and contains four practice examples of complaints. However, the website is difficult to navigate, and the existence of the MHCC is unknown to most consumers and carers. Complaints can also be made about specific practitioners to the Australian Health Practitioner Regulation Agency (AHPRA).

In neither set of principles is it easy to identify how to make a complaint about stigma experienced by mental health professionals. As a result, when a complaint is not upheld, it is difficult for a consumer or carer to understand why their experience of stigma did not align with the definitions outlined by the agencies.

Recommendation 20: Information on the MHCC and AHPRA complaints processes should be clearly available to all accessing services.

Recommendation 21: The MHCC should provide clear guidance – and exemplars – on how to make a complaint about the stigmatising practice of a mental health professional.

Stigma by mental health professionals also makes it difficult to provide a safe working environment for mental health staff with a mental illness. Research has found health professionals experiences high rates of psychological distress.[xxxi] Health professionals with a lived experience are precisely the kind of people we want to keep working in the system, but for whom stigma creates a barrier.

Recommendation 22: Victoria should advocate for the inclusion of employee mental health standards within the National Safety and Quality Health Service Standards, and other relevant healthcare standards.

Compounded stigma

For many, stigma is complex. The stigma they face as a person experiencing mental illness is bound up with the stigma of their identity.

Racism, homophobia, transphobia and many forms of discrimination are all clear contributors to mental ill-health. Young LGBTI people are twice as likely to experience mental illness.[xxxii] And the suicide rate for young Aboriginal men is the worst in the world.[xxxiii] These are not coincidences. These communities have faced historical trauma and ongoing discrimination.

As well as contributing to mental illness, stigma around mental health and issues of identity have a major impact on how people engage with mental health services. Stigma around mental health issues can prevent people from diverse backgrounds from discussing their problems. Fear that they will face discrimination and racism at the hands of services prevents people from reaching out. More than that, for many people of Aboriginal and culturally diverse backgrounds, the western biomedical health system can hold a fundamentally different understanding of how bodies and minds work. That's why work to improve understandings of concepts such as social and emotional wellbeing in mainstream settings is so important.

Consumer voices are vital to improving access to and the quality of mental health services and systems. Philosophically, I think it's important that services for us are not designed

without us. However, when it comes to potentially stigmatised communities, hearing from diverse voices is especially important because these voices are so under-represented.

For services, this means thinking about the voices which are not currently heard, and reaching out to provide opportunities. But providing opportunities is often not enough. Engaging with under-represented communities often means actively supporting people to engage because without this the barriers to participation can often be insurmountable. Participation opportunities need to be culturally safe, held at welcoming hours and in language and spaces that are accessible.

Sharing stories of lived experience is well-established as a communications tool to break down stigma and discrimination. There is a risk, given stigma occurs, in relying on consumers and carers to challenge stigma. Working as a mental health advocate can be emotionally exhausting as you are forced to use your own negative experiences to improve the system. The fallout can trigger new and complex emotions.

Lived experience advocacy is vital to create a better mental health system, and to challenge the stigma and discrimination that many with mental health conditions still face. However, it must be done safely.

Recommendation 23: Consumers and carers should be involved in service design and delivery. Engagement should be informed by the following principles:

- *broader in scope than singular appointments to advisory committees*
- *inclusion of diverse stakeholders, representing a range of mental health diagnoses and social and cultural backgrounds*
- *evaluated to understand the impact of consumer and carer co-design, with lessons shared across the service system*

Measurement

Measurement is important to understand progress and to hold government to account for its action. However, there are several key challenges to measurement within the current Victorian mental health system.

Data availability

Current data collection relating to the prevalence of mental health conditions and their treatment is woeful at a Victorian and national level.

At a national level, the last national collection of mental health prevalence was the *National Survey of Mental Health and Wellbeing* undertaken by the ABS in 2007.

In Victoria, the Victorian Population Health Survey collects indicators of psychological distress and lifetime prevalence of depression. VicHealth's Indicators Survey collects indicators of gender equality, neighbourhood connectedness and trust, and resilience. Both of these data collections are relatively infrequent.

The only regularly collected indicators related to health outcomes are suicide rates, length of stay and readmission rates for acute stays, and community service contacts and hours.

As someone working in mental health policy and service design, it is extremely challenging to make evidence-informed decisions about appropriate treatment based on the data available in Victoria. This results in various not-for-profits and government agencies undertaking expensive, for-purpose data collections that are ad hoc, point-in-time and provide limited comparison value.

Data accountability

At a service level, practitioners report swimming in activity data, reporting and recording all their client contacts. However, this data is not effectively translated into outcomes-based data at the service planning or state level. Therefore it is difficult to assess the extent to which mental health services in Victoria have an impact.

The data that is collected is not tied to any systematic reporting system or framework for government accountability. This significantly undermines the Government's attempts at reform.

VAGO released a scathing report on the current mental health data systems in early 2019, finding:[xxxiv]

- “DHHS and other stakeholders have directed significant resources to implementing the activities underpinning the 10-year plan; however, there is no evidence of activity milestones, nor these being met.”
- “DHHS does not track and report progress against the [implementation] wave priorities.”
- “Without targets, it is unclear what level of improvement DHHS is aiming for.”

DHHS has accepted all VAGO’s recommendations in-principle, pending the findings of this Commission.

> *Recommendation 24: The Department of Health and Human Services must develop a comprehensive suite of outcome indicators for mental health against which to track its reform progress.*
>
> *Recommendation 25: Data on mental health outcomes should be made available for service planning, evaluation and research.*

Summary of recommendations

Recommendation 1: The Victorian Government should work closely with Primary Health Networks to encourage the uptake of low intensity mental health services and act as a knowledge broker across the state.

Recommendation 2: The Victorian Government should fund Area Mental Health Services to undertake outreach with GPs, psychologists and other system gatekeepers to encourage earlier referrals to community mental health services.

Recommendation 3: The Victorian Government should undertake a comprehensive mapping exercise of available public mental health services (including waiting times) and fund increased capacity and improved treatment pathways.

Recommendation 4: The Department of Health and Human Services should implement VAGO's recommendation to reassess Area Mental Health Service catchment boundaries and service distribution.

Recommendation 5 The Department of Health and Human Services should develop a consumer-facing online system navigation tool.

Recommendation 6: The Department of Health and Human Services should invest in a peer support workforce to support consumers and carers on their mental health journey.

Recommendation 7: The Department of Health and Human Services should adequately resource a multidisciplinary approach, including dedicated case management funding.

Recommendation 8: The Department of Health and Human Services should embed a trauma-informed practice framework into all public health services.

Recommendation 9: The Victorian Government should continue its progress towards treaty with Victoria's first peoples.

Recommendation 10: Increase recurrent funding for Aboriginal community-controlled health organisations.

Recommendation 11: The Department of Health and Human Services must adequately resource the *Aboriginal health and human services workforce strategic action plan 2018-2019*, and commit to future years of Aboriginal workforce planning

Recommendation 12: The Department of Health and Human Services should support the co-location and integration of mental health and AOD services.

Recommendation 13: The Department of Health and Human Services should develop and implement a dual diagnosis strategy, including commitment to increased AOD system capacity and interdisciplinary training for staff.

Recommendation 14: The Department of Health and Human Services should regulate private AOD rehabilitation providers.

Recommendation 15: The Victorian Government should adopt a justice reinvestment approach which prioritises place-based mental health interventions for at risk communities.

Recommendation 16: The Department of Health and Human Services should support access to affordable holistic physical and mental health treatment programs.

Recommendation 17: Embed preventative mental health approaches across government through:

- the development of a whole-of-government mental wellbeing framework assigning responsibilities and accountabilities across departments
- monitoring and annual reporting of whole of government mental health indicators
- the development of a social and mental wellbeing assessment framework by the Department of Treasury and Finance in the assessment of budget bids.

Recommendation 18: The Department of Health and Human Services should incorporate de-escalation models into their plan to achieve a 2025 suicide reduction target.

Recommendation 19: The Victorian Government should model stigma reduction through the rollout of a workplace health and wellbeing strategy across the Victorian Public Service.

Recommendation 20: Information on the MHCC and AHPRA complaints processes should be clearly available to all accessing services.

Recommendation 21: The MHCC should provide clear guidance – and exemplars – on how to make a complaint about the stigmatising practice of a mental health professional.

Recommendation 22: Victoria should advocate for the inclusion of employee mental health standards within the National Safety and Quality Health Service Standards, and other relevant healthcare standards.

Recommendation 23: Consumers and carers should be involved in service design and delivery. Engagement should be informed by the following principles:

- broader in scope than singular appointments to advisory committees

- inclusion of diverse stakeholders, representing a range of mental health diagnoses and social and cultural backgrounds
- evaluated to understand the impact of consumer and carer co-design, with lessons shared across the service system

Recommendation 24: The Department of Health and Human Services must develop a comprehensive suite of outcome indicators for mental health against which to track its reform progress.

Recommendation 25: Data on mental health outcomes should be made available for service planning, evaluation and research.

References

[i] National Mental Health Commission (2014). *Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services*. Accessed from: https://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx
[ii] VAGO (2019). *Access to mental health services*. Accessed from: http://audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf
[iii] VAGO (2019). *Child and Youth Mental Health Services*. Accessed from: https://www.audit.vic.gov.au/sites/default/files/2019-06/050619-Youth-Mental-Health_0.pdf
[iv] DHHS (2019). *Statewide - Median wait time for routine specialist clinic appointments - Psychiatry and behavioural disorders, including Alcohol and Drug - Quarterly Data*. Accessed from: https://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=681
[v] Senate Standing Committees on Community Affairs (2018). *Accessibility and quality of mental health services in rural and remote Australia.* Accessed from: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report
[vi] VAGO (2019). *Child and Youth Mental Health Services*. Accessed from: https://www.audit.vic.gov.au/sites/default/files/2019-06/050619-Youth-Mental-Health_0.pdf
[viivii] WHO (2014). *The social determinants of mental health*. Accessed from: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=2E9ADCC7848FF9547423181F3564A04E?sequence=1
[viii] Council to Homeless Persons (2018). *Housing security, disability and mental health*. Accessed from: https://chp.org.au/mental-health-disability-and-homelessness/
[ix] AIHW (2019). *The health of Australia's prisoners 2018.* Accessed from: https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents
[x] Heath (2017). *The surprising link between mental illness and poverty*. Accessed from: https://www.sbs.com.au/topics/life/health/article/2017/11/07/surprising-link-between-mental-illness-and-poverty
[xi] OECD (2015). *Mental health and work: Australia*. Accessed from: https://read.oecd-ilibrary.org/employment/mental-health-and-work-australia_9789264246591-en#page1
[xii] Blue Knot Foundation (2015). *The cost of unresolved childhood trauma and abuse in adults in Australia.* Accessed from: https://www.blueknot.org.au/Portals/2/Economic%20Report/The%20cost%20of%20unresolved%20trauma_budget%20report%20fnl.pdf
[xiii] Agency for Clinical Innovation (n.d.). *Trauma-Informed Care and Practice in Mental Health Services*. Accessed from: https://www.aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services
[xiv] Mental Health Australia (2014). *Trauma-informed practice.* Accessed from https://mhaustralia.org/general/trauma-informed-practice
[xv] DHHS (2013). *Dual diagnosis*. Accessed from: https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis
[xvi] AIHW (2019). *The health of Australia's prisoners 2018.* Accessed from: https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents
[xvii] AIHW (2019). *The health of Australia's prisoners 2018.* Accessed from: https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents
[xviii] Just Reinvest NSW (2018). *New evidence from Bourke.* Accessed from: http://www.justreinvest.org.au/new-evidence-from-bourke/
[xix] Erlangsen, et al. (2017). 'Cause-specific life-years lost in people with mental disorders: a nationwide, register-based cohort study' in *Lancet Psychiatry*, 4(12). 937-945
[xx] NEDC (nd). *Eating disorders in Australia*. Accessed from: https://www.nedc.com.au/eating-disorders/eating-disorders-explained/something/eating-disorders-in-australia/
[xxi] ABS (2018). *3303.0 - Causes of Death, Australia, 2017.* Accessed from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3
[xxii] Beyond Blue (2019). *Submission to the Productivity Commission Inquiry into Mental Health.* Accessed from: https://www.pc.gov.au/__data/assets/pdf_file/0011/240788/sub275-mental-health.pdf

[xxiii] Duckett (2018). *Waiting for better care*. Accessed from: https://grattan.edu.au/news/waiting-for-better-care/
[xxiv] Beyond Blue (2019). *Beyond the Emergency*. Accessed from: https://www.beyondblue.org.au/docs/default-source/default-document-library/beyond-the-emergency-report.pdf
[xxv] Beyond Blue (2019). *Beyond the Emergency*. Accessed from: https://www.beyondblue.org.au/docs/default-source/default-document-library/beyond-the-emergency-report.pdf
[xxvi] SANE Australia (2019). *Reducing stigma*. Accessed from https://www.sane.org/information-stories/facts-and-guides/reducing-stigma#what-harm-does-stigma-do
[xxvii] Beyond Blue (2012). *Depression monitor.* Accessed from: https://www.beyondblue.org.au/about-us/depression-monitor
[xxviii] Mental Health Australia (2011). *Consumer and carer experiences of stigma from mental health and other health professionals*. Accessed from: https://mhaustralia.org/sites/default/files/imported/component/rsfiles/stigma/Consumer_and_Carer_Experiences_of_Stigma_from_Mental_Health_and_Other_Health_Professionals.pdf
[xxix] Corrigan and Rao (2012). 'On the self-stigma of mental illness: stages, disclosure and strategies for change'. *Canadian Journal of Psychiatry*. 57(8), 464-469.
[xxx] Nehls (1998). 'Borderline personality disorder: Gender stereotypes, stigma, and limited systems of care.' *Issues in Mental Health Nursing*. 19, 97-112; McNab, McCutcheon and Channing (nd). *Research Bulletin: Borderline Personality Disorder, Stigma and Young People*. Accessed from: https://www.orygen.org.au/Our-Research/Research-Areas/Personality-Disorder/Research-Bulletin-BPD.aspx?ext=.
[xxxi] Beyond Blue (2013). *National Mental Health Survey of Doctors and Medical Students*. Accessed from: https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web.pdf?sfvrsn=845cb8e9_12; Maharaj, Lees and Lal (2019). 'Prevalence and risk factors of depression, anxiety and stress in a cohort of Australian nurses'. *International Journal of Environmental Research and Public Health*. 16(1), 61.
[xxxii] National LGBTI Health Alliance (2016). *The statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia.* Accessed from: https://lgbtihealth.org.au/statistics/
[xxxiii] The Commonwealth Youth Programme (2016). *Australian Youth Development Index.*
[xxxiv] VAGO (2019). *Access to mental health services.* Accessed from: http://audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf