2019 Submission - Royal Commission into Victoria's Mental Health System

SUB: 0002.0023.0015

Name
Anonymous

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Submission to the Mental Health Royal Commission from [redacted]. I work for a service which works in the Gambling Harm and Mental Health Space and would like to make this submission to highlight the impact of the Co-morbidity, highlighting the importance of addressing gambling harm within the mental health space. I believe mu submission also answers the identified question to be addressed. Research was conducted in a partnership between a public mental health service (Alfred Psychiatry), a problem gambling service (Gambler's Help Southern) and a research centre (Monash Alfred Psychiatry Research Centre: MAPrc) in 2006 and repeated in 2009 found that approximately 17.6% of people presenting to the crisis or emergency mental health services of Alfred Psychiatry (The Alfred) were experiencing problem gambling. Following this research funding became available to try and address some of the impact of Gambling Harm and Mental Health please refer to this article link which speaks to some of the work being done, https://www.insidegambling.com.au/editions/15/feature/complex-treatment-at-the-crossroads. Note this article of about a service which is State-wide and operates with the staffing of 2.5FTE a very small allocation for a large piece of work. Below I would like to highlight what this areas needs to be addressed and better resources in the Mental Health Field. The State-Wide Gambling Team highlighted in this article has delivered an Assessment, recommendation and Linkage Service to people experiencing problem gambling and mental illness and provided a capacity building role to staff working in the area. Working in Collaboration and very closely together mainly with Gamblers Help (GH) counsellors allows both team members if the PG&MHP and GH workers feel part of a team. This Collaboration is a hallmark to the success of the team and stronger use of core principles of collaboration and treating expertise of community services and hospital services and equal in what they have to offer could be a beneficial intergration for the wider Mental Health Area through- out Victoria. PG&MHP works across Victoria and travels through-out the state and the similarity of services working as Solo entities appears to be a problem across the state. Often I hear stories of Services trying to refer clients, being turned away from Mental Health Services and Gambling is not seen as core business, or hear mental health clinicians saying that they have no gamblers on their case load yet then identify that they have never actually asked the question. I have seen people stop taking medication due to financial stress from gambling and this not being identified till people have experienced several hospital admissions due to relapse in mental health illness due to having no medication. Gambling Disorder and its co-morbidity with mental health is large and needs to be addressed and acknowledged within the Mental Health field and services need to truly work holistically and combine the resources of all services. In this submission will demonstrate some of the impacts of gambling behaviour and mental health. Gambling in Australia In Australia, gambling is a culturally acceptable and popular leisure activity (Gainsbury 2012). Although the majority of people gambling recreationally with few serious harms, there are small percentage of individuals who experience significant harm due to their gambling. The industry heavily promote gambling as a pleasurable pastime and State governments, while providing

extensive regulation of the activity, continue to support the liberalization of gambling because they derive a significant amount of taxation from it. An estimated 70% of Victorian adults have gambled in the past year (Lubman et al, 2017), while estimates from the Victorian prevalence survey are that 0.8% of adults fit the criteria for problem gambling, (Hare et al, 2015). Gambling harm Gambling has the potential to develop into an addiction, as defined by the Diagnostic and Statistical Manual of Mental Disorder 5th Edition (DSM-5: American Psychiatric Association, 2013). Gambling may precipitate harm to self, others and the community, including harm to one's physical, emotional, and psychological well being. It can further engender financial stress, workplace difficulties, relationship discord, and criminal activity (Brown et al. 2016). There is as yet no internationally or nationally agreed definition of harm as it relates to gambling (Browne et al, 2016). Researchers, however, have suggested several broad categories, into which gambling harms may fall, covering aspects such as: Health Fewer Leisure activities Critical incidents Education and Employment Social Financial Psychological. Financial hardship is one of the better recognised forms of harm, and may be the precipitating factor which first brings people to gambling help services (Browne, et al. 2016). However financial harm and other problem gambling measures are not, in themselves, sufficient to capture the extent to which gambling may precede or exacerbate harm, whether to the gambler themselves, or to family, friends, community and society (in widening circles of affected others) (Brown et al, 2016). Additionally, the burden of financial harm caused by gambling falls disproportionately on those with lower income or other assets (Blaszczynski, et al. 2015). From a public health perspective, therefore, attention must be focussed on those who suffer the most serious harm from the gambling behaviour of themselves and others (VRGF, 2015). The Ottawa charter delineates 5 domains for effective public health interventions. Working across these domains, effective, evidence-based interventions must recognising the complex interplay between the determinants of health and our collective behaviours. In recognising the wider harms which accrue to problem gambling behaviours, addressing the most serious harms should have ripple effects on public health through decreased harm to the gambler and decreased harm to affected others. Of particular concern is the intergenerational impact of gambling harms on the children of problem gamblers "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
see below

What is already working well and what can be done better to prevent suicide?
"Gambling and mental health In addition to financial and other harms which arise from problem gambling, the correlation between gambling and other comorbidities such as addiction, mental health issues, social impairment and other issues such as homelessness is well established. Co-morbid mental health disorders include alcohol and other drug use disorders, mood, anxiety, impulse control and personality disorders. The contribution of gambling itself is difficult to isolate and measure (Browne, et al. 2016), and it is likely that causal pathways may work in both directions, with problem gambling leading to mental health conditions such as anxiety and depression, while pre-existing conditions such as impulse control disorders may exacerbate gambling behaviours (Lubman, et al. 2017). It is likely that co-morbid gambling problems and mental health conditions may compound the harms experienced by this cohort of the population. A recent study conducted in Melbourne found that approximately 17% of people presenting to Alfred Health crisis or emergency mental health services were also experiencing problem gambling (Lee et al. 2012). This study led to the development of the Statewide Problem Gambling and Mental

Health Partnership as mentioned above, designed specifically to meet the needs of this complex group. Yet only funded for 2.5 FTE of a Multi-disciplinary team to cover the state of Victoria. Large scale studies, such as the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) in the US have illustrated high levels of substance misuse among people with disordered gambling (Blaszczynski, et al. 2015). A Canadian study of high school students also found a high level of co-morbidity between problem gambling and other problem behaviours in youth, including delinquency, substance use, and mental health conditions (Cook et al, 2015). While adolescent gambling doesn't necessarily lead to adult gambling, gambling becoming problematic in adults is more likely the earlier the gambling started (Ledgerwood and Petry, 2004). The evidence suggests that mental health conditions and gambling need to be treated in an integrated fashion (Lubman, et al. 2017). It is therefore critical that mental health services screen for problem gambling, and for gambling services screen for or refer to, mental health services. Because only a minority of people seek help for their gambling issues, a suicide attempt may be the first time a problem gambler has come into contact with services. Gambling and suicide Gambling-related suicide represents the most extreme form of self-harm, which adversely impacts the gambler, their family, friends, treatment providers and the broader community by way of grief and loss, stigma, shame, vicarious trauma and loss of human potential. The relationship between problem gambling and co-morbid mental health and psychosocial issues, including suicidal ideation, is well established (Browne et al. 2016). The Victorian Suicide Prevention Framework (VSPF, 2016-2025) notes that the grief, loss, stress, and vicarious trauma experienced by those close to the suicidal completion can subsequently increase that person's vulnerability to suicidality. Victoria's State Coroner Judge, Ian Gray, released a coronial report in 2013 citing that from 2002-2012, 128 Victorians took their own lives due to gambling addiction; he further identified Electronic Gaming Machines (EGM) as a significant contributing factor (Coroners Court of Victoria, 2013). The Australian Productivity Commission has estimated that the cost of gambling-related suicide attempts were seventy to one hundred and seventeen million dollars per annum, with the further costs to the immediate family rising to one hundred and sixty dollars million dollars per annum (Productivity Commission, 1999). Research shows that, compared to the rest of the population, completed suicide and suicidal ideation are higher amongst problem gamblers (Ledgerwood and Petry, 2004). A United Kingdom study examining treatment-seeking gamblers found that approximately 30% of individuals accessing treatment had attempted suicide (Sharman et al. 2019). Additionally, compared to patients with substance abuse issues, the rates of suicidal ideation are significantly higher among problem gamblers (Manning et al 2015). Furthermore, a study involving the Hong Kong coroner's court files (n=1201) consisting of 1201 suicide completions, found that 233 (19.4%) of these individuals displayed gambling behaviour prior to taking their own lives; 110 of these gambling suicides (47.2%) consisted of individuals who were indebted as a result of their gambling behaviours (Wong et al 2010). Black, et al. (2015) demonstrated that suicidality is an indicator of more severe gambling problems. In addition, their study found that children of problem gamblers had higher rates of suicide than children of controls, powerfully demonstrating the ripple effects of suicide harm. "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"Trauma and Gambling The Victorian Gambling Prevalence Study found that 70% of adults had gambled in the previous 12 months and 0.8% met criteria for problem gambling. Harms associated with problem gambling are immense, and include damage to relationships (e.g. relationship conflict or breakdown), emotional and psychological distress (e.g. feelings of failure

worthlessness, extreme distress and vulnerability), health (e.g. self-harm, loss of sleep), financial (diverted finances, bankruptcy) and other (e.g. criminal justice system involvement) impacts. Research has examined factors that contribute to the onset and maintenance of problem gambling and the effectiveness of intervention aimed at reducing drivers of (e.g. venue access, gambling urge, distorted thoughts about gambling, loneliness) and consequences of problem gambling (e.g. family conflict, poverty, psychological distress and suicidality). The Pathways Model of Gambling has emerged as an important theoretical framework for understanding why gambling becomes a problem. Three subtypes of problem gamblers were identified: 1) behaviourally conditioned (BC); 2) emotionally vulnerable (EV); and 3) antisocial/impulsivist (AI). Identified within each path are vulnerability factors (e.g. poor coping skills and presence of emotional distress in path 2; reduced behavioural control in path 3) which predispose individuals towards problem gambling. A recent study of 150 non-treatment-seeking problem gamblers not only confirmed the presence of these sub-types, but also found differences in trauma and psychiatric history and willingness to engage in problem gambling treatment. AI and EV subtypes had significantly greater childhood trauma histories, as well as higher rates of lifetime mood, anxiety and substance dependence diagnoses. People in the EV group were most likely to report coping motives for gambling as well as current interest in problem gambling treatment. The importance of treatment and support was also highlighted with 1 in 4 in the EV group having experienced gambling-related suicidal ideation or attempt. A recent systematic review highlighted the consistency with which childhood maltreatment is associated with problem gambling. Gambling problems were found to be more likely in 6 of 7 studies measuring sexual abuse, 4 of 5 studies measuring physical abuse and 2 of 3 studies measuring neglect. However, these differences were in most cases no longer significant after controlling for other mental disorders highlighting the potential for childhood maltreatment experiences to first cause other mental disorders which in turn contribute to the onset of gambling problems (consistent with AI and EV problem gambling subtypes). Three studies also found that problem gamblers were more likely to engage in child abuse and neglect, highlighting the potential for inter-generational effects with the children of problem gamblers at higher risk of childhood maltreatment. A recent study in one problem gambling clinic in Melbourne, Australia, suggested the potential for trauma-related personality changes to contribute to more severe gambling problems and consequences. In 150 consecutive treatment seekers, 43% screened positive for a personality disorder. These individuals also displayed greater problem gambling severity, psychological distress and work/social problems. While this study measured trauma symptoms, the nature and timing of adverse childhood or other trauma experiences were not measured. Whether particular adverse childhood experiences impact most strongly on altering personality or the development of interpersonal and coping or emotion regulation processes that are often impaired in personality disorder is unclear. Similarly, whether protective or resilience mechanisms are present in people with complex trauma experiences who do not develop problem gambling is also unclear. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

N/A

What are the needs of family members and carers and what can be done better to support them?

N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"Conclusion It is clear that the nexus between problem gambling, mental health conditions and suicidal ideation is inextricably linked. Moreover this cluster of conditions drives behaviour with significant and lasting harms to the individual and any number of affected others to varying degrees. Given the strong link between problem gambling and suicidality, it is important that specific interventions are devised to respond to these individuals' needs. For example, work by Lubman et al. (2017) suggests that problem gambling typically precedes and predicts the onset of other mental health conditions, suggesting that it has the potential to complicate treatment plans and hamper treatment outcomes(Lubman et al, 2017). There is therefore a pressing need to develop and more effective interventions and ways of working closely between the services so that people receive effective and timely support in all their areas of need co-currently. This is a specialised and complex cohort, to ensure that the harm from gambling and mental health co-morbidities are reduced and addressed presevention, intervention and support needs to start early. Majority of referrals to PG&MHP would not be deemed as severe enough with mental health acuity to be seen within the traditional mental health teams which are already stretched to capacity. Time and resources need to be created to meet the needs of clients at times when they request in with flexibility and adaptability to work with the client and the other support supports the clients already have in place. Ongoing gambling behaviour and mental health conditions need to be treated effectively and sustainably in collaboration with all services. To begin with Gambling and other Process addictions need to be provided with the same importance and equal weight as all other mental health conditions. Currently majority of Mental Health Clinicians are not even asking about gambling and the risk of not exploring this area can be devasting to individuals, affected others and a large burden of harm to society. Observations I have the benefit in me current role to travel across the state and see the interplay between public Mental Health Service, Private Mental Health, D&A and Community Services and Gamblers Help. Weather Metro, Regional or Rural I notice similarities. Unfortunately a hierarchy seems to have developed and instead of all services sectors working together and valuing what each has to offer, Mental Health services appear to be busy closing there door to various diagnosis's, not open to exploring different ways of working which could also reduce workload for all and add to better outcomes for clients if services were flexible, with a true open door policy. Statistics show that 75% of Continuing Care Mental Health referrals are for psychotic disorders. I see every day how stretched all the services are and also see how creative rural settings often have to be to meet demand. Yet until we see radical structural and cultural change and acceptance of all mental health problems and address contributing factors leading to severe unwellness starting with collaboration from all the funding bodies and decrease working in Solos I fear change will continue to be difficult. The teams where I do tend to feel there is more progress are the smaller teams which work closely in collaboration with other services or in strong partnership arrangements and also work closely which where the client is at and with community. I think if the great work for farmers mental health project along the great ocean road region, some of the new suicide prevention programs operating and how some of the HOPS teams work. I do wonder whether times have changed and that it is time to see an end to the Continuing Care teams for newer more collaborative ways of working and also easier cross overs when people meet age cut off for services or move catchment areas. I would like to also see clients given more choice in the type of programs / treatment options they are provided. Allowing people to choice services based on models and evidence based practice. Some areas are offering Open Dialogue, some offer a DBT Program, some offer MBT yet all these are often area bound and not open to all clients to decide. The private sector is often unobtainable to clients due to high gap payments and Private Clinicians not wanting to accept some clients it

would be great to explore increased linkage and working together with the private sector. This may also need increased collaboration between Commonwealth and State funding bodies. Thank you for the opportunity to submit some thoughts, and if possible I would value an opportunity to be involved in any think tank opportunities in the development of a new Mental Health Service that address all levels of Maslows Hierarchy of Needs and sees services and people working together. I am happy to be contacted at any time. [redacted]. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
see below

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
I wrote my answers all in a report yet to be able to submit on this system I had to break into sections. I could submit as one if you print each section in will read as a report

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
" References American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC. Blaszczynski, A, Anjoul, F, Shannon, K, Keen, B, Pickering, D and Wieczorek, M (2015). Gambling Harm Minimisation Report. Commissioned by NSW Government Department of Trade & Investment Office of Liquor, Gambling and Racing. Retrieved from https://www.responsiblegambling.nsw.gov.au/__data/assets/pdf_file/0020/138116/gambling-harm-minimisation-report.pdf 12 May 2019. Browne, M, Langham, E, Rawat, V, Greer, N, Li, E, Rose, J, Rockloff, M, Donaldson, P, Thorne, H, Goodwin, B, Bryden, G & Best, T (2016). Assessing gambling-related harm in Victoria: a public health perspective, Victorian Responsible Gambling Foundation, Melbourne. Retrieved from https://responsiblegambling.vic.gov.au/resources/publications/assessing-gambling-related-harm-in-victoria-a-public-health-perspective-69/ 15 April 2019. Cook, S, Turner, N, Ballon, B, Paglia-Boak, A, Murray, R, Adlaf, E, Ilie, G, den Dunnen, W and Mann, R (2015). Problem gambling among Ontario students: Associations with substance abuse, mental health problems, suicide attempts, and delinquent behaviours Journal of Gambling Studies 31: 1121-1134. Doi 10.1007/s10899-014-9483-0 Coroners Court of Victoria (2013). Data Summary: Coroners prevention Unit. Gambling-related suicides, 2000-2012. Retrieved from https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/cpu%2Bdata%2Bsummary%2B-%2Bgambling%2Brelated%2Bsuicides%2B-%2B10%2Bsep%2B2013.pdf 6 May 2019. Gainsbury, S. (2012). Internet gambling: Current research findings and implications. New York: Springer. Hare, S. (2015). Study of gambling and health in Victoria: Findings from the Victorian Prevalence Study 2014. Melbourne: Victorian Responsible Gambling Foundation and Victorian Department of Justice and Regulation. Hing, N, Russell, A, Nuske, E, and Gainsbury, S. (2015). The stigma of problem gambling: Causes, characteristics and consequences. Melbourne: Victorian Responsible Gambling Foundation. Retrieved from

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Submission to the Mental Health Royal Commission from [redacted].

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Often I hear stories of Services trying to refer clients, being turned away from Mental Health Services and Gambling is not seen as "core business", or hear mental health clinicians saying that they have no gamblers on their case load yet then identify that they have never actually asked the question. I have seen people stop taking medication due to financial stress from gambling and this not being identified till people have experienced several hospital admissions due to relapse in mental health illness due to having no medication.

Gambling Disorder and its co-morbidity with mental health is large and needs to be addressed and acknowledged within the Mental Health field and services need to truly work holistically and combine the resources of all services. In this submission will demonstrate some of the impacts of gambling behaviour and mental health.

Gambling in Australia

In Australia, gambling is a culturally acceptable and popular leisure activity (Gainsbury 2012). Although the majority of people gambling recreationally with few serious harms, there are small percentage of individuals who experience significant harm due to their gambling. The industry heavily promote gambling as a pleasurable pastime and State governments, while providing extensive regulation of the activity, continue to support the liberalization of gambling because they derive a significant amount of taxation from it. An estimated 70% of Victorian adults have gambled in the past year (Lubman et al, 2017), while estimates from the Victorian prevalence survey are that 0.8% of adults fit the criteria for problem gambling, (Hare et al, 2015).

Gambling harm

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- Health
- Fewer Leisure activities
- Critical incidents
- Education and Employment
- Social
- Financial
- Psychological.

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The Ottawa charter delineates 5 domains for effective public health interventions. Working across these domains, effective, evidence-based interventions must recognising the complex interplay between the determinants of health and our collective behaviours. In recognising the wider harms which accrue to problem gambling behaviours, addressing the most serious harms should have ripple effects on public health through decreased harm to the gambler and decreased harm to affected others. Of particular concern is the intergenerational impact of gambling harms on the children of problem gamblers

Gambling and mental health

In addition to financial and other harms which arise from problem gambling, the correlation between gambling and other comorbidities such as addiction, mental health issues, social impairment and other issues such as homelessness is well established. Co-morbid mental health disorders include alcohol and other drug use disorders, mood, anxiety, impulse control and personality disorders. The contribution of gambling itself is difficult to isolate and measure (Browne, et al. 2016), and it is likely that causal pathways may work in both directions, with problem gambling leading to mental health conditions such as anxiety and depression, while pre-existing conditions such as impulse control disorders may exacerbate gambling behaviours (Lubman, et al. 2017). It is

likely that co-morbid gambling problems and mental health conditions may compound the harms experienced by this cohort of the population. A recent study conducted in Melbourne found that approximately 17% of people presenting to Alfred Health crisis or emergency mental health services were also experiencing problem gambling (Lee et al. 2012). This study led to the development of the Statewide Problem Gambling and Mental Health Partnership as mentioned above, designed specifically to meet the needs of this complex group. Yet only funded for 2.5 FTE of a Multi-disciplinary team to cover the state of Victoria.

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Gambling and suicide

Gambling-related suicide represents the most extreme form of self-harm, which adversely impacts the gambler, their family, friends, treatment providers and the broader community by way of grief and loss, stigma, shame, vicarious trauma and loss of human potential. The relationship between problem gambling and co-morbid mental health and psychosocial issues, including suicidal ideation, is well established (Browne et al. 2016). The Victorian Suicide Prevention Framework (VSPF, 2016-2025) notes that the grief, loss, stress, and vicarious trauma experienced by those close to the suicidal completion can subsequently increase that person's vulnerability to suicidality. Victoria's State Coroner Judge, Ian Gray, released a coronial report in 2013 citing that from 2002-2012, 128 Victorians took their own lives due to gambling addiction; he further identified Electronic Gaming Machines (EGM) as a significant contributing factor (Coroners Court of Victoria, 2013). The Australian Productivity Commission has estimated that the cost of gambling-related suicide attempts were seventy to one hundred and seventeen million dollars per annum, with the further costs to the immediate family rising to one hundred and sixty dollars million dollars per annum (Productivity Commission, 1999).

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Trauma and Gambling

The Victorian Gambling Prevalence Study found that 70% of adults had gambled in the previous 12 months and 0.8% met criteria for problem gambling. Harms associated with problem gambling are immense, and include damage to relationships (e.g. relationship conflict or breakdown), emotional and psychological distress (e.g. feelings of failure worthlessness, extreme distress and vulnerability), health (e.g. self-harm, loss of sleep), financial (diverted finances, bankruptcy) and other (e.g. criminal justice system involvement) impacts.

Research has examined factors that contribute to the onset and maintenance of problem gambling and the effectiveness of intervention aimed at reducing drivers of (e.g. venue access, gambling urge, distorted thoughts about gambling, loneliness) and consequences of problem gambling (e.g. family conflict, poverty, psychological distress and suicidality). The "Pathways Model of Gambling" has emerged as an important theoretical framework for understanding why gambling becomes a problem. Three subtypes of problem gamblers were identified: 1) behaviourally conditioned (BC); 2) emotionally vulnerable (EV); and 3) antisocial/impulsivist (AI). Identified within each path are vulnerability factors (e.g. poor coping skills and presence of emotional distress in path 2; reduced behavioural control in path 3) which predispose individuals towards problem gambling. A recent study of 150 non-treatment-seeking problem gamblers not only confirmed the presence of these sub-types, but also found differences in trauma and psychiatric history and willingness to engage in problem gambling treatment. AI and EV subtypes had significantly greater childhood trauma histories, as well as higher rates of lifetime mood, anxiety and substance dependence diagnoses. People in the EV group were most likely to report coping motives for gambling as well as current interest in problem gambling treatment. The importance of treatment and support was also highlighted with 1 in 4 in the EV group having experienced gambling-related suicidal ideation or attempt.

A recent systematic review highlighted the consistency with which childhood maltreatment is associated with problem gambling. Gambling problems were found to be more likely in 6 of 7 studies measuring sexual abuse, 4 of 5 studies measuring physical abuse and 2 of 3 studies measuring neglect. However, these differences were in most cases no longer significant after controlling for other mental disorders highlighting the potential for childhood maltreatment experiences to first cause other mental disorders which in turn contribute to the onset of gambling problems (consistent with AI and EV problem gambling subtypes). Three studies also found that problem gamblers were more likely to engage in child abuse and neglect, highlighting the potential for inter-generational effects with the children of problem gamblers at higher risk of childhood maltreatment.

A recent study in one problem gambling clinic in Melbourne, Australia, suggested the potential for trauma-related personality changes to contribute to more severe gambling problems and consequences. In 150 consecutive treatment seekers, 43% screened positive for a personality disorder. These individuals also displayed greater problem gambling severity, psychological distress and work/social problems. While this study measured trauma symptoms, the nature and timing of adverse childhood or other trauma experiences were not measured. Whether particular adverse childhood experiences impact most strongly on altering personality or the development of interpersonal and coping or emotion regulation processes that are often impaired in personality disorder is unclear. Similarly, whether protective or resilience mechanisms are present in people with complex trauma experiences who do not develop problem gambling is also unclear.

Conclusion

It is clear that the nexus between problem gambling, mental health conditions and suicidal ideation is inextricably linked. Moreover this cluster of conditions drives behaviour with significant and lasting harms to the individual and any number of affected others to varying degrees. Given the strong link between problem gambling and suicidality, it is important that specific interventions are devised to respond to these individuals' needs. For example, work by Lubman et al. (2017) suggests that "problem gambling typically precedes and predicts the onset of other mental health conditions, suggesting that it has the potential to complicate treatment plans and hamper treatment outcomes"(Lubman et al, 2017).

There is therefore a pressing need to develop and more effective interventions and ways of working closely between the services so that people receive effective and timely support in all their areas of need co-currently. This is a specialised and complex cohort, to ensure that the harm from gambling and mental health co-morbidities are reduced and addressed presevention, intervention and support needs to start early. Majority of referrals to PG&MHP would not be deemed as severe enough with mental health acuity to be seen within the traditional mental health teams which are already stretched to capacity. Time and resources need to be created to meet the needs of clients at times when they request in with flexibility and adaptability to work with the client and the other support supports the clients already have in place. Ongoing gambling behaviour and mental health conditions need to be treated effectively and sustainably in collaboration with all services. To begin with Gambling and other Process addictions need to be provided with the same importance and equal weight as all other mental health conditions. Currently majority of Mental Health Clinicians are not even asking about gambling and the risk of not exploring this area can be devasting to individuals, affected others and a large burden of harm to society.

Observations

I have the benefit in me current role to travel across the state and see the interplay between public Mental Health Service, Private Mental Health, D&A and Community Services and Gamblers Help. Weather Metro, Regional or Rural I notice similarities. Unfortunately a hierarchy seems to have developed and instead of all services sectors working together and valuing what each has to offer, Mental Health services appear to be busy closing there door to various diagnosis's, not open to exploring different ways of working which could also reduce workload for all and add to better outcomes for clients if services were flexible, with a true open door policy. Statistics show that 75% of Continuing Care Mental Health referrals are for psychotic disorders. I see every day how stretched all the services are and also see how creative rural settings often have to be to meet demand. Yet until we see radical structural and cultural change and acceptance of all mental health problems and address contributing factors leading to severe unwellness starting with collaboration from all the funding bodies and decrease working in Solos I fear change will continue to be difficult. The teams where I do tend to feel there is more progress are the smaller teams which work closely in collaboration with other services or in strong partnership arrangements and also work closely which where the client is at and with community. I think if the great work for farmers mental health project along the great ocean road region, some of the new suicide prevention programs operating and how some of the HOPS teams work. I do wonder whether times have changed and that it is time to see an end to the Continuing Care teams for newer more collaborative ways of working and also easier cross overs when people meet age cut off for services or move catchment areas.

I would like to also see clients given more choice in the type of programs / treatment options they are provided. Allowing people to choice services based on models and evidence based practice.

Some areas are offering Open Dialogue, some offer a DBT Program, some offer MBT yet all these are often area bound and not open to all clients to decide.

The private sector is often unobtainable to clients due to high gap payments and Private Clinicians not wanting to accept some clients it would be great to explore increased linkage and working together with the private sector. This may also need increased collaboration between Commonwealth and State funding bodies.

Thank you for the opportunity to submit some thoughts, and if possible I would value an opportunity to be involved in any think tank opportunities in the development of a new Mental Health Service that address all levels of Maslows Hierarchy of Needs and sees services and people working together. I am happy to be contacted at any time.

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