

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

Organisation Name

N/A

Name

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What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

"Individuals with serious mental health conditions die approximately 25 years earlier than the general population, and the cause of this early death is largely owing to medical illness that can often be attributed to substance use disorders. In addition to early mortality, the severity and prognosis of the primary mental illness are worsened in the context of substance dependence and higher presentations to Emergency Departments and increased frequency of admissions to acute Inpatient MH services. People with dual diagnosis (co-occurring mental health-substance use) have poorer access to treatment because of 'dual stigma' the stigma associated with their substance use and the MH issues they are experiencing. There is an anxiety and reluctance amongst many mental health clinicians about identifying substance use problems e.g. stigma associated with substance use, lack of confidence or sense of competency in integrated treatment and sometimes a misguided belief that it is not their role to address substance use issues with their consumers -the latter often as a result of increasing pressure to prioritise limited resources and increasing caseloads. Stigma is an issue and it is multiplied when it comes to dual diagnosis but going a bit deeper - one likes to fail. Our workforce and our funders want success. The measurement of these needs to be considered because when we are working with this group, we know that outcomes take longer, you need more persistence and often this group responds slowly, despite this there is evidence that consumers can successfully move into recovery. Workers can feel demoralised (like they are not making a difference - leading to a sense of therapeutic nihilism) and funders frustrated - waste of money! So it's not surprising services want to avoid treating when they know the outcome may not be forthcoming in the short term (which is the framework they are expected to work within). It's not necessarily only stigma but avoidance. Furthermore outcome measures need to be really carefully crafted. For example abstinence and reduced use of substances are great indicators, however they are limited. Health impacts and general life satisfaction, other goals etc. are all an important indicator for treatment being effective. It would be sad if efficacy became tied only to quantitative measures. There is often a lack of basic understanding amongst MH staff of alcohol and other drugs and related issues leading to missed opportunities for risk management and interventions resulting in increased readmission rates, possible accidental drug overdose and an increased burden on health services. This stigma is further compounded by community bias, prejudice and misinformation based on sensational reporting by media around incidences involving people with MH and substance use issues. There is a need for community education around the issues associated with MH & Substance use. School programs, positive media campaigns and other targeted community awareness programs. Changes to Workforce training and service system structures will also help change attitudes and cultures within MH service systems and reduce the stigma associated with providing service to people with both MH & Substance use issues. These initiatives should also address the issue of diagnostic overshadowing - focus on the mental health or and substance use diagnosis but not physical health needs. People living with a mental illness have poorer physical health yet receive

less and lower quality health care than the rest of the population. Some estimates suggest that up to 75% of people with substance abuse problems may also have a mental health issue (Department of Health and Human Services [DHHS], 2017). The DHHS has suggested that a typical person with a dual diagnosis (DD) is likely to be alienated and lack support from family and friends, and have difficulty engaging with siloed single issued focused health care providers. There are several problems associated with the current systems approach to DD. These include but are not limited to: Temporal precedence (i.e., did the mental health issue precede the substance abuse problem, or vice versa), Integrated treatment can be difficult (e.g., the person with a DD might be treated through disparate systems, which can impede treatment and diagnosis), and The number of workers trained in DD is limited. These findings do not consider the difficulties faced by members of minority groups who have a DD. For example, it is known that Aboriginal Australians experience significantly higher levels of comorbidity than non-Indigenous Australians, but engage with primary healthcare services at lower than expected levels. Thus, the issues faced by those with a DD (e.g., lack of support) may be compounded in Aboriginal Australians and other minority cultural and marginalised groups. Recommendations around stigma: The area of stigma around MH, and even more so for people with MH and substance use issues is such an enduring and significant issue for service users, their families and service providers and the community at large that we feel there needs to be targeted recommendations from the Commission that Resources and funding dedicated programs & packages to tackling stigma Targeted programs for Service users and their families Programs, supports and a dedicated (funded and incentivised + dedicated EFT) approach to encourage service providers to ensure they address attitudes and cultures in services to better address stigma issues from a service delivery frame of reference. Targeted Programs for the Community in particular working closely with media; social media; and community agencies and services that can exert a change of attitude. All these areas should include a stream that deals with the dual stigma experienced by people who have both substance use issues and MH the dual stigma. "

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?

"The early intervention and prevention around MH has been a neglected area in recent years. The school programs and other community activities and resources that used to exist have been cannibalised to provide more funding and resources to the acute, hospital / bed based services or have been defunded. There is a need for more early childhood, family and community supports that are targeted at preventative work around vulnerable communities and /or populations. Their goal should be to create increase awareness around improving MH with a whole of population approach linked in with schools /education, councils, welfare, community and all service sectors. Specific programs should be promoting an increased awareness of the bi-directional links between MH & AOD (and vice versa). The CODA model developed as part of the harris Project' in New York is an example of a school based program that could be considered. - #CODAConnects and empowers youth to save lives | theharrisproject.org Co-occurring disorders (COD), the combination of 1 or more mental health challenges and substance misuse and/or addiction, Some of the Area MH services have introduced PACER teams; some have suicide prevention teams (HOPE) and more recently there has been additional funding provided for Acute MH services to provide Intensive, targeted support and evidenced based interventions for clients within their services who have been having frequent admissions or exhibiting little improvement over the past year. Where service elements, such as PACER, HOPE, PARC are present and linked up into a model of care the clients receive a better level of care access can still be an issue, but once in the service clients appear to have a more wrapped around and supportive model. However once

again if the client has co-occurring substance use issues this often excludes them from accessing these service streams i.e. some of the suicide prevention teams exclude people where substance use in part of the reason they presented with a suicide attempt. Currently there is an emerging trial at 6 sites across Vic. to introduce a Hub in 6 emergency departments to provide targeted support to people presenting with acute MH & Substance use issues (see VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2017/18, for details). Although this is not yet proven to be an effective model or intervention it would appear to be a step in the right direction, bringing together combined AOD & MH focused interventions and supports. The stepped care programs such as PARC have also been a worthwhile development in the past 10 years; however these programs are under threat due to the introduction of NDIS for MH clients which has had a huge impact on the MHCSS who often provide the operational components to these PARC's. Although access for people with a DD is often difficult to these sorts of recovery options due to a prerequisite that people are abstinent during their stay. If they do get in their substance use issues are often inadequately managed and supported which often sees them exited early. Some of the PHN's (Eastern PNG) are trialling a stepped care model for MH clients and this is showing some promise and should be looked at as providing a potential framework for a MH model in the future. The recent introduction of two residential Dual Diagnosis rehabs for people with MH & Substance use has been a positive move. These resources need greater investment and a more collaborative, linked up inter sectorial (AOD & MH) framework. In addition there needs to be more than two services as the need in other regional and rural areas is great. These are 12 week programs and consideration should be given to having these extended to 6 months given the complexity of the clients accessing these services. Recommendations for What's working well: We have outlined under this heading a number of elements that exist in the current MH service system that provide good care and support to people with MH issues. If these elements are to be effective they need to be linked up under a well-articulated model of care. This model of care needs to be applied state wide and not left to the local interpretation at each area MH service. These models of care must be integrated with the other sectors such as AOD & Primary health and Welfare with shared care planning and joint interventions been encouraged, rewarded and expected (KPI'ed). A top down (from DHHS), well-articulated plan with clear governance processes and mechanisms and well defined reportable KPI's should inform this approach. The models of care and frameworks chosen must be inclusive of people with MH & Substance use. These models must reflect a capacity to provide active engagement, support and treatment for this group. "

What is already working well and what can be done better to prevent suicide?

"As stated above the introduction of suicide prevention teams has had a positive impact for people presenting to ED's or acute MH services following a suicide attempt. These services can provide bridging support and link people to ongoing supports and case management if deemed necessary. However, the exclusion of people with substance use remains an ongoing concern as they are over represented in people who suicide. Advanced Suicide Assessment and Planning (ASAP) is a practical training and education package that was initially developed in NSW and adopted within Victorian Mental Health. It has a strong focus on complexity including client who experience Dual Diagnosis. The training is evidence based and peer reviewed and currently forms the major platform for suicide prevention delivered by the training cluster, i.e. the Western Training Cluster. Recommendations around Suicide (working well): This area needs to address the inequities related for people who present with mental health and substance use. The suicide prevention model needs to have models, frameworks and staff trained in responding and providing service where DD is present (not all MH services appear to have accessed to or utilised the ASAP training above). As suicide and suicidal behaviour is also a significant issue in people accessing the AOD

service system an integrated AOD & MH cross-sector service, comprised of a blended team of MH and AOD service providers, supported and informed by Peer workers (LEW), both consumers and Carers would be a good innovation. PACER could also be extended to include AOD focus rather than just mental health. "

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.

"The current structure, threshold for service provision, catchment criteria and location of acute MH services make it extremely difficult for clients, carers and service providers alike to access and navigate the system I would also refer you to the VAGO - Access to Mental Health Services report (March 2019). The central intake hubs & triage processes act as a gate-keeper designed to reduce access to only those in imminent danger it doesn't provide support and direction to those deemed not acute enough or with Serious mental health issues (Psychosis). This is in part due to the pressure on an already over-extended acute MH services (Victorian Auditor General's Report 2019). Clients with substance use issues who attempt to access through these central intake hubs are often automatically rejected on the basis of their comorbid substance use issues often told to deal with their substance use issues before accessing the MH service system. As a result of these barriers many people wanting or needing support turn up to, or are sent to Emergency departments attached to their local hospitals. The emergency departments are extremely busy, high stimulus areas which can often aggravate the underlying issue that led to the person presenting there in the first place. This coupled with extended waiting periods often leads to people leaving without accessing MH input. If the person present intoxicated or with a history of substance use, they are often poorly assessed and discharged as it is deemed to be a drug related issue and not a mental health issue. When discharged often the family / carers are not notified and no follow-up or linkage provided some clients are given a number to call (direct Line). If the MH service system had dedicated assessment Hubs that could assess and support people needing mental health support, not just those in crisis then this more flexible, lower threshold for access to service would reduce the burden on ED's and acute MH services. These hubs should be established (wide distribution across the community) and resourced adequately to provide brief interventions (4 to 6 sessions) for those not requiring case management. The assessment centres should also have the appropriate links to the case management components of the service for those with more acute and long-term needs. These hubs should also have the capacity to provide service to people with substance use and mental health issues. Providing timely and evidenced based brief interventions, treatment and support. The links between the acute MH service system and the follow-up community support services (Primary health, AOD services, welfare etc.) is inconsistent and often very poorly linked up once the acute presentation has been responded to. The need for more integrated and linked up services has been an ongoing challenge in this area, in particular for clients with complex co-morbid mental health & substance use issues. Any future state service system model must have a clearly articulated linked up service system with shared care plans, colocation- where and when possible; cross sector collaborations that are KPI'ed for all sectors. The issues and recommendations we have sited around stigma and access and workforce development will assist in providing a more positive experience for people accessing MH services. An increased Lived Experience workforce (LEW) element will go a long way to improving the experience of consumers and families accessing MH services as well. The information we have included around the service system changes that would reduce siloing and improve community access will also help address some of these challenges related to poor service linkage and shared care, which should sit at the heart of any integrated service system.

Development of a new frameworks common language include a focus on positive mental health rather deterministic, deficit oriented and largely pessimistic miasma created by using an exclusively biogenetic model to explain mental disorders. Promotion and inclusion of experiential knowledge and advocacy from service users, supported later by sound qualitative research. Mental illness is like any other medical illness: a critical examination of the statement and its impact on patient care and society. Ashok Malla, Ridha Joober, Amparo GarciaJ Psychiatry Neurosci. 2015 May; 40(3): 147150. doi: 10.1503/jpn.150099 PMID: PMC4409431
Recommendations: The need for more integrated and linked up services has been an ongoing challenge in this area, in particular for clients with complex co-morbid mental health & substance use issues. Any future state service system model must have a clearly articulated linked up service system with shared care plans, colocation- where and when possible; cross sector collaborations that are KPI'ed for all sectors. "

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

" When it comes to the issue of people or groups that are over-represented with mental health & substance use issues the following groups have been identified Regional and remote communities Aboriginal communities Older adults Marginalised youth populations CALD communities LGBTI+ Homeless Populations The issues for these populations are stigma, social isolation lack of targeted services -often they are reluctant to engage with mainstream services because of not worthy for service' experiences and difficulties navigating how to access the service system. Poverty, lack of or inappropriate housing, unemployment and other social issues also impact these populations more so than the general population. Recommendations: We would recommend targeted programs for these specific populations. The need for a more flexible and assertive engagement (the service system outreaches and actively engages) of these populations is key to ensuring they have their mental health & substance use needs addressed in an integrated manner, with integrated service delivery modalities that address both issues at the same time. Allocating of and prioritising access to housing and community supports is important. Training and upskilling of the workforce tasked with providing targeted programs, is essential. Ensuring that the services delivered are evidenced based, practical and not as time limited or restrictive for access as current MH and AOD services are. "

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

"Services should have dedicated policies and procedures for working with DD carers that includes seeing carers as part of the treatment team and involving them wherever relevant and appropriate. The inclusion of Lived experience workers in the workforce across all elements of the service system should be a goal for the future MH service (see The strategy for the family carer mental health workforce in Victoria'). Currently there are many service providers (Nurses, doctors, allied health) who have lived experience as either carer or consumer, or both. However, the culture is such in MH services that this experience is heavily stigmatised and a barrier to people's professional growth if they disclose this lived experience. This culture needs to be changed and the lived experience of the workers should be both valued and celebrated. Having lived experience could be written into the selection criteria and duty statements of potential new staff and seen as a strength rather than a deficit. Further supports and education for Carers to assist them to better understand and manage as well as be able to navigate and advocate on behalf of their loved ones (an intentional Peer support program for carers and resources such as Carers can Ask

<https://www.svhm.org.au/our-services/departments-and-services/n/nexus/carers-can-ask>). Inclusion of carers in treatment & care meetings and discharge planning should be mandatory. Recommendations: Dedicated resources and supports for carers should also be made available (the CMHL will have dedicated LEW resources available) and again an assertive arm for family support developed rather than wait for families to make contact the service should be actively reaching out to them with offers of education, support and linking them to financial supports if necessary. Meeting with them in their homes and in the community rather than in a formal IPS environment would be preferable. "

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

"The Graduate and post graduate tertiary training programs/ curriculums for MH Nursing and allied health have fallen behind what industry is experiencing and working with in the workplace. The challenges facing workers in their frontline settings are related to dealing with complex presentations that have significant substance use issues as a key component as well as other complex psycho-social challenges, housing and physical health issues etc. The move away from having specialist MH degrees for nurses and other allied health disciplines and an insufficient focus on providing service to people with complex needs (which include substance use / addiction) has had an impact on the MH workforce confidence, skill and capacity to work effectively once they graduate. Many graduate or post graduate programs have these essential elements of Dual diagnosis and complex care as an elective only or in some instances are not available to people going through these programs. In line with the National practice, standards for the mental health workforce 2013 future MH Workforces should be component to provide the following in relation to people presenting with comorbid mental health & substance use issues: Recognises the effects of intoxication and withdrawal from alcohol and other drugs and facilitates or conducts appropriate screening or assessment when necessary (p.15) Sensitively explores issues related to drug and alcohol use (including prescription medications), exposure to trauma, grief/loss, violence, sexuality, sexual health, sexual identity, gender identity and intimate relationships (p.16) Identifies the possible impacts of a family member's or caregiver's disability, mental health or drug and alcohol problems on the person and other family members Standard 9: Integration and partnership: People and their families and carers are recognised by mental health practitioners as being part of a wider community, and mental health services are viewed as one element in a wider service network. Practitioners support the provision of coordinated and integrated care across programs, sites and services (p.18). Inclusion of and investment in Working with DD carers & consumers as part of the workforce Peer working models Create and promote dual diagnosis nurse practitioner roles and other DD specialist roles within the workforce ensure adequate numbers of DD specialists as standalone positions burn out. The establishment of the Centre for Mental health learning is a positive step forward in providing a focal point for service providers to be aware of and able to get access to a variety of training and education opportunities to further develop their knowledge, skills and confidence in key service delivery areas e.g. Trauma informed care; Working with Dual Diagnosis; Working with carers etc. There is a complete paucity of Addiction Psychiatrist expertise within mental health services across Victoria, in comparison to New South Wales, to assist with and support dual diagnosis specific interventions. A significant number of consultant psychiatrists and registrars are reluctant to initiate opiate replacement therapies stemming from an anxiety about prescribing the drug and a lack of training. This is an area requiring more prioritization and development, including the establishment of clinical positions and career pathways for Psychiatrists and Medical staff. Emergency departments have recently been funded to provide AOD input but are not necessarily linked to the Mental Health Services in

the ED. There is an Addiction Medicine Department at some metropolitan hospitals which sits separately to Mental Health and the relationship between the two is often very poorly articulated if both are present a clearly articulated framework for supporting consumers and improving outcomes for DD clients accessing the service should be developed and expected by the DHHS. Due to the identified gap in DD Consultant Psychiatrist who are also addiction medicine specialist there is a requirement for DD Nurse Practitioners (NP) to undertake taken the role of prescribing opiate replacement medication in the rural and regional areas of Victoria. Further, the separate DHHS funding for metropolitan-based DD Consultants Psychiatrists attached to metro DD teams needs to be extended to regional DD programs and their regional hospitals. This separation of funding and training needs to be actively addressed. This will help to improve service delivery and enhance treatment practices and outcomes for consumers and their families/carers/ supports. Currently there is a move towards increasing the profile of the Lived Experience workforce and the following strategies under the stewardship of a cross sector reference group should pave the way for the emerging Lived Experienced workforce (LEW), both consumer and carers. Lived experience workforce strategies: Stewardship and roles and responsibilities The Victorian lived experience workforce strategies comprise: The strategy for the consumer mental health workforce in Victoria The strategy for the family carer mental health workforce in Victoria A strategy for the alcohol and other drug (AOD) peer workforce in Victoria Stewardship of these strategies is held collectively by the Centre for Mental Health Learning (CMHL); The Victorian Mental Illness Awareness Council (VMIAC); Tandem; the Carer Lived Experience Workforce Network (CLEW); The Self Help Addiction Resource Centre (SHARC); The Bouverie Centre; the Centre for Psychiatric Nursing (Melbourne University); Mental Health Victoria; and the Department of Health and Human Services. These agencies, contributing to a Lived Experience Workforce Strategies Stewardship Group will: Advocate for, promote and support lived experience workforce. Identify and drive opportunities to progress toward the vision of the strategies. Identify, create or advocate for funding opportunities to undertake actions of the strategies. Provide leadership and oversight for implementation of, and progress towards, strategy priorities. A proportion of the MH workforce should be made up of Consumers and carers the Lived Experience Workforce (LEW). This should be between 5 to 10% of the workforce and the strategies alluded to above should inform the development and credentialing of the LEW. These strategies should inform the new generation of LEW and how it should sit in any redesigned or redeveloped MH service system. These three strategies will be launched on 1/7/19 In recent years there hasn't been an expectation that services create and provide dedicated reflective practice spaces for workers. This should be a funded activity in the service system as it reduces burn out; improves clinical governance and strengthens the workforce when done well and frequently. We would encourage Educational institution to have an enhanced focus on evidence based psychological treatments in undergraduate programs including Nursing. There is a growing need for the Development of a regional/rural recruitment and retention strategy. "

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?

"Many of the programs for people with mental health issues have been provided by the MHCSS and the MH services with some input from NGO's and some councils. However often these programs are time limited and have high expectations and do not provide adequate ongoing support to the person with the mental health issue. When the person is identified as having substance use issues as well as mental health concerns often they have been excluded. The changes to psychosocial programs brought about by moving over to the NDIS for the people with

mental health has been profound and very often negative. This area needs a considered examination and clearly articulated response as part of the MHRC. There have been a number of employment programs in MH services for people with MI however the investment and resourcing of these has often been minimal which has led to limited success. It is imperative to have programs that improve community engagement, create a sense of purpose and contribution as well as recognise that some people with serious and enduring mental health conditions will need ongoing support. The issues of stigma identified earlier has led to people with mental health issues been marginalised within the community. Where possible programs should be targeted and working towards including people with mental health conditions into integrated programs with the general community. However, consideration should be given to the possibility that some people would function better in a service stream dedicated to providing them with a highly supported, skills focussed, confidence building with provision of training opportunities before integrating them back into a more mainstream service system. With the introduction on NDIS a number of day and community-based group programs have disappeared. There is a need to provide flexible, tailored and targeted community programs that engage people with mental health issues in a meaningful way. This would include day programs, drop in centres and active outreach services for those isolated due to their mental health issues or social circumstances. These service elements need to be funded well, staffed with highly skilled and trained staff and not seen as something that can be provided by NGO's or other community agencies. It should be an integral part of the MH service system. It needs to be integrated into and linked up with, all the elements of the MH service system and the appropriate community agencies. These programs and staff should have the capacity to work with people who have mental health & substance use issues and the use of substances should not preclude people from accessing these services. "

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?

"In the wake of the 2007 Victorian Dual diagnosis - Key directions and priorities for service development policy, MH made significant gains towards and was internationally recognised for developing a 'No Wrong Door' service system that had developed increased capacity to provide integrated treatment. Unfortunately, many of these gains have been eroded by the reform of the Victorian AOD and MHCSS (formerly PDRSS) systems the rise of competitive tendering and for-profit providers and the advent of the NDIS the increasingly crisis-driven, reactive, bed-based priorities of clinical MH services (at the expense of community-based care and recovery). Mental Health is the most significant under-resourced component of Australia's health care system (Recent Victorian Auditor General's Report into mental Health). To be effective mental health services need to be community-based and should not be subsumed under either General Hospital or Community Health Centre models. The current separation between the mental health and alcohol and other drug sectors has produced a 'silo' mentality. Consideration should be given to placing the mental health services in the community sector as an independent needs-led body (i.e. mainstreaming has driven our MH services towards a restricted, bed-focused model that is ineffective at meeting the needs of people with dual diagnosis and other complexities). This would relieve pressure on emergency departments and provide for a more preventative rather than reactive approach. This would also reduce the siloing between the AOD & MH services. Other Possible Service system changes to be considered when working with DD service users: DHHS and providers to agree pathways of care and routinely measure outcomes which will enable collaborative delivery of care by multiple agencies in response to individual need. Joint working across sectors needs strong, senior and visible leadership underpinned by safeguarding and quality governance arrangements. The establishment of a dual diagnosis withdrawal service

attached to all AMHS. Ideally such a service would be gazetted by AMHS and based close to, or preferably integrated into, existing psychiatric inpatient services. Establishment of intensive outreach teams (that have dual diagnosis capability) across all AMHS. This will be essential due to the longitudinal approach and complexities associated with engaging and working collaboratively with dual diagnosis consumers and their families/carers. All clinical teams to have a DD champion(s) dedicated and trained in dual diagnosis with a remit to inform - the delivery of effective care include a strong therapeutic alliance, therapeutic optimism, and care that reflects the views, needs and priorities on the person and a welcoming No wrong door response when a person presents to services. All Emergency Departments to have a dual diagnosis pathways, models and or/ team supported by an Addiction Psychiatrist. Establishment of a smoking prevention and cessation clinic with access to NRT at each AMHS. Consumer/carers with dual diagnosis lived experience to be integrated into clinical teams across all AMHS sites.

Recommendations: It is essential that there are specific KPI's that make providing DD care a key priority area for service delivery (and not an optional extra). Mental Health service needs a completely new framework, one created around a common language that provides in house environmental, social, psychological and culture models of care that are researched and evidence based and co designed with service users, families and significant others. "

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

"The implementation of any changes to the MH service system should be done in a graduated, stagewise manner informed by Implementation science and evidenced based change management processes. Often when changes are been implemented it has been the expectation that the existing service providers implement these changes with minimal direction, no extra resources or funding and an expectation that they deliver services as usual while implementing the changes. A dedicated team of people should be put together to conduct meaningful consultation and engagement of stakeholders and service providers around the proposed changes to be implemented. This team should be left in place for 3 to 5 years (extended timeline if required). There needs to be a clear top down policy and well-articulated plan endorsed by the Department to provide direction, structure, resources and clear governance around the changes to be made. This needs clearly articulated outcomes and deliverables that will allow the project team, service users and service providers to recognise when they have completed the implementation of these changes and have moved to the delivery phase of the new service system. This should include measuring whether the new changes are improving access and outcomes for consumers and carers and improving their overall mental health and wellbeing. All service providers should follow the one plan rather than allowing each to produce their own interpretation of the change to be implemented. The process for introducing the new changes should be conducted using a co-design, co-production format involving consumers and carers. Some immediate steps that can be taken in preparation for this is the reinvigoration of Inter-sectorial alliance meetings to begin breaking down the silo's Increase in the LEW in as many areas of the current MH service system as possible Establishment of co-design teams comprised of existing service providers, lived experience consumers and carers; community representation from high-risk / vulnerable populations i.e. Regional and remote communities, Aboriginal communities, Older adults; Marginalised youth populations; CALD communities LGBTI+; Homeless Populations "

Is there anything else you would like to share with the Royal Commission?

"Under this heading the additional suggestions and recommendations are not weighted or placed

in any particular order of priority as we believe all these additional ideas are of equal value. Consideration should be given to how each will help improve the MH service system, in particular for people with complex needs where substance use and mental health is a confounding and complicating factor in the persons recovery. Policy Driver: When it comes to addressing the issue of Dual Diagnosis we believe a really good starting point is the Dual diagnosis - Key directions and priorities for service development policy. We would recommend that this Policy be revisited, revised & updated. Additional supports and resources should be put in place to strengthened it and enablers put around it to help it to drive more effective responses for service delivery to people with mental health & substance use issues. This should include KPI's and target not only identification of DD Clients but also provide a focus on responses and interventions. Models of Care should reflect an evidenced based approach to complexity including (but not exclusively) people with comorbid mental health & substance use issues. The Models of care should be supported by quality improvement mechanisms. These QI process should ensure collaboration with people with lived experience, families and team members. The models of care should use tools Eg. www.reasonsforusepackage.com and outcome measures to support, record and monitor improvement in practice and takes steps to address problems in particular with regards to clients accessing services. It should support working in partnership with clients and carers at a service planning and evaluation level to enhance outcomes and ensure greater participation at all level. We need to develop treatment models that are oriented around the expectation that people will have multiple complex needs - at a minimum service models need to have the capacity and capabilities to routinely provide in-house, mono-agency, treatment of both mental health and substance use concerns. A good guide for developing a comprehensive model of care that caters for people with complexity, where substance use and mental health already exists, it is the CCISC model: A Comprehensive, Continuous, Integrated System of Care Model. The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. (Attached is a PDF with more details on this model). Green Fields approach: Another option to consider is Mental Health service needs a completely new framework, one created around a common language that provides in house environmental, social, psychological and culture models of care that are researched and evidence based and co designed with service users, families and significant others. We will never be successful at addressing the needs if we simply create special programs with extra resources we don't have (Dr. Ken Minkoff on Value-Driven Systems Change). Mental healthcare, treatment and housing Exiting acute care into homelessness is self-defeating. Homelessness is not only destructive to a person's mental health, but a lack of suitable accommodation, undermines the provision of subacute and outpatient support required by hospital-leavers. The number of Victorians who have exited mental health facilities into homelessness has grown by 55 per cent since 2012-13. The number of people accessing Victorian homelessness services who report having a mental health issue has increased by 84 per cent in this same period the majority of these will also have substance related issues. The period of transition from a psychiatric hospital into the community is marked by instability and stress. In particular, a lack of housing and poorly coordinated supports mean that many people exiting such facilities do not have their needs adequately met during this time. Mental health hospital discharges who received transitional housing support required 22 fewer psychiatric in-patient bed days per participant the related financial savings eclipsed the cost of providing this support. Consumers' living conditions also improved. It is essential that housing for DD clients is a priority area for the MHRC to focus on.

Mental health hospital discharges who received transitional housing support required 22 fewer psychiatric in-patient bed days per participant the related financial savings eclipsed the cost of providing this support. Consumers' living conditions also improved. It is essential that housing for DD clients is a priority area for the MHRC to focus on. This is especially, true for DD patients in a rural setting and further true for youth, adolescents and young adults. The establishment of the Homeless Youth DD Initiative (HYDDI) program where a clinician was co-located in the housing sector to work with young people that had both AOD and mental health issues, and were homeless or couch surfing. Further, to capacity build housing workers to screen for AOD and mental health issues, and refer onto relevant treatment services for an assessment. This program has had good traction within the homelessness sector. Therefore, there is a requirement that HYDDI receive ongoing funding from DHHS as it is currently funded by the commonwealth National Partnership Agreement on Homelessness (NPAH). In the past funding has occurred either one or two yearly since 2010, this has affected ongoing recruitment into the position and the progress of the HYDDI program due to uncertainty over ongoing commonwealth funding.

NDIS Impact and implications for future state of MH service delivery in Victoria There have been significant challenges to providing MHCSS to people with mental health since the introduction of the NDIS. People with mental health and substance use issues have been significantly disadvantaged as the NDIS has little or no capacity to recognise and respond to the impact of substance use on people's mental health conditions. In many instances, the mere mention that substance use is a feature of a person's presentation has meant that supports or packages are not made available. We would like to draw your attention to a recent article titled Personalisation schemes in social care: are they growing social and health inequalities? BY: Eleanor Malbon, Gemma Carey* and Ariella Meltzer. We believe the introduction of the NDIS has been responsible for growing social and health inequalities' for people with mental health and even more so for people with Dual Diagnosis. Recommendation: It is our hope that the MHRC will place a significant focus on the iniquities and inequalities been created around the introduction of the NDIS for a population that do not fit into the framework provided by this scheme. A review of Victoria's engagement with the scheme for people with mental health issues should be undertaken with some urgency. Consideration should be given to either withdrawing this population from the scheme or articulating and putting in place the enablers that can assist people not only to access it, but also get appropriate service through it. We would ask that the commission have this as a priority area of focus in their deliberations and recommendations.

Mental Health Peak Body: In drug and alcohol and other sectors there has been a history of peak bodies been established to help direct and advocate for that sectors development. In Victoria no such peak body exists for the MH service system and as a result we have a number of specialty areas informing the direction of the sector - often discipline specific peaks such as the College of Psychiatry; the MH Nursing division etc. We think it is time to establish a Peak Body for the Victorian MH sector. This will assist with the Governance of the MH service system. This body will set the standards for service delivery; coordinate the workforce standards; provide research and evidence for models of care, treatment - what works; benchmark the Victorian MH service against national and international services. Unlike other peaks this could have a consumer and carer membership from the outset that would ensure the approaches taken are clearly informed by the service users experience.

Central Database for AOD & MH presentations: In Victoria as in other parts of the world there is a distinct absence of good quality data around comorbid AOD & mental health presentations. One suggestion would be to have one central database which both the AOD & MH sectors feed their data into. Data collection Sound data is a requirement for policy and service development, ongoing service monitoring and evaluation. It is clear that dual diagnosis is significantly under-reported by services, impeding effective planning and the development of sustainable approaches

tailored to need. The development of a common minimum data set for use by both mental health and drug treatment services would enable information to be shared, service performance to be better understood, and information about client outcomes more reliably collected. Research has demonstrated that the process of implementing collaborative approaches to information gathering through IT can contribute to changes in service and enhance collaboration. Developing such an approach requires commitment between programs centrally and locally. (Dual diagnosis - Key directions and priorities for service development). Dual diagnosis and other complex concerns: While to date there has been a justified focus (by virtue of prevalence and harms) on co-occurring mental health and substance use concerns there is now also wide spread, growing recognition, across-health that people experiencing mental health or substance use issues also commonly - experience a range of other health and social needs. Combinations of mental health, substance use, physical health, ABI, trauma, housing, forensic, legal issues, parenting issues, educational issues, social isolation, vocational issues and cognitive/learning issues. Currently one of the foremost challenges for healthcare systems is to evolve to meet the needs of people with complex needs. 8. 5% of Australian's experience multiple disadvantages with attendant huge social and human costs and economic costs to government (a 2011 study on homeless people with complex needs found life-course institutional costs for 11 individuals, aged between 23 and 55 at the time, ranged from around \$900,000 to \$5.5 million each). Therefore, we believe a focus on complex care should inform the frameworks and decisions around shaping any changes to the MH service system. Statewide Assessment and Planning tools for MH: We support the introduction of a comprehensive statewide assessment and treatment planning tool and suite of interventions based on that comprehensive assessment. All service providers should use the same tool and processes to inform complex care, in particular but not exclusively where substance use and mental health are a key component of the complex presentation. NSW have a statewide tool for some time and we could look at this and other examples nationally and internationally to find the best option for Victoria. References/Attachments: CCISC Model: A Comprehensive, Continuous, Integrated System of Care Model By: Ken Minkoff Commonwealth's Productivity Commission Inquiry into Mental Health Council to Homeless Persons Messaging Guide to the Royal Commission into Mental Health; Housing, Homelessness and Mental Health Dual diagnosis: Key directions and priorities for service development, Victorian Government Department of Human Services, 2007 [attached] Nexus Website Dual Diagnosis Evidence Based Tools and Resources <https://www.svhm.org.au/our-services/departments-and-services/n/nexus/resources> Research Article (BMC Public health); Personalisation schemes in social care: are they growing social and health inequalities? By: Eleanor Malbon, Gemma Carey* and Ariella Meltzer VAGO Victorian Auditor-General's Office - Child and Youth Mental Health - June 2019 VAGO Victorian Auditor-Generals Office - Access to Mental Health Services (March 2019) Victoria's Mental Health Services Annual Report 201718 VMIAC - Royal Commission into Mental Health The strategy for the consumer mental health workforce in Victoria The strategy for the family carer mental health workforce in Victoria strategy for the alcohol and other drug (AOD) peer workforce in Victoria Victorian strategic directions for co-occurring mental health and substance use conditions - Information Bulletin October 2013 "