

Submission to Victoria's Royal Commission Into Mental Health – by Sandra Goode (individual)

INTRODUCTION

My name is Sandra Goode. I have worked in the community mental health sector for 10 years, primarily in the Personal Helpers & Mentors (PHaMs) and Mental Health Respite: Carer Support (MHR:CS) Commonwealth programs. I identify as a mental health support worker, a mental health carer, and a person with lived experience. Like so many others who have experience of this system, whether as a worker or a program participant or a support person, I am heartbroken at what our mental health system has become. Throughout numerous changes in the sector over the last decade I have somehow retained my passion for working in the sector and this Royal Commission offers a glimmer of light that I shall be able to do continue to do so; that we are (finally) working toward real change rather than the bandaid solutions that are currently in place and failing dismally.

My submission is written in two parts. In Part 1 my submission begins by firstly taking a look back. A look back at what came out of the consultations for the Victorian 10-Year Mental Health Plan in 2015 which I and some of our PHaMs participants and some carers participated in. I am going to reflect on and discuss the five objectives outlined in that plan (p35), and on the fourth goal focus area around the service system (p3). Many of these areas will overlap as they are inter-related. I will also briefly discuss the impact of the NDIS, then in Part 2 list my responses to the questions posed by the Commission.

PART ONE – COMMENTS ON THE VICTORIAN MENTAL HEALTH PLAN

DISCUSSION

OBJECTIVE 1: WORKFORCE AVAILABILITY & SKILL – People with mental health issues receive the care they need and want from a skilled, appropriate and available workforce.

- Funding arrangements: It is counterproductive to fund services under short-term funding contracts whilst simultaneously expecting to retain a workforce which has been under threat since recommissioning in 2014. I was fortunate to move from a PHaMs position to a MHR:CS position in 2017 but most of my colleagues have had to either test out roles within the NDIS, or leave the sector. The majority of the community mental health workforce, particularly those doing outreach, is already lost and will now take time to rebuild, especially given there is little financial incentive to do so.
- Change fatigue: the degree of constant change since recommissioning in 2014 has resulted in clients, carers and workers feeling confused, fatigued, frustrated and lost. Those of us still working in the system find it difficult to navigate and can only imagine the additional challenges people must be facing whilst trying to find help. In Victoria, when the recommissioning outcomes were decided, our service originally had just 6 weeks to transfer our state-funded PDRSS clients across to one of the two new providers. Although we were given an additional 4 weeks for the transition, this is not an adequate period for clients who have taken months, or

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even years, to develop relationships with services. The recommissioning resulted in extensive waitlists where prior to this these were minimal. As the roll out of the NDIS became imminent, many of our former PDRSS clients were exited from MHCSS programs so once again left without community supports. Currently, the local agency which was delivering the PHaMs program and providing Support Coordination has again had to advise clients they are ceasing service and need to transfer elsewhere, with only about 5-6 weeks notice. The system as it is is actually creating mental illness, at times for clients and for staff. Closure of the Commonwealth DSS programs, together with the loss of Victoria's MHCSS, has left people with nowhere to go.

- Funding 'bandaids': while it is good to have funding shortfalls acknowledged, the bandaid solutions being introduced are confusing and not being well communicated. For example, different funding streams being delivered by PHN's with different eligibility and different types of support. Why are programs that were working well (PHaMs, PIR) being dismantled and funding given to PHNs which in turn are not expected to be long-term? Again, significant system change being done in a very short timeframe creating additional and unnecessary disruption for people accessing these services.
- Difference between the 'metro' system and the 'country' system: I live in Central Victoria and believe it is extremely important to acknowledge that the issues and concerns I cover in this submission will be multiplied the further you are located away from a metropolitan area, to the point there almost needs to be two separate funding systems where the needs diverge, such as some type of loading for regional and rural workforces.
- Workforce training: Over the years it has become apparent to me that, while it is expected workers will acquire certain skills, organisations are not funded for staff to actually attend professional development. For example, trauma-informed practice is a desired skill but the only reason I have any training is because I have been fortunate to attend free training. If sector standards demand workers to be practicing a certain approach then this must be funded accordingly. I have concerns that other training that should be mandatory is not; things such as the ASIST suicide prevention program. I also have concerns that, since the advent of the NDIS and pricing caps, organisations are unable to afford truly skilled workers, or workers are being underpaid for the skill level they have acquired.
- General Practitioners as 'gateways': GPs are seen as the referral point for everything but cannot possibly have extensive knowledge of every other part of the health or mental health system and may, therefore, not have the time or skills to make thorough and appropriate referrals. My experience has certainly shown they tend to be the least knowledgeable about the NDIS. There are often challenges around GPs being accessible, particularly in rural areas. I have no doubt that the removal of the Mental Health Nurse Incentive Program (MHNIP) from clinics has had a negative impact for people. Can there be a different, more straightforward, pathway into services instead of GP referrals?
- Psychiatrists: finding a psychiatrist who can provide ongoing care is a further challenge. Those in the public system don't have the capacity and patients are discharged well before they are well enough. People living with a mental illness generally don't have the means to access a private

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psychiatrist due to lack of money, lack of choice, or need to travel excessively to find one that is suitable to their individual needs. Similarly to GPs, psychiatrists seem to know very little about the rest of the system that can support their patients, and the system still seems to place them in the position of highest power and influence, rather than the patient.

OBJECTIVE 2: WORKFORCE SAFETY & SATISFACTION – The workforce operates within safe and supportive environments and cultures.

- Support for staff: A safe and supportive workplace values team building, training, professional development, and supervision. These must be built into the scope of any future workforce design. Also building in designated roles where staff can speak with a representative who is trained to provide debriefing, an independent opinion, guidance, or support to lodge workplace grievance. Could we introduce mental wellbeing days, over and above sick leave, where a doctor's certificate is not required?
- Workloads: this is a fairly obvious issue. Quality support cannot be provided in a context of unrealistic worker/client ratios. Community mental health ratios used to be realistic but clinical services are overrun. It seems the more acute you become, the less staff are available. This is almost an 'anti-recovery' model.

OBJECTIVE 3: WORKFORCE INTEGRATION – workforces collaborate across service and sector boundaries to ensure vulnerable people with multiple and complex needs get the right care.

- Relationships: any effective system relies on good relationships, communication and collaboration. In my opinion, a good worker will take time to research what services are around, and make connections with them. It is also important to be able to network effectively. Having these skills can make the difference between whether a client gets a very basic service, or a genuinely holistic assessment and is linked to additional services as appropriate. It really is still a case of 'who' you know and 'what' you know.
- Community Engagement: This is another area where it is expected of workers to do this, but is not funded for. I have been involved in many different types of networks and am often disappointed by the lack of consumer and carer inclusion. When I worked in Maryborough I collaborated with the Partners in Recovery worker to establish a mental health network called GoldMinds. We intentionally made our meetings an open forum and welcomed consumers, carers, workers and community members. We had established relationships across the board so people knew we were trustworthy and reliable. The network successfully staged a 'Stamp Out Stigma' day in mental health for two years which included a 'Walk for Wellness' through the main street, with local students participating, and speakers such as former AFL players Wayne Schwass and Glenn Manton. Since myself and the PIR worker have moved on, both GoldMinds

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and the community events have ceased. It sometimes doesn't need a huge investment to make a big difference in a community.

- Funding silos: despite decades of recognition that mental illness is influenced by a number of complex factors, and everyone's experience is different, service delivery still occurs in silos.

OBJECTIVE 4: CO-DESIGN AND CO-DELIVERY WITH CONSUMERS & CARERS – the needs and preferences of people with a lived experience shapes workforce planning, development and composition.

- I am yet to see this occurring in any meaningful way in my region. Even if it does happen, and a service is designed by consumers and/or carers, we really only have one community mental health service in the area so they have the monopoly and don't necessarily have to base programs around co-design principles. I also believe this is difficult to do in an NDIS business environment; who facilitates it and who pays for it?

OBJECTIVE 5: WORKFORCE INNOVATION – innovation in mental health practice is informed by and contributes to research into better outcomes and experiences of care.

- Similar to above, until there is widespread co-design and co-production, and more generally a massive culture shift in the way organisations are structured, I can't see how this will happen.

FOCUS AREA 4: THE SERVICE SYSTEM IS ACCESSIBLE, FLEXIBLE AND RESPONSIVE TO PEOPLE OF ALL AGES, THEIR FAMILIES AND CARERS AND THE WORKFORCE IS SUPPORTED TO DELIVER THIS.

- In practice this is not happening uniformly or consistently. Perhaps it is because "consumer and carer experiences of services is yet to be defined" according to page 13.17 of the 'Mental Health Management Report on Government Services 2017'. Yet, on the same page it is stated this "is an indicator of governments' objective to provide universal access to services that are high quality, safe and responsive to consumer and carer goals". Page 13.13 of this same report explains that "high or increasing proportions of paid FTE direct care staff who are consumers or carers implies better opportunities for consumers and carers to influence the services received". However, page 13.14 shows that paid FTE *consumer* staff per 1,000 paid FTE direct care staff has basically stagnated in Victoria since 2010. This contrasts to the FTE of paid *carer* staff where Victoria has basically maintained the highest rate since 2010. These numbers are obviously also relevant to questions about the mental health peer workforce.
- I would also refer you to the submission from the Loddon Mallee Mental Health Carers Network - of which I am secretary - in respect to this topic.

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IMPACT OF THE NDIS

- Travel: The business model of the NDIS has no incentives for providers to travel which seriously impacts the services available. NDIS participants may have a well funded plan but are then unable to source the necessary supports. I would love to be able to build a practice and deliver supports to people in areas not usually serviced, but the costs and effort required to register as a provider, and remain registered, are prohibitive for a sole trader.
- Staff skills: Contact with the NDIA or an LAC is like playing bingo; it's all in the luck of the draw. You 'might' get someone who has some understanding of mental illness but this is unlikely. If you have any level of complexity, or you have a somewhat unique condition (e.g. agoraphobia) it is almost impossible to communicate the impact of this to a person you have met for the first time, and rely on them to capture the details for a planning delegate to interpret.
- Bureaucracy: perhaps the largest of my many frustrations with the NDIS is that most of the issues were known from the trials back in 2013. Numerous reports, advocacy papers from peak bodies, research and a Parliamentary Inquiry since then are yet to be realised in change to existing or potential participants. Attempts to access the scheme are making people unwell. This is ludicrous. Issues are echoed across various sectors as has been evidenced by the many Joint Standing Committee Inquiries.
- Psychosocial disability: having been involved for over 4 years in the transition of PHaMS clients and now Mental Health Carers into the NDIS, I am thoroughly convinced that mental health needs to be taken out of the NDIS. Transitions are not going smoothly for clients in DSS funded programs. A recent report highlights that 50% of clients currently in these programs have not yet applied; and, of those, 91.7% stated it was because of the stress involved. The report also showed that the further you live from a metropolitan area, the less appropriate your NDIS is likely to be. For instance, in areas classed as RA3/4, only 25% of PIR clients rated their plan as appropriate to their needs, and for PHaMs it was even lower at 12.5%. A total of 96% of people who rated their plans as not appropriate stated the reason was because the plan was not aligned with their psychosocial support needs.

(file:///F:/NDIS/NDIS%20&%20Psychosocial%20Disability/CMHA-and-University-of-Sydney-NDIS-Tracking-Transitions-Phase-2-Report-version-3.pdf)

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PART TWO – RESPONSE TO THE COMMISSION'S QUESTIONS

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

- Include community education and events in funding. People/places/services that already do this are competing for funding to deliver this, if they are funded at all.
- Make use of lived experience speakers (both consumers and carers); have a 'speakers bureau' where the community can easily access a list of trained speakers who can provide education and information. Something like this exists with the Black Dog Institute and beyondblue but needs to be a central register.
- There are lots of great initiatives happening but there is no central place to source them, find out what they do, what they cost. Like the mental health system, they seem fractured and uncoordinated. For example, great things are happening in sporting groups and in schools but unless you know the name of them it can be hard to find them.
- Programs such as Psychological First Aid, Mental Health First Aid, and the ASIST training should be more accessible, costs can be prohibitive for community members
- Education around its links to family violence, trauma, homelessness, grief, loss, bullying, racism, sexism, unemployment etc...

2. 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?

- There is very little that is currently working well. Programs that have the potential to help are grossly understaffed and overworked.
- Victoria's mental health system has slowly been dismantled, particularly since the recommissioning of community mental health in 2014. I have seen statistics for my local hospital which showed mental health presentations per 10,000 head of population to the Emergency Department increase from 57.6 in 2014/15 to 81.6 in 2017/18.
- The establishment of the peer workforce is fantastic but this needs to expand - now!
- GPs are the gateway to most services yet often have the least knowledge of the system. GP clinics need dedicated roles where people who present with suspected mental health issues can speak to someone straight away for assessment and appropriate referral.
- Make use of DNA science. I, along with some clients, have had DNA tests to determine efficacy of psychiatric drugs. It may not yet be widely accepted by the medical community, but surely if it can inform prescribing it is a worthwhile investment, rather than using clients as 'guinea pigs' and having to trial different medications. Also, it is recognised psychiatric medication has some disastrous side effects or may not help at all. For the cost of \$100-\$150 it is surely better than having someone end up in hospital. (<https://www.mydna.life/mental-health-medication/>)

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

- Although the two overlap, there does need to be some separation maintained. Not everyone who experiences a mental illness becomes suicidal, and not everyone who is suicidal necessarily has a mental illness.
- Intensive supports must be provided post any suicide attempts. Far too many people get discharged after very short hospital admissions; they have not suddenly 'recovered' from what brought them to that state. Throughout the mental health system the biggest gap is around delivering trauma therapy, for however long that is necessary, in an effort to prevent people having to cycle round the system.

4. 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.

- Take psychosocial disability out of the NDIS. It is not working and 'fixing' it is taking far too long. Mental health does not 'fit' with an NDIS model of business and service delivery.
- Have a one-door, open-door entry point. The PHaMs (Personal Helpers & Mentors) program did not require a person to have a diagnosis to be eligible.
- Utilise peer workers as the first point of contact/welcome.
- Co-locate services: imagine having a centre where you have GPs, psychiatrists, psychologists, counsellors, community and outreach workers, peer workers, mental health nurses, individual programs, group programs, allied health, complementary therapists, occupational therapists etc... all together and a care coordinator can build a team to wrap around that person.
- Many people who experience mental ill health find complementary and alternative therapies extremely helpful in staying well. Why can't these be funded as a form of prevention?
- Think outside the box as to what constitutes effective intervention. For example, 'talk' therapy is not for everyone, especially young people. However, it is extremely difficult to source therapists who can use different approaches, or who are suitable for people with more complex presentations.
- For some people the service or support they need doesn't even exist. One example is a young person who has become violent and can no longer live at home. The only alternative for him is to go into residential care. What he needs is a secure residential environment where he is contained, safe, and can receive intensive therapies over a 6 to 12 month period. Another example is a young adult who lives with intense OCD. He could also benefit from a residential program where he could receive intensive supports.
- The 10 sessions available under Medicare are completely unrealistic for most people. These sessions are the only therapeutic services that can be accessed but they are capped! It is little wonder then that people keep cycling around the system.
- Genuinely embed the principles of co-design and co-production at all levels, not just written into policies. Make these principles a standard to be accountable to.

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- Introduce roles such as Care Coordinators (not Case Managers, people are not 'cases') who can guide and support people through the system, build a support team around the individual's needs, make sure referrals are acted on, advocate when required, and ensure some degree of continuity.
- If services continue to be funded in silos they will be delivered in silos, to the detriment of the people accessing these services. Attempting to navigate even one confusing and complex system is enough when you are well, let alone multiple broken and fractured systems when you are unwell.
- Have a client record system that is used across services, or at least integrates in some way. A system that can have different permission levels, including one for clients to access their own records. This would also allow for better data and, therefore, a better system.
- Knowledge of services and supports available in a region is essential to delivering effective supports, however, networking and researching is not a funded activity. My current role allows me to still attend local mental health network meetings but numbers have steadily dropped over the last two years since the NDIS was introduced.
- Consider developing local community mental health 'champions'. People need to be supported within their own communities, but those communities need education and the 'champions' nurtured and well supported in such a role.
- We now live in a 24/7 world but services are still primarily only available from 9-5. We need to think more creatively and provide supports around the clock. Some members of the workforce might actually prefer to work an afternoon or night shift job. I am not referring to a CAT team, but a community outreach team which may be a clinician and a peer worker.
- Have a 'one-stop online shop' i.e. one website which is the primary access point for information, or at least one for each state/territory. I recently went searching online for mental health services in Victoria. The DHHS website showing youth mental health services has not been updated since 29/10/18 and still lists PDRSS services which have not existed since 2014.

(<https://services.dhhs.vic.gov.au/youth-mental-health-services>)

A similar search on the Victorian Health website showed it has not been updated since 3/8/15. How can people possibly source assistance if government pages are so unreliable?

(<http://www.health.vic.gov.au/mentalhealthservices/>)

- Even where programs do exist, they are often only available in metropolitan areas, and cannot possibly meet the demand. Services such as EPPIC (Early Psychosis Prevention & Intervention Centre) and Headspace's YEPS (Youth Early Psychosis Service). These need to be implemented across the state if they are proving effective, as a matter of urgency.

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

- Lack of services: psychiatrists, GPs, mental health nurses, community mental health outreach, assertive outreach, child and adolescent services, and community programs. I'm not sure that funding is always directed to where the greatest need is. My local government area, which is a regional city, has 18.8 registered mental health clients per 1,000 head of population, far higher than the State average of 11.9. People are struggling to find a GP who is accepting new clients, yet GPs are the main referral path to get supports. Additionally, CAMHS statistics for our region for the 2018/19 year so far show that follow up rate within 7 days of discharge has declined from 88% to 75%, and the average length of a case has steadily increased over the previous 9 months from 151.6 days to 234.6 days. Numbers like these clearly show the demand, and the pressure that clinical services are experiencing. At a broader level, on reading the 'Mental Health Management Report on Government Services 2017', I noted that in Victoria we have the *lowest level of specialised mental health services* but the *highest use of MBS subsidised services*; whereas, the Northern Territory has the highest level of specialised mental health services but the lowest use of MBS subsidised services. This indicates – to me at least – a clear correlation between the two. This report also shows that across metropolitan, regional and rural regions in the state, Victoria has one of the lowest percentages of population using mental health services, and one of the highest percentages for using MBS items. This high rate of MBS item usage is also consistent across the age groups of the under 5's up to those aged 18-25 years.

(<https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/mental-health-management>)

- Can't access any bulk-billing GPs, psychiatrists or psychologists.
- Lack of infrastructure: transport, appropriate housing and employment opportunities are huge issues in regional and rural areas.
- Stigma, loneliness, isolation (e.g. we had a fantastic volunteer program in our city, Compeer, which matched volunteers with a person with a mental illness so they could socialise. This has now closed after being run for several years through St Vincent de Paul).

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

- Even if their loved one does get supports, often carers and family members do not. For instance, a single mother whose teenage son is chronically self-harming and suicidal gets no support. She and her son present at least weekly to the Emergency Department, wait to be seen by a clinician (if one comes), and are then sent home with a promise of an appointment or a phone call. And the cycle continues with no therapeutic intervention for either of them. The mother struggles with her own mental health issues. This is everyday life for them, and

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their situation is replicated across probably thousands of Victorian families. There is no education, outreach supports, intensive supports, respite, long-term counselling, brokerage, nor time to do anything except monitor her son 24 hours a day. A few months ago her son absconded from home, was given a mix of drugs and made to have sex for payment of them. On being taken to the hospital by police when he was located, he wasn't screened for drugs or sexually transmitted diseases, let alone given any trauma counselling. NOTHING. This young man has continued to deteriorate.

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

- Longer term funding would go a long way to attracting and retaining skilled workers. Since the recommissioning in 2014 community programs have been funded in 12-month blocks, hence many left the sector due to employment instability. Short term funding also impacts the capacity for clients to have continuity of supports.
- The peer workforce could easily be grown by asking existing non-peer workers with lived experience if they would be willing to perhaps undertake some additional training or development to be able to be included in that part of the workforce.
- Supervision, team building, networking, and professional development must be valued and funded.
- Have adequate and fair worker/client ratios.
- Allow for flexibility in programs (e.g. the PHaMs program had this, support could be adjusted according to the current need of the participant).
- There is a lot of bullying in the sector, across both the peer and non-peer workforces. Worker mental health and wellbeing should be a KPI and assessed independently, and organisations made accountable.
- We need a massive rethink about the hierarchy of the system. Clients should be at the top of the tree, the workforce is – in theory – then working FOR them and WITH them. Similarly, I question the way face-to-face service delivery is viewed. For example, working in the community sector, the more experience and qualifications I get the more unlikely it is that I will be doing direct service work, especially if I want a career path. Direct service work is generally the lowest paid positions. This is, in my view, an insult. These should be viewed as the most important roles, the workforce who are relied upon to be able to build trusting relationships, become heavily involved in people's often complex lives, apply principles and theories of recovery, provide guidance across all life domains, and who often end up becoming 'life managers' as they are the only trusted person in the client's life. As with similar direct service delivery roles in other sectors, there is more and more being expected of this workforce, likely due to increased complexity and increased need to understand the interplay between family violence, housing, justice, health etc...

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8. 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?

- Provide appropriate housing support within people's communities. This might mean building supported accommodation units or complexes for people who are not unwell enough to be hospitalised, but who may require longer term support for recovery (i.e. longer than PARC's can currently provide).

- In relation to housing, AHURI recently published an excellent report:

<https://www.ahuri.edu.au/research/research-in-progress/trajectories>

- Make it easier for people to access the Disability Support Pension, or get exemptions from looking for work when unwell. Why can't the DSP be granted for a period of 12-24 months so that income stress can be eased and the person is able to focus on their recovery?
- Build capacity and services where people live; this may need to include local governments.

9. Thinking about what Victoria's 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 would like the Commission to go and read the numerous other inquiries, reports, research that has occurred over decades. I think it will become clear what is needed, it has just been the political will to actually do anything about it that has gotten in the way.
- Recognise that mental health funding can't necessarily exist as a separate service, it intersects with other co-occurring health conditions (e.g. acquired brain injury, chronic pain, alcohol and drug misuse, autism, intellectual disability).
- Embedding peer support workers at every level. People experiencing a mental illness are exceptionally vulnerable and are highly unlikely to complain or be able to advocate for themselves.
- Prioritise keeping people out of hospitals and the justice system (adults and young people). These will only exacerbate the illness. There seems to be no plan or pathway when discharged.
- Getting some stability and predictability back into the system. For example, post-suicide attempt supports are available in some hospitals but not all. People should be able to walk into any hospital and be able to access these programs.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

- I think there will need to be a massive culture change, particularly in the medical / clinical / psychiatry sector. The 'academic' knowledge needs to be balanced with the 'lived experience' knowledge and recovery more focused on working in partnership as collaborators, rather than disempowering people in their recovery and management.

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- Make sure Commonwealth, State and Local Governments are talking. Individuals who are experiencing a mental health issue don't care who is responsible for what, they just want help where and when it's needed.
- I have some concerns about the responsibility being placed on PHN's to commission services, and their communication to the public about what it happening. Despite repeated invitations we can't get a PHN representative to attend our local mental health network meetings, even though they are now the key players in our region.
- Start thinking about the workforce and training that will be required to fulfil this new system and start training accordingly. I understand this is difficult given we are still in the early stages of the inquiry but we know there has already been around 1,000 mental health workers lost since the introduction of the NDIS.

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

- There has never been a lack of ideas or innovation, programs appear and disappear due to lack of committed funding. These are often 'grassroots' consumer-led programs.
- I find it difficult to balance the concepts of 'innovation' and 'best practice'. How can something become best practice if it is not first innovative, piloted, evaluated and refined?
- My last point is to outline some myths and assumptions that may be out there:
 - Having money and means will get you appropriate treatment
 - Treatment is available when and where it's needed
 - Traditional treatment (i.e. psychiatric medication) is effective
 - GPs know who and where to refer patients to, and what the local service system looks like
 - Inpatient care at a hospital is positive for recovery
 - Services are inclusive of families, carers, children etc...
 - It is easy to find help online
 - That 'telehealth' is the answer for regional and rural communities (where is the choice)
 - A 'diagnosis' equals a 'solution'

I was fortunate to have sat at the table with Minister Foley when he visited Bendigo to consult on the Royal Commission's Terms of Reference. I asked a key question:

"Are we just going to go through this to keep band-aiding the system, or can we dream big and pull the whole thing down and start again?"

Minister Foley's response was to encourage us to dream big. I'm confident that our community can, I hope with all my heart that we have a State Government who can do the same.

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My closing comment is that a fully funded mental health system will require courage, commitment and creativity. It must fundamentally put people with lived experience at its heart, and genuinely value these Victorians and their quality of life. I implore the Commissioners and the State Government to take the time to get it right; to build a system you would be proud and confident in for your own loved ones.

Thank you for considering my submission.

Sincerely,

Sandra Goode